QUALITY HEALTH STARTEGIES

Moderator: Keaonia Shaw
July 25, 2013
9:30 am CT

Operator: Ladies and gentlemen thank you for standing by. Welcome to the let's talk about falls conference call.

During the presentation all participants will be in a listen-only mode. Afterwards we will conduct a question and answer session.

At that time if you have a question please press the one followed by the four on your telephone.

If at any time during the conference you need to reach an operator please press star zero.

As a reminder this conference is being recorded Thursday, July 25, 2013.

I'd now like to turn the conference over to Ms. (Ernestine Johnson) - quality improvement consultant.

Please go ahead.

(Ernestine Johnson): Thanks (Chris) and welcome everyone to this webinar today. My name is (Ernestine Johnson) and I'm one of the quality improvement consultants here at (Demall) Foundation which is your quality improvement organization for the state of Maryland and the District of Columbia.

We are pleased to be able to offer you this webinar on let's talk about falls.

This session will be repeated this afternoon at 3:30. This recording and PowerPoint presentation will be posted on your (Demall) Web site - www.dcqio.org and www.mdqio.org.

So you can share with your staff at your convenience.

Phone lines will be muted during the call and we'll have a question and answer period at the end at which the Operator will instruct you on how to pose a question.

I am pleased to introduce our presenter Dr. (Fatina Monoque).

A graduate of Wayne State University in Detroit Michigan. While completing her residency she developed an interest in what we know as a not so sexy specialty - geriatrics.

And noticed that about almost 60% of the patient population was in fact geriatrics.

Dr. (Monoque)'s mission is to improve the environment and overall quality of life of the frail and elderly population especially those in long-term care settings even when they only have a few days to live.

She's a certified medical director at (Bellpre) Nursing and Rehabilitation Center whose parent corporation is Communicare.

What's really compelling about her history is that early on in her training while caring for the elderly she felt like something about their care was missing. It just kept tugging at her heart strings and she struggled to identify missing element and caring for this frail population.

And went about trying to identify ways to improve the care they receive.

As she pursued her fellowship in geriatrics at Stony brook in Long Island New York, practicing in both the hospital and long-term care setting she became acutely aware, in fact she had an ah-ha moment while analyzing the data that the team had collected that falls in the elderly population was a common issue.

And moreover, the residents experiencing these falls had significant morbidity and mortality rates.

As a result of the extensive research on fall prevention she developed a tool for both the nursing and physicians staff which resulted in the implementation of individualized plans of care for each resident.

And something amazing happened. This tool was found to be very effective in identifying the positive factors of falls and hence it's used served as an assisted tool to help the team at preventing falls.

Two of Dr. (Monoque)'s eight publications are the review of fall preventing guidelines, published in the journal of geriatrics and passion and power of medicine.

In fact she had an opportunity to create a fellowship training from pioneers, an expert in the field of palliative medicine from Harvard University in Boston Massachusetts where she became certified in palliative and hospice medicine.

By now you might be starting to form a mental model of the type of physician she is - one of great compassion.

After obtaining certification in geriatrics three years ago she moved to the great state of Maryland where she continues to elevate care for the frail and elderly.

So without further ado let's hear from her now - Dr. (Monoque) let's begin. It's all yours.

(Fatina Monoque): Hello everyone and (Ernestine) I think you for such kind words.

Today we are just going to talk about falls and as you all know it's more like my passion, geriatrics, rather than anything.

After the extensive features and work involved there are a few things we can do. So let's talk about it and I would welcome any questions.

During my presentation if you have any questions that pops up in your mind please jot them down because we will not be able to do the interactive discussions and I will welcome any questions after the end of the talk.

So let's begin our discussion, the learning objectives of my talk are we will begin with a case and then we will do some kind of - some introduction, we'll talk about the causes of falls.

Then we will discuss how we can treat and above all we are going to talk about how to prevent falls which is more important aspect of all of these objectives.

We will - and then later on do the case discussions and then in the end we will conclude.

