



Long Term Care Highlights



North Dakota Department of Health
Division of Health Facilities

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“CATCH ME WHEN I FALL” FALL PREVENTION IN THE ELDERLY

By Rhonda Lowenstein, RN, Health Facilities Surveyor

According to Health Care Services, falls are the leading cause of injury and the sixth leading case of death among the elderly. Approximately two-thirds of those who experience a fall will fall again within six months. At least one-third of falls occur at home during normal daily activities as a result of environmental hazards. Almost half of admissions into long-term care facilities are the result of falls. Older adults are more likely to sustain seriously injury from a fall than any other age group. Most commonly, the resulting injury is a fracture. This makes fall prevention an extremely important step in the prevention of serious injury among the elderly.

There are many contributing factors that increase the risk of a fall in the elderly. Age-related changes can increase the risk of falls. These changes include:

- Impaired vision.
- Impaired gait (mobility).

- Loss of muscle strength.
- Impaired balance.

Environmental factors that increase the risk of falls in the elderly include:

- Poor or inadequate lighting.
- Wet floors.
- Loose or torn carpet or rugs.
- Clutter or obstructed pathway.

Other factors that contribute to increased risk of falls in the elderly include:

- Multiple medication use/drug therapy.
- Use of hypnotics (sedatives), anti-anxiety or hypotensive medications.
- Improper footwear.
- Behavioral factors, such as confusion or wandering.
- Improper use of assistance devices, such as a walker.

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Preventing falls is the key to avoiding serious injury or fracture in the elderly. Long-term care residents who have fallen previously are at higher risk of falling again. It is important to assess fall risk in the elderly and implement appropriate interventions. The reason/cause of unsteadiness or falls should be investigated carefully. Medications, environmental factors, age-related changes and history of falls all need to be considered in assessing risk. Prevention should

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include interventions to address the above risk factors. Goals should include reducing the number of falls; reducing trauma associated with falls; maximizing strength, balance and mobility; and medications to counteract loss of bone density in residents with osteoporosis.

Interventions to minimize the risk of falls and serious injury may include:

- Adequate lighting and a clean, uncluttered environment.
- Non-skid rugs.
- Properly fitting, comfortable footwear.
- Physical therapy to maximize strength, balance and mobility.
- Monitoring medication regimen, including hypnotics, anti-anxiety and hypotensive medications.
- Periodic assessment of fall risk
- Adaptive equipment, such as a low bed, accessible grab bars, call lights and light switches.

There are many other preventative measures to prevent falls in the elderly; one of the most important factors to prevent falls is education. It is vital for nursing facility staff, families and residents to be educated about the risk factors and preventative measures to avoid falls and the subsequent injuries that so often follow.

REFERENCES

www.healthcareservices.gov.bc.ca/prevent/preventing_injuries "Preventing Injuries."

www.bmj.com/cgi/content/full/327/7406/89 . "Preventing fractures in the elderly."

www.ext.colostate.edu "Preventing Falls in the Elderly."

Nurse Aide Training Programs: What IS REQUIRED in the Curriculum?

*Carolyn Desper, RN BNSc,
Health Facilities Surveyor*

If your facility has a Nurse Aide Training Program (NATP), you are aware of the guidance that requires an every-other-year survey of the program. Historically, the one item consistently discussed and revised is the NATP course curriculum. The Code of Federal Regulations (CFR), Subpart D – Requirements that must be met by States and State Agencies: Nurse Aide Training and Competency Evaluation provides the minimum standards a NATP must follow to be in compliance.

The curriculum component of the CFR is at 483.152 (b). The NATP survey is a very small "snap shot" of the education provided. In order for a program to meet the minimum curriculum requirements, the curriculum is required to have the **exact wording** of the CFR. Following is the exact wording of the CFR, starting at 483.152 (b) (2). Review of your program is encouraged to ensure this wording is in the curriculum (the underlined portion does not need to be included in the curriculum).

(2) Basic nursing skills: (i) Taking and recording vital signs; (ii) Measuring and recording height and weight; (iii) Caring for the residents' environment; (iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; (v) Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to: (i) Bathing; (ii) Grooming, including mouth care; (iii) Dressing; (iv) Toileting; (v) Assisting with eating and hydration; (vi) Proper feeding techniques; (vii) Skin care; (viii) Transfers, positioning, and turning.

