



Resident Falls How Staff and Families Can Improve Communications

Falls are the most common resident safety issue in long term care settings. Given that about half of all residents will fall every year, it is impossible for long term care homes to prevent their occurrence entirely. This is because many nursing home residents are frail and have multiple medical problems, which compound the risk of falling.

While many things can be implemented to reduce the number of resident falls — and, most importantly, prevent injuries as a result of those falls — open and honest communication between staff and family members is actually a key factor in improving resident safety issues.

In 2005, Baycrest and the Ontario Long Term Care Association (OLTCA) began a collaborative research study on falls in long term care settings, with funding provided by the Canadian Patient Safety Institute. Eight OLTCA-member homes

were involved in the study. Conversations held with administrators, directors of care, frontline staff and family members from the eight participating homes highlighted communication as a key factor in their ability to manage resident falls.

How can staff and families improve communication around falls? How does communication play a role in keeping residents safe and relatively free from injury? Let's take a look.

Risk factors for falling

Numerous factors can cause a resident to fall, with most residents sharing at least one of these risk factors. Some factors are easily modified (the environmental surroundings), while others are not (a resident's personal falls history). Common risk factors for falling include:

- previous fall history;
- vision problems such as cataracts;
- disorders that can affect balance, such as arthritis and Parkinson's disease;
- psychiatric problems, such as dementia, wandering and agitation;
- bladder and bowel problems, including incontinence;
- certain medications (antipsychotics, anti-anxiety or medications to reduce blood pressure); and
- environmental (poor lighting, slippery floor, improper footwear and clutter).

What the care team needs from families

It can be a struggle for family members and staff to know how to handle issues of safety. When a resident is admitted to a home, family members may feel a tremendous amount of guilt that they have entrusted their loved one to total

strangers. Consequently, when an event such as a fall occurs, they may want to automatically blame the staff for not doing their best.

Here are some constructive ways that family members can contribute to a falls prevention program:

- Alert the staff to any history of falls, behavioural problems or wandering at the time the resident is admitted.
- When visiting, alert the staff to any hazards that may increase a resident's risk for falls, such as spills on the floor, broken equipment, alarms that are not working or a stairwell door that is ajar.
- If the resident is at high risk for falls, inform the staff when you are leaving so that the staff can resume their monitoring of your loved one.
- Limit the amount of clutter in the resident's room and do not bring in throw rugs.
- Check with staff before giving the resident new shoes (those with high heels as well as slippers are not safe to wear because they can cause the resident to slip).
- Staff always notify a family member immediately when a fall causing an injury occurs, regardless of the time of day. It is helpful to know if you wish to be called in the middle of the night if your loved one falls and there is **no** injury present, or if the notification can wait until the morning.

What family members need from the care team

When a resident does fall and staff have followed their home's policy and procedures on post-fall management, the next step is to inform the family member as soon as possible. Usually the charge nurse

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has this responsibility. In the instance that you are unable to make contact with the family member by telephone, leave a short and factual message on the answering machine to avoid raising any undue anxiety. In addition to communicating the incident in a professional manner, with the nurse expressing concern about the incident, the nurse should include the following information in the conversation:

- When stating the facts, tell the family member exactly what happened, including how the resident was found and what he or she was doing at the time, if known.
- Do not make excuses or speculate as to why the fall occurred. If the reason for a fall can be identified, this information should be shared; otherwise simply relay the steps the care team is taking to identify contributing factors.
- Tell the family member what injuries were sustained, if any, and what you are doing to treat the injury, including pain and comfort management.
- Inform the family member what type of monitoring will occur after the fall (for example, neurological checks if the resident has hit his or her head) and how this information will be communicated to the staff on the next shifts.
- Share with the family member what will be done to prevent a fall from occurring in the future. Make sure that this information is communicated to the rest of the care team as well.

Strategies to improve communication about falls

Strategies to facilitate communication between family members and other staff could include the following measures:

- Incorporate falls education into your staff orientation program as well as regular inservice sessions. Team members should include staff from administration, nursing, dietary, activities, housekeeping, laundry and maintenance. Although the charge nurse is ultimately the one responsible for communicating falls information with family members, other members of the team should have the opportunity to interact with residents and family

members on a regular basis.

- Alleviate family members' concerns by providing information at the time of admission on how falls are managed in the home (information about the home's policy concerning falls prevention and management, as well as least-restraint, and points on how family members can help with falls prevention could be contained in a brochure).
- Implement a "falling stars" or "falling apple" program (colourful star or apple symbols are placed on residents' doors or over the beds to communicate to staff and family members which residents are at risk for falls).
- Include a family member on your falls quality improvement team.
- Include information such as a resident who is "at risk to fall or who has fallen" on the shift-to-shift report for personal support workers and care aides.

Conclusion

Families and staff are partners in caregiving. Entering a long term care home is an emotionally challenging experience for many residents and their families. Care providers need to recognize that every family has individual preferences, values and beliefs concerning the care of their loved one, and must be sensitive to the questions and concerns they might have with regard to falls. Establishing a "caregiver coalition," in which families and staff form an interdisciplinary team to regularly discuss resident care planning is an effective means to increase family involvement, open the lines of communication, and address the need for mutual trust, respect and understanding.

Nobody likes to deliver bad news. Research suggests, however, that full disclosure of the event builds a trusting relationship between care providers and families. Moreover, the establishment of mutual trust and respect facilitates greater discussion and more effective communication between care providers and families with regard to falls information.

To prevent falls and fall-related injuries, it is important that both families and care providers work together to educate one another on their individual needs and expectations, openly express their concerns with regard to falls, and maintain an open and honest line of communication at all times. **LTC**

RELATED READING

Nursing Home Falls, by Kenneth N. Margolin, Ed. Publisher: Law Office of Kenneth N. Margolin, 2007.

Abstract: Anyone who has seen an elderly loved one living in a nursing home may think that falls are an inevitable part of aging with frailty. That perception is inaccurate. While some nursing home falls may be inevitable, many can be prevented. Doing everything feasible to prevent falls is a primary obligation for nursing homes. Falls can begin a downward spiral, leading to complete dependence or death. They can be fatal in and of themselves. Preventable falls in nursing homes often fall into one of the following categories: (1) physical obstacles in the home itself, such as cleaning equipment left in passageways or furniture jutting out where residents may walk; (2) inadequate assessment for fall risk; (3) improper maintenance of a patient's safety equipment; (4) poor internal design; (5) inadequate supervision.

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