2019 Update on Falls and Fall Prevention, or . . . . “What do we talk about when we talk about falls?”

Jonathan M. Evans MD MPH CMD FACP
Goals:

• Challenge conventional thinking and practice regarding fall prevention and goal setting
• Review studies of fall prevention interventions in nursing facility
• Critically evaluate care and communication with residents and families regarding falls
• Reflect on current practices in your facilities in order to promote more honest communication and reasonable care approaches for patients at high risk of falls
What do we talk about when we talk about falls?

• What are residents and family members told
  – by Admissions/marketing? By clinical staff after a fall?
• What were you told in training?
• What do we tell one another?
Background/Context

• Trust is the fundamental basis for the Doctor/Patient relationship. How do falls in care settings affect trust? (undermine our business)

• 2008 CMS proclaimed falls with injury to be never events in hospitals
• Hip protectors/ hockey pants/ alarms
Why are injurious falls the number one cause of successful lawsuits in all care settings?
What have you been taught to know, think or do about falls?

• Why do people fall?
• Are falls normal?
• Are they preventable?
• What works?
• What is our responsibility?
• What should we tell people (Family members, staff)?
Reality:

• Risk of falls (prior falls) is a big reason why people move into our facilities/communities
• They trust us to keep them or their loved ones safe
• We tell them we will.
• If a fall occurs, they may be told to pay more (ALF), which further raises expectations.
• A fall with injury is considered by the general public (jurors) to be a failure on our part.
• We do a number of things that give people the impression that falls are preventable.
• We don’t do the one thing that has been shown to be effective in reducing falls.
Reality Part 2:

- Residents are more likely to fall after moving into our facilities/communities (why?)
- Current fall intervention strategies don’t work *except* medication discontinuation!
- We seldom attempt to change what we do for someone in response to a fall, and almost never immediately.
- Patients with dementia most likely to receive meds that can cause falls.
- Patients with dementia, those with recurrent falls most likely to be injured.
- Patients with dementia, receiving psychotropic drugs most likely to sue and win if injured.
Reality Part 3:

- Our residents are all at high risk of falls
- Injurious falls are the number one cause of successful lawsuits against care providers in all care settings
- Stopping or reducing medications is the only thing we can do that will reliably reduce falls
- Most of our clinical staff are not qualified to make that happen
- Systematic (corporate driven?) processes are therefore necessary if we intend to reduce falls and fall injuries, injury related lawsuits
- We systematically reinforce the mistaken belief among our patients/families that they will not fall or be injured in our community
- Injurious falls in patients with dementia, those who fall repeatedly and/or those who take medications that contribute to falls most likely result in successful lawsuits
Expectations

- Nursing Literature: ”A fall is an unmet need”
- Implies that falls are largely preventable with good care. Therefore:
- Falls symbolize a lack of care/caring to many
- That makes people scared and angry when falls occur
- J. Evans: “A fall is a mismatch between what is expected and what happens”
- (. . . . What does the care plan say?)
- There is a fundamental mismatch between care delivery in all U.S. health care settings and what is theoretically necessary to reduce falls, prevent many other ‘avoidable’ problems in patients with cognitive, functional impairments (which is why many current fall interventions don’t work)
Fall Prevention: Medical Evidence

- Many known risk factors for falls
- Many studies of fall prevention strategies (methodological limitations (related to blinding/bias)
- Most studies showed no benefit regardless of fall intervention. Some showed harm due to intervention (alarms, patient education)
- Many medications associated with falls. Stopping meds likely the only intervention that will work in our setting/population
- Evidence for fall prevention ok in healthy older people (mobility exercises: Tai Chi, Yoga- not strengthening)
- Evidence Terrible among older people in care settings (why?)
- Best result reported: 21% reduction in recurrent fallers (but no reduction in falls overall or the number of people who fell) with multiple individualized strategies
Dementia and Falls

• Community dwelling individuals with dementia twice as likely to fall
• Five times more likely to enter LTC as a result
• More likely to be injured and/or die from fall
• Why?
Fall Concepts

