1. Introduction

2. Claims, Costs, Considerations

3. Assessments and Interventions

4. People, Technology and Strategies

5. Quality Assessment Performance Improvement
Disclaimer

The materials, comments and other information contained in this presentation are intended to provide general information but not advice about certain regulations and initiatives.

This information is not and not intended as legal or other advice and each situation may vary depending on the particular facts and circumstances.

You should not act upon this information without first consulting with qualified legal counsel.

Thank You.

Bloom’s Taxonomy of Action Verbs

Participants will be better able to:

1. **NAME** (Knowledge) … To remember previously learned information
2. **EXPLAIN** (Comprehension) … To demonstrate an understanding of facts
3. **CHANGE** (Application) … To apply knowledge to actual situations

Sustaining Quality:
The Dollars and SENSE of Reducing Falls Risk in LTC

Falls Session Agenda

1. Introduction
2. **Claims, Costs, Considerations**
3. Assessments and Interventions
4. People, Technology and Strategies
5. Quality Assessment Performance Improvement
1. **How BIG is the “falls” problem?**

- **2012 = $30 B**
- **65+ = 1 in 3 fall**
- **20-30% < morbidity and mortality**
- **65+ = Hospitalized 5x for falls than other causes**

*Actual direct costs but not long term disabilities, lost wages, quality of life &*$

2. **A couple of related details to this COST**

- **Increases rapidly with age**
- **Costs for women* = 2–3x’s higher** than the costs for men

* 58% of older adults
** based on 2000 medical costs

3. **TYPE of fall-related injuries**

   (in 2012 dollars)

- **Av. hospitalization = $34,294**
- **44% of direct medical costs = hip fractures**
- **Hip fractures = most serious and costly fracture**
- **Fractures (~67%) = most common [(33%) & costly (61%)]**
- **78% of deaths & 79% of costs = TBI* and lower extremities (hips??)**

*Traumatic brain injuries
5. What do other say?

1. Most claims are settled
2. Large Corporation’s Experience:
   a. $137K av. spent to “settle” falls claims
   b. 41 claims settled 9/30/2011 to 8/31/2014
3. Residents that fall = 18% / month (National LTC av. = 20%)

6 a. What are they worth?

1. (03/23/02) $1.99 million verdict … struck her head … died 6 days after admission. Assessed as “high risk for falls” …
   failure to supervise … transported to hospital 10 hrs. after fall
2. (date unpublished) $200,000 settlement … 80-yr-old NH resident … died < 1 month after she fell …frx. femur … alarm
   NOT turned on
3. (date unpublished) $862,500 settlement … subdural hematoma … 76-year-old AL resident … fell … struck her head
4. (date unpublished) $195,475 arbitration verdict: 9 diagnoses
   (Osteoporosis, syncope, hypertension, depression, peripheral neuropathy, hypothyroidism, history of
   hip frx, chronic hip/leg pain, osteoarthritis of knee and hip). Death Certificate:
   complications of R femur frx due to a fall

6 b. SO, what is a claim worth?

NO average settlement
NO simple “approximate number”

What actually determines how much, if any, you’re going to pay?

1. Facts
2. Medical expenses
3. How many next of kin
4. Available insurance coverage
5. Time between accident and death
**Plaintiff**: accuser, complainant, litigant, applicant, pretender

**Defendant**: perpetrator, offender, respondent, suspect, culprit

Designed to:

a. Resolving the dispute without going to jury trial

b. Encourage extensive discovery and negotiations between adversarial parties

---

**The Plaintiff (the person bringing the lawsuit against you) Must Prove:**

1. **Professional DUTY** owed to the resident
   - Dignity, Safety, Standards of Care

2. **BREACH** of that professional duty
   - Elopement, Fall, Infection, Weight Loss

3. **INJURY** caused by the breach
   - Malnutrition, Bedsore, Fracture, Death

4. Resulting **DAMGES**
   a. Noneconomic loss (pain, suffering)
   b. Economic Loss (lost wages, related health care costs)

---

**Your Duties as taught by Title 42 CFR, Sec. 483**

1. **Promote care** … environment of dignity/respect … full recognition individuality;