So let's begin with the case. This is Ms. (Clara) she's a 90 year old lady residing in nursing home. And then I got a call this morning from the nurse that she fell at 6 am.

And when I asked the nurse, okay so what was the environment around? How did she fall?

Then I got the answer that oh she was trying to get up from the bed.

And then after I inquired again do you know why she was trying to get up from the bed I was told that, she told me that she needs to go to the bathroom so she wears diapers all the time.

This is something probably you all must have heard not one time, I would say many times.

Then we just talk about the pre/past medical history as you all know these residents residing in the nursing home have as I would say a combo of everything in it.

She has moderate dementia, she has high blood pressure, she had type diabetes but now is insulin dependent, she has urinary incontinence, she's not able to walk because of her arthritis which is progressive.

She also has coronary heart disease, she has had two bouts of CHS and also she was a smoker so now she is suffering from COPD.

And not to our surprise she does have anxiety for which is on medication and being followed by a psychiatrist also at the nursing home.

These are some of the many medications she's on and for the sake of presentation I did not jot down all the list of medications which are more than nine.

She's on 15 medication but the relevant medications for this presentation she's on (Lasics), she's on (Detrotan), (Merazatam), (unintelligible) for her CHS, she's on (Lanzet) and for COPD (unintelligible) she's on (unintelligible).

I'm sure by this time you are thinking as to looking at with (Clara) and the fall she had and now with the past medical history and the medical list I'm sure you all are thinking something about what clearly led to this fall.

Now are going to talk a little bit about her past. This is not the first fall that she has had. This is her second fall. And the first fall she had was four weeks ago.

Four weeks ago she slipped from her new chair. That's how the nurse told me when I inquired how did that fall happen she said oh she was trying to reach for something which was on her bedside table and she did not - she was not able to estimate the direction and the distance and she slipped to her wheelchair.

And I'm sure this is something that you quite often here in the nursing home almost all the time.

So at that time four weeks ago there were fall prevention measures which were incorporated and looks like didn't really work.

So my question would be for all of us to ask ourselves at this time is what are the key elements we need to consider in this case.

What are the key elements you need to consider as we work next to this fall? What are the factors we can do to help Ms. (Clara)? And moving onwards, how can we prevent this fall?

So now we will go onto the introduction. As you all know by twenty-thirty there will be almost 71 million older adults and as much as there will be 20% of the whole US population.

And now just that the healthcare spending would be expecting to increase by 25% and this is going to cause a major shift in the healthcare spending.

We can see and foresee all the problems and complications which aren't going to happen by that time.

And in order to prevent this, in order to avoid that chaos that's going to happen we are working very actively to help our elderly population.

This is just a brief charge, just a quick overview of cause of (unintelligible) in geriatrics.

This is as old of 2009 but the reason it says has not really changed much.

And as you see number of causes is still current yet. If you focus on the cause - number eight cause which is unintentional injuries and is only 1.8% of the cause's effects is these of intentional injuries are happening because of the fall.

And as much as 32,000 people die every year from their fall and from the injuries that happen secondary to the fall.

I don't think we should underestimate this number or the percentage of the cost effects because more so these causes and more so these falls for many reasons are avoidable falls.

This gives us just a rough estimate of the intensity of the causes of falls and what we can each do in our elderly population.

It is very important to know that the first fall in our geriatrics solutions is actually a red flag.

That is the time a physician, a nurse, a nurse practitioner, or a staff in the nursing facility - all (unintelligible) to that home needs to start worrying about what should we do next.

Because it has been shown in the research again and again that the first fall that happens in elderly populations is an independent predictor of significant mortality and morbidity.

First fall many times leads to injuries and fractures and the factures heal but many times patients end up dying from other causes.

It does lead to mortality unfortunately these falls are multi- (unintelligible) and they involve many symptoms of the (unintelligible) that the risk of fall and the rate of fall really has to be controlled.

And at that time we need to start our new who falls analysis.