- A fall is unintended movement toward the ground
- Mechanisms:
  - Loss of balance (may be environmental hazard, sensory impairment, lack of awareness)
  - Mechanical (orthopedic/neuromuscular) failure
  - Acute brain failure
    - Reduced blood flow to brain
    - Sudden change in blood pressure/pulse
    - Seizure
- Cognitive impairment vs. Normal cognition (including competing priorities i.e. continence) is fundamental to fall prevention.
  - They can't remember what they told them to do or not do
  - They fall differently as a result of cognitive impairment.
Medications and Falls

• Conceptually, medications that increase risk of falls fall into certain categories, based upon fall mechanisms
• Medicines that affect BP, pulse
• Medicines that affect cognition, awareness (including vision)
• Psychotropic drugs, drugs that cause dehydration, low sodium, anemia
• Medicines that cause urinary or fecal urgency
• Greatest risk of medication adverse effect is within 1-2 weeks of admission, even if medication was taken for years before—why?
You vs. the Facility

- You tell people what to do but they don’t change
- You belong to a different tribe
- Individuals (including you) are doing exactly what they expect of themselves
- Probably doing what they have always done, what they were taught to do (directly or, indirectly (i.e. what they observed/what others do))
  - Everybody does what everybody does
- No incentive to change, lots of reasons not to (Reasons nos 1 through 100 for not changing: “I’m busy”)
- No direct consequences for not changing
- You have to focus on monitoring, changing systems and processes
- Set expectations, inspect what you expect . . . . provide feedback
What can you do?

• You can do some of what the people in the building can’t
  – They cannot function effectively as patient advocates outside the community (something families absolutely expect us to do!)
  – Facility staff generally cannot/ do not look at pharmacy data or facility wide data re falls

• You can:
  • Provide education and training (essential but insufficient to change behavior)
    Look at data- identify patterns, develop/change processes in response; give people tools
  • Change processes to change what’s easy (What’s easy and convenient is what gets done)
Data Analysis Exercise

- Patterns for a skilled Nursing Facility:
- 17 falls this month. 15 falls in prior month. Is this a trend?
- How many people fell vs. how many falls
  - Same building: 13 people fell last month (15 falls)  7 people fell this month (17 falls)
- You notice that falls are more common on Saturday evenings than any other day. Also falls tend to cluster around 3 pm, and 7 pm. What ideas do you have that might explain that?
- 5 percent of residents account for 70% of falls in your building. How does that change your approach to fall prevention in this community?
My Recommendations

- At time of/prior to admission:
- Honest communication in person and in writing prior to admission, upon admission informing families/and patients they are likely to fall, what we are going to do but that they are still likely to fall, and that we care. We will help them communicate with doctors
- Realistic care plan related to meds/falls
MY Recommendations:

- Immediately after a fall:
  - Systematic assessment -> data collection
  - Systematic review of fall data by you on a regular basis
  - Focus on recent admits, 3 or more falls

- Every fall: Notify attending physician directly every time
  - send them med list, vitals prior to fall and an order sheet
  - Ask for PT referral
  - Revise care plan
  - 3 or more falls: consultant pharmacist review of meds
3 or More Falls

- Request family meeting
- Discuss prognosis (more falls)
- Discuss medications, care plan
- Solicit feelings, feedback

(Do not ever say the resident has the right to fall! That is Nursing home BS guaranteed to make people angry)
My Recommendations:

• Aggressive systematic plan to identify and discontinue psychotropic drugs, sliding scale insulin, three or more cardiac meds
Summary

• Our residents are all at high risk of falls
• Injurious falls are the number one cause of successful lawsuits against care providers in all care settings (Dementia + drugs + injury + winner!)
• Stopping or reducing medications is the only thing we can do that will reliably reduce falls
• Most of our clinical staff are not qualified to make that happen
• Systematic processes including communication processes are therefore necessary if we intend to reduce falls and fall injuries, injury related lawsuits
• We systematically reinforce the mistaken belief among our customers that they will not fall or be injured in our facility
• We owe it to our patients and families to tell them the truth