2. **Provide care/services** … to attain or maintain the highest practicable physical, mental, and psychosocial well-being, IAW comprehensive assessment and plan of care;

3. **Unless Clinically Unavoidable**: ADLs are not diminish, pressure sores do not develop AND a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores;

4. **Adequate supervision and assistance** devices to prevent accidents;

5. **Provide a nourishing, palatable, well-balanced diet** that meets the daily nutritional and special dietary needs & maintenance of nutritional status (e.g. body weight, protein stores, unless clinically not possible);

6. **Sufficient fluid intake** to maintain proper hydration and health;

7. **Drug regimen**: (free from excessive does/duration; adequate monitoring)
Your Duties As Taught by a Plaintiff Attorney

Signs of Nursing Home Abuse and Neglect:
1. Bedsores
2. Malnutrition
3. Dehydration
4. Broken Bones
5. Unexplained Injuries
6. Unexpected Deaths

http://www.wilkesmchugh.com/nursing-home-abuse.html

6. Claim topics we won't discuss

1. Tort Reform?
2. Toughest states?
3. Labor hours involved in costs?
4. Hard or Soft Med Mal insurance market?
5. Will a Dem or Rep White House or Congress make a difference?

What is a “NON-ECONOMIC damage" that many Residents experience with or without a lawsuit?
“Fear of Falling”

**WHAT:**
A lasting concern … can lead to an individual avoiding activities that he/she remains capable of performing

**WHO:**
- 46% of NH residents
- More women than men
- Underreported by men?

**WHEN:**
- Post-fall
- Age = 80+
- Visual impairment
- Sedentary lifestyle
- Lack of emotional support

---

All at once or a “Cycle of Fear”?

FALL(s)

Fear of falling → Restricts activity

Physical capabilities reduced

Restricts more activities

:. more impaired physical capabilities

Is the “Cycle of Fear” reversible?

---

Falls and the Dignity of Risk

Was it worth it?

What Changed?
How did Ruth succeed? On her own?

1] She and her healthcare Team had a clear purpose
2] They were committed to that purpose
3] They consistently followed through
4] They had the resources (time, training, tools)

---

**FUNDAMENTALS of “Risk”**

What we’re use to:

1. Risk
2. Risk Assessment
3. Risk Management

Some newer ideas:

1. Risk Benefit
2. Risk Enablement
3. Risk Enablement Plans

---

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---
What is the one thing, if you could change it, that would have the greatest impact on reducing falls in your communities?

ASSESSING: Your Perceptions

SIDEBAR: Assess My Mom

“Elinor Miller, 83 years old, talked herself out of a speeding ticket by telling the young officer that she had to get there before she forgot where she was going.”

ASSESSING: Your Residents
Multi-factorial Assessment Process

http://www.axeny.com/resources/Checklists/Piper%20Cherokee%20180.pdf

Multi-factorial Assessments
Multi-factorial Fall Assessment

1. Focused History
2. Physical Examination
3. Timed Up-and-Go Test
4. Orthostatic Hypotension
5. Where do you find Clinical Practice Guidelines?

Clinical Practice Guidelines

- American Medical Directors Association (AMDA)
  - Clinical Practice Guidelines: Falls & Fall Risk (Revised 2011)

- American Geriatrics Society (AGS)
  - Clinical Practice Guidelines: Prevention of Falls in Older Persons (Rev. 2010)

- Agency for Healthcare Research & Quality (AHRQ)

1. An important predictor of future falls
2. Ask the RESIDENT about the fall

1. Did you have a recent change in medications?
2. What do you think caused you to fall?
3. What were you doing before the fall?
4. How were you feeling before the fall?
5. Were you injured due to the fall?
6. Did you seek treatment?
Another Kind of Resident Assessment

NEW:
1. Pain
2. Cough
3. Color change
4. Posture change
5. Change in routines
6. Off patterns or habits
7. Less visible in the community
8. Hospitalization / physician visit: check for changes in meds

WHO?  WHY?

