FALLS MANAGEMENT PROGRAM
IN A SKILLED NURSING FACILITY POPULATION

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North Shore-LIJ Health System

- 16 Hospitals (6,000 Beds)
  - 5 Tertiary
  - 7 Community
  - 3 Specialty
  - 3 Affiliates
- 3 SNF / Rehab Care Facilities
- 34 SNF/Senior Living Affiliates
- Feinstein Institute
- Comp. Continuum of care
- Regional Health System Affiliates (Montefiore & Hackensack)
- 7 million population served
- 4 million patient contacts
- 283,700 Discharges
- 25,600 Births
- 133,400 Ambulatory Surgeries
- 640,000 Emergency Visits
- 504,000 Home Care Visits
- 91,400 Ambulance Transports
- 2nd Largest Secular Health System in the United States
- $6.7 Billion in Revenue
- More than 44,000 Employees
  - 10,000 Nurses
  - 9,400 Physicians
  - 1,500+ Residents and Fellows
- 2010 NQF National Quality Award
- Hofstra North Shore-LIJ School of Medicine
Broadlawn Manor

- 320 bed state of the art, skilled care facility
  - 60 short-term rehabilitation beds
  - 260 long-term care beds
- Avg over 50 admissions/ month with a total of 600 admissions for the year
- Comprehensive patient/resident care services
  - Complex Medical and Nursing Services
  - Full-service Rehabilitation Department
- Scope of Service
  - Orthopedic, Neurological, Cardiac, Pulmonary, Post Acute Surgery Rehabilitation; Long term intravenous therapy; Picc lines, clysis/ Bi-Pap/ Palliative/ Hospice care; Heart failure program; Patient/family education
  - We offer full clinical services (Expert medical team; PT/OT/ speech therapy; Nutrition services w/ 4 Registered Dietitian; Social work services w/ 5 LMSW/ Therapeutic recreation w/ music, art therapy, and pet therapy.
  - Synchronized clinical services with the NSLIJHS hospitals, (sunrise clinical, PAC system, CORE lab, Home Care, Eclipsys, etc.) to ensure interdisciplinary communication and coordination to mitigate risk and maximize the continuum of care.

Orzac Center for Rehabilitation

- 120 bed state of the art, skilled care facility
  - 90 short-term rehabilitation beds
  - 30 long-term care beds
- Avg over 130 admissions/ month with a total of 1538 admissions for the year
- Comprehensive patient/resident care services
  - Complex Medical and Nursing Services
  - Full-service Rehabilitation Department
- Scope of Service
  - Orthopedic, Neurological, Cardiac, Pulmonary, Post Acute Surgery Rehabilitation; Long term intravenous therapy; Peritoneal Dialysis; Trach care/ Bi-Pap/ C- Pap; Palliative/ Hospice care; Heart failure program; Patient education
  - We offer full clinical services (Expert medical team; PT/OT/ speech therapy; Nutrition services w/ 4 Registered Dietitian; Social work services w/ 8 LMSW/ LCSW; Therapeutic recreation w/ music and art therapists
  - Synchronized clinical services with the NSLIJHS hospitals, (sunrise clinical, PAC system, CORE lab, Home Care, Eclipsys, etc.) to ensure interdisciplinary communication and coordination to mitigate risk and maximize the continuum of care.
Stern Center for Rehabilitation

- 249 bed state of the art, skilled care facility
  - 219 short-term rehabilitation beds
  - 30 long-term care beds
- Avg over 200 admissions/month with a total of 2746 admissions for the year
- Comprehensive patient/resident care services
  - Complex Medical and Nursing Services
  - Full-service Rehabilitation Department
- Scope of Service
  - Orthopedic, Neurological, Cardiac, Pulmonary, Post Acute Surgery Rehabilitation; Long term intravenous therapy; Peritoneal Dialysis; Trach care/ Bi-Pap/C- Pap; Palliative/ Hospice care; Heart failure program; Patient education
  - We offer full clinical services (Expert medical team; PT/OT/ speech therapy; Nutrition services w/ 4 Registered Dietitian; Social work services w/ 8 LMSW/ LCSW; Therapeutic recreation w/ music and art therapists
- Synchronized clinical services with the NSLIJHS hospitals, (sunrise clinical, PAC system, CORE lab, Home Care, Eclipsys, etc.) to ensure interdisciplinary communication and coordination to mitigate risk and maximize the continuum of care.

