Webinar | December 17 & 19, 2019

Using Video of Falls to Understand why Assisted Falls occur in Memory Care
Agenda

• Analysis of a witnessed fall
• Exploring common causes of witnessed falls
• The importance of transfer status
• How to promote safety during transfers in Memory Care
• Summary of witnessed falls

Disclaimer: The purpose of this webinar is to share insights and data gathered through extensive video review in assisted living memory care communities and promote thoughtful examination of their current risks around falls. Content should be reviewed by internal clinical staff for suitability.
01

Real Witnessed Fall Event
Real witnessed fall event

Scene Background:
• After dinner, 6:15PM
• Care staff enter the room and grab pajamas from the dresser
• Within 30 seconds of entry, the care staff is asking the resident to stand up
• The resident can’t support the transfer and slides to the ground

Staff opportunities:
• Upon entry, sit in front of the resident at eye level
• Communicate with the resident what the plan is so they can prepare themselves to get up.
• Get the items you need and available before cuing the transfer
Recognizing barriers through video review

- Time restraints
- Staff turnover
- Reluctance to impose on co-workers
- Change in resident status
- Census changes
02

Most Common Causes
SafelyYou Fall Definitions

**Fall**: Any *unintentional* change in position where the individual ends up on the floor, ground, or other lower level.

- **Fall Severity Defined**:
  - 1 – Near Fall
  - 2 – Fall with self-recovery
  - 3 – Fall without injury
  - 4 – Fall with possible injury
  - 5 – Fall with traumatic injury

**Behavior**: Any *intentional* change in position where the individual ends up on the floor, ground, or lower level. Resident may also self-recover.

**Witnessed fall**: Any *fall with a care staff in the room*.

**1600+ falls reviewed**

<table>
<thead>
<tr>
<th>Residents</th>
<th>Total Residents</th>
<th>% Residents w/ a Witnessed Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Residents</td>
<td>337</td>
<td>18%</td>
</tr>
<tr>
<td>Residents w/ 2+ falls</td>
<td>200</td>
<td>25%</td>
</tr>
<tr>
<td>Residents w/ 3+ falls</td>
<td>131</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: Excludes severity 1, 2, or behavior with self-recovery.

- **Residents with a witnessed fall**, will likely have repeat unwitnessed falls.
Statistics on Causes of Witnessed Falls

128 Witnessed Falls Reviewed:

• 66% related to a **transfer**
  - 82% underestimating support needed
  - 36% incorrect use of mobility aid
  - 34% challenging behaviors
  - 19% cuing resident prematurely

• 34% sliding out of bed upon entry, self-lowered, change in status, other
The importance of transfer status
Transfer Safety

Ask if:

• Are you properly communicating a change in transfer status with all care staff?
• Do you have transfer/gait belts care-planned?
• Does training include key distinctions in level of support required during transfers?
• Do staff know how to react in the event of a witnessed fall?
Transfer Support Status Defined

- **Independent** - ambulates without support
- **Modified Independent** - independent with use of mobility aid
- **Supervision** - eyes on during ambulation for safety
- **Contact Guard Assist** - light touch for safety
- **Minimum Assistance** - minor assistance to stand
- **Moderate Assistance** - hands-on support required for standing and sitting
- **Maximal Assist** - non-ambulatory, stand-aid may be used
- **Total assist** - Hoyer lift
04

Promoting Safe Transfers
Steps for Success

1. Engage in social interaction at eye level
2. Explain what will be happening and why
3. Motivate with items/activities of interest
4. Utilize verbal, tactile and visual cues to support
5. Allow additional time for processing
Steps for Success

6. Pre-Fall Risk Assessment

Examine the Resident:
• What is the resident wearing? Clothing fit?
• Footwear? Non slip socks? Glasses?
• Does the resident appear weaker?
• Is the resident acting differently?
• Will I place myself or the resident at risk?
• What are alternative transfer options?

Examine the Environment:
• Where is the mobility aid? Is it properly placed? Is it locked?
• Did I plan my route? Is my pathway clear to exit?
Steps for Success

7. Prepare for transfer
   ✓ Does the resident appear ready to support you?
   ✓ Be mindful of transfer status changes based on time of day
   ✓ Do I have enough staff members?

8. Perform transfer
   ✓ Attend to proximity during transfers/ambulation
   ✓ Stand towards the side to support ascent/descent from bed/chairs
   ✓ Maximize resident engagement, limit distractions for resident
Training Steps for Success

1. Create an environment that is real or use a resident’s bedroom.
2. Position obstacles or props that would require the care staff to be mindful of when preparing a transfer. (mobility aids, clothing, glasses)
3. Ask a care staff to role play as a resident while another care staff walk through the Steps for Success.
4. Switch roles and perform until all care staff have played both roles.
5. Shadow care staff after training to observe the Steps for Success.
Summary of Witnessed Falls
What to do during a witnessed event?

1. Move behind resident and support at the waist/hips
2. Utilize a wide stance and straight back as you slowly lower the resident
3. Protect head from possible injury
4. Provide comfort
5. Alert care team
6. Document fall and notify necessary parties
7. Review opportunities for reducing risks
Success Stories addressing the Barriers

1. Time restrictions >> Balance tasks based on available time
2. Staff turnover >> Ensuring specific resident training
3. Reluctance to impose on co-workers >> Create team environment
4. Change in resident status >> Thorough communication between shifts
5. Census changes >> Proactive communication with new admits
Prevention of Witnessed Events

- Ensure current transfer training includes some variation of the 8 Steps for Success

- **Post Witnessed Fall** Review scenario in person and areas of opportunity. Shadow resident transfer post fall to collaborate on prevention

- Shadow care staff with challenging residents to assess best approaches and techniques specifically for the resident and share during huddles

- Highlight lead care staff to promote best practices and procedures

- Consult with PT/OT to ensure transfer method used is most appropriate
Questions?

Disclaimer: The purpose of this webinar is to share insights and data gathered through extensive video review in assisted living memory care communities and promote thoughtful examination of their current risks around falls. Content should be reviewed by internal clinical staff for suitability.