May 2007

Toolbox for Implementation of a Falls Prevention Program in Long-Term Care

Based on the RNAO Best Practice Guideline *Prevention of Falls and Fall Related Injuries in the Older Adult (2005)* and on the *Toolkit: Implementation of clinical practice guidelines (2002)*

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

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Toolbox for Implementation of a Falls Prevention Program in Long-Term Care

What is this Toolbox about?

The aim of this Toolbox is to provide assistance to individuals and organizations in establishing a robust resident falls prevention program on their resident care unit or across their entire long-term care home. The Toolbox can be used to set up a new program or enhance your existing falls prevention approaches. The centerpiece to the falls prevention program is the implementation of the RNAO best practice guideline *Prevention of Falls and Fall Related Injuries in the Older Adult.*

How will the Toolbox assist you in your efforts to prevent falls in the long-term care home?

The Toolbox is designed in a step by step method to assist individuals and/or groups leading the efforts to implement a resident falls prevention program. Long-term care homes are often familiar with best practice guidelines or are able to access the practice guidelines but may have difficulty in implementing an approach wherein best practices are consistently used to prevent falls and/or fall related injuries.

An example of a fictional long-term care home will be used throughout the Toolbox as a case-study to provide a practical demonstration of how each step in the Toolbox can be executed. The example is based on a compilation of lessons from a number of homes.

What will you achieve by using this Toolbox?

This Toolbox will help you acheive:

a) A systematic process for the prevention of falls & fall related injuries.

b) A demonstrated decrease in falls and fall related injuries in your long-term care home.

Guiding Principles

Recommendation 1 from the BPG *Client Centered Care*

Nurses embrace as foundational to client centred care the following values and beliefs: respect; human dignity; clients are experts for their own lives; clients as leaders; clients' goals coordinate care of the heath care team; continuity and consistency of care and caregiver; timelines; responsiveness and universal access to care. These values and beliefs must be incorporated into, and demonstrated throughout, every aspect of client care and services.

The Toolbox is based on four key principles informed by the experiences of a number of organizations that have successfully implemented the RNAO best practice guidelines.

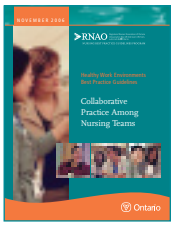
These principles are:

a) Resident centred care philosophy is foundational to any falls prevention strategy.

b) All staff, residents, their families, all departments and management have a role in falls prevention.

c) A team based approach is very important to the success of the program with all team members having a valuable role in prevention.

d) Organizations must appreciate that resident falls are a key issue to be addressed by long-term care homes. Until there is a demonstrated need, it is difficult to secure organizational commitment to change.



The Healthy Work Environments guideline *Collaborative Practice Among Nursing Teams* was developed to assist nurses, nursing leaders, other health professionals and senior management teams to enhance positive outcomes for patients/clients, nurses, and the organization.

This BPG identifies:

- best practices that effectively address collaborative practice/teamwork; and
- the organizational culture, values, relationships and the structures and processes required for developing and sustaining effective nursing teamwork.

Framework

12 Steps on the road to success in falls prevention:

Case Study

The setting is a 250 bed long-term care home, in a large urban city in Ontario, Canada. The home has a long standing reputation for quality care in the community and has been cited for excellence in leadership. The leadership in the home along with their quality management committee believe that the organization can do better in preventing resident falls in their home. They had previously become aware of the RNAO guideline on falls prevention and wondered if this resource might assist their efforts.

As they began their discussions and planning, they identified a need for proper planning and the need to address falls prevention using a-long term approach. They could sense that this issue was not going to be resolved quickly nor would the approach be a simple solution.

Step 1: Establish a Steering Committee

What do you need to do to begin?

Establishing a steering committee, team, taskforce or working group will help you develop an action plan that is appropriate for your organization. Having other individuals who share your objectives will allow you to support each other, in terms of sharing activities as well as encouraging each other.

Before you begin, each member of the steering committee should review this Toolbox and as a team adopt, adapt or modify the Toolbox to meet your organization's culture and your team's consensus.

