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Contents

Pages 1, 2 and 3
Understanding the VA Fall Reduction Program

Page 3:
Types of Falls and Suggestions to Reduce Them

Page 4:
Visit Falls Toolkit Today

VA National Center for Patient Safety
P.O. Box 486
Ann Arbor, MI 48106-0486

Phone: .....(734) 930-5890
Fax:.....(734) 930-5877
E-mail:..... NCPS@va.gov

Web Sites:
Internet: ..www.patientsafety.va.gov
Intranet:...vaww.ncps.med.va.gov

Robin R. Hemphill, M.D., M.P.H.
VHA Chief Safety
and Risk Awareness Officer

Director, VA National Center
for Patient Safety

Editor
Joe Murphy, M.S., APR
Public Affairs Officer

Graphic Design and Copy Editing
Deborah Royal
Visual Information Specialist

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Understanding the VA Fall Reduction Program

By Joe Murphy, NCPS public affairs officer

Falls reduction is a critical aspect of the VA patient safety program and a concern for caregivers around the nation.

As noted by the Centers for Disease Control and Prevention:

In the next 13 seconds, an older adult will be treated in a hospital emergency department for injuries related to a fall. In the next 20 minutes, an older adult will die from injuries from a fall. Falls are the leading cause of injury among adults aged 65 years and older in the United States, and can result in severe injuries such as hip fractures and head trauma … In 2013, the direct medical costs of falls among older adults, adjusted for inflation, were over $34 billion.[1]

Falls reduction resources available on the Falls Toolkit Web page compromise just over half of the 50 thousand downloads of patient safety-related material made from the NCPS website annually.

Importance of Teamwork

I recently asked Pat Quigley and Julia Neily to discuss the VA fall and injury reduction efforts. Quigley is associate director, VISN 8 Patient Safety Center of Inquiry, and leads many of the center's fall and injury reduction efforts. Neily is associate director for the NCPS field office, and has been involved in many quality improvement initiatives.

Both have authored or coauthored numerous articles on a wide range of patient safety issues, given conference presentations, and worked together to revise and update the Falls Toolkit.

Neily first addressed a popular misconception concerning nurses' ability to effectively prevent falls.

"Nurses need the benefit of a multi-disciplinary team to effectively prevent falls and fall-related injuries. Fall risk factors are too complex. VA's overall approach to falls is based upon evidence confirming that a multi-factorial assessment is required," she said.

Neily also considers an interdisciplinary team approach essential. "For instance, when physical therapists, occupational therapists, nurses, physicians, and nursing assistants work together to provide individualized fall prevention plans of care for our Veterans," she said. "Fall reduction can be achieved when providers at all levels work together and build strong relationships with one another and with patients."

"A clear example of why nurses cannot deal with it alone is that so many falls occur because of problems with gait, balance and mobility," noted Quigley. "And that's why nurses need assistance from a group of people – physical therapists, rehabilitation services staff – because of their areas of expertise."

"This brings up a really great point that I didn't mention earlier," added Neily, "which was the importance of pharmacy and physicians. The prescribing providers can examine the medications that a patient is taking to see if any would increase the risk of a fall."

Focus on Reducing Injuries

"We accepted a long time ago that you cannot prevent all falls," Quigley said. "We have people who are going to get up without us. Who are not going to call for help. So we embraced the assumption that anyone could fall anytime in our care."

"Our commitment, for almost two decades, has been that if someone were to fall in our care, we do not want them to get injured," she continued. "And that's why our 'zero' or marker of success for keeping people safe in relation to falls and falls injury is that they do not get injured if they fall. Even a mild injury – one that someone thinks might have very little impact can be really grave for people – especially older people."

She noted that a low distance, low velocity fall, even without a head strike in older people, can still result in subdural bleeds. "And when micro-tears occur around or within the brain, a patient can have a delayed onset of a subdural bleed that can lead to mild traumatic brain injury," said Quigley.

"As Pat noted, not all falls can be prevented," said Neily, "and it's really important to know the type of falls that are occurring in our care and why. It's a very important aspect of a fall and fall injury prevention program."

"We predominantly use the Morse Falls Scale in the VA," she continued, "and the types of falls were defined by Dr. Janice Morse and colleagues in 1997: accidental, anticipated physiological, and unanticipated physiological falls." [2]

Continued on page 2

Understanding the VA Fall Reduction Program

(Continued from page 1)

Neily said certain types of falls, such as an unanticipated physiological fall, cannot be prevented: For example, a patient can fall during a seizure or an unexpected cardiac event.

