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LIMITLESS

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ArizonaLeadingAge.org

Dementia and Fall Risk Management:

An Interprofessional, Value-Based Approach

Prepared for:

Arizona LeadingAge

Prepared by:

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Sarah Cooper, PT, DPT, GCS is a physical therapist and Clinical Director at Powerback Rehabilitation. She received her Doctorate of Physical Therapy in 2016 and completed a Geriatric Physical Therapy Residency Program in 2017. Following residency, she successfully became a Geriatric Certified Specialist (GCS) through the American Board of Physical Therapy Specialties. In her current role, Dr. Cooper provides clinical support and education to rehab teams across the country. She has presented locally, nationally, and globally on a variety of topics related to rehabilitation for older adults.

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Crystal Steinbrook, MCD CCC-SLP, CDS, CDP

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Crystal Steinbrook is a Speech Language Pathologist and Certified Dementia Practitioner with 19 years experience with evaluation and treating people living with all forms of Dementia. She has also been a Positive Approach to Care Certified Independent Trainer and Coach for the last 4 years and is actively involved with not only Powerback Rehab but Teepa Snows' Positive Approach to Care. She has worked across all settings of Skilled Nursing, Assisted Living, Memory Care, Home Health, as well as Hospitals.

Under these certifications she has taught over 25 classes to licensed professionals and families. She has worked with patients through all stages of Dementia as well as worked directly with families to educate and train them on communication techniques and approaches to decrease the burden of care on loved ones while making visits more meaningful for People Living with Dementia. She has provided CEU courses to therapists, nurses, CNA staff, and other healthcare professionals through a hands-on learning experience to promote carryover of skills into everyday work life.

Her approach to treating patients is that all people are different and therefore should be treated as such. She uses her expertise in Dementia care and Speech Language pathology to show others that Someone Living with Dementia can continue to thrive and have a meaningful life with the right care.

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Objectives

- Define interprofessional practice and outline the roles and expectations of key team members in interprofessional fall risk management for persons with dementia.
- Examine fall risk factors and how dementia impacts those factors.
- Apply interprofessional approaches to develop meaningful intervention for fall risk management through case examples.

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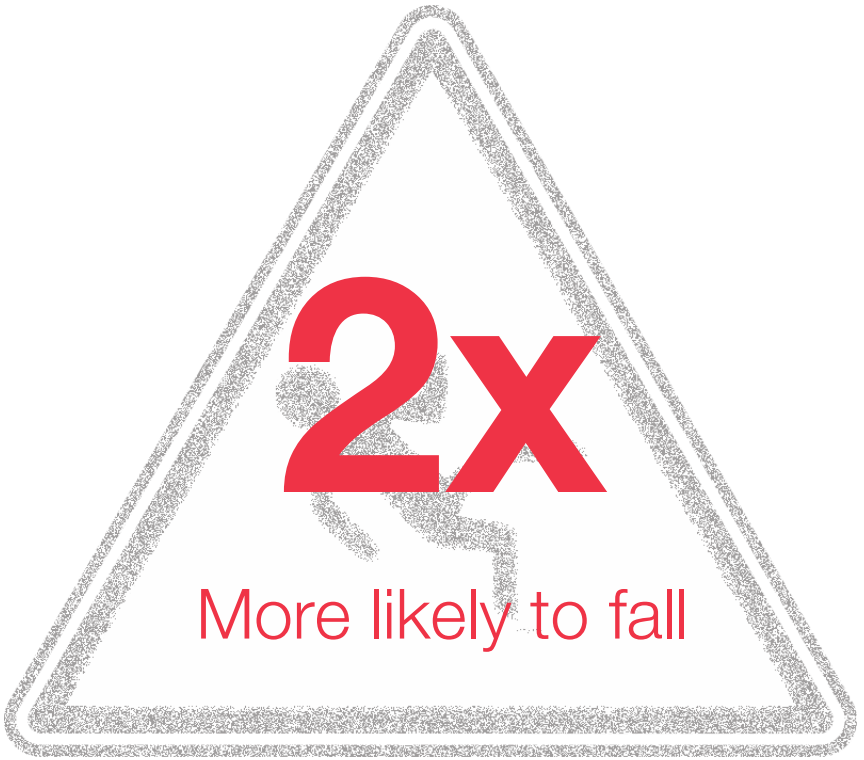
Dementia And Falls

12.7 million by 2050 (Alz.org)



