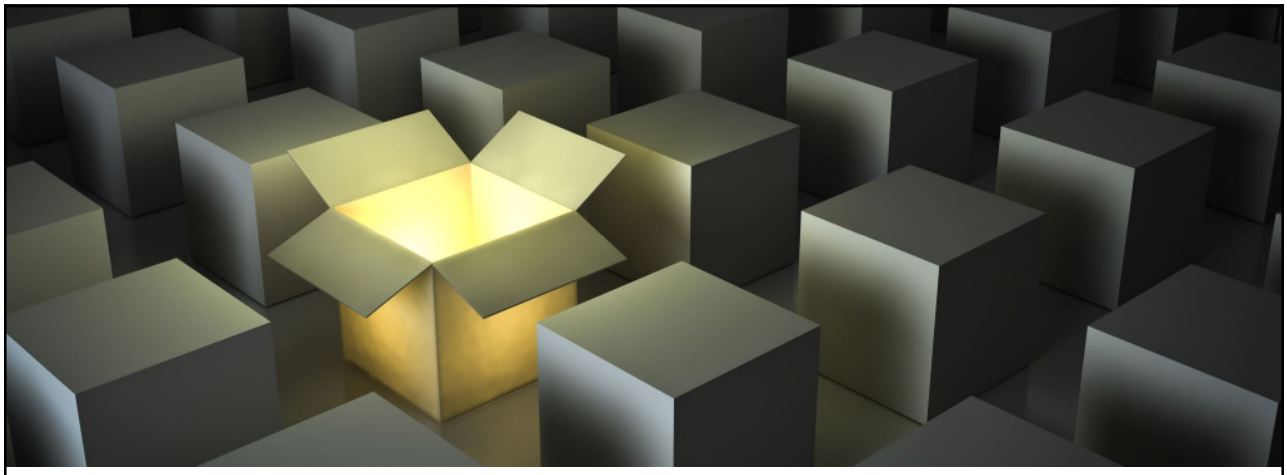

Outside the Box

Fall Prevention and Screening Refocused

1

Beth Payne

OT

NARA's Regional Coordinator - Northeast

VP of Operations

Independence Rehab

Settings include: SNF, HH, OP

Live in Northern Virginia just outside Washington DC

Wife, mother of 2 girls, age 7 & 10 and a Bernedoodle named Porter

Love exploring nature, traveling, and recently started Pilates

2

What we will do...

- Review staffing
- Discuss screening forms and processes
- Discuss Solutions for clinicians to be more effective with evaluations, treatments and discharge planning

3

What I am NOT going to do today?

Regurgitate data

Debate which assessment is best

4

POLL #1

- **What is your role within your company?**
  - Therapist/Assistant
  - Director of Rehab/Manager
  - Corporate leadership

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POLL #2

- **If you could add one element to your existing fall prevention program, what would it be?**
  - More staff (nursing, therapy, etc.)
  - More staff training (fall-risk, post-fall interventions, etc.)
  - More equipment (low-beds, BSCs, walkers, wheelchairs, etc.)
  - Better fall-risk assessment and communication/identification system

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POLL #3

- **What is your biggest challenge with staffing?**
  - Lack of/Staff shortage
  - Burn-out/tired/not motivated to do anything above and beyond
  - Lack of training important to their work and the bigger picture
  - Other

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POLL #4

- **What areas is your workplace short staffed in?**
  - Administration (administrator, DON, MDS, social services, etc.)
  - Nursing
  - Therapy
  - Housekeeping, maintenance, dietary, etc.
  - All of the above

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Staff Shortages

- According to a recent survey by the American Health Care Association and National Center of Assisted Living (AHCA/NCAL):
  - More than half are limiting new admissions due to staffing shortages.
  - Nearly every nursing home of the 1,183 surveyed is currently asking staff to work overtime or extra shifts
  - 86% of nursing homes said their workforce situation has gotten worse over the last three months, with 57% of that group describing it as "much worse."
    - PowerPoint Presentation (ahcancal.org)
    - 58% of Nursing Homes Are Limiting New Admissions Due to Staffing Shortages - Skilled Nursing News

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Outside the Box Staffing Solutions

- Therapists can:
  - Work as nursing assistants as regulations allow
    - For facility, this allows for more admits and higher census
    - For therapists, more work
    - For patients, better care
  - Provide RNA services
  - Continue Walk-to-dine and other programs
- Can work whether you are in-house or contract therapy
- What else?

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9 weeks - 11,944.5 miles

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POLL #5-7 - Screens

- **How often are screens being completed…not when SHOULD they be completed, but how often are they ACTUALLY being completed?**
  - Quarterly
  - Monthly
  - Only as requested
  - Never
  - I don't know
- **How long does it ACTUALLY take you or the therapist to do a screen?**
  - One hour
  - 30 mins
  - 15 mins
  - 5 mins
  - I don't know
- **Is the screen form comprehensive or does it only include ROM or simply to identify "decline in function"?**
  - Comprehensive
  - Limited or specific info only
  - I don't know

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Screening for Success Solutions

- The purpose of a screen is to determine a person's appropriateness for rehab.
  - It is informal.
  - It is quick (3-15 minutes).
  - It should be hands-off. If a person requires hands-on assist, further evaluation may be justified.
  - It should be comprehensive.
- Completing a screen: Use your clinical reasoning. The thought process is no different for an evaluation than for a screen.
  - Is the patient at their prior level of function?
  - Is caregiver training required to maximize patient functional safety and independence?
  - Do they demonstrate potential to benefit from or progress with therapy services?
    - If an area or deficit is identified, then evaluative rehab services are warranted
- A screen is NOT an evaluation.
- An evaluation does NOT guarantee a plan of care will be developed or goals will be established. An evaluation may need to be completed in order to determine if a person would benefit from further skilled therapy services. If not, an Evaluation Only is appropriate to document and bill for.
- A screen does NOT require a physician order.
- Document the screen in the medical record demonstrating its completion and supporting the findings of the screen.