The North Shore-LIJ Health System’s three skilled nursing facilities, Stern Family Center for Rehabilitation, ORZAC Center for Rehabilitation, and Broadlawn Manor Nursing and Rehabilitation Center have reduced patient falls with injuries far below state and national benchmarks by utilizing an interdisciplinary team approach and engaging patients/residents and families in risk reduction strategies.
Falls are a critical indicator of the quality of care rendered in a skilled nursing facility. Falls management reflects good care and best practice. At the three owned skilled nursing facilities of the North Shore LIJ Health System, falls and falls without injury have been avoided utilizing an interdisciplinary team approach and focusing on evidence-based practices.

Our objective is to reduce falls and injuries from falls in the skilled nursing facility population, initiate hourly rounding with a purpose, improve communication within and between departments, and improve patient/resident/family education on risk factors related to falls.
A FALL: Definition

• An unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed)
  
  or

• Is reported to have landed on the floor (un-witnessed) not due to any intentional movement or extrinsic force such as stroke, fainting, seizure (CMS)

  • Found on Floor/FOF

Introduction and Scope

• Falls cannot be prevented

  • We can only reduce the RISK of falling and reduce the RISK of getting injured from that fall

  • Fall Management among patients in acute/long term healthcare settings requires a multifaceted approach

  • The recognition, evaluation and management of patient falls are significant challenges for all who seek to provide a safe environment in any healthcare setting
• Falls are common in nursing facilities. Of the 1.6 million residents in the U.S. nursing facilities, approximately half fall annually. About 1 in 3 of those who fall will fall two or more times in a year.

• Falls often have serious consequences, especially in frail older residents. Fall-related injuries decrease the resident's quality of life and ability to function.

• One in every 10 residents who fall has a serious related injury and about 65,000 patients suffer a hip fracture each year. (CDC)

Prevalence

• 30% of those over 65 fall annually
• Falls go up with each decade of life
• Rate increases to 40% to 50% for persons over the age of 80 years
• Half are repeat fallers
• Over half of those in nursing homes and hospitals will fall each year
• 90% of the annual 350,000 hip fractures result from falls
• Fall rate ranges from 2 to 3 times as great for women over men
Consequences of Fall Event

Major consequences
- Fractures
  - Hip
  - Wrist
- Decreased mobility
- Psychosocial dysfunction
- Fear of falling
- Head injury
- Death

Minor consequences
- Bruising, lacerations

Cost factors:

In 2000, the total direct medical costs of all fall injuries for people 65 and older exceeded $19 billion:
- $0.2 billion for fatal falls
- $19 billion for nonfatal falls
  - Fractures were both the most common and most costly nonfatal injuries. Just over one-third of nonfatal injuries were fractures, accounting to 61% of total nonfatal costs or approximately $12 billion.

In 2000, the direct medical cost of fatal fall injuries totaled $179 million.
Clinical Importance
Impact of Hip Fractures

• 1% of falls result in hip fracture
• $2 billion + in medical costs annually
• 25% die within 6 months
• 60% have restricted mobility
• 25% remain functionally more dependent

Total Lifetime Medical Costs of Unintentional Fatal Fall-Related Injuries in People 65 years and older by sex and age, United States, 2005 (CDC)
Clinical Importance: Falls Cause Morbidity and Mortality

- Mortality: found on floor
- Fractures: 6% of falls
- Soft tissue injury, head injury, subdural hematoma
- Fear of falling can result in decreased activity, isolation, and further functional decline
- Loss of independence = Loss of Quality of Life

Psychological Dysfunction

- Fear of Falling:
  - Warning Signs
  - Need to touch or hold onto things or people
  - Walks very slowly
  - Takes small steps
  - Limited movement
  - Expresses a fear of falling

- Downward Cycle of Fear
  - Increased fear of falling
  - Moves slower
  - Avoids movement
  - Becomes de-conditioned
  - Decreased strength & endurance
  - Increases risk of falling
Cause of Falls

• It has been helpful for some to classify falls based on environmental, as well as physiologic, factors as a way to better understand their causes.

• One approach, presented by researcher Janice Morse, suggests that falls be classified as:
  – Accidental
  – Unanticipated physiologic
  – Anticipated physiologic
  – Intentional Falls

Accidental falls
Occur when patients fall unintentionally. For example, they may trip, slip, or fall because of a failure of equipment or by environmental factors such as spilled water or urine on the floor.

