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Falls: Current Strategies for the Enduring Challenge

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Learning Objectives

- Describe current trends in CHI falls claims.
- Identify 3 variables contributing to falls and their associated risk mitigation strategies.
- Review 2 fall prevention technologies and consider usefulness in your environment.

Success Story – Falls Collaborative

- 12 large, multisite CCRCs participated from 2019 – 2021
  - Quarterly webinars, PIPs, monthly fall rates
- Decrease in fall rates (from 2019 through June 2021)
  - 11% decrease in overall fall rates and 20% decrease in LTC fall rates
- Decrease in claims $ paid
  - Annual average number of falls claims decreased by 8.4%
  - 2019 through 2020, saved an estimated $643K on claims per year
- Facilitated evaluation of falls programs and implementation of appropriate intervention

Current Challenges to Preventing Falls for Healthcare Providers

- What we see
  - Frequent fallers
  - Staff education and training
  - Root Cause Analysis
  - Data collection, tracking, analysis
  - Setting realistic expectations

- What we hear
  - "This is the way we've always done it"
  - "If everyone is a high falls risk then no one is"
  - "We have too many other priorities"
  - "We currently don't have the staffing levels to support our falls program"

Current Evidence-based Research

- Outdated Interventions and Processes
  - Bed and chair alarms[1]
  - Ineffective Assessments[2]
- Mobility devices increase risk for falls[3, 4, 5]
  - When using or not using a recommended device
- Technology is helping but be wary of initial results[6, 7, 8]
  - Low quality studies, controlled environments, non-older adult samples
- Focus on preventing injuries[9]
  - Bone health risks, exercise, environment
- Dementia specific research still lacking[10, 11, 12]
  - Significant increase in risk for falls and number of risk factors
  - Non-pharmacological interventions are best
- Most research focuses on community-dwelling older adults

Maintain mobility, independence, and autonomy

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Prevent falls

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Exploring Technology to Prevent Falls[13]

- First, be ready to:
  - Be cautious with the research
  - Talk to actual users about the tech
  - Determine staff needs and preferences
  - Assess your readiness for technology
  - Assess system needs for technology
  - Have questions and concerns ready during demo
    - Ask about compliance concerns
    - Ask about data security

- Then, discuss implementation with your staff:
  - Is it appropriate for patient/resident population?
  - Is it manageable and easy to use?
  - Is it efficient?
  - Is it easy to clean and disinfect?
  - Is it readily available?
  - Is it compatible with other products or systems in use?
  - Does it have appropriate security features?

Considerations for Fall Prevention Technology[14]

- Does it meet basic requirements of safety and efficacy?
- What configuration is most appropriate based on your facility's existing workflow and clinical needs?
- Do you need two-way audio and video connectivity, or is one-way communication sufficient?
- Do you want to send data from cameras to the patient's electronic medical record (EMR)?
- Do you want the system to interface with peripheral devices or systems?
- Have you made sure to consider all associated costs?

Current Fall Prevention Technology[15]

- Prescriptive analytics[16]
  - Reviews a patient's EMR and identify specific fall risk factors
  - Qventus
- Predictive analytics
  - Foresight[17]
    - Sensor systems ("sitter")
    - No sensors in bathroom
    - Predictive (based on gait and speed) and detective
  - VirtuSense (VSTOne)
    - Continuous video monitoring
    - Virtual rounding (vitals, telemetry, telehealth)

- Video review system
  - SafelyYou[18]
    - Falls detection only
    - Decrease time on ground
    - Immediate review of fall to determine cause and potential for head injury
- Bed-exit alarm system
  - VirtuSense (VSTAlert)
    - Bed and chair exits
    - Staff may have to adjust camera throughout the day

Medications and Fall Risk

- Opioids[19, 20]
  - Increased risk of falls, fall injuries, and fractures
    - Within 2 weeks of filling opioid prescription were 2.4 times more likely to have a fall
- Polypharmacy
  - Increases the odds of adverse related hospital visits by 88%[21]
    - Fall-related fractures make up 10% - 25%
  - Independent factor for both increased fall risk and hospitalization[22, 23]
  - More medications = higher their fall risk[24]
    - ≥4 medications increases fall risk by 18%
    - ≥5 medications by 21%
    - 10 or more medications increases fall risk by 50%