"These are the types of falls that we can't control; we can't prevent," Neily said. "So we don't spend our time and energy trying to prevent them."

She noted another falls type that caregivers can work to prevent: anticipated physiological falls. "These are falls that we could predict would happen," Neily said, "so we try to intervene on what we consider to be the related modifiable falls risk factors, such as orthostatic hypotension or gait and balance problems."

Accidental or environmental falls can occur because of a number of reasons, such as uneven flooring or lack of proper lighting. "With this type of fall, as with anticipated physiological falls, we can often take actions to prevent them," she continued. "So understanding this and examining reasons for falls can be really helpful when trying to decide where to put prevention efforts and have as much impact as we can have on falls prevention."

Additional Approaches

Screening vs. Assessment

Quigley considers an over-reliance on falls screening tools, as the basis for falls prevention, to be a problem in many health care systems: that screening for falls risks should prompt interdisciplinary assessment and care team management; that screening is not assessment, but the process to determine a need for assessment.

"Other hospital systems require nurses to use these screening tools every day, every shift," she said, "as if they were an assessment tool and they are not. They are a screening tool."

Quigley noted that since at least 2008, the VA has used these fall screening tools correctly as a driver for assessment. "If there is a positive response, a 'yes' to any of the variables on the screening tool, our templates expand to that assessment can begin," she said. "For example, if the patient says 'yes' to having a history of falls during the last three months, the template expands."

"The nurse will then ask the patient to describe the falls, how many, under what circumstances they occurred, symptoms before the falls, if any, and injuries that may have resulted," Quigley continued. "But then we go beyond that and ask about fall injury history. So for us, we have really implemented these tools as they were intended – as a screening tool that is a driver for an assessment."

When there is an over-reliance on the potential for a fall, using a score developed from such tools, the score often drives practice. "And we don't want to do that. We don't want a score to drive practice or a level of fall risk," Quigley said. "What we want to focus on is identifying actual risk factors that an individual has and seeing what we can do to mitigate or eliminate that risk factor."

"For us, it's about individualizing plans of care and getting to risk factors and being able to help someone be *better*," she continued, "because we are better able to identify and treat those risk factors."

Opportunities for Change

In line with reducing over-reliance on screening tools, Quigley believes nurses should be encouraged to focus on clinical assessment, not just screening for fall risk. "We should promote nurses focusing on completing a clinical assessment," she said. "And if this is done, then the nurses can actually identify interventions that are specific to a risk factor – such as impaired vision, dropping blood pressure, a patient's trouble being able to feel his or her feet."

Neily believes another focus of change should be implementation of a population-based approach to care. "And one of the tools we really have recommended to people is the 'ABCS' tool," she said.

- A for noting a patient's age, as those 85 or greater or frail elders in general have a greater risk for falls
- B for the condition of a patient's bone structure
- C for anticoagulation, as related medications might contribute to a the risk of a fall
- S for post-surgical patients

"Many times we've seen a patient who was admitted and was not at risk for falls or falls-related injury," Neily said, "but then after a surgery, the patient is at a greater risk for falls or falls-related injury."

"The other reason why I really like using this approach in the VA," she continued, "and why we recommend it, is because so many times staff will share, 'Well, I don't know what else to do to prevent falls. I feel at a loss. I feel like I have done everything I can do.' And that's when we like to point them to population-based actions that can be implemented."

Educating Patients

Neily believes redesigning VA's patient education efforts, so that patients consider themselves full partners in their care, could also help prevent falls and falls-related injuries.

"Why is this so important? Well, we really have a strong population that is fiercely independent, which is great, and we really promote patient autonomy," she said. "So when we teach patients to say, 'Please ask me for help,' before you get up, or go to the bathroom or ask for something, we also need to ask them if that is something they are willing to do. They need to agree to that. And if we don't check back with them to see if they agree with this plan of care, then we are missing a very important piece of our approach."

Celebrate Success

Quigley said that she likes to help caregivers find ways to celebrate patient safety successes, and not just focus on adverse events that have occurred.

"When you do the work in patient safety and focus on fall or injury reduction, it's so easy to just focus on an adverse event," she said. "Focusing on the fall that occurred; whether you could have prevented it or not – and not celebrating all those we kept safe in our care."

"Many of our Veterans don't fall," Quigley continued. "Falls are relatively rare. So there are opportunities to be able to celebrate success – as we keep safe from falls those patients who are really difficult to manage; patients who are confused; patients who are very, very vulnerable that we do keep safe because they are in our care. We should all find

ways to celebrate success, it's not just about the adverse events – but still focus on reducing risk. You've got to get to those risk factors."