Sometimes (geriatricians) need to work as detectives I feel. Especially when you have these falls and then (unintelligible) really unknown, you don't know where to find the source and at that time I would tell all my colleagues to start thinking like detectives and to start doing the who falls analysis.

This is just a (unintelligible) to help you remember that it's the time of first call when you need to start worrying, you need to start working towards finding the causes, we need to start working towards preventing these falls because it's the first fall that leads to the fear of falls in elderly patients.

There has been a lot of research done as to why these fear of falls happen in these elderly population.

And unfortunately it has been seen that secondary to those fear of fall the elderly population, our patients, our residents, they stop walking, they stop moving around as they were doing before.

And this leads to more re-conditioning of their status that seems to further decline and it has been shown in research that that really leads to mortality as well.

Now we are going to talk about the factors involved in the fall.

So we decide how to divide and explore all these causes of fall. For the sake of simplicity we have divided the falls and the reasons of falls to the (intrinsic) factors and the (explinded) factors.

The (intrinsic) factors are the factors which are present and which are there within the resident or the patient himself or herself.

Most of those factors are non-modifiable factors and some of the factors are modifiable factors.

(Explinded) factors are the factors which are outside the patient. And to understand the causes of fall we are going to talk about these factors in details because that is what really, really helps you understand the causation and the treatment of falls.

I have included a recent fall in the (intrinsic) factor because that is an independent factor as we discussed in our previous slide.

Age is something that is never in our hands. We all are growing older by every day and every year.

And it has been shown that if a resident is over 75 and that is an independent factor - for whatever reason I do not understand, maybe you can help me understand, female factor.

Maybe because of the risk of osteoporosis is an independent risk factor also.

(Unintelligible) and ultra-static hypertension other than that be loss of talent, (unintelligible) and other commodities which we are going to talk about.

And some of them were mentioned in my case.

The other (intrinsic) factors are functional interment which sometimes is related to and associated with prognitive interment and sometimes it is not.

If a patient had a stroke and had (unintelligible) and still is able to function properly but he's not able to walk properly he would try his best to walk as much as he can and then he will end up falling.

I have a resident who's a smoker and who just had a very massive recent stroke which left him (unintelligible).

And he still goes out and smokes, he still tries to do everything that he used to do before and he has fallen like 12 times since his recent stroke.

This was just an example of the functional interment.

(Unintelligible) because of many reasons, many medications can cause this and if a patient has visual impairment and you all can see that most of our elderly folks have almost all of the above.

Patient is on drugs and we are going to talk about it in detail in a few minutes. Many times we don't really realize the foot wear of our residents. What kind of footwear they have - is it safe? Is it not safe? Is it slippery? Are they able to wear it properly because of original interment?

That's a very important factor we need to look into.

Also as far as incompetence has been shown to be a risk factor for falls.

And now we are going to talk about the (explinded) factors. (Explinded) factors as we talked about is all the factors which are there other than the resident or the patient himself.

And that's where now you need to start wearing your chief detective's hat and start looking at environment and I will begin usually with where the patient was slipping.

What was the location of the fall? And then I would go on the floor.

What kind of floor was it? Was it a slippery floor? Was the floor wet? Was the floor uneven? What there any bedrails?

Those bedrails which are not so common these days anymore where there any time in the hospital as well in the nursing home.

And it's been found that rails has actually contributing - a contributing factor to the (unintelligible) of falls.

The other important is the illumination, the light. What was the time of the fall? Was the fall happening at night time when resident was trying to go up and go to the bathroom and could not see and slipped?

Was there enough like for the resident to see around while the resident was walking?

And then environment is another factor which is a key element to (unintelligible).

Was there a clutter in the environment?

As small rooms in the nursing homes we have - residents want to bring in everything, all of your belongings, your possessions. Sometimes we don't always look into the clutter that's around the residents or how I said we can clean up a space for the residents to walk around and doing the night time or early in the morning when the residents are a little bit more confused and they are in a rush to go to the rest room, they trip and they fall.

