2003

Assisted Living Innovations in Quality

California Assisted Living
CALA
Association

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California Assisted Living Facilities Association

Assisted Living – Innovations in Quality

Fall Prevention

Members of the California Assisted Living Association (CALA) are committed to providing residents with quality care and quality of life. To meet this commitment, CALA members design, implement and carry out innovative programs. CALA's *Assisted Living – Innovations in Quality (AL-IQ)* program will recognize and promote those programs and policies that result in enhanced quality of care and quality of life for assisted living residents in California. We hope you will join with us in this effort by submitting your organization's innovative program for *fall prevention*. All CALA members, regardless of size, location, or affiliation are strongly encouraged to participate. If you have any questions regarding this submission form, please contact Heather Harrison at 916-448-1900.

AL-IQ Highlights:

- Topic – **Fall Prevention**
- Entries are due by **Wednesday January 22, 2003.**
- Honoree will be announced and recognized at CALA Spring Conference in June 2003. Honoree will be invited to lead an educational session at the Spring Conference.
- Selection Committee members are not participants in this program.
- Submissions to the Selection Committee will be anonymous (no reference to community, company, or individuals).

To Participate:

- Limit the entry to no more than **six pages** (no smaller than 12-point font) including attachments.
- Complete, sign and submit the ***AL-IQ*** Cover Sheet with the entry.
- Do not include information that identifies the provider, residents, or staff on the entry (other than the cover sheet).
- Submit your entry no later than **Wednesday, January 22, 2003.**
- Mail **six copies** of your entry or email to:

  CALA
  Attn: AL-IQ Program
  455 Capitol Mall, Suite 330
  Sacramento, CA 95814
  or email one copy to: hsh@CAassistedliving.org

Assisted Living Innovations in Quality

2003 Honoree for Fall Prevention

"Corporate-Wide Comprehensive Fall Prevention Program"

Silverado Senior Living

Corporate-Wide Comprehensive Fall Prevention Program

I. Introduction

Fall prevention has been a concern of our organization since its inception in 1997. We recognized that the population we serve is frequently frail and prone to falls. Research (Annals of Long-term Care, 2000) has demonstrated that falls are a major source of morbidity and mortality in the elderly. Approximately 30-40% of elderly in the general population experience a fall each year. These rates increase significantly in residential care environments such as assisted living settings. Falls are of even greater concern in a cognitively impaired population. Fracture rates tend to be almost twice as high compared to a non-cognitively impaired population ((Buchner & Larsen). For a resident with dementia, a bad fall may result in more rapid decline in overall functioning, which not only adversely impacts that person, but also their family and other loved ones. These facts led our organization to the conclusion that an important element of quality enhancement for our residents would be a comprehensive fall prevention program. This was consistent with our mission of maximizing independence and functional status of all of our residents.

Our organization is a proponent of the "dignity of risk" concept. This means that we believe our residents should be encouraged to have as much mobility and independence as possible. Because of this, falls were not an uncommon occurrence in our first community. We realized that while falls could not be entirely prevented, we had an excellent opportunity to lower the incident of injury and fracture secondary to falls. We believed that the more physically active residents were, the less likely they would be to experience awkward falls and that better conditioning would lessen the probability of fracture. We also recognized the relationship between over-medication and increased fall risk. We believed that assisting our residents in the process of finding appropriate medication regimens would be a key element of our fall prevention program. A system for data collection was agreed upon to test our hypotheses.

II. Program Description and Goals

Goals

The initial goals of our organization's fall prevention program were:

1. To achieve better results than the national fracture rate-to-fall average of 7% for a cognitively impaired population.
2. To demonstrate year-to year improvement in the fracture rate-to-fall average until we achieve an average rate of 3% or less.
3. To improve overall conditioning of our residents in an effort to maximize independence and improve overall quality of life.