Beyond Blame

Neily points out that when a patient falls, providers involved often feel a sense of shame because of it.

"As much as we promote a blame-free culture for patient safety, sometimes people have shared that there's still some guilt when a patient falls," she said. "And we don't want that, we want people to feel that they can talk freely about events that occurred."

"We recommend doing a post-fall huddle or an after action review and really look at what happened, why it happened," Neily continued, "and what can we do to prevent it from happening again – without people feeling badly about that. After all, we promote mobility and independence and that may lead to a fall. But again, we want to do our best to prevent injury, as we can't prevent all falls."

Leadership

VA has been introducing integrated reduction strategies since 2004, when the Falls Toolkit was launched.

"We were the first to actually integrate floor mats for reducing injury; hip protectors for people at risk for hip injuries," Quigley said. "No one else had done that in health care in the United States. The VA has really been the leader in reducing injuries related to falls."

"And everybody should feel very good about the leadership that the VA has taken to reduce injuries from falls over the years, at every level of the organization," she concluded, "because that's what has helped set us apart and that's what brings people looking to us for help."

References

1. CDC: Cost of Fall Injuries in Older Persons in the United States. Retrieved June 23, 2015 from *http://www.cdc.gov/HomeandRecreationalSafety/falls/data/cost-estimates.html*
2. Morse, J. (1997). *Preventing patient falls*. Sage Publications: Thousand Oaks, Calf.

Types of Falls and Suggestions to Reduce Them

by Pat Quigley, associate director, VISN 8 Patient Safety Center of Inquiry

The types of falls noted below are based on work by Dr. Janet Morse and her colleagues.[1]

Accidental falls are falls that happen because of an unsafe environment where patients fall because they trip over something or are holding onto furniture that is not secure for support. Interventions that create a safe environment or reduce environmental hazards decrease accidental falls.

Suggestions to reduce this type of fall are specific to creating and ensuring a safe environment:

1. Reduction of slip and trip hazards
2. Proper lighting
3. Safe exit transfer sides from bed or chair
4. Elevated toilet seat
5. Grab bars on either side of the toilet seat
6. Height adjusted beds, individualized to the patient's height

Anticipated physiological falls are those falls that are a result of known physical and physiologic problems, referred to as extrinsic or intrinsic factors. These known risk factors are identified through multifactorial fall risk assessment. Multidisciplinary interventions to treat and modify these actual risk factors will reduce this type of fall.

Suggestions to reduce this type of fall are specific to identifying and reducing fall risk include collaboration with interdisciplinary team members:

1. Complete multifactorial fall risk screening and assessment to determine risks
2. Link interventions for treatment to specific fall risk factors
3. Determine medications that increase fall risk and modify if possible
4. Examine mobility and transfer skills and deficits and individualize plans to help patients modify or compensate
5. Evaluate presence of postural hypotension and educate patients to compensate if present
6. Educate patients and family members about fall risk factors and treatment plan of care
7. Scheduled toileting program for patients who are on bladder retraining programs or require toileting assistance
8. Utilize teach-back strategies to verify patients learned and are able to perform skills to prevent falls and injury

Unanticipated physiological falls occur because of sudden, unidentified or unexpected medical conditions or conditions, such as heart attack, stroke or seizures that could not be anticipated. Medical management is required to mitigate or eliminate these medical events; however, nurses' assessment of changes in conditions and early warning signs can and does reduce harm impact and impact health care outcomes.

Nurses' vigilance to injury risk is also essential to protect patients from injury should a fall occur.

The four-prong approach to protect from injury or reduce severity include:

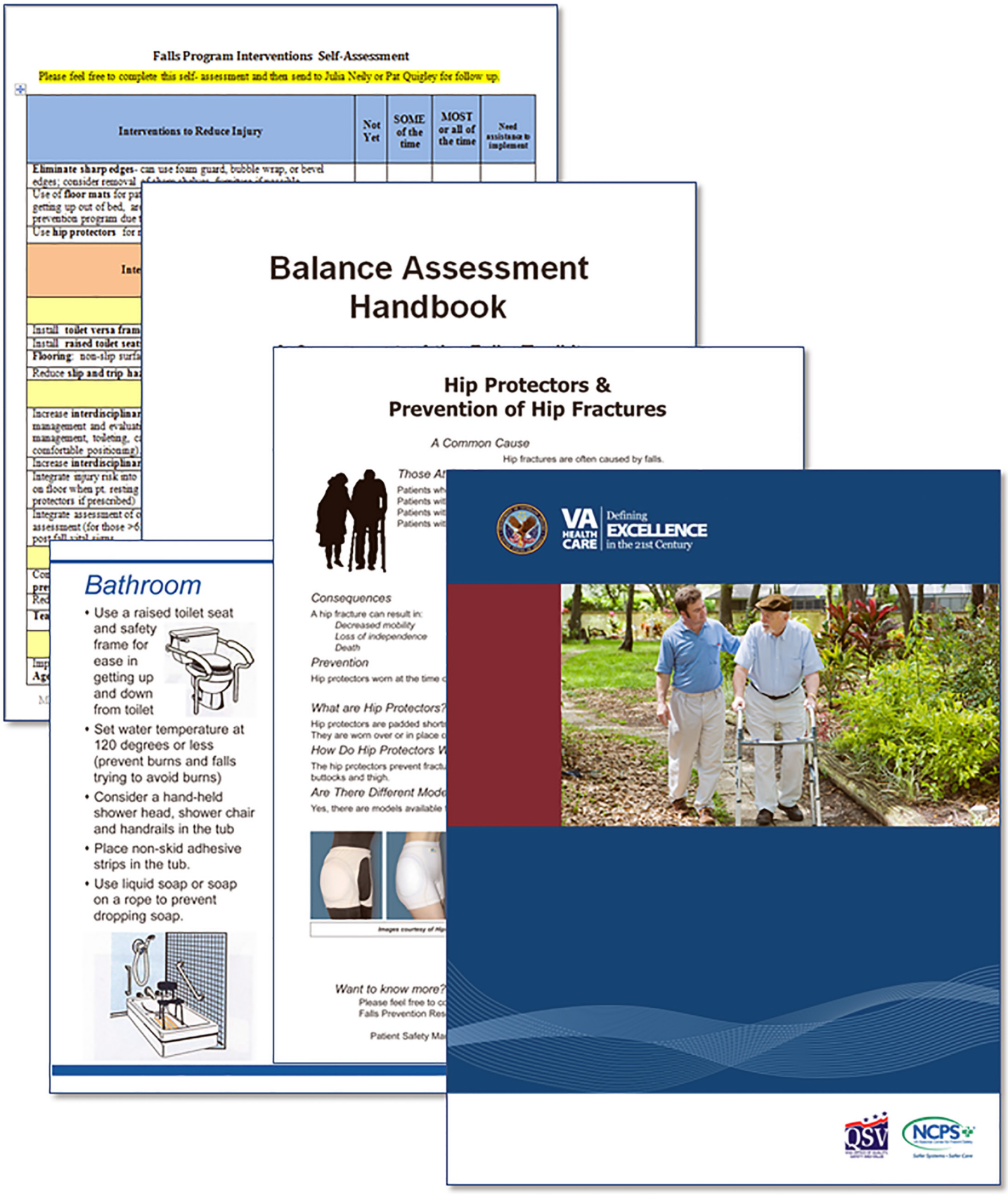
1. Environmental assessment of fall injury risk factors with recommendations to modify the environment
2. Fall risk assessment on admission for fracture and/or bleeding risk
3. Population-based approach to fall injury risk ("ABCS")[2]
4. Use of injury reduction equipment (hip protectors, floor mats, helmets) to reduce injury risk

Still, within the inpatient settings, nurses must be able to act when a patient fall occurs, to quickly evaluate the event with the patient, using the post-fall huddle process. Implementing post-fall huddles and post-fall management show promise for reducing repeat falls in individuals.

Once a fall occurs in our care, the immediate root cause of the fall must be investigated to prevent future occurrences. Post-fall huddles are used in inpatient care settings to determine the cause of a fall and to intervene appropriately.

The definition of huddle varies from study to study; but, a huddle is an immediate evaluation of each fall, by a team, preferably interdisciplinary, with the patient in the environment where the patient fell. It is NOT a comprehensive post-fall assessment and should not be recorded in a medical record or an incident report. Fall analysis and differential diagnosis is missing from current taxonomy used in hospitals, despite evidence that various types of falls exist.

Falls reducing resources are available at the NCPS Falls Toolkit Web page. Please visit the site and do let us know what resources were helpful to you.

1. Morse, J. (1997*) Preventing patient falls*. Sage Publications: Thousand Oaks, Calf.
2. See the previous article for a full explanation of the acronym

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