

Patient Falls In A Long Term Care Setting

Avoid Caregiver Injury

By Michael Boldt, NHA, ARM

Those in the business of caring for the infirm are duty bound to help patients reach and maintain the highest level of function for which they are capable. With these efforts comes the risk that the patient will fall. As facilities struggle with this paradox, it is important to consider the wellbeing of the caregiver along with that of the care receiver.

There are three main topics regarding caregiver safety as it relates to falling patients: Maximum efforts should be made to prevent a fall from happening; If, in spite of best efforts, a resident begins to fall, employees should be prepared to safely act; Lastly, healthcare workers must know what to do after a fall has occurred.

Prevention

The most important component for caregivers in preventing falls is vigilance. Even for the elderly living at home, one-third to one half tend to fall or do fall (Warshaw 2006). For the elderly who require the services of a care giver, the risk of falling is obviously higher. Caregivers at all levels of care must be aware of the falling risks associated with each patient for whom they are caring and have the appropriate equipment to assist in preventing falls.

Awareness on the part of caregivers requires planning and communication. All individual care plans for the elderly

Planning and Communication

- Care Plan
- Visual Symbol System
- Shift Change Notes
- Heads-Up

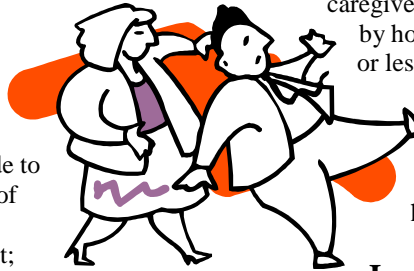
should address the risk of falling and prescribe clear strategies for preventing falls.

Certain medications and a history of falling are key risk factors in determining the propensity of an individual to fall. Even elderly patients without these key risk factors should have fall prevention as an element in their care plan. Advanced age is in itself a risk factor for falling. Whereas some elements of a care plan are implemented by only certain members of the care team, everyone is responsible for the elements of a care plan related to fall prevention. Family members and ancillary staff should be deployed in the struggle to prevent falls, as well

To facilitate maximum participation in the fall prevention program, many facilities have implemented a system to communicate the level of fall risk for each patient by marking doors, beds, and/or charts with a colored dot or other symbol. These systems are effective because they quickly signal the fall risk to new caregivers who might not

have had the chance to review the care plan for a particular patient. The symbols also serve as a reminder even to those staff members familiar with the individual at risk for falling.

Communicating the fall risks and prevention strategies via care planning and symbols are good most of the time, but caregivers must also be aware of the day to day and hour by hour fluctuations in condition that make falls more or less likely. This final piece of the communication puzzle requires communication between one caregiver and another through change of shift notes along with a simple heads-up when appropriate (e.g. "Watch Mr. Jones carefully, he has been a little wobbly today").



In addition to planning and communication, safety equipment should be utilized to prevent falls and safeguard the health of caregivers. Gate belts, walkers, etc must be used where indicated. Many facilities have fall prevention equipment and well documented policies and procedures related to the use of that equipment, but nevertheless the equipment remains in a closet unused. The usual explanation for this disregard for caregiver safety is that the caregivers themselves find deploying the equipment inconvenient and therefore choose not to use it. The proper use of safety equipment should not be considered voluntary. Workers who fail to deploy the prescribed equipment must be dealt with according to each organization's progressive discipline policy.

During A Fall

Most loss control programs only very briefly touch on the subject of a falling patient. Typically, a brief warning is included within the larger subject of lifting and transfer. An example of how this subject is handled is shown below.

If falls do occur, no attempt should be made to stop them abruptly. Stopping falls is a sure way to get hurt. The safest method involves guiding, slowing, and lowering the patient or resident to the floor while trying to maintain a neutral body posture. (Tweedy, 2005)

It is very unlikely that a caregiver will be able to react safely to a falling patient given only the statement above.

Healthcare providers who wish to reach the very highest level of safety should spend time practicing, or at least demonstrating, the guided fall. A local martial arts or gymnastics instructor is a good source of expertise on the subject. Of course, care should be given to practice this procedure safely.

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After A Fall Has Occurred

After a fall has occurred, there is a danger healthcare workers might be so frazzled they will ignore the ergonomic hazards involved in transferring a patient from the floor. Caregivers should know that their own safety and the safety of their patients require careful professional actions rather than haste.

In the seminal 1997 document created by the occupational safety experts at Cal/OSHA (Feletto and Graze, 1997), guidelines are provided for transferring from the floor. Many long-term care providers use off-the-shelf safety policy and procedure binders that incorporate these guidelines. While the guidance provided is sound from an ergonomic standpoint, it is flawed due to lack of medical context.

A frail person, who has fallen, needs trauma medicine rather than the custodial care for which most long term care providers are proficient. Unless a trauma care professional * is available, a care provider should call the local EMS and provide first

911

* In some cases long-term care staff can obtain the knowledge and skills required to provide this care.



About the Author:

Michael Boldt is the president of Boldt Risk Management Solutions Inc. Mr. Boldt is a Licensed Nursing Home Administrator, an Associate of Risk Management, and has passed the Workers' Compensation Self Insurance Administrators Exam. Michael is currently contracted by Convalescent Employers Safety Association CESA to provide expert advice regarding the association's safety efforts and to provide individualized safety services to CESA member facilities. Contact Michael at safety@cesa-cal.com or Michael.Boldt@BRMSinc.com.



Convalescent Employment Safety Association (CESA), in association with the State Compensation Insurance Fund, provides group workers' compensation insurance programs to California nursing homes and residential care facilities. The partnership between CESA and State Fund has provided employers with stable and superior services since 1980. For additional information, contact CESA at info@cesa-cal.com.

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Feletto, M and Graze, W., *A Back Injury Prevention Guide for Health Care Providers*, CAL/OSHA Consultation Services, November, CA 1997, pp. 40

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aid in place until paramedics arrive. EMS professionals are not only better at evaluating the medical requirements of a person who has fallen, but have the training and experience required to transfer that person from the floor without injuring the patient or themselves.

Conclusion

The risk of falls in the elderly and infirm is high. Great efforts should be made to prevent falls from happening in the first place. Even in facilities with effective fall prevention programs, however, caregivers must be prepared to deal with falls in a way that is safe for the patient and the caregiver. Fleeting reference to the subject is not enough. Time must be spent demonstrating and safely practicing the infrequently used skills required to guide a falling patient safely to the floor and to providing first aid after the fall until EMS arrives.