Program alignment with corporate strategic objectives

These goals all aligned with our corporate strategic objective of becoming a leader in the world in providing quality care and services to an assisted living population suffering

from Alzheimer's disease and other dementias. More specifically, the design for our fall prevention program aligned particularly well with four of our organization's core values:

- To provide all residents at each of our assisted living communities with the level of care we would want for our own parents.
- To continuously innovate and improve the level of services, setting the standard of care, doing the impossible.
- Getting Alzheimer's and other chronic diseases does not have to be the end of living.
- Economic rewards follow from quality service.

Early program development and innovation

Our original fall prevention program took approximately one year to evolve and develop, and a second year to implement and begin a data collection and measurement process. The first full year of standardized data collection and measurement was 1999. The drivers of program development were our corporate director of nursing at the time and our corporate clinical records and quality assurance auditor. Program development was further supported by one of our corporate founders who had vast experience with provision of services to a frail elderly population.

The truly unique component of our fall prevention program involves our rigorous data collection procedure. We recognized that without careful measurement, it would be difficult to ascertain the impact of our program. A second "innovative" component of our program is the comprehensive scope. Since falls are not one-dimensional phenomena, effective intervention must be multidimensional in breadth. A third unique aspect of our program involves the openness to new research developments that may be incorporated as indicated by our own measurement as well as by other external developments.

Program Description

Our fall prevention program has three key sections and a fourth "R&D" component.

1) *De-conditioning prevention*
2) *Reduction of sedating medications*
3) *Fall Data Tracking System*
4) *Fall prevention pilot programs (R&D)*

De-conditioning prevention

Research has indicated that de-conditioning is the leading cause of falls in the elderly. A reduction in bone density is also related to an increase in risk for a fracture. A key part of our fall prevention program is promoting physical activity and "weight-bearing" whenever possible. This includes the following:

- Wheelchair transfer program – Wheelchair-bound residents are assisted with transfers out of their wheel chairs at all mealtimes. This consists of being aided with walking to the extent possible to their seat in the dining area. This provides an opportunity three times per day to counteract bone-

- Exercise program – All residents are encouraged to participate in daily stretching and exercise programs offered in all of our communities. These activities are tailored to meet the abilities of our residents.
- Specific environmental design to promote physical activities - All of our communities have outside walking paths and gardens with ready access for all of our residents. Frequent walking increases bone density and decreases fracture risk. Many residents take on the responsibility of daily "dog walking" with our community pets.

Reduction of sedating medications

Many residents come to our communities with prescriptions for a variety of medications. It is not unusual to find prescriptions from as many as five different physicians. Medications that impact level of consciousness through sedation or disorientation contribute to falls. The following measures are in place to assist with medication reduction:

- Review of medication regimens at the time of admission – The nursing director in each community takes responsibility for evaluating the resident medications at the time of admission. If there are questions or concerns, these are directed to the appropriate prescribing physician. This step alone has caused a significant reduction in the use of sedatives.
- Behavior management case conference calls – Because our resident population suffers from dementia, there are occasional behavior management challenges. We work hard to give our associates tools to manage difficult behaviors without medication whenever possible (in part, to minimize side effects that may result in falls). Every other week our corporate office sets up a case conference call with a specific community to review a challenging resident case. All communities are encouraged to listen and participate with these calls. As associates become more skilled at effective interventions, the need for medication intervention generally decreases.
- Monthly review of psychotropic medication use in all of our communities – All of our communities are required to report on medications being used within their community each month. This information helps identify patterns that might need additional focus. If unusual patterns emerge in a community, physician consultations are arranged as necessary.

Fall Data Tracking System

Effective intervention relative to falls is dependent in part on accurate data collection. Our organization created a thorough system of monthly data collection in the following areas:

- Fracture Rate – Fracture rate is defined as the number of fractures in a community divided by the average monthly census. This statistic is of particular importance since fractures in the elderly are correlated with decreased life expectancy.

