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How to Maximize Your Technology Investment
The Digital/Human Intersection —
Reducing Falls and Risk

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Speakers

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Agenda

1 Review most common gaps in fall programs

2 How to select the right technology

3 Learn best practices for digital and human touchpoints to fall programming

4 Case Study: AI-technology and fall management

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Most common gaps to fall programming

The Basics of Fall Management Programs

Fundamentals of successful fall management programs

"CULTURE OF SAFETY"

→ Team approach to resident safety through open communication, clear performance criteria, and quality improvement processes

RESPONSE TO FALL PROCEDURES

→ Process from the fall event to post fall (24 hours)

PROACTIVE APPROACH TO REDUCE OF FALLS

→ Screening and assessing resident risks on a routine schedule or change of condition

Fall Management Program Details

Below are components to a comprehensive fall program:

Communication

Documentation: Policies & Procedures

Education & Training

Fall Risk Assessments

Interventions

Fall Response / Investigation

QAPI

Most Common Fall Programming Gaps

→ Insufficient fall response (assessment, notification, documentation)

→ Most communities do not conduct multidisciplinary fall huddles

→ Failure to implement individualized interventions

→ Insufficient fall analysis to determine root cause

→ Lack of expertise and resources to collect and extract data easily

Fall Response

Fall Huddle

Interventions

Quality Assurance

Fall Analysis

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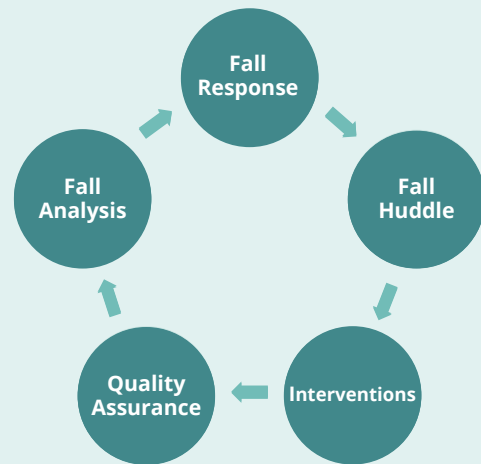
Most common fall technology

Most common fall technologies are focused on the response to falls

→ Pendants or wearables

→ Pull cords or nurse call lights

→ Bed or floor alarms

→ Motion sensors

⚠ **None solve the key point of understanding how falls are occuring.**

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How to select the right technology

What are we trying to solve?

In order to select the right technology you need to know what you are trying to solve. Below are ways to get that answer.

Define the problem

- Falls data review
- Trends by frequency and severity

Who should be part of the conversation?

- Nursing
- Departmental
- CNA / Care Staff focus groups

What do we want to find out about falls?

- What happens before the fall?
- What happens during the fall?
- What happens after the fall?

How will it be applied?

Understanding how the technology will be used and applicable to the community is critical to its success. Below are questions to consider:

→   What is the impact to residents?

→   Will it be a burden to staff to use or train? Ease of use?

→   What information will be useful to use? How does it change decision making?

→   How does this support communication or family satisfaction?

How does the technology support your goals?

Understanding your fall programming goals and how the technology supports achieving those goals will help determine the right solution.

- Formulate goals based on what you can measure

- Define actionable goals as a team. Try to avoid large goals like "reduce falls" as it can be difficult to reach those as individuals or a team

- Understand how you plan to measure the goals and create quality assurance for accuracy

- Create a schedule when to report goal attainment and milestones

- Be open to adjusting goals

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Sample Goals

Reducing Time...