The following is a checklist to assist you in establishing a steering committee/team:

- ❏ Who has the authority in your organization to formalize such a team?
- ❏ Who will assist in establishing such a team?
- ❏ Who will be appropriate individuals for the team?
- ❏ What will the terms of reference look like for the team?
- ❏ How will the team members be recruited?
- ❏ Who will chair the team?
- ❏ When will the team start meeting?

Case Study

The Director of Care (DOC) and Administrator discussed the need for a steering committee for improving practices on falls prevention. After discussing the possible mandate of the team and potential members, the two leaders felt that their existing quality management committee should undertake this project and act as the steering committee. They also felt that additional membership should be added for the purpose of this project.

At the next meeting of the quality management committee, the DOC presented the project and proposed that the committee take on the planning and oversight of the falls prevention project. The committee members felt that this was within their mandate and that a focused approach to a quality improvement project would actually help their committee members feel they had something valuable to work on. They also agreed on the proposal to add additional members.

The committee discussed the need to address falls prevention across their home – although they did not know how this would be received by all the units. To start, they invited one staff member from each discipline (RN, RPN, PSW, housekeeping, dietary, recreation, physiotherapy, pharmacist). There was a physician already on their committee and the committee felt that another physician was not needed at this time.

Several committee members took on the task of drafting the terms of reference for the steering committee role and presented these for discussion at their next meeting.

Step 2: Establish a Baseline

Assessing the need for change

Once a steering committee is established, it is important to understand how significant the problem of falls is in your long-term care home. Getting a current baseline plus any historical trends is important. This will help the steering committee evaluate whether your falls prevention attempts are making any difference. Using baseline information will help get staff buy-in to prevention interventions, and ongoing data will provide concrete feedback on the impact of the interventions in preventing falls.

The following are therefore reasons for establishing a baseline:

- To understand how big the problem is.
- To raise awareness of the issue with stakeholders.
- To get buy-in from staff.
- To help to evaluate the impact of falls prevention strategies or interventions.

If you don't already have a database or a method for collecting resident fall information, the following is a checklist that will help:

- ❏ Are you collecting any fall information in MDS or other reporting system?
- ❏ Do you have incident or occurrence reporting?
- ❏ Does the data on falls get collated? If so, have you seen any reports?
- ❏ What type of data is collected?
- ❏ Is the available data adequate? Will you need to modify the current system of collecting information? Will you need to develop a new system?

IT IS VERY IMPORTANT TO ESTABLISH THE BASELINE BEFORE YOU START ANY IMPLEMENTATION WORK.

Falls can be measured in different ways and therefore it is important to ensure you have a consistent definition that is used by staff, and that the data is collected accurately. Some examples of falls information that organizations should collect are as follows:

- All residents who come to rest inadvertently on the ground or floor or other lower level (RNAO, 2005).
- Falls may be observed or unobserved – it is important to collect both but to distinguish between the two.
- A history of falling (repeat falls) puts a resident at higher risk and therefore, collecting all falls per resident is important.
- It is also important to collect falls with or without injury.
- It is also important to distinguish the severity of the fall. There are no standards on this; however, minor injury would include scrapes, bruises; moderate may include gashes, sprains; severe may include fracture, and even death.

See pages 38-39 of the RNAO guideline , Prevention of Falls and Fall Injuries in the Older Adult, for a complete list of indicators to consider for the baseline data collection.

Case Study

The Steering Committee discussed the need to obtain baseline data. After reviewing the type of data that were already collected in the home, the team decided that they needed some external assistance. Most recently, the DOC had engaged a professor at a nearby University to mentor one of the registered nurses. The DOC felt that this professor may have some expertise to support their efforts. The professor was invited to assist and the response was an enthusiastic "yes".

With the help of an external resource, the long-term care home established a set of indicators for data collection. A simple Excel database was established and two staff members – a RN and a RPN were trained to use the database; a ward clerk was instructed to enter data. Since the home was establishing a new database, they felt they had the freedom to collect a lot more detail than they would have if they had used their existing sources. Therefore, they collected information such as date, time of day of fall, location of fall, what was occurring at the time of the fall, as well as other information discussed in the guideline.

The database became a very important part of the falls prevention program. When the team got together to discuss a resident after a fall had occurred, the data in the database – especially trended data for the resident became important information to review. The team found that one resident was having repeat falls at a certain time of day. It was determined that the cause of the fall was the need for the resident to be toileted. The PSW changed her order of residents to toilet and the falls experienced by the resident disappeared. These types of experiences reinforced the need to maintain a detailed and accurate database but more importantly, the use of the data for planning the care of the resident.