Unanticipated physiologic falls
Occur when the physical cause of the falls is not reflected in the patient’s risk factor for falls. A fall in one of these patients is caused by physical conditions that cannot be predicted until the patient falls. For example, the fall may be due to fainting, a seizure, or a pathological fracture of the hip.

Anticipated physiologic falls
Occur in patients whose score on risk assessment scales indicates that they are at risk of falling. These patients have some of the following characteristics: a prior fall, weak or impaired gait, use of a walking aid, intravenous access, or impaired mental status.

Intentional Falls—occur when patients intentionally fall to the floor, as when acting out behaviorally.
Evidenced-Based fall risk assessments have the following elements:

- History of falls within last 6 months or less
- Unsteady gait/Difficulty in transferring
- Assessment for dizziness and balance issues
- Assessment for confusion/STM issues
- Assessment for visual impairment/depth perception
- Medication analysis
- Diagnosis review: Seizure, arthritis
- Assessment for Incontinence and frequency
- Assessment of temperament/compliance

*Quantitative designation of Risk and initial steps to considering implementing*

Fall Risk Identification is a key factor in fall management. Intrinsic and extrinsic risk factors should be considered:

**Intrinsic factors include:**

- Effects of aging on gait, balance and strength
- Acute medical conditions
- Chronic diseases
- Reconditioning from inactivity
- Behavioral symptoms and unsafe behaviors
- Medication side effects
Risk Factors & Etiology: Intrinsic

• Decreased Muscle Strength
  • Deterioration in:
    • Isometric strength
    • Dynamic strength
    • Speed of muscle contraction

• Decreased Coordination
  • Gait speed declines 1.6% per year after 65
  • Variable cadence between legs
  • Increased path deviation

Risk Factors & Etiology: Intrinsic

• Abnormal blood pressure
  • Orthostatic hypotension
    • Drop of 20mm of systolic BP after standing
    • 2-25% of seniors suffer from this
  • Postprandial hypotension
    • Reduction in systolic BP after meals
  • Carotid sinus hypersensitivity
    • Can cause a drop of up to 50mm of systolic BP

• Cardiac arrhythmia
  • Inconsistent heart-rate
    • Cerebrovascular insufficiency
      • Cardiac output diminished
      • Lower blood pressure
Risk Factors & Etiology: Intrinsic

• Impaired mobility and balance
  • Deficits in sensory and motor functions
  • Increased trunk sway
  • Failures in the postural control mechanisms
  • Inability to stand on one leg
    • Impaired proprioception
  • Vestibular disturbances
    • Sense of imbalance even when lying down

• Visual deficit
  • Visual field loss
  • Impaired contrast sensitivity
  • Loss of night vision
  • Weakened stereo vision
    • Lack of depth perception

Risk Factors & Etiology: Intrinsic

Normal Aging Changes with Aging

• Neurologic
  – Increased reaction time
  – Decreased righting reflexes
  – Decreased proprioception
• Vision Changes
  – Decreased accommodation & dark adaptation
• Decreased muscle mass

• Multiple co-morbidity
  – Depression, anxiety, insomnia, neuroses
  – Osteoporosis, osteoarthritis
  – Cerebrovascular and cardiovascular disease
  – Cognitive impairment
  – Parkinson’s disease
  – Hypertension
  – Incontinence, malnutrition, gait disorders
Risk Factors & Etiology: Extrinsic

• Medication Use
  • Pharmokinetics
    • Related to drug dosage, concentration and elimination
      • Absorption is similar to younger persons
      • Distribution, metabolism and elimination is affected by aging
        • Due to reduced metabolic activity and renal function
  • Pharmodynamics
    • How drugs react in the body
      • Increased sensitivity to drugs in older persons

Risk Factors & Etiology: Extrinsic

• Medication types
  • CNS Active
    • Sedatives, benzodiazapines
    • Anti-depressants
    • Anti-psychotics
    • Opiates
  • Others
    • Cardiovascular drugs
    • Anti-hypertensive medications
    • Anti-convulsants
**Risk Factors & Etiology: Extrinsic Medications and Falls**

- Sedative-hypnotics, especially long acting benzodiazepines, increase falls (e.g., Ambien)
- Small association between most psychotropics and falls
- SSRIs and TCAs increase falls
- Weak association between anti-dysrhythmics, digoxin, diuretics, laxatives, and falls