→ On the Ground
→ To Acknowledge
→ To Respond
→ To Assist

Interventions Implemented within 2 Weeks

Reduction in Fall Severity

Staff Training & Education

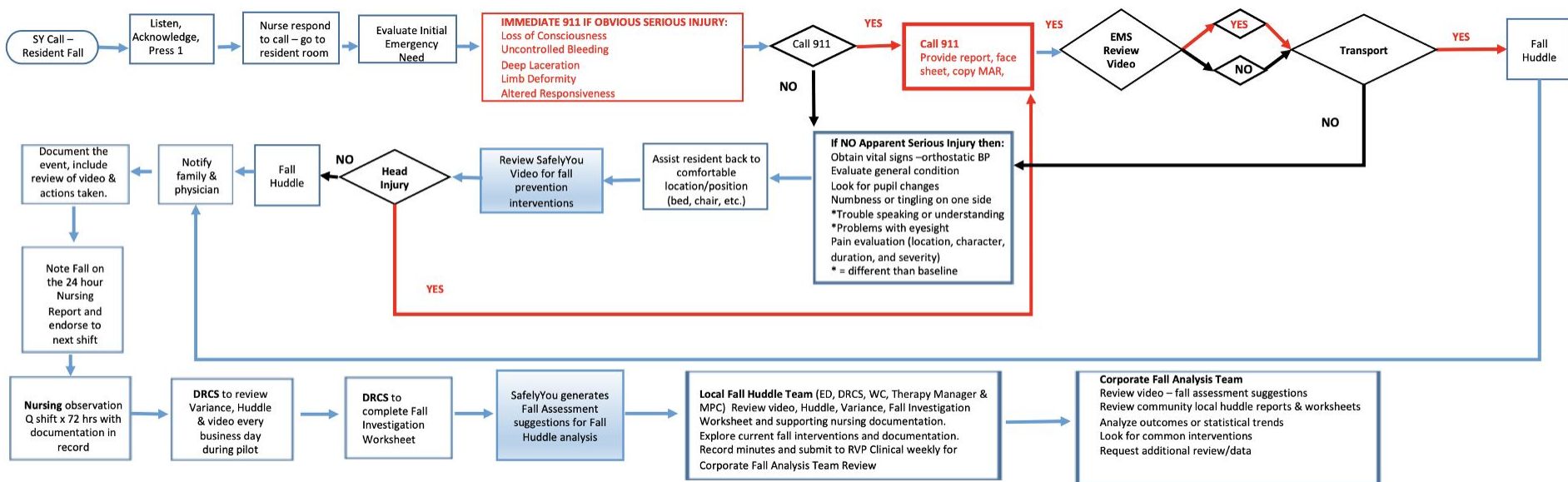**Improved Documentation, Reporting & Analysis**
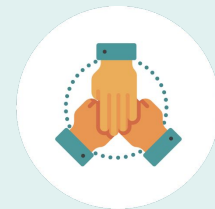
Fall Huddles within Set Time after Fall

Person-Centered Fall Response

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Best practices of digital and human touchpoints

Fall response workflow + technology

Make sure you assess the workflow and where the technology fits

SY Call – Resident Fall → Listen, Acknowledge, Press 1 → Nurse respond to call – go to resident room → Evaluate Initial Emergency Need →

IMMEDIATE 911 IF OBVIOUS SERIOUS INJURY:
Loss of Consciousness
Uncontrolled Bleeding
Deep Laceration
Limb Deformity
Altered Responsiveness

→ Call 911 — **YES** → **Call 911** Provide report, face sheet, copy MAR, — **YES** → **EMS Review Video** → YES / NO → **Transport** — **YES** → Fall Huddle

Call 911 — **NO** →

If NO Apparent Serious Injury then:
Obtain vital signs –orthostatic BP
Evaluate general condition
Look for pupil changes
Numbness or tingling on one side
*Trouble speaking or understanding
*Problems with eyesight
Pain evaluation (location, character, duration, and severity)
* = different than baseline

Transport — **NO** →

Assist resident back to comfortable location/position (bed, chair, etc.) ← Review SafelyYou Video for fall prevention interventions ← **Head Injury** — **NO** → Fall Huddle → Notify family & physician → Document the event, include review of video & actions taken.