- Anesthesia[25, 26]
  - Not directly associated to falls
  - Peripheral nerve blocks not associated with increased risk for falls
- Surgery [27, 28]
  - Periop fall risk associated with age, frailty
  - Postop period risk for falls based on preop medical status, surgery type, hospitalization, pain meds

Preventing Medication-related Falls

- Common medication errors related to falls[29]
  - Failure to anticipate inherent risks for medications
  - Inadequate proactive clinical assessments
  - Communication gaps
    - Medication Reconciliation
  - Failure of medication-use processes
- Medication Reviews[30]
  - Prevents fall-related injuries and fractures
  - LTC – Med Directors & Pharmacists
  - Pharmacist Fall Risk Assessment

Facilitators to Improving Medication Review Processes[31]

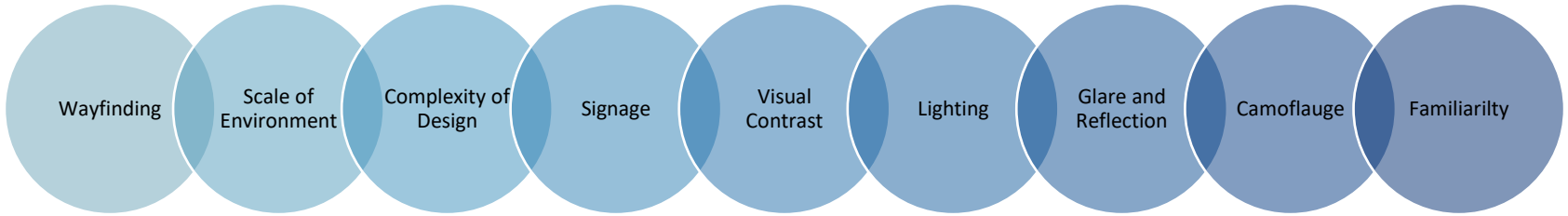
- Ability to prioritize medications through resident collaboration
- Use of screening tools/decision aids
- Unfamiliarity with the actual resident, leading to unbiased decisions
- Education through multidisciplinary team collaboration
- Full medical chart for pharmacist review

Barriers to Improving Medication Review Processes[31]

- Lack of collaboration with residents who have cognitive deficits
- Unfamiliarity with screening tools and/or decision aids
- Unfamiliarity with the actual resident, leading to dependence on clinical literature
- Multidisciplinary team lack of understanding of each other's roles
- Physicians limiting the roles of nurses and pharmacists
- Postponed new medication orders
- Lack of time for nurses to participate in medication reviews
- Difficulty educating resident on medication changes or difficulty reaching a resident representative

Dementia-related Falls

- Non-pharmacological interventions need to be first line intervention to reduce behavioral & psychological symptoms in dementia (BPSD)
  - Exercise
    - Long term exercise (≥1 year) can decrease risk of falls and decrease risk of injurious falls[32]
  - Sleep
    - Predicts mental well-being, ability to perform ADLs, fall risk, risk of hospitalization[33]
    - Lowest risk of falls 7-8 hours of sleep per day[34]
  - Therapeutic Activities
    - Reduce BPSD through activity kits, sensory stimulation, recreational activities[35]
  - Environment[36]
    - Greater declines in vision and hearing, visual-spatial orientation, and misperceptions of visual images (shadows)



Mitigating Risk of Falls and Risk of Claims

What is working

- Huddles
- Purposeful Rounding
- Staff education and training
- Falls Leader
- Internal benchmarking

What we also recommend

- Setting realistic expectations
- Patient/resident education
- Disclosure
- Culture of safety

Recommendations to Endure the Challenge

- Evaluate fall risk assessment for appropriateness
- Focus on internal benchmarks
- Take the time to assess your needs for technology and discuss with staff
- Evaluate medication review processes for effectiveness
- Strive for person-centered interventions for dementia residents
- Collaborate with other providers
- Rely on your Therapy staff for fall prevention strategies, interventions, education, etc.

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Questions