Step 3: Engage Stakeholders

Who is interested in this issue?... Who is/will be affected?

Use the following checklist to make sure you have this step covered:

- ❑ Do you have access to the RNAO *Toolkit: Implementation of clinical practice guidelines* (2002) If not, you can access it on-line at www.rnao.org or order a hard copy of this resource on-line on the same website. Worksheets are provided on a CD with the hard copy of the Toolkit.
- ❑ Did you access the worksheet to define, select and engage stakeholders? If not, sample of this is provided in Appendix A.
- ❑ Have all stakeholders that may be impacted or affected been informed, engaged or otherwise addressed in the plan for falls prevention?

Involving people who are affected by any change process is important for several reasons: to understand their perspective and include this in planning consideration, to get them to "own" the issue and participate in making it better, to address issues of potential resistance to change or barriers to change.

The RNAO *Toolkit: Implementation of clinical practice guidelines* (2002) has a chapter on identifying, selecting and engaging stakeholders in the change process. See Appendix A for a worksheet that you can use to work with stakeholders.

To have an effective falls prevention program, a multi-faceted strategy needs to be used and this means that the number of potential stakeholders can be large. Not all stakeholders need to be engaged at the same time or in the same manner. Some may be involved in the steering committee, others in preparing for the baseline database, others may be involved in planning educational material, documentation tool changes, or just to provide feedback and consultation. It is important to create an inclusive environment where people feel they have had meaningful input in the planning process, decision-making process and change process.

One group that is often excluded are the residents themselves and/or their families and loved ones. Residents and families may be concerned about falls intervention strategies if they are not involved, if they have not been provided with simple and adequate information and if they don't understand the reasons for the interventions. For example, if the level of strength training exercise is increased and is tiring the resident, the resident and family may not be happy; or if the side rail of the bed is left down (minimal restraint), family may think it is unsafe.

Case Study

The Steering Committee was familiar with the RNAO Toolkit as several of its staff had recently attended the RNAO Best Practice Champions Network orientation workshop. Several hard copies of the Toolkit were available in the home. One of the Champions was asked to facilitate a session with the committee members using the worksheet. As a result of this work, the following key stakeholders were identified as high influence and high support: Resident's Council, Families of Residents, Administrator, DOC and the Best Practice Champions. The following stakeholders were identified as high influence but currently could not provide adequate support: Physician, Pharmacist, Physiotherapist, some of the RNs and RPNs. In order to maintain those who were already providing high support, the Steering Committee devised ways of ensuring they were kept informed and, where possible, were involved in providing feedback to the committee.

In order to harness support from those who were of high influence but low support, an extensive set of strategies were developed:

- Involving stakeholders in the Steering Committee in an active manner.
- Engaging the physiotherapist to do some of his own research on whether Tai Chi or other types of strength training would be better than the current interventions.
- Increasing the time available to the Pharmacist and using this time on a flexible basis for post fall debriefing meetings.
- Providing a presentation on the baseline falls data to RNs, RPNs and PSWs to have them identify areas of concern.

Step 4: Develop Capacity

One of the benefits of any change process is the opportunity to develop additional skill sets and capacity in an organization. These skill sets will not only help with the falls prevention project but with other change initiatives of similar scope. Some of the areas for skill development include:

- Evidence based practice – understanding levels of evidence, developing the ability to search for research or existing clinical practice guidelines, knowing how to assess for quality practice guidelines, etc.
- Networking with external peers and/or other organizational members – identifying who has implemented falls prevention programs, how they have implemented, developing ways in which to collaborate or share best practices, etc.
- Improved understanding of how to prevent falls – increasing the repertoire of strategies based on the RNAO guideline on falls prevention.
- Understanding and managing the change process.
- Developing greater skill sets in knowledge translation, transfer, implementation and sustainability.