**Side Effects of Psychotropic Medications**

- Dry Mouth
- Skin Reactions
- Blood Abnormalities
- CNS Disturbances
- GI Upset
- Severe Constipation
- Difficulty Urinating
- Liver Involvement
- Changes in Blood Pressure
- Weight Gain or Loss
- Addiction
- Tremors
- Water Intoxication
  - Prolonged Seizures
  - Neuroleptic Malignant Syndrome
- Involuntary Movements
  - Akathisia
  - Acute Dystonia
  - Extrapyramidal Symptoms
  - Tardive Dyskinesia
Examples of extrinsic risk factors include:

- Poor lighting
- Cluttered living space
- Uneven floors, wet areas
- Unstable furniture
- Unstable bed wheels
- Ineffective wheelchair brakes
- Missing equipment parts
- Improper footwear
- Hard-to-manage clothing
- Inaccessible personal items

Interventions and Risk Reduction Strategies

- Instruct the patient to request assistance as needed
- Instruct the patient to wear non-skid footwear
- Provide an appropriate armchair with wheels locked at the patient's bedside
- Ensure that the pathway to the restroom is free of obstacles and properly lighted
- Ensure the hallways are clear of obstacles
- Place assistive devices/call bell within a patient's reach
- Raise the side rails as appropriate for access to bed controls, support and repositioning
- Evaluate chair and bed height
- Consider peak effect for prescribed medications that affect level of consciousness, gait and elimination when planning patient care i.e. HTN meds at night
Interventions and Risk Reduction Strategies

• Do not leave “at risk” patients unattended in diagnostic or treatment areas
• Ensure patient transported by stretcher/bed have all side rails in the up position during transport, or if left unattended briefly while awaiting tests or procedures
• Inform and educate patients and /or family members regarding a plan of care to prevent falls
• Include the patient’s family in the development of an individualized safety plan, considering age-specific criteria and patient cognition when planning care
• Collaborate with the patient’s family to provide assistance as needed while maintaining the patient’s independent functioning
• Communicate the patient’s “at risk” status during SBAR shift report and with other disciplines as appropriate
• Observe environment for potentially unsafe conditions, such as loose carpeting and water on the floor

Ensure that you’re assessments are accurate: NEVER ASSUME

• You must rule out an organic reason for a behavioral outburst before you ASSUME that it is secondary to dementia or other psychiatric/psychological diagnosis

• Use the correct pain assessment tool
  • Wong Baker Faces
  • Numeric Scale 1-10
  • Dementia AD

Treat What You Know
Not Necessarily What You See
Ensure that you’re assessments are accurate: NEVER ASSUME

• Narcotics are not always the answer
  • Central Pain
• Much of elder pain is caused by inflammation
  • Peripheral pain
• Narcotics
  • Consider patches
• Pain medication should not be PRN
• Only use PRN for breakthrough pain

The AH HA Moment

• Underscoring pain secondary to using the wrong scale

• Attributing behavior for psychiatric issues which lead to the over use of psychotropic medications and the under use of appropriate pain medicine

• True Quality of Life Issue
Using Your Human Resources Appropriately

- When and where are your falls?
- What was happening on the unit at the time?
- Address the issue with the correct caregiver
- Keep your demented patients engaged

Remember you cannot PREVENT a fall

- But you can manage RISK
  - Appropriate protective gear
  - Concave Mattresses with Bed Alarms
  - Mats on the floor
  - Mattresses on the floor
  - BEAN BAGS
Assessing and Reassessing Patient

• Initial assessment of the patient for risk takes place on admission to the health care facility

• Reassessment of the patient's condition and risk of falling should occur on an ongoing basis every shift

• Formally documented every month

Fall/Harm Risk Assessment

• **All Patients** – Universal Safety Interventions

• **Fall Risk Interventions** - High Risk for Fall (Answers ‘yes’ to 1a or 1b OR 2 of the Fall Risk assessment)

• **Fall with Harm Risk Interventions** - Increased Risk for Falls and Harm from Falls (Answers ‘yes’ to either question 1a or 1b or 2 AND yes to question # 3 of Fall Risk assessment)
Universal Safety Interventions