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Myth: They're "Independent" – No Skilled Need

PT
- Community Mobility – Get Into Real World
  - Mobility with distractions and obstacles, curb steps, uneven terrain, car transfers, etc.
- Falls recovery or learning how to fall
- Stair training

OT
- IADLs – Meal prep, med management, laundry
- Environmental Modifications – lighting for low-vision, DME/AE, etc.
- Problem Solving Tasks – Following a recipe, finding a phone number, tracking appts or making a schedule

SLP
- Management of thickened liquids and/or textured diet, resources to obtain
- Communication strategies for safety, making needs known
- Memory strategies such as using a calendar or setting reminders

Discharge Considerations
- Where are they going? What will be provided? IL/ALF services offered vary widely and can be expensive.

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"Supervision"

If a patient is discharging at a supervision level has sufficient patient/caregiver/family training been provided and documented?

15

Myth: They're "Dependent" – No Skilled Need

PT

- Bed positioning, rolling, bridging, EOB, transfers as appropriate
- Wound care
- Wheelchair positioning

OT

- ADLs - Toileting program, AE/DME
- Environmental set-up – Position of call light, location and ability to use phone
- Activity box appropriate for interests and cognitive level

SLP

- Use of Memory Strategies
- Training with Staff – Communication strategies, safe swallow strategies

Discharge Considerations

- Restorative Nursing vs. Part B (or even Palliative or Hospice)
- Ensure social and cognitive engagement from activities out of room, or in room if patient bed-bound

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Scenario – Eval Only

Current Referral	Reason for Referral / Current Illness: Patient is a long term resident of this SNF with progressed dementia who is on comfort cares. Staff recently reported that she rarely is out of bed and is developing contractures but no skin breakdown.
Reason for Therapy	Clinical Impressions/Reason for Skilled Services: Patient is not appropriate for skilled OT services but would benefit from restorative care for PROM of her B U/Es and B L/Es.

No Restorative Services established.

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Eval Only Considerations

- When, if ever, is an "eval only" justified?
  - Is therapy on trial basis more appropriate?
    - Trial different time of day, different nursing shifts, establish caregiver competency, etc.?
- If an eval only is warranted, it needs to be justified in the documentation

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Utilize Full Scope of Practice

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Solution – Make the most of treatment time and required documentation

- NO cookie cutter goals or POC
- Reassess often
- Ensure the goals and POC are:
  - Patient oriented
  - Function oriented
  - Discharge oriented, regardless of d/c setting.

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Plan Of Care (POC) Scenario

- **91 y.o. female admitted to hospital due to a GI bleed.**
- **Mod I prior to admission. Plan to d/c home. Lives with son.** Uses 4WW. 5 stairs to enter/exit. Standard tub w/ shower chair.
- **Eval: set-up w/ FWW for 50 ft w/ 2 turns**, sup w/transfers, partial/mod A with bathing and LB ADLs.
- **2 weeks after SOC, pt. had functional decline w/ O2 sats in 70s while ambulating up to 100 ft.**
- **Physician discharged PT due to decreased O2 sats while ambulating.**
- What do you think is the best course of action? (POLL #8)
  - Discharge PT and/or OT
  - Medical hold for PT and/or OT until further notice
  - Re-assess/re-eval and update therapy POC for PT and/or OT

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Answer: Reassess and update POC for both PT & OT

- **After PT discharge, patient fell 2x over weekend attempting to get out of w/c provided by nursing to go to the bathroom.**
- Therapy should have advocated/educated physician on therapy scope of practice to update POC to include:
  - New goals for w/c management and safety,
  - Add new goals for Perceived Level of Exertion (PLE) with transfers or ambulation
  - Monitoring of vitals and activity as tolerated within physician parameters
  - Focus on PLB, energy conversation with ADLs
  - Family/caregiver training for discharge planning as patient and son determined to return home.

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POLL #9

- When do most falls happen at your facility or for your patients?
  - At night
  - When walking to bathroom without assist
  - During the day
  - With therapy

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Share our tips and tricks with nursing and help them out!

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POLL #10

- What is a more common PT goal that you write or see?
  - Pt. will ambulate 100 ft. with min A using LRAD
  - Patient will safely ambulate 50 ft. with min A using FWW on level and uneven surfaces under high-attention demand situations without medical complications in order to prepare for discharge home.

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Back To Basics

- Falls don't occur when a person is walking down a nice wide, flat, straight hallway with minimal distractions.
- Falls don't occur from poor upper body strength. We all know that core strength is more important with fall prevention.
- We need to get back to the basics of incorporating functional assessments and functional goals to address the root cause.
- We need to be comprehensive in our assessments, education, and training to both patients and caregivers to include:
  - Vision (especially in low light scenarios/changes in lighting)
  - Sensation (especially in feet),
  - Proprioception/vestibular
  - Core strength
  - Appropriate adaptive device/surface changes
  - Learning to Fall & Fall Recovery
- **Practice the activity itself in its entirety, not just components or simulated.**

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Takeaway for today – You already have the skills, but you may want to consider rearranging how you use them to maximize effectiveness of your screening and fall prevention processes.

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References

- https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Workforce-Survey-September2021.pdf

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