

Evergreen Home and Community Services Fall Prevention Program

Our mission is to keep our patient population safe at home with a reduction in the number of falls and to reduce the rate of emergent care and hospitalization due to fall injury.

We provide a multidisciplinary approach to fall prevention by assessing a patient's fall risk upon admission and at least every 60 days. Our multidisciplinary interventions are then individualized based on the patient's individual fall risk factors.

Skilled nursing, physical therapists, occupational therapists, medical social workers, psychiatric nurses and hospice nurses have specific skilled interventions with educational materials available to all our patients who are at high risk for falls.

Here's a breakdown:

- Skilled nursing can assess, educate and intervene with high risk medications, high risk diagnosis, orthostatic hypotension and urinary incontinence.
- Physical therapy performs a thorough assessment of the patient's strength, mobility and fall risk. They provide education on the importance of the sensory system, community resources, foot wear and provide an individualized exercise program to improve strength and balance.
- Occupational therapy maximizes safety through patient and caregiver training in home modifications and use of adaptive equipment. Safety awareness is stressed during ADL and IADL activities. Perceptual and cognitive limitations are also addressed to improve safety as appropriate.
- MSW can provide community resources to patients on alternate living arrangements and additional community resources. Psychiatric nurses can assess, educate and intervene to decrease anxiety, fear of falling or other behavioral issues that impact a patient's fall risks.

Measurements and Success

The number of patient falls is monitored regularly. The number of falls department-wide in 2006 was 290, compared to 285 for 2007 thus far. Our clinicians are much more aware of the importance of patient falls, and the actual reporting of falls has increased. Our clinicians complete a Fall Report on every fall while on our service. The cause of the fall and any education is documented and tracked.

We also gather data on emergent care related to injuries sustained during a fall. Our rate in 8/2006 was 2.91 %, compared to 2.37 % in 1/07. We believe that our interventions are reducing injuries related to falls.

We have linked with Evergreen Care Network to follow up with those patients who have been referred to a senior clinic or other location which provides a maintenance exercise

program. This follow-up can occur approximately two weeks after DC to improve compliance with this critical piece.

Barriers to success

- Lack of compliance with recommendations for wearing shoes and using assistive devices;
- Language barriers with caregivers and/or patients;
- Cognitive and/or behavioral barriers with some clients: lack of ability to understand instructions and recommendations;
- Lack of coordination with community resources that can help keep patients safe and free from falls once we discharge.

Opportunities and solutions

- Improve collaboration with senior centers;
- Volunteer programs for elderly for assistance with exercise;
- Video on different levels of exercise for strength, conditioning and balance including Tai Chi;
- Seamless transitions for patients from program to program.