- Community comparisons – All communities are given the data from all other communities for purposes of comparison. This allows for unusual patterns to become quickly apparent.
- Falls with injury versus falls without injury – Falls with injury are defined as falls that require acute hospitalization or an ER visit for a repair of a wound.
- Fall location – Locations are specified as outdoors, within room or apartment, in a common area, or in a hallway.
- Fall time – Times are described as day shift, evening shift, or night shift.
- % of residents with a fall, fracture due to fall, and # of residents with a fall – These measures help explain the data set to account for situations where one resident may have multiple falls, for example, that skew the data set.
- Witnessed versus un-witnessed fall – This information provides information about appropriate staff coverage within our communities.
- Monthly Fall Meetings – Each of communities meets once per month (administrator, social worker, director of nursing and sometimes a consulting physician) to review all of the fall data for the month.

Fall Prevention Pilot Programs

Although we believe that our overall fall prevention program is comprehensive, consistent with our core values, we are always trying to improve. Current pilot programs include the use of "hip savers" at several of our communities and the introduction of out "PEP" option. PEP stands for "physical enhancement program". This program involves an option for residents (or their guardians) to purchase a one-on-one physical training package. The resident then receives a pre-determined number of sessions aimed at improving physical conditioning and decreasing falls. Preliminary data have shown this program to be both cost-effective and to decrease the number of falls for program participants. This program will continue to be evaluated for implementation at our other communities as part of the broader comprehensive fall prevention program.

III. Outcomes and Evaluation

Measurable Differences

We measure the results of our fall prevention program primarily in terms of examination of fracture rates due to falls. This is the most significant variable given the potential devastation of a hip or other fracture. Those results are as follows:

Organization –wide fracture rate due to falls

1999	**6%**
2000	**3%**
2001	**1%**
2002	**2%**

These results frankly, exceeded our own expectations. While there was a slight increase in fracture rates from 2001 to 2002, the results are still significantly less than the 7% national *fracture rate due to falls* average for cognitively impaired populations. It also met our second stated goal of maintaining a fracture rate at 3% or less. Other measurable gains that relate to our fall prevention program include 421 residents since 1999 that have shown improvement in ambulation, and consistent reductions in those psychotropic medications known to cause side effects such as dizziness or sedation.

Changes in terms of Quality of Care and Quality of Life

All aspects of our fall prevention program are related to a better quality of life for our residents. As independence declines, it frequently impacts residents with dementia by further hurting their self-esteem and sense of self-worth. Focusing on improved ambulation and prevention of de-conditioning maximizes resident's ability to remain independent for longer periods of time. This allows for greater enjoyment of our communities. Reduction of medication use allows residents to engage more fully with their environments versus being subjected to sedation. Finally, our data tracking system improves quality of care because it keeps fall prevention at the forefront of everyone's minds on a monthly basis. Having comparison data from all of our communities keeps a focus on maintaining a high standard of care relative to fall prevention.

Impact on Staff and Residents

As mentioned in prior sections, the primary impact of our fall prevention program on our residents has been a meaningful reduction in the probability of a fracture due to a fall. Secondarily, our efforts at increasing mobility and maintaining bone density while reducing sedating medications have improved resident quality of life (This has been corroborated through positive customer satisfaction surveys). There have been several impacts of the fall prevention program on staff. Staff has shown great pride in achieving positive fall reduction results. They understand the relationship between our overall corporate mission to improve the quality of life for our residents and the discipline to collect and measure data that gives us feedback about our efforts. There is additional work required relative to some basic documentation and monthly meetings. However, this time is likely offset by time saved due to not having to deal with as many injuries due to falls.

Costs and Savings

The primary cost of our program is the employment of an individual that heads up our data collection and quality assurance efforts. This is a full-time position that reports primarily to our Vice-president of Health Services. Costs for individual communities are minimal. The philosophy of reducing medication use and promoting mobility are central to our core values as an organization. Potential savings can be projected by estimating the costs of a fracture rate due to falls consistent with a national average. This rate is over three times higher than our rate. This means that there would likely be three times more hospital trips that might result in discharge and lost revenue. From a sales and marketing perspective, our fall prevention program is reassuring to potential admissions as well as to current residents and their families.