Some of the ways the above types of capacity development can occur in Ontario include:

- Involving the Best Practice Long-Term Care Coordinator to assist in identifying other organizations that have implemented the falls guideline, identifying other research and guidelines, etc.
- Taking advantage of government initiatives such as the Late Career Initiative, Nursing Education Initiative funding, New Graduate Guarantee Initiative, RNAO Advanced Clinical Practice Fellowship, RNAO Best Practice Champions Initiative, etc.
- Hosting a Best Practice Champions open house to share implementation successes and challenges for the falls guideline.
- Contacting members of the RNAO Falls guideline expert panel or other experts to assist in mentoring, leading round table discussions, etc.

Case Study

The Administrator and DOC of the long-term care home had started capacity development activity for several years with other initiatives. They had taken advantage of almost all of the available provincial initiatives including having five Best Practice Champions identified, trained and involved in various working groups. One of the Champions had been supported and mentored using the funding available from the Advanced Clinical Practice Fellowship. She took the lead in working with the University Professor in establishing and using the falls database. The Champion also prepared short, 15 minute in-service content geared towards discussing the best practice recommendations and challenges faced by the front line staff in falls prevention.

Several nurses were involved in the late career initiative. One of the nurses assisted in supporting falls risk assessment coaching and developing intervention plans individualized for each high risk resident. This hands-on type of coaching was found to be very successful and staff appreciated the "problem-solving" approach and support.

Step 5: Get the Word Out

How to let everyone know about the issue and what is being done about it.

Creating a visible and high profile initiative allows staff, residents and family members to recognize the importance of the initiative and demonstrates that the home is putting a concerted effort towards resident safety. Establishing a written communication plan ensures that this activity does not get forgotten or addressed in a haphazard manner.

Communication channels can be as diverse and varied as resources and creativity will allow. Some examples are as follows:

- Launch party organized to share the commencement of the initiative. A short presentation to staff, residents, volunteers, families, etc can help to send the message that resident falls prevention is everyone's business.
- Logo, tag line, or some feature associated with the falls prevention initiative can be used consistently throughout the roll-out of the initiative. This gives instant visibility to the project.
- Newsletter – internal or chain newsletter gives profile to the initiative, and allows you to share positive results and/or lessons learned.
- Community newspaper highlighting the event. Local papers are often interesting in these types of human interest stories.
- Posters – with key falls prevention messages – this allows the project to gain visibility and to cue staff and others on specific interventions. e.g. reminding everyone that a history of falls puts the resident at high risk for a repeat fall.

Case Study

The Steering Committee, with help from a volunteer public relations specialist, put together a communication plan using the following template. The following is a sample to demonstrate the use of the template and an example.

	Key Message	Target Audience	Communication Strategy	Materials Needed	Responsibility	Timeline
Goal: Ensure residents, their families, staff and visitors are aware of home's strategic focus on resident safety; specifically, the Resident Falls Prevention Project						
1	Falls prevention is everyone's business	All	Poster campaign Internal Newsletter Community Local Paper	HR, design work, paper, printer.		
Goal: Staff are aware of the progress and impact of their extra attention to falls prevention interventions.						
2	Results of the latest falls data	All staff	Small group meetings to discuss the latest data Display of results in the main lobby of the home	HR, poster presentation		

Step 6: Know the Best Practices Thoroughly

What is the best practice?

When implementing any best practice guideline, it is crucial that a close and thorough review of the recommendations made in the guideline occur. Although this is listed as Step 6 here, it can be performed much earlier.

Use the following checklist to ensure your home has done a thorough review:

- ❏ Access the best practice guideline – one copy for each member of the working group, steering committee and at minimum one copy for each unit in the home. Although the guideline can be downloaded, it may be more impactful if a printed copy is presented to the team.
- ❏ Each person in the working group should read the recommendations and the evidence supporting the recommendations – at first on their own and then discuss the recommendations as a group. This way, everyone in the working group has a clear understanding of the best practices and can obtain clarification where needed.
- ❏ Where there are questions that can not be addressed within the working group, it may be necessary to contact RNAO or another expert in the field. You may need to access some of the articles referenced in the guideline to get a more thorough understanding of the evidence.
- ❏ It is important to start making notes on which recommendations you feel your organization has already implemented, which recommendations it could improve on and which recommendations are not in place at all. This will be an important exercise later when you assist your home to conduct a "gap analysis".

Case Study

The Steering Committee formed a working group of four individuals to closely read the entire guideline and make a presentation to the rest of the steering committee about their understanding of the guideline at their next meeting. They were also asked to present on which recommendations the home should implement and why.