Head Injury — **YES** →

Document the event → Note Fall on the 24 hour Nursing Report and endorse to next shift → Nursing observation Q shift x 72 hrs with documentation in record →

DRCS to review Variance, Huddle & video every business day during pilot → **DRCS** to complete Fall Investigation Worksheet → SafelyYou generates Fall Assessment suggestions for Fall Huddle analysis →

Local Fall Huddle Team (ED, DRCS, WC, Therapy Manager & MPC) Review video, Huddle, Variance, Fall Investigation Worksheet and supporting nursing documentation. Explore current fall interventions and documentation. Record minutes and submit to RVP Clinical weekly for Corporate Fall Analysis Team Review →

Corporate Fall Analysis Team
Review video – fall assessment suggestions
Review community local huddle reports & worksheets
Analyze outcomes or statistical trends
Look for common interventions
Request additional review/data

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Fall Huddle Basics

WHAT:

Interdisciplinary meeting led by the **fall champion** to review fall incidents & interventions

WHY:

Benefits include accurate reporting, promote collaboration and the ability to analyze effectiveness of interventions

WHO:

Attendees may include executive director, nursing, activities coordinator, maintenance, direct care staff and a designated **fall champion**

WHEN:

Scheduled Weekly

Note: Event (Post) Fall Huddles should take place immediately following the fall event, within an hour, with key personnel to ensure all proper documentation is collected and any interim interventions can be implemented. In addition, a deep dive Fall Huddle (Root Cause Analysis) supports QAPI structure to support the fall program.

Fall huddle process and the technology

How does the technology provide knowledge about the fall to provide insight to understand the fall and support interventions

Review incident documentation Does it support the incident reporting?

Understand the fall scene and details Does it give you event details?

Root cause analysis How does it provide insight on the cause?

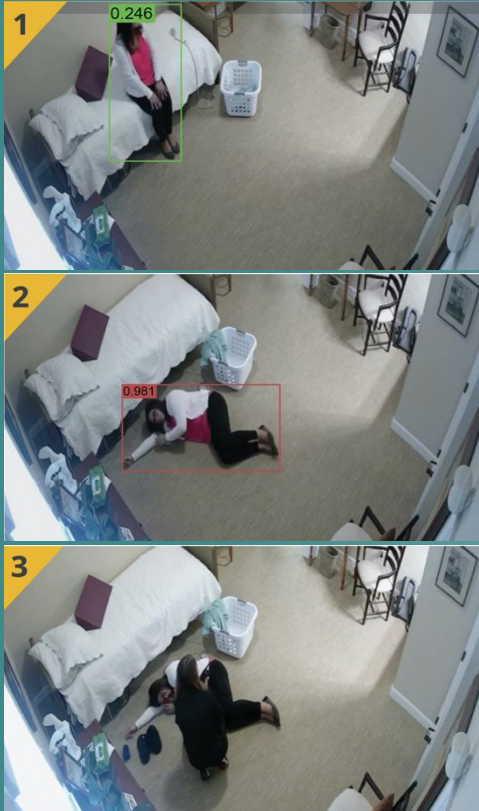**Interventions and Action Items** Can it support closing the loop of actions?

Data trends What information can you trend?

Case Study: AI technology and fall management

Artificial Intelligence

SafelyYou Optimizes the Fall Response

→ Continuous fall monitoring for consented residents

→ Video is automatically deleted if no fall is detected

→ 99% fall detection accuracy
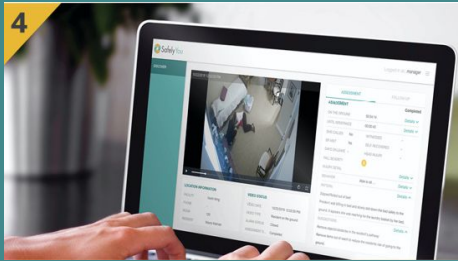
→ Fall video is uploaded to SafelyYou-Discover website