Relationship between Outcomes and Goals of the Fall Prevention Program

- To achieve better results than the national fracture rate-to-fall average of 7% for a cognitively impaired population.: *In 2002, our average was 2%.*
- To demonstrate year-to year improvement in the fracture rate-to-fall average until we achieve an average rate of 3% or less.: *We have three years in a row (2000-2002) at 3% or less.*
- To improve overall conditioning of our residents in an effort to maximize independence and improve overall quality of life.: *Overall conditioning has improved (421 residents with improvements in ambulation since 1999) and quality of life has improved as outlined throughout this report.*

IV. Sustainability

Our fall prevention program has been fully functional since 1999. It has truly become a part of our corporate culture. It is viewed as an expectation and a regular part of operations rather than as an *added* program. The Vice-President of Health Services is responsible for maintenance and improvement of our program. She is assisted in this process by our clinical data collection and quality assurance specialist. Since data is routinely collected on a monthly basis, it allows for monthly monitoring and evaluation of effectiveness. We have modified our data collection several time to increase compliance and to make sure the information collected best matches the questions we are asking. We are always examining ways that we can improve the overall conditioning and physical activity opportunities for our residents.

V. Replication

The most important advice regarding a fall prevention program relates to the development of an effective system of regular data collection. This is the piece often missing in new program development. Without effective measurement, it is hard to assess ultimate return on investment of time and energy. There must be a clear relationship between program goals and specific data collected to assess progress toward those goals. Ongoing data collection really forces consistent focus on issues surrounding falls. This has impact on the way that staff sees their community and increases the frequency of fall prevention activities. It also helps ensures accountability relative to continuity.

Assisted Living Innovations in Quality

2003 Entry
Fall Prevention

"Q2 Quality of Care & Quality of Life Program"

Summerville Senior Living

2
Q

Quality of Care & Quality of Life Program

INTRODUCTION

One of the biggest challenges and concerns facing our company was the increasing number of incidents among our residents. These incidents often manifested themselves as falls, resulting in negative outcomes affecting our resident's Quality of Life and Quality of Care. We firmly believe that we as a company have a moral and ethical obligation toward our residents in the preservation and enhancement of their Quality of Life and Quality of Care. We have named our program for our commitment to the two Q's: Quality of Life and Quality of Care.

Based on our company's experience with fall incidents, the top ten (10) reasons that led to the initiation of our fall prevention program includes the following:

1. Steady increase in the number of falls
2. Repeated falls without an intervention protocol
3. Repeated negative outcomes (e.g. skin tears, bruise, fracture, death, etc) with no formal process in place for investigating these falls
4. Resident education was not in place
5. No accountability at all levels (Administration, line staff, etc.)
6. No formal policy and procedure on fall prevention
7. Lack of staff education on how to manage resident falls
8. Perception of resident falls as being "normal"
9. Increasing number of lawsuits and claims
10. Increasing cost of liability insurance

Our company decided to hire an individual that would be responsible for creating a Quality Services department and for addressing the above concerns by creating a systemic and proactive process to achieve quality outcomes which would position the company as the preeminent provider of Assisted Living services in the industry. The person chosen to develop this process is a Registered Nurse and has extensive clinical and management experience within the long-term care industry.

PROGRAM DESCRIPTION/GOAL(S)

We made sure to set goals that were realistic, measurable, and that address the top ten concerns enumerated above:

1. Decrease the number of falls. Our plan to decrease falls included staff and resident education and the creation of the Risk Management Report. See attachment A.
2. Intervene immediately in all repeat falls. We developed a tool, "Post Fall Review" to minimize and/or possibly eliminate repeated falls with appropriate resident-specific interventions. The form contains questions to determine a possible underlying cause of the repeat falls.
3. Minimize and or possibly eliminate negative outcomes from incidents through staff education. We in-serviced staff on all newly created forms. We have educated our staff to understand that residents fall for a reason.
4. Achieve full compliance in completing our Risk Management Report with accuracy, timeliness and appropriateness. We also developed a Weekly Tracking form to ensure all Risk Management Reports have been faxed to the Quality Services department.