The working group was fortunate that they had already been given a copy of the falls guideline and they decided to individually review the guideline and then meet to discuss their thoughts. At their first meeting, they identified that although their home did follow most of the recommendations in the guideline, they had concerns about the following:

- They were unsure of how consistently the recommendations were being followed.
- There was no consistent way of assessing residents for risk of falling.
- There was no way of flagging residents who were at higher risk of falling. The working group felt that most residents would be considered at high risk if they used some of the existing fall risk assessment tools. This was raised as a major concern and required some expert input.
- There were also concerns raised in terms of availability of the pharmacist to assist in reviewing medications as well as time to conduct post-fall debriefing meetings.
- The working group felt that the few hip protectors they had were bought several years ago and no one was using these. They wondered if there were better products on the market that would be considered more acceptable by the residents and staff.

Step 7: Conduct a Gap Analysis

How does current practice compare to best practice?

This step is often completed at the same time as the review of the best practice guideline. However, the gap analysis should be extended beyond the working group. It is important for staff, residents and others to participate in the gap analysis process so they not only understand the recommendations but also provide their input in the gap analysis and create consensus and a sense of ownership.

There are many ways a gap analysis can be conducted. Here are a few examples:

- ❏ Use a short paper, on-line, or verbal survey.
- ❏ Have short resident/staff mixed meetings or separate meetings to discuss the findings of the working group and then ask for the participants agreement, their thoughts, whether they have additional suggestions, etc.
- ❏ Have each unit conduct their own gap analysis – this is often important if the units serve very different types of residents and the way care is organized is different.

Case Study

The working group decided that they had conducted a fairly good gap analysis when they reviewed the guideline and had their own discussion. They decided each member of the working group would go to different units and have meetings with staff and residents to present their findings from the gap analysis and to get additional input. In order to ensure others were equally familiar with the guideline, a short PowerPoint presentation was developed that each member used to familiarize staff and residents with the best practices.

Step 8: Validate Gaps Identified

What do stakeholders think are the gaps? Do they agree on the issues?

Besides front line staff and residents, it is important to ensure that other stakeholders such as the broader Steering Committee and others are engaged in validating the findings from the gap analysis.

Case Study

The working group presented to the Steering Committee the findings of their own gap analysis but also the summary of the reactions they received when they had presented at each unit and engaged others in the gap analysis process. Although most of the working group's findings were also echoed by the staff and residents, they found a few important additional findings:

- Staff was not sure how strength training exercises that the residents currently received were different from what the guideline was recommending. They had never thought about Tai Chi and based on the little they knew of it, they felt it would not be appropriate. Nonetheless, they were curious to learn more about this form of exercise and wanted the Physiotherapist to do some research.
- Several units commented that falls were not an issue on their unit and that they would not like to participate. After some discussion, they agreed that if they were shown some data on falls, they might rethink their position.
- Several RPNs were not familiar with how medications can put a person at high risk and asked if they could have more information on this aspect.
- Many of the PSWs commented that they would be afraid of leaving one side rail down in the event the resident rolled over. They wanted to understand better what is considered a restraint and what is not.

The working group members took careful notes of these findings to take away and discuss with the Steering Committee as they created the implementation plan.

Step 9: Develop an Action Plan

What will be done to address the gaps? What is the time frame? Who will be involved?

As you can see from the above steps, there are many important considerations that could fall through the cracks when creating an implementation plan. It is important that the action plan take into account the gap areas, not only knowledge gaps, but also attitudes, skills, behaviours, materials, areas of the home that need greater attention than others, etc.

Having a written, systematically developed action plan allows for better implementation, focused attention and assurance that due attention has been provided. The plan should be monitored regularly and modified if needed. Consider the adage, "What gets documented, gets done. What is only discussed and not documented, gets forgotten".

Case Study

The Steering Committee took all the information they had gathered and developed a written action plan. The following is the template they used to document their action plan. They used the RNAO *Toolkit: Implementing clinical practice guidelines* for the template, and to identify interventions that were found to be effective.

Activity	Target Date	Most Responsible Person	Outcome/ Deliverable	Progress

Step 10: Measure the Results

How will you know you have made any difference?