→ Immediate fall notification & escalation

→ Integrations to nurse call systems

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Immediate Video Review (actual fall event)

SafelyYou Supports Fall Prevention

→ Immediate Video Review for specific associates

→ Confirm root cause, possible injuries, and interventions

→ Fall Insight – Detailed fall assessment by SafelyYou clinicians

→ Fall Huddle – Review fall details and incident report with SafelyYou

→ Staff Insight – Quality assurance on protocols and staff engagement which drives performance improvement

→ Documentation accuracy

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Case Study 1

Found on Floor

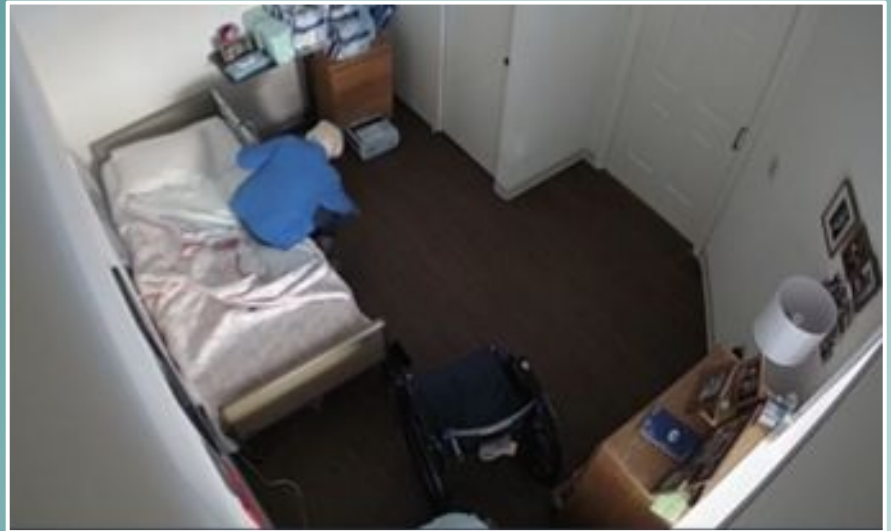Self-Transfer, WC position, Unlocked

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Case Study 2

Found on Floor

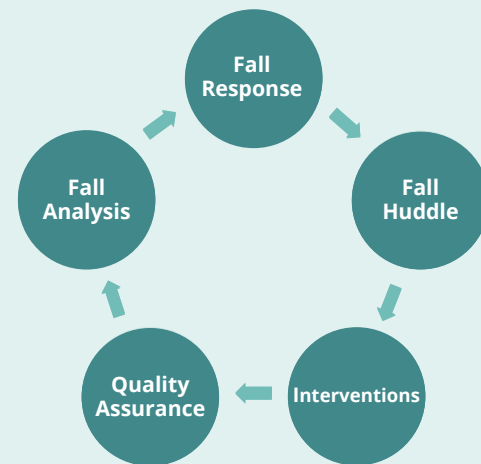Witnessing Actual Event

Case Study 3

Found on Floor

Interventions Implemented

Technology supporting gaps in fall programming

SHORTCOMINGS	CULTURE OF SAFETY
Lack of standardization in workflow and documentation	✔ 99% fall detection accuracy ✔ Automated escalations ✔ Event detail accuracy
Most communities do not conduct multi-disciplinary fall huddles	✔ Root cause analysis ✔ Multi-disciplinary witnesses ✔ Remote clinical fall assessment ✔ Fall expert support
Unable to determine root cause	✔ Understand how falls occurred ✔ Observe prior falls and interventions
Limited documentation inputted by 1 person	✔ Comprehensive event details ✔ 3rd party fall and staff observations
Lack of expertise and resources to collect and extract data easily	✔ Time analysis of event details ✔ Trending for cause, interventions, fall patterns

Fall Response → Fall Huddle → Interventions → Quality Assurance → Fall Analysis → Fall Response

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Questions?

Thank you.

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