Earlier Identification

Earlier Response

"Itchy Vigilance"

Assessing the Environment:

Internal

1. Lighting:
2. Walking:
3. Equipment:
4. Furnishings:
5. Monitoring Systems:
6. Risks in specific spaces:

Assessing the Environment:

External

1. Shade
2. Patios
3. Security
4. Vehicles
5. Sidewalks
6. Parking lot
7. Way finding
8. Grassy areas
9. Weather-related
10. Seating and benches
### Considerations with Strength & Balance Concerns

#### Flooring
- Entry mats
- Wax buildup
- Transition points
- Carpet pile height
- Raised thresholds
- Patterns (tile / laminate)
- Slippery / uneven surfaces

#### Furniture
- Beds height
- Chairs:
  - W/ arm rests
  - Firmer seats
  - Supportive back
  - Not too deep / too low
  - Avoid castors on chairs (and tables)

### What Else?

#### Industry Trends
1. **Sleep and Activity Monitoring**
   - Resident trends, identifying changes in condition earlier
2. **Upgrading nurse call and resident monitoring systems**
   - Provide more data on resident location, movement & patterns
3. **Upgrading gyms, adding fitness & wellness programs**
   - Promote physical activity & exercise to improve strength & balance

### What do you see?
1. GIVEN: Patient safety is an ORGANIZATIONAL PRIORITY
2. Two fundamental, consistent Falls Prevention messages:
   a. EVERY patient is at risk for falls
   b. EVERY employee has a role
3. Easy-to-understand data that drives unit level change
4. Ongoing assessment of plan effectiveness
5. Proper support equipment and resources
6. Simplified and standardized approach
7. Designated resources for managers
8. Staff education and training

RESEARCH: Resident Assessments and Interventions

Anticipated Physiologic Fall

Unanticipated Physiologic Fall

Accidental Fall

Anticipating the Fall


VA Decision Tree for Determining Preventability

#1: Could the care giver have anticipated this event with the information available at the time?

YES = Clearly or likely Preventable

NO = Clearly or likely Unpreventable

#2: Are the "precautions" in place?

YES = (2nd question)

NO = Not preventable
RCCC Health and Rehabilitation: Dining Affects Falls

**ISSUE:** Increasing number of resident falls

**METRICS:**
1. Significant number of falls at meal times

INTERVENTION 1

RCCC Health and Rehabilitation: Dining Affects Falls

**ISSUE:** Increasing number of resident falls

**METRICS:**
1. Significant number of falls at meal times
2. Low participation in congregate dining

INTERVENTION 1
RCCC Health and Rehabilitation: Dining Affects Falls

FINDINGS and ANALYSIS:

1. Meal time
   a. In-room and social dinner served simultaneously
   b. Assisted dining served second

2. Staff location at time of falls
   a. Staff was charting
   b. Call lights not answered
   c. Staff not available to assist

3. Negative staff and resident perceptions
   a. RESIDENTS: Meal served sooner in resident rooms
   b. STAFF:
      i. “Other things” to do at meal time
      ii. “Meal-to-resident” vs. “resident-to-meal”

INTERVENTION 1

RCCC Health and Rehabilitation: Dining Affects Falls

GOALS:

1. INCREASE Residents dining participation
   AND

2. REDUCE:
   a. Falls
   b. Weight loss
   c. Food Complaints
   d. Behaviors / Increase socialization
   e. Pressure ulcers / Increase movement

INTERVENTIONS:

1. Mandated change for chart times
2. Re-education of staff & resident perceptions

INTERVENTION 1

RCCC Health and Rehabilitation: Dining Affects Falls

INTERVENTION 1
Case Study: Mr. B*

INCIDENT: 84-year-old NH resident. Recently tripped and fell on a step … did not see the step, “my vision seems to be growing fuzzier.” Referred to optometrist to confirm eyeglass prescription for distance vision. The optometrist diagnosed macular degeneration.

INTERVENTIONS:
1. Resident given instructions re/ walking
2. Staff supervises Mr B when negotiating steps
3. Staff took measures to provide a safe environment
4. Checked room lighting and added a light by his bed
5. Encouraged to call for help when lacking confidence
6. Walker positioned by the bedside at night (self-toileting)

How are you going to implement them?