The RNAO best practice guideline has a section discussing indicators. This is a good starting place for development of any falls evaluation plan. Accessing evaluation support from external consultants, academic partners, doctoral students, etc. might be a good idea if the home does not have experience in this area. Nonetheless, there are simple strategies that can be used to measure the impact of the falls prevention initiative. The following are some evaluation questions and strategies to address each question?

Execution of the Implementation Plan

a) How well was the implementation plan executed? Was the action plan robust enough? Was the action plan followed? Were there any barriers or challenges to implementation of the action plan? Did the Steering Committee maintain focus on this initiative?

Organizational Capacity for Falls Prevention

b) Were staff engaged in various phases of the implementation?

c) How well prepared are staff in falls prevention?

d) Do staff feel they can implement the falls prevention recommendations?

Reduction of Number of Falls in the Home

e) What was the rate of falls in the home (broken down by units) before the falls prevention project was implemented?

f) Did the falls prevention project impact on the falls rate in the home or by units?

g) Rate of falls (total), rate of falls with minor, moderate, severe injuries, repeat falls, observed, and unobserved falls.

Case Study

The Steering Committee was very concerned that all the effort, time and resources spent on the falls prevention project would be in vain if they were not able to demonstrate any impact. It was therefore very important to institute a comprehensive evaluation program. They instituted a data collection system for three months before any significant implementation or communication strategy was established. They wanted to ensure that there was a valid baseline. They would then continue to use their evaluation plan and compare results against the baseline and conduct trend analysis by unit and across the home.

Step 11: Support Just-in-Time Learning/Actions

Putting falls prevention strategies into daily practice.

To ensure sustainability of falls prevention interventions, it is important to create strategies that will support staff in their implementation efforts. It is well known that when staff face barriers to implementation, they will revert back to previous behaviours. When this type of situation occurs, staff lose faith in the intended change and are found to be more resistant to conducting other changes in the future. You will often hear staff say, "been there, done that".

Case Study

As mentioned earlier, the home had a late career nurse allocated to assist resident care units in their falls prevention efforts. One of the key roles she played was to spend time with staff in developing individualized resident fall prevention plans and to assist them when they were finding that the plan was not appropriate or needed to be modified. For example, she would walk around the units and offer to assist PSWs with transfers, toileting, etc. During these times, she would discuss with the PSWs how they felt the resident was responding to the falls prevention interventions; whether there were factors that had not been addressed, etc.

Some of the concrete changes or supports provided during these types of on-the spot supports were:

- A few PSWs were found to use the new ceiling slings with inappropriate sling sizes. These errors were easily corrected and the residents were found to feel more safe during transfers.
- An RN on one shift noted that she did not know what to discuss when they held post fall debriefings and felt unprepared for these meetings. As a result, these were not readily held and usual care proceeded. After some reassurance, the RN and the late career nurse devised a checklist of activities that needed to be addressed in the post fall debriefing meeting. The checklist included such things as gathering relevant data on the resident related to previous falls, timing of falls, what was occurring at the time, data on medications, behaviour, etc. In addition, the RN needed to assess what interventions were already being used, whether these were consistently used, effectiveness of the interventions, etc. The RN felt that this was assessment data that she could gather and bring to the discussion at the post-fall debriefing meeting.

Step 12: Sharing Best Practices in Falls Prevention

Since resident fall prevention has been a long-standing concern in the long-term care industry, it is very important to create systems and processes for sharing each other's best practices or successes. There are many ways these communications can occur – some were discussed earlier:

- Best Practice Champions open houses
- Community and internal newsletters
- Seniors Resource website
- Publications and presentations
- Internally at in-services and best practice rounds; etc.

Case Study

While the falls prevention initiative was still underway, the home shared their project and results to date at a long-term care conference. They also attended a open house organized by the Long-Term Care Best Practice Coordinator and were provided with one table/booth to tell the story of their falls prevention strategy. This was an excellent way to share their lessons with others who were attending and were interested in falls prevention. Lots of "show and tell" type material was presented, and was enthusiastically received.

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Appendices

Appendix A: Stakeholder Assessment Worksheet

Key stakeholder	Nature of the vested interest	Stakeholder Influences & support (high, and low)		Management strategies	revise
		Influence	Support		