(Unintelligible) is another important aspect. Not so much so in nursing homes but IV tubing, catheters and the straints, they are also the positive factors in leading to falls.

Now we are going to talk about medications. And as you all know and can agree very, very important aspect, all (unintelligible) positive factors of falls is medication.

As much as we want to use medications for our residents to help them get better and give them these medications, many times these medications are the sources of falls also.

And it's a fine line we always have to maintain in helping our residents as to what is best for them.

I'm just mentioning really important list of medications which has been shown to be the cause of the factors of falls.

And anti-hypertensive is on top of that list as you can see.

Other than that antihistamine, all the (unintelligible) that's (unintelligible) is also a very important risk factor for falls.

Anti- (unintelligible) these are I would think the most important list of medications which is - which contributes to the fall and if you want to really go over the list you can go on and on forever.

The most recent research has shown that (unintelligible) including narcotics are not so much contributing factor for falls which was suggested to be for many reasons.

We can talk about it later if you have any questions about that but (phsycotopis) has been shown including SSRI anti-depressants have been shown positive agent for falls.

After exploring the reasons and I would probably think when you are looking into the causes of falls - so if my patient has (intrinsic) factors what are those (intrinsic) factors which led to the fall?

And I'm sure you can find more than five reasons for (intrinsic) factors. And then to explore the (intrinsic) factors you would ask the nurse okay so what was the time of the fall? What was the location of the fall? Was the patient in his room? Was patient in the dining room? Was the patient trying to walk and go somewhere?

So that's how you would ask the nurse - nursing and staff all these questions.

And also at that time you will try to explore other reasons in the environment. Many times you might not get all the answers of your questions but that's how I have helped my nursing staff as well as my GNA's by asking these questions again and again and they know I'm going to ask all these questions.

So every time when they call me for any follow-up for residents they know what to answer.

So keep asking all these questions and you will get the answers someday very soon.

Now we are going to talk about the examination. The most important factor is to evaluate the patient for acute injury and as we all know unfortunately fall is the leading cause of mortalities and acute injury.

Acute injury is the most important and the most common factor where patients present in the ER and then it peaks to mortality also.

So we have to rule out acute injury. We have to do the patient assessment head to toe. You have to make sure there's no bruises, no bumps, no bleeding.

You have to make sure patient's vital signs are okay. Anytime you do not see an obvious element of acute injury, the pulse will be high.

You have to make sure you check the blood pressure of the patient - make sure we check the postural blood pressure.

At that time we will evaluate delusion, the balance, the (unintelligible) and that time we will do the functional assessment and also never forget to do the medications review.

If you have any questions at this time I would suggest please write them down and I would get back to you once we are able to discuss.

After you explore the (intrinsic) factor, you explore and go onto the (explinded) factor, fully examine the patient, you examine the environment, I would suggest make a plan for the patient.

I call it post fall plan.

And unfortunately there is not one (unintelligible) that needs to be done. It's more like a multi (effectorial) approach on changes in (unintelligible) you will look into what are the patient factors? You will look into what are the factors you need to educate this task?

Many times the way that nursing home environments is that you need some modification in the environment to make sure the clutter is not there.

And sometimes you have to keep doing it again and again to make sure that the staff is all and we all are on the same page.

So this post fall plan is actually a very important plan that needs to be done I would suggest within 24 to 48 hours.

At that time a nursing dispatch or the nurse who was present at the time of fall should consider or think of the - back to positive factors and come up with a plan and a physician I would suggest (unintelligible) begin for the aide of 24 hours and then come up with the plan also to prevent this fall.

What we have seen is every time a fall happens, the nursing staff report the fall to the physician or the nurse practitioner, it is best to assess the patient after every fall within 48 hours and come up with a post fall plan.

It has been shown to prevent further falls.

(Unintelligible) and appropriate and the work can be done. On lab work sometimes people - demented patient have urinary tract infections and you would do a US. This should be done after a thorough assessment.