5. Development of a database with entries of all Risk Management Reports. See Attachment B.
6. Development of a Wellness program geared towards resident education. Our goal is to help the residents identify symptoms or the possible indication of a possible change in their condition and the timely reporting of these exhibited symptoms to the staff. Many residents are reluctant to advise staff and family of their falls because they do not want anyone to worry about them or are worried about being sent to a skilled nursing facility.
7. Development of a tool called "Highlights of Risk Management Report" to raise staff awareness and accountability. This form requests additional information regarding an individual Risk Management Report or a noted trend in the community.
8. Development of a comprehensive but simple policy and procedure for Resident Risk Management utilizing a one-page flow chart in order to understand the process even at a glance. This form is also part of our Policy and Procedure Binder. See attachment C.
9. Provide education to community leadership and all staff of the new company policy on Resident Risk Management.
10. Eliminate or minimize lawsuits and liability claims
11. Having an effective program hopefully could pave the way for our company being self-insured or negotiate a better liability insurance rate for our company.

The program was developed by putting a task force together. The task force was led by the Vice President of Quality Services. The team designed a program that was geared toward achieving the above goals.

The draft was then developed and was sent out to communities for their input in order to have a complete buy-in from each of the communities.

Our whole company Senior Management Team including our CEO/President went to all the regions to officially campaign this new innovative program. Formal training and introduction to the program was introduced to the Regional Management level, and the Executive Director and Director of Resident Care of each community.

We consider this program to be innovative for the following reasons:

- ✓ It is comprehensive
- ✓ It is one of a kind in the industry
- ✓ Our ability to trend falls and other incidents by all criteria tracked

All the Risk Management Reports which include fall incidents are faxed daily by the communities to our home office and reviewed daily by the Vice President of Quality Services and his Administrative Assistant. These reports are entered into the data base.

Our data base has the ability to sort the information by day, month, time of occurrence, region, resident, and specific incident and frequency of occurrences. The incidents tracked include: falls without injury, falls with injury, specific 911 incidents, medication errors, death, behavior incidents, and suspected abuse. This allows us to visually see trends, create graphs and allows us to identify focused residents, to focus on an individual community or region. Our goal has been to educate staff and residents in the prevention of falls. Our goal for ourselves has been to analyze our reports and data to predict and prevent repeat falls and other incidents.

OUTCOMES AND EVALUATION:

We can prove our outcome because of our database. Compliance was measurable as evidenced by an increase of reported falls and incidents in almost all our communities upon initiation of this program. Our staff completes the Risk Management Report for each incident, the Administrative

Assistant reads every report, enters data, and flags the reports to be viewed by the VP. The VP analyzes the reports and trends. There has been obvious decline in the number of repeated falls and injuries based on our database. Through this database we can identify the most fragile individuals in our communities. These individuals may need a physician visit to discover an underlying condition, a new resident assessment to determine level of care, or a different placement. Our intervention tools keep dialogue open between the Quality Services department and the communities. These tools also serve to keep the family and physician current on what is occurring in the lives of our residents. Through our focus on early intervention, we have had the satisfaction of seeing our efforts make a difference in the lives of our residents. We personally know the names of the individuals in our communities who are experiencing incidents. All our newly created tools have had a direct effect on the preservation and enhancement of our resident's Quality of Life and Quality of Care.

The newly created position of Vice President of Quality Services and his Administrative Assistant are the main costs related to this program. We have a fax machine that is solely dedicated to the risk management report faxes; we use a lot of paper and DEDICATION.

As an added bonus, our liability insurance carrier just confirmed the effectiveness of the program as evidenced by no new attempted claims since the inception of the program.

SUSTAINABILITY:

The program has been in place since July of 2002. The Vice President of Quality Services is responsible for the company program. The Regional Director of Quality Services is responsible at the regional level. The Executive Director and Director of Resident Care are responsible at the community level.

The program is evaluated at least quarterly.