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What's important to prevent falls?
Falls Prevention

- Exercise
- Daily "contracting" with residents
- Mitigation
- Review/reduce medications
- Alert systems
- Remove obstacles
- Track/Share trends
- Low beds w/o rails

**ASSUMPTION:** You can't prevent falls.

**REBUTTAL:** Falls prevention can be effective.

**EXAMPLES:** Important falls prevention elements?

![Silverado Average Percentage of Falls Resulting in Injury 1999-2007](http://www.mnhospitals.org/index/tools-app/tool.362?view=detail)

---

**“Daily Contracting” with Residents**

**SAFE from FALLS Toolkit**

1. Verbal "contracting" by each shift's care giver:
   i.e., "We don’t want you to fall, Mr. Smith. We’re a Team, right? Will you promise to call me for some help before you get up?"

2. Resident and Family Education and Involvement:
   i.e., "You know Mom just had a medication change. If you notice anything different, please let us know."

---

**Other things that Staff could remind a Resident of?**

1. Ask for help! It is OK.
2. Book … glasses … water … etc.
3. Wear your glasses / hearing aids
4. It’s OK to pause **before** you stand up.
5. Wear your shoes / slippers / non-skid socks
6. Keep your walker/cane/WC within reach and use it
7. Use the **handrails** in the bathroom and hallways
8. Make sure your **pathway** is clear
9. Tell us about any **spills**
“Daily Contracting” with Residents “Family Tips”

Sample tips:

1. Before you go home, please make sure (glasses, water, call light, over bed table, phone, Kleenex, etc.) are within reach.

2. Please notify staff / us before leaving if you notice confusion or disorientation in your Dad.

3. Please remind Mom to ask for help when she gets up.

How can People “HELP” to prevent falls?

RESIDENTS:

1. PARTICIPATE IN their Quality of Care
2. SEEK and ENGAGE IN their Quality of Life

STAFF and FAMILY:

1. IDENTIFY resident’s barriers to preventing falls
2. LEARN the changes a resident is willing to make
3. DEVELOPE an individual falls prevention program
4. VERIFY the residents’ understanding and retention
5. ENGAGE family members in falls prevention strategies
6. DEFINE “falls prevention” as staying independent longer
7. EMPOWER Residents and Families to discuss and decide

Authority v. Familiarity*
“Technology will be the key driver for Senior Living providers looking to reposition their communities in the future.”

Recent Clinical Technology Advances

- Tracking Wound Healing with Sensors
- Using Cell Phone Cameras to Measure Vital Signs
- Managing Continence in Nursing Homes

1. Sensor identifies an “event”
2. Event and observations transmitted to computer
3. Care giver notified thru technology
4. Care giver tends to resident needs & documents
1. Tripping seniors on purpose to stop future falls

By LINDSEY TANNER; Aug. 28, 2014 1:22 AM EDT;

http://bigstory.ap.org/article/tripping-seniors-purpose-stop-future-falls

Mnemonics

“Every Good Boy Does Fine”

+ “FACE”

“ROYGBIV”

“Hand-off” Mnemonics

1. Just Go NUTS
2.
3.
4.
5. SBAR
6. I-SBAR
7. SBARR
8. I PASS the BATON
9. SBAR-T
I-PASS the BATON

- Introduction:
- Patient:
- Assessment:
- Situation:
- Safety
- Background:
- Actions:
- Timing:
- Ownership:
- Next:

Just go NUTS

- Name
- Unusual or unique
- Tubes
- Safety

S-BAR Iterations *

S-BAR
- Situation
- Background
- Assessment
- Recommendation

I-SBAR
- Introduction
- Situation
- Background
- Assessment
- Recommendation

SBAR-T
- Situation
- Background
- Assessment
- Recommendation
- Thank residents
  (note: handoff done at bedside)

SBAR-D
- Situation
- Background
- Assessment
- Recommendation
- Documentation

STRATEGY
I want to talk about “RCA”. WHY?

Element 5: Systematic Analysis and Systemic Action

The facility… uses a systematic approach:
1. To fully understand the problem, its causes, and implications of a change.
2. To determine how identified problems may be caused or exacerbated by the way care and services are organized or delivered.
3. The facility will demonstrate proficiency in the use of RCA to prevent future events AND promote sustained improvement.

Element 11: Getting to the Root of the Problem

“Use the RCA process to look at the system rather than individuals when something breaks down”

What is RCA?