It should not be a major (unintelligible) that my patient has fallen and I need to make sure that there's no infection.

And please note that many times patients at this stage have a symptomatic (unintelligible).

Many residents in the nursing home have or had multiple urinary tract infections, they have received multiple antibiotics and their urine has organism.

So we have to make sure we are not treating a symptomatic bacteria. We are treating the cause that is there.

(Unintelligible) if needed. If patient has acute injury then the patient needs to go to the ER. (Unintelligible) it has been shown and it is very important to look at the risk of medication every time a fall happens.

It is extremely crucial and I cannot underestimate the value or the impact of pharmacy on our residents.

This is just a quick review of what we have been discussing so far as to - after every first fall we will do an initial screening.

That patient would be in our important list. We will monitor that patient very closely.

And then after that we will do the assessment, we will have - we should have discovered the pre-disposing factors, the resituating factors for the fall and then just a brief summary of the management that we have been talking about.

(Unintelligible) test, static blood pressure because of many reasons we need to work on that.

Work on the mobility between the exercises, step down the medications which you don't think they should need.

Look at all the PI and medications, look at how the patient is walking, look at what shoes the patient is wearing.

See if the patient needs new glasses, see if (unintelligible) and we have to keep on following it up probably one every week.

Unfortunately in spite of all what we have been discussing it has been shown that many times residents continue to fall most of the time.

But the picture is not as gloomy as I am just saying right now. What it has been shown that once in the art of doing all these measures we are treating the patients, sometimes the falls, the number of falls you cannot avoid.

But the injuries and the morbidity and mortality that happens from the fall can be avoided.

So patients do fall again and again but the impact of fall is not that significant.

There is a lot of research on how to prevent falls, what needs to be solved, how can we stop people from falling?

What is it that we can treat within a patient that can help him from falling and can help them with their balance and their (gate)?

And after extensive research there are very few elements that have been suggested which really work for the patient.

And one of them is the excessive physical rehabilitation. Every patient that falls needs to be evaluated for (gate) and balance and needs to be either in the rehab program or restorative therapy.

Somewhere we can help them gain physical strength.

And it has been shown that it does decrease as I was talking risk of does not decrease the rate of fall but it does decrease the morbidity of fall.

This is the reason work that has been done extensively all over the world about prevention of osteoporosis and the use of vitamin D and calcium supplements.

It has been seen that therapy for osteoporosis in calcium and vitamin D supplements have actually prevented the factors.

They have not prevented the fall but they have prevented the rate of fall and to some element they have prevented the fractures also.

Though the evidence is not clear there is a lot going on in the research world because the theory is if you are freeing patients from osteoporosis giving them

the supplements then not only the rate of fall should decrease but also the risk from the fall which is factor should fall to.

In a few years probably the big that we will have - we'll have much clearer picture.

Another important point to note is this (unintelligible) has been shown to be beneficial even in long-term patients.

Environmental modification has a key and very important and has been shown to eliminate the recurrential fall.

(Unintelligible) plan actually what works best. So every patient needs to be looked at very closely and we need to explore what is the factor which contributed to this fall and we need to work on those factors for that specific individual.

Long-term care settings, the key elements as we have been successing what were the timings of the fall? What was the resident specific situation prior to the fall?

Making a fall incident report is very important. I call it chief detective task. At that time we can do staff education regarding the seriousness of fall.

Again medications review is very important.

We were talking about the post assessment plan done by the nurse and the MD or the nurse practitioner and to follow-up fall either in a weekly brief meetings or monthly quality improvement meetings are very, very important because

that is the way we can really monitor the rate of fall in the residents - is happening in the long-term care setting.

And that's how we can reduce the numbers and we can prevent the significant mortality and morbidity.

I'm going to share this data review which is from my facility and we thought that our fall prevention program in our facility was starting from this year and as you can see on the YX is the number of falls.

And then injury (unintelligible) to falls is actually here - the red line is the injury which happens with the falls and the blue line is the number of falls.

