Interdisciplinary team strategies to prevent falls and injury at Nithview Home

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Nithview Home, New Hamburg

Nithview Home is part of a seniors' community with diverse types of housing and services in the town of New Hamburg. It is part of a non-profit group called Tri-county Mennonite Homes. The long-term care (LTC) home has 99 residents.

During 2017, Nithview's falls program fell apart. The home went through a leadership change. There was shortage of staff. New complex residents led to an increase in workload. The low point was in January and February 2018, when 61 falls occurred.

To address the high rates of falls, an interdisciplinary falls team was formed. Members included the Director of Care (DOC), Physiotherapist, Restorative Personal Support Worker (PSW) and the Behavioural Supports Outreach (BSO) Lead.

In May 2018, Shaila Aranha, LTC Best Practice Coordinator for Waterloo Wellington region helped the falls team complete a gap analysis. They compared the home's falls prevention program to the best practice guideline (BPG) *Preventing Falls and Reducing Injury from Falls*, fourth edition (2017). The team found gaps in their falls program. They did an action plan that laid out the steps to improve care.

First, the Nithview team learned how to put a BPG into practice. Members took part in the Best Practice Champions eLearning Course from the RNAO. They learned about new tools and resources to help them. The team became member of the RNAO's Champions network. They joined other LTC homes in a community of practice (CoP) on falls prevention and management. Shaila hosted three CoP learning sessions between May and October 2018.

The Nithview team rolled out many strategies. One-by-one, they addressed the home's main concerns to prevent falls.

1. Enhanced the admission assessment on risk of falls (May 2018) - The process used to assess fall risks had gaps. Therefore, the team added in-depth questions to the history of falls. The list of risk factors in Appendix E (2017) of the falls BPG was a useful resource. The new questions helped to screen and assess new residents for fall risks and risk for injury. They improved the process by getting the data before the resident came into the home. Now, before the resident arrives, a focused care plan is done with measures to prevent falls.
2. Introduced a new 'post-fall huddle' form - The gap analysis revealed the huddles held after each fall were low-key. They did not involve the health care team. Now, a new post-fall huddle form helps to formalize the process. The format helps staff study the fall and look at the root cause by using the "five whys". This tool details questions about factors causing the fall. It asks about the day, time, place, activity, environment, and interventions in place. This approach engaged the care team. They share their thoughts on other methods to help prevent future falls. The falls team reviews all post-fall huddle forms. They also follow-up on care plans, do medication review, and add the falls prevention interventions.
3. Provided a "Fall's kit" on each unit - The kit includes night-lights, grip socks, hip protectors, chair alarms, glide locks, transfer belts, floor mats and reachers. Staff use "in the moment interventions" to prevent further falls. At the start, the fall kits were stored away from the

resident area. Staff had to ask the falls team members for a kit. Now, for quick and easy access, the fall kits are on each unit. The unit staff updates the care plan with the new approach. The falls team assess the new measures with the front line staff.

4. Raised the profile of falls prevention in all parts of the home - Posters about the fall prevention program are on display. Some posters focus on "comfort rounds". The restorative care PSW does "just-in-time" daily teaching with unit staff. Topics covered include resident safety; scanning the environment for fall risks; following the plan of care to prevent falls; charting in comfort rounds and using the post huddle forms.
5. Started comfort rounds - In July 2018, the team did two hourly comfort rounds during the night shift. Their data had showed most falls occurred during the night time hours. The comfort rounds include staff using the four P's: Pain, potty, possessions, and positioning when checking on the residents. Now, residents who are at a high risk for falls have comfort rounds done every hour over 24 hours. These residents are identified from the monthly fall data.
6. Identified high-risk residents with a red bracelet - A resident who has frequent falls, or is at high risk for falls, now wears a red bracelet on their wrist. As well, a label is put onto their mobility device. The Falls team reviews the plan for these residents each quarter and as needed.
7. All care team staff attend a "Dementia tours" learning session - In September 2018, the BSO team held education for all staff. Staff actively took part in learning situations. They wore gloves with Popsicle sticks, goggles covered with tape, earplugs and walked on beans in their shoes. Their tasks reflected a day in the life of a resident. Now, there is a stronger sense of empathy, and safety knowledge amongst staff.

The outcome of all this work is a decrease in the fall rates of residents at high risk. If a fall did occur, it was without injury. In October, the number of falls reduced to 34 falls from 61 earlier in the year.

In months with a high number of falls, it was due to newly admitted residents with high risk and complex health problems. The falls team is certain these methods will help prevent falls for these residents.

There remain some hurdles to conquer. An increased workload, a staff shortage, turnovers of leaders and the rising cost of equipment are a few. A new challenge to address is incomplete and late charting after PSWs have finished the comfort rounds.

Overall, the project is a success. The team works at keeping the staff engaged by sharing the impact of the fall program. Resident falls have decreased and staff concern has increased.

The falls team strives to maintain comfort, safety, and fall prevention for residents in the home as they work to refine and sustain the program.

The team meets monthly as part of the home's Quality Risk Committee. At these meetings, the team discusses falls prevention based on the number of residents who fell in the last 30 days. They look at triggers for falls; compare variation in the number of falls in areas of the home and factors that could cause a fall. They see the residents on these high-risk areas as the focus and as a result employ measures to prevent falls.

- **About Nithview Home –**
Nithview Home is a 99-bed non-profit long-term care home located in New Hamburg, Waterloo.

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