Safety Standard of Care Applies to all patients/residents

1. Orient to call system
2. Instruct patient to call for assistance before getting out of bed/chair
3. Call bell within reach
4. Personal items and telephone within reach
5. Bed in lowest position with wheels locked & appropriate side rails in place
6. Check patient has glasses and/or hearing aids
7. Non-slip footwear when patient is out of bed
8. Physically safe environment-no spills, clutter, cords, unnecessary equipment
9. Room/bathroom lighting operational, light cord within reach
10. Reassess patient daily and when change in status
11. Ask patient/family to bring prescribed assistive device with non-skid covers

Fall Risk Interventions

*Implement Universal Safety interventions

PLUS Fall Risk Interventions

1. Provide visual cues: YELLOW colored wrist band
Fall with Harm Risk Interventions

*Implement Universal safety interventions, and Fall risk interventions PLUS

Provide visual cues
- Yellow wrist band
- Red Socks on patient

Fall Risk Interventions

Monitor gait and stability
2. Monitor for mental status changes
3. Reorient to person, place, and time as needed
4. Review medications for side effects contributing to fall risk
5. Reinforce activity limits and safety measures with patient/family

Select interventions from the following based on patient's needs

- Use of Alarms-bed, chair or voice tab
- Implement hourly rounding
- Discuss with provider need for PT consult
- Move patient closer to Nurses’ Station
- Assisted toileting using “arm’s reach” rule for commode and bathroom
- Provide interpreter or use interpreter phone to ensure that patient/family understands safety measures to prevent falls.
**Fall/Harm Risk Assessment: Answer all 3 questions**

1. Is the patient 85 years old or older?  
   - **NO**  
   - **YES**

2. Has the patient fallen in the last 6 months or during this admission?  
   - **NO**  
   - **YES**

3. Is this a recent post surgery?  
   - **NO**  
   - **YES**

**Does this patient: Universal Safety Interventions**

- Inform patient/family to visit: WWW.northshorelij.com/preventfalls

**Fall Risk Interventions**

- Any Selected Fall Risk Interventions

**Are there harm risk factors based on your nursing judgment?**

- **NO**  
- **YES**

**Provide visual cues:** Yellow Wrist Band, Red Socks, and Room signage (Red Sock Sign)

**Conclusion:** Universal Safety Interventions

**Other:____________________________________________________

**Surgery**

**Coagulation**

**Bones**

**Age**

**Harm Risk Assessment Guide**

3. **1.** Need assistance with standing, walking or toileting?  
   - **NO**  
   - **YES**

2. **b)** Attempt to get out of bed/chair unassisted when assistance is needed?  
   - **NO**  
   - **YES**

3. Is the patient 85 years old or older?  
   - **NO**  
   - **YES**

4. Has the patient fallen in the last 6 months or during this admission?  
   - **NO**  
   - **YES**

5. Is this a recent post surgery?  
   - **NO**  
   - **YES**

6. **a)** Need assistance with standing, walking or toileting?  
   - **NO**  
   - **YES**

7. **b)** Attempt to get out of bed/chair unassisted when assistance is needed?  
   - **NO**  
   - **YES**

**Fall Risk Interventions**

- Patient screen: YES to Question #1a or #1b, OR YES to Question #2

**Universal Safety Interventions**

1. **1.** Universal Safety Intervention  
   - **YES**  
   - **NO**

2. **b)** Attempt to get out of bed/chair unassisted when assistance is needed?  
   - **NO**  
   - **YES**

3. Is the patient 85 years old or older?  
   - **NO**  
   - **YES**

**Selected Fall Risk Interventions**

- Patient screen: YES to Question #1a or #1b, OR YES to Question #2

**4.** Use of Alarm(s)  
   - Bed Alarm  
   - Voice Tab Alarm

5. **Review medications for side effects contributing to fall risk**

6. **Reinforce activity limits and safety measures with patient and family**

**Education:**

- Patient/family verbalized understanding of fall prevention interventions
- Reinforce education with patient/family
- Educate patient/family using Ask Me 3 Format and Teach Back.  Unable due to__________________________________