It's maybe one resident or its maybe more than one resident which is happening. It's just the number of falls.

As you saw in January we had 13 falls. We started our fall prevention program with the help of the DON, the nursing staff, myself helping the GNA's, the nursing aid and within a month the falls did decrease significantly.

And as you can note we had four major injuries in January but only one in February.

And as you can see as we moved on this is not a very smooth class - the number of falls really bumped up to 17 in the month of May.

But what you can see and note was there was no acute injury.

So the fall prevention program actually was not able to prevent the rate of fall as we have already talked about in our presentation here today but it did prevent the injury that happened form the fall.

And actually there were two residents who kept falling again and again and that bumped up our graph.

And we again implemented and worked for aggressively towards fall preventions and in the month of June we had eight falls and unfortunately we did have one injury.

Moving along, as you can see, for every resident what we did. We had our individualized care plan for each resident.

And I feel that is what has really prevented each fall.

So I always ask myself there are so many reasons now that I am going over and over again and the patient factors, environmental factors, the medications which I cannot cut down, my patient is getting depressed, he needs therapy for his CHS, how can I control these factors?

What can I do to prevent all these things? Is there something I can really do?

And then we actually depicted and went into more details and this is a new complicated graph but this really helps us find the number of falls which were happening again and again.

And as you can see the two most important factors which help us, which we found was happening in our residents at my facility was as you can see the falls were happening at 3 to 11 or night shift.

So this was very important factor to know why patients are falling from 3 to 11 shift or in the night shift, the residents were falling very early in the morning at like 6 am.

And the other cause was the fall which was happening residents were falling out of their beds and that was also happening very early in the morning.

And then we explored the causes, most of them were either were confused early in the morning or most of them felt the need to go to the restroom.

So we explored these causes, we focused on solving into these problems, we educated our GNA's, we helped them - we told them to be more prompt and be more active very early in the morning and help residents with their needs.

And that really as you can see in June the - these graphs are still high but they're not as high as they were before.

So now we are almost coming to the end of our conclusion and our case.

I'd like to review the case again.

Again she's a 90 year old, she fell early in the morning and she was trying to go to the restroom.

These are the list of medications as you can see. Every time as I look at the list of medications of my patients I, with each medication, ask this question - is this something my resident really needs? Is this something I can work on trying to do a paper trial?

Can I discontinue this medication? Can I hold it off for a few days and see if my patients will do well without this medication?

And also never to forget, look into the PRN medication which sometimes we give to our residents but we forget to discontinue to them and the nursing staff sometimes give it to them like Benadryl or antihistamine which leads to the falls.

So just a brief conclusion - we looked into the past medical history, we reviewed the medication, we know the timings, we will explore the environmental factors, we have discovered the resident factors if she could see or not, we will explore the environmental factors and we would make a specific assessment and plan which would begin who was that (unintelligible).

This is the end of my presentation, these are some of the incentives I had and I'm happy to take any questions.

Operator: Ladies and gentlemen if you'd like to register for a question please press the one followed by the four on your telephone keypad.

Once again that is the one followed by the four to register for a question.

Another reminder ladies and gentlemen it is the one followed by the four to register for a question.

It appears we have no questions at this time. I'm turn the call over to you ma'am.

(Fatina Monoque): Okay.

(Ernestine Johnson): Doctor thank you so much for providing us with a timely and rich content on falls. You've given us something that our participants can go back to their facility and put into practice immediately.

As we close, those of you on the WebEx portion of this call please don't forget to complete the brief evaluation. We do value your feedback.

Remember this webinar will be repeated again at 3:30 today.

You'll be receiving information shortly on the next learning session call scheduled for August 21 of this year.

Take this opportunity to hear what your peers are doing across the nation. Mark your calendars also for our learning session number two which is scheduled for Thursday, October 24.

Again thanks so much for joining us today.

(Ashley), this officially ends the call.

Operator: Ladies and gentlemen that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.

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