A process to figure out:
1. What happened
2. Why did it happen
3. How to prevent it from happening again
4. OR, to prevent it from happening the 1st time
SIDEBAR: Ishikawa / Fishbone-ing

Change to Contracted Laundry Services – Asking “WHY”

Cause Mapping – “Post-It Note Analysis”
### Step 1. Issue / Problem Outline

<table>
<thead>
<tr>
<th>What</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>When</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td>Different, unusual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Location</td>
</tr>
<tr>
<td></td>
<td>Care / Work</td>
</tr>
<tr>
<td></td>
<td>Process</td>
</tr>
</tbody>
</table>
Sidebar: Examples of Quality Improvement Goal Categories and Goals

<table>
<thead>
<tr>
<th>Goal Categories</th>
<th>Specific Goals</th>
<th>Goal Categories</th>
<th>Specific Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Mobility</td>
<td>Risk and Safety</td>
<td>Severity</td>
</tr>
<tr>
<td></td>
<td>Pressure Ucers</td>
<td></td>
<td>Patterns</td>
</tr>
<tr>
<td></td>
<td>Pain Management</td>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>Infections (C. difficile)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medications (Antipsychotics)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Choice</td>
<td>Bathing</td>
<td>Regulatory</td>
<td>osha</td>
</tr>
<tr>
<td></td>
<td>Mobility</td>
<td></td>
<td>F Tags</td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td></td>
<td>K Tags</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Life Safety Code</td>
</tr>
<tr>
<td>Organizational</td>
<td>Staff stability</td>
<td>Education</td>
<td>Orientation</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Hospitalizations</td>
<td></td>
<td>Family education</td>
</tr>
<tr>
<td></td>
<td>Person-Centered Care</td>
<td></td>
<td>Annual re-inservice</td>
</tr>
<tr>
<td></td>
<td>Consistent Assignments</td>
<td></td>
<td>Mandatory inservices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continuing Education</td>
</tr>
</tbody>
</table>

Step 3. Finding the Causes
-
RCA and Cause Mapping
("The Weed" and "Post-It Note Analysis")

Step 3a. Asking Why

Step 3b. Cause Mapping
("Post-It Note Analysis")

Step 4. Interventions / Solutions
**Step 1: Problem Outline**

<table>
<thead>
<tr>
<th>What</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall on parking lot pavement due to snow and ice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
</tr>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Care / Work Process</td>
</tr>
</tbody>
</table>

---

**Fall Scenario: Mr. Regis, 77 y.o., active, alert, visually impaired due to macular degeneration, slipped and fell on ice getting out his daughter’s car, returning to building (fx elbow and shoulder)**

**Step 3a. Asking WHY**

<table>
<thead>
<tr>
<th>People, Hiring, HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly contracted snow/ice removal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P&amp;P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parking lot snow starts removal @ 3” &amp; ongoing</td>
</tr>
<tr>
<td>Ice melt applied based on conditions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical, Medical</td>
</tr>
<tr>
<td>1.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintenance monitors conditions ongoing</td>
</tr>
<tr>
<td>2. Contract compliance in question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unseasonal storm</td>
</tr>
<tr>
<td>2. Sunday morning event</td>
</tr>
<tr>
<td>3. Saturday thaw and refreeze lead to unusual ice build up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Broken weather radio</td>
</tr>
</tbody>
</table>

---

**Step 3b. Cause Mapping**

**Step 4. Interventions / Solutions**

<table>
<thead>
<tr>
<th>Physical Plant (snow / ice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Fall</td>
</tr>
</tbody>
</table>

| Staff to inform or escort resident to car |
| Resident not aware of unsafe conditions |
| Contracts are with weather radios |
| Staff to inform or escort resident to car |
| New snow removal contractor |

---

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A Story

He smiled as he patted my hand and said, “She doesn't know me, but I still know who she is.”

I had to hold back tears as he left. I had the goose bumps on my arm, and thought, “That is the kind of love I want in my life.”

True love is neither physical, nor romantic. True love is an acceptance of all that is, has been, will be, and will not be. The happiest people don't necessarily have the best of everything; they just make the best of everything they have.

“Life isn't about trying to survive the storm but how to dance in the rain.”