One exceptional aspect of our program is its adaptability. We recently made two additions to our Risk Management Report tracking tool by adding a place to indicate the Level of Care. This will allow us to identify how much assistance the resident is currently receiving and determine if an increase in care is needed based on the individual's incidents. This will also keep us in line with the manpower costs of additional assistance that we may not be charging for but that our caregivers are providing. The other change was to identify where the individual lives in our community. We have Assisted Living apartments and also two types of Alzheimer's/dementia units.

We feel the recent changes will give more relevant information about the resident. We are anticipating changes as we enhance this program. We are also hoping to bench mark this data at 12 months of operation.

REPLICATION:

It is imperative to consider the following in order to replicate this program:

1. Consider your company's strategic objectives and mission
2. Identify your goals
3. Identify the staff that will drive the program at the corporate level, regional level and community/facility level.
4. It is important to have the full support of your company Senior Management
5. You must be dedicated to the program as it is time consuming. You will spend a great deal of time in the beginning handling the issue of compliance. There are new reports that the communities must complete and fax in a timely manner in order for the program to work.

Community Name: _____ Region 1: A.L.____ Alzheimer's 1____ Alzheimer's 2____

RISK MANAGEMENT REPORT

Level of Care (0-4) _____

INCIDENT INSTRUCTIONS: Report all incidents that occur within the community and its surrounding ground that are dical or non-medical incidents. To be completed by Director of Resident Care and forward to Executive Director.

RESIDENT / VISITOR NAME: _____

DATE OF MOVE-IN: _____ DATE OF MOVE-OUT: _____ AGE: _____

DATE INCIDENT OCCURRED: _____ APPROXIMATE TIME: _____

DESCRIBE EVENT OR INCIDENT; INCLUDE LOCATION, PERPETRATOR, NATURE OF INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY/ALL INJURIES:

RESIDENT MENTAL STATUS:

☐ ALERT & ORIENTED ☐ CONFUSED AT TIMES ☐ CONFUSED ALL THE TIME

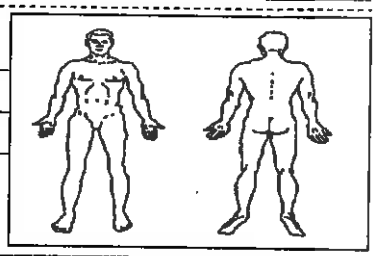
DISPOSITION: ☐ REMAINED IN COMMUNITY ☐ E.R. VISIT ☐ HOSPITAL ADMITTANCE

X-RAYS TAKEN: ☐ YES ☐ NO

URY / OUTCOME:

☐ NONE APPARENT ☐ BRUISE ☐ ABRASION ☐ BURN ☐ SPRAIN

☐ LACERATION ☐ FRACTURE ☐ DEATH OTHER:



VITAL SIGNS: BP _____ PR _____ RESP: _____ TEMP: _____

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN, (INCLUDE PERSON(S) CONTACTED):

FAMILY REACTION (IF KNOWN): _____

FAMILY NOTIFIED:

_____ (Name of Relative) _____ (Date) _____ (Time)

PHYSICIAN NOTIFIED:

_____ (Doctor Name) _____ (Date) _____ (Time)

_____ (Signature and TITLE of Person Completing Form (Director of Resident Care and or Licensed Prof.)) _____ (Date) _____ (Time)

_____ (Reviewed by: Executive Director Signature) _____ (Date) _____ (Reviewed by: Director of Resident Care Signature) _____ (Date)