**Types of Assessment**

- Daily
- AD Question #3                           Fall with Harm Risk

- **YES** Question  #3
  - **YES** Question  #3

**Implementation**

- **YES**
- **NO**

**Admission**

- **YES**
- **NO**

**Identified Need for Reassessment**

- **YES**
- **NO**

**Transfer to Different Level of Care**

- **YES**
- **NO**

**Date:______________       Time:____________      Unit:_____________

**Nurse (Print Name):________________Nurse Signature:________________

**Type of Assessment:**

- Daily
- AD

**Add to: Universal Safety Intervention  
   - Room signage (Red Sock Sign)

**Add to: Universal Safety Intervention  
   - Room signage (Red Sock Sign)

Revised 4/23/13
Reporting Falls

• Falls and fall injuries should be reported internally to the organization through the Quality/Risk Management Program
  • Investigation
• Internal communication to the staff about falls helps underscore the importance of the program and involves the team in reviewing the protocol and interventions
• Assessing conditions and patterns will guide improvement of the falls management program
• Falls are reported internally for analysis to determine if they need to be reported externally

Improving Falls Management Program

• A systems approach to falls management and safety ensures that an interdisciplinary team addresses the issue from multiple perspectives

• It also allows for local management of issues and barriers that are specific to the unit, staff and patients

• Using systems and processes will assist in analysis of falls data in order to create a continuous improvement cycle
Restraints and Fall Management

Restraints do not lower risk of falls or fall injuries (24,25)

Restraints can actually increase the risk of fall–related injuries and death (5,25)

Restraints limit patients' freedom to move around and leads to muscle weakness and reduces physical function. (3)
Restraints and Fall Management

Physical restraint use in Nursing homes has decreased from 40% to 10% since 1980 (26)

Some facilities saw an increase in falls since regulations took effect, but have also seen a drop in fall-related injuries (9)

Prevention and reduction of falls and injuries from falls reflects good care and best practice and interdisciplinary team approach including:

• Fall management program initiated upon admission with a fall risk assessment and immediate implementation of interventions for high-risk patients
• Hourly rounding with a purpose
• Use of devices to prevent falls including positioning of beds and recliners, use of bed and wheelchair alarms, assistive devices, floor mats
• Other interventions include toileting schedules,
• Review of medications, lighting and providing a safe environment
• Physical Therapy consults for patients with decline in ambulation
Improve communication within and between departments:

• Open communication maintained with staff
• Rehabilitation therapy involvement after a fall, as needed
• Trends reviewed with interdisciplinary team
• On-going staff education (immediate when needed, staff and management meetings, PICG, patient safety rounds, in-services)

Improve patient/resident/family education on risk factors related to falls:

• Staff provides education to patients/residents/families regarding risk factors of ambulating/transferring without assistance and the use of equipment to promote safety (adequate lighting, proper footwear, use of assistive devices such as walkers and canes)

FALLS MANAGEMENT STRATEGIES AND QUALITY OF CARE:

• All falls have complete investigations with data analysis for patterns and trends
• Implementing evidence-based practices and an interdisciplinary team approach
• Engaging patients/residents and families in risk reduction strategies
• Have reduced patient falls with injuries far below state and national benchmarks in all three facilities
RESULTS

**Stern Family Center for Rehabilitation**—fall rate decreased from 3.5 falls per 1000 resident care days in 2011 to 3.2 in 2012.

**ORZAC**, the fall rate decreased from 4.3 falls per 1000 resident care days in 2011 to 3.5 in 2012.

**Broadlawn Manor** falls rate decreased from 7.5 falls per 1000 resident care days in the 4th Quarter of 2012 to 4.4 in the 1st Quarter of 2013. (Broadlawn Manor calculated fall rates differently in 2011 as they were not a part of the NSLIJ HEALTH System then).

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**RESIDENTS EXPERIENCING ONE OR MORE FALLS WITH MAJOR INJURY**

**LONG STAY RESIDENTS (Scale 0%-5% (increments of 0.5%)**

On the CMS Nursing Home Compare website, the publically reported Quality Measure of Long Stay Residents Experiencing One or More Falls with Major Injury reveals that Stern, ORZAC, and Broadlawn Manor have lower fall with injury rates than the New York State and National Averages.

Source: www.medicare.gov/NursingHomeCompare
Strict monitoring of high-risk patients/residents, shift-to-shift walking rounds and the use of bed/wheelchair alarms are among the many evidence-based practices that were adopted and have proven value in fall management and reduction of falls/fall related injuries.

**STERN FAMILY CENTER FOR REHABILITATION HAS ACHIEVED ZERO FALLS WITH INJURIES FOR THE PAST 22 MONTHS.**

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