(4) Mental health and social service needs: (i) Modifying aide's behavior in response to residents' behavior; (ii) Awareness of developmental tasks associated with the aging

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process; (iii) How to respond to resident behavior; (iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; (v) Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents: (i) Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others); (ii) Communicating with cognitively impaired residents; (iii) Understanding the behavior of cognitively impaired residents; (iv) Appropriate responses to the behavior of cognitively impaired residents; (v) Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services: (i) Training the resident in self care according to the resident's abilities; (ii) Use of assistive devices in transferring, ambulation, eating, and dressing; (iii) Maintenance of range of motion; (iv) Proper turning and positioning in bed and chair; (v) Bowel and bladder training; (vi) Care and use of prosthetic and orthotic devices.

(7) Residents' Rights: (i) Providing privacy and maintenance of confidentiality; (ii) Promoting the residents' right to make personal choices to accommodate their needs; (iii) Giving assistance in resolving grievances and disputes; (iv) Providing needed assistance in getting to and participating in resident and family groups and other activities; (v) Maintaining care and security of residents' personal possessions; (vi) Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff; (vii) Avoiding the need for restraints in accordance with current professional standards.

The curriculum must identify the requirements at CFR 483.152 (b) (1): At least a total of 16 hours of training in the following areas prior to any direct contact with a resident; (i) Communication and interpersonal skills; (ii) Infection control; (iii) Safety/emergency procedures including the Heimlich maneuver; (iv) Promoting residents'

independence; and (v) Respecting residents' rights. This section does not require exact wording, but the time dedicated to each area must be clearly defined in the curriculum and needs to add up to 16 hours.

For instance, the topics for CFR 483.152 (b) (7) (i – vii) [Resident Rights] will provide that education component, but would also count for resident rights training as part of the 16 hours of required training prior to direct resident contact specified in CFR 483.152 (b) (1) (v).

The curriculum must identify the requirements at CFR 483.152 (a) (3): "Include at least 16 hours of supervised practical training (SPT). *Supervised practical training* means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse." The curriculum must accurately define a minimum of 16 hours of supervised practical training.

Education conducted to meet the requirements of CFR 483.152 (b), will be part of the 16 hours of required SPT at CFR 483.152 (a) (3). For example, the return demonstration by the trainee of skin care will meet the requirement of SPT and be a component of the training for skin care at CFR 483.152 (b) (vii).

The curriculum must clearly define the hours of training. CFR 483.152 (a) (1) "Consist of no less than 75 clock hours of training." Clock hours do not include meal breaks. Clock hours also do not include breaks provided during training; i.e., coffee break, bathroom break, stretch break, etc.

Each program has the freedom to develop a curriculum which follows the book they use. The information from the CFR does not have to be in the order of the CFR, but the words from the CFR must be in the curriculum.

If you keep this information in mind each time a revision is made to your program's curriculum (to match a new textbook or by a new instructor), you could save yourself the time and effort of another revision at your next NATP survey.



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RAI Updates

By Joan Coleman
State RAI Coordinator

The Centers for Medicare and Medicaid Services (CMS) has posted the Minimum Data Set 3.0 (MDS 3.0) timeline for implementation. The updated draft version of the MDS 3.0 form, the written introduction, and the timeline are now available on the CMS website at: [http://www.cms.hhs.gov/NursingHomeQuality-Initiatives/20_NHQIMDS20.asp#TopOfPage](http://www.cms.hhs.gov/NursingHomeQuality-Initiatives/NHQIMDS20.asp#TopOfPage)

Since 1995, extensive clinical updating of the MDS has not occurred. According to CMS, the main advances in MDS 3.0 are:

- Giving the resident a voice.
- Increasing clinical relevance.
- Increasing accuracy.
- Increasing clarity.
- Reducing the time to complete the assessment by 45 percent.

The changes in MDS 3.0 have been designed to improve data assessment, care planning and quality measurement. CMS now plans to evaluate the impact of the MDS 3.0 changes on the resident classification system, RUG-III, used in the Medicare payment structure. The results of this evaluation will be available in late 2008 or early 2009. Plans are for the MDS 3.0 to be finalized and implemented nationally on October 1, 2009.

Our New Health Department Employee

By Cindy Kupfer



You will be hearing a new voice when calling the Certified Nurse Aide Registry. We have added Rocksanne Peterson to our staff. She will be working with Cindy in all aspects of the CNA registry. Please help us make her welcome.



QUOTE:

In frustration it's easy to jump to the conclusion that life is out to get you. Wrong assumptions will invariably lead you to wrong conclusions.

Richard S. Vegas



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