PRIVILEDGED AND CONFIDENTIAL

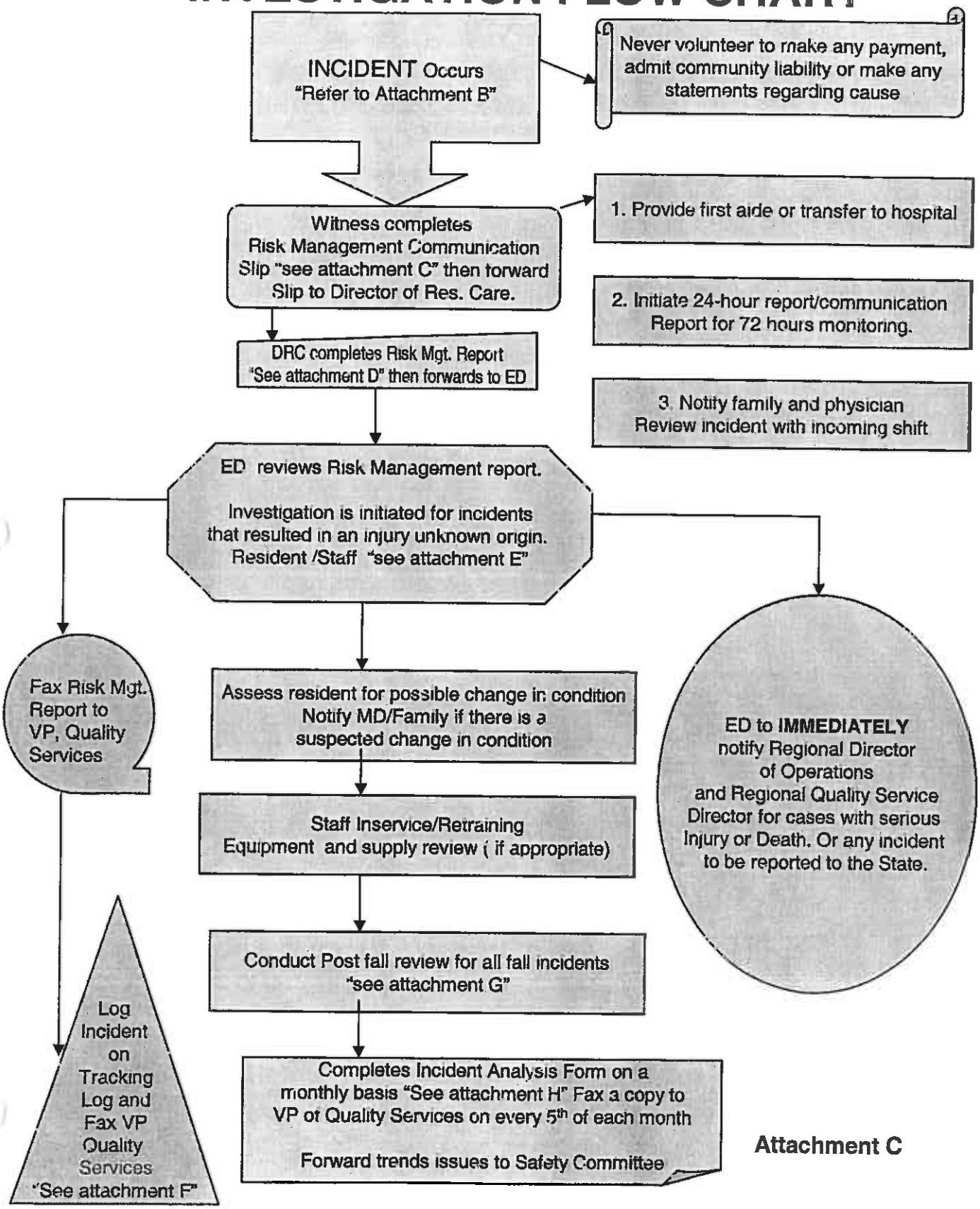
Attachment A

Community Name

Last Name	First Name	Level of Care	Resides in:	Date	Time	Alleged Abuse	Fall s injury	Fall c/injury	Falls w/fx	Skin	Choking / Aspiration	Med/Tx error	Bx episodes	Elopement	911	Death
July						0	0	0	0	0	0	0	0	0	0	0
August						0	0	0	0	0	0	0	0	0	0	0
September						0	0	0	0	0	0	0	0	0	0	0
October						0	0	0	0	0	0	0	0	0	0	0
November						0	0	0	0	0	0	0	0	0	0	0
December						0	0	0	0	0	0	0	0	0	0	0
Totals						0	0	0	0	0	0	0	0	0	0	0

Attachment B

RESIDENT INCIDENT INVESTIGATION FLOW CHART



Attachment C