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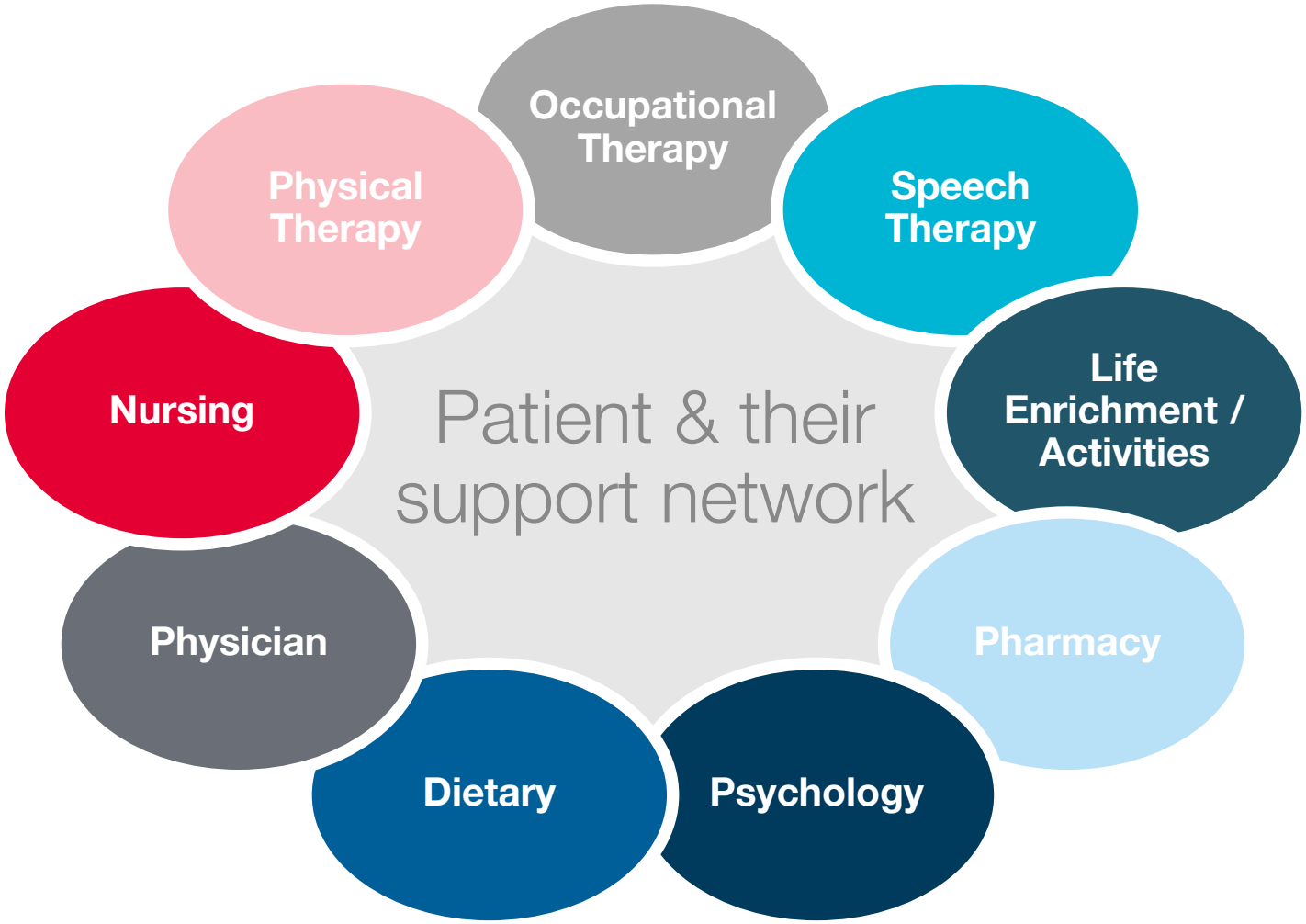
Interprofessional Practice Model & Dementia



(IPEC, 2011)

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Fall Management

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Increased Fall Risk Factors Related to Dementia

- Type of Dementia
- Depression/Anxiety
- Orthostatic Hypotension
- Gait Velocity
- Multiple Medications

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Principles of Fall Risk Management

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Fall Risk Management Standards

1. Scan room for possible safety hazards
2. Instruct in the use of bed controls, call lights
3. Ensure personal item, call lights, and fluids are within easy reach
4. Provide adequate lighting to allow support safe mobility
5. Remove Clutter to allow a free path for mobility
6. Inspect floor for wet or slick areas
7. Lock wheelchair and bed wheels
8. Provide skid resistant footwear
9. Maintain bed height to maximize safety and mobility
10. Keep eyewear within easy reach
11. Educate resident/family regarding precautions
12. Reinforce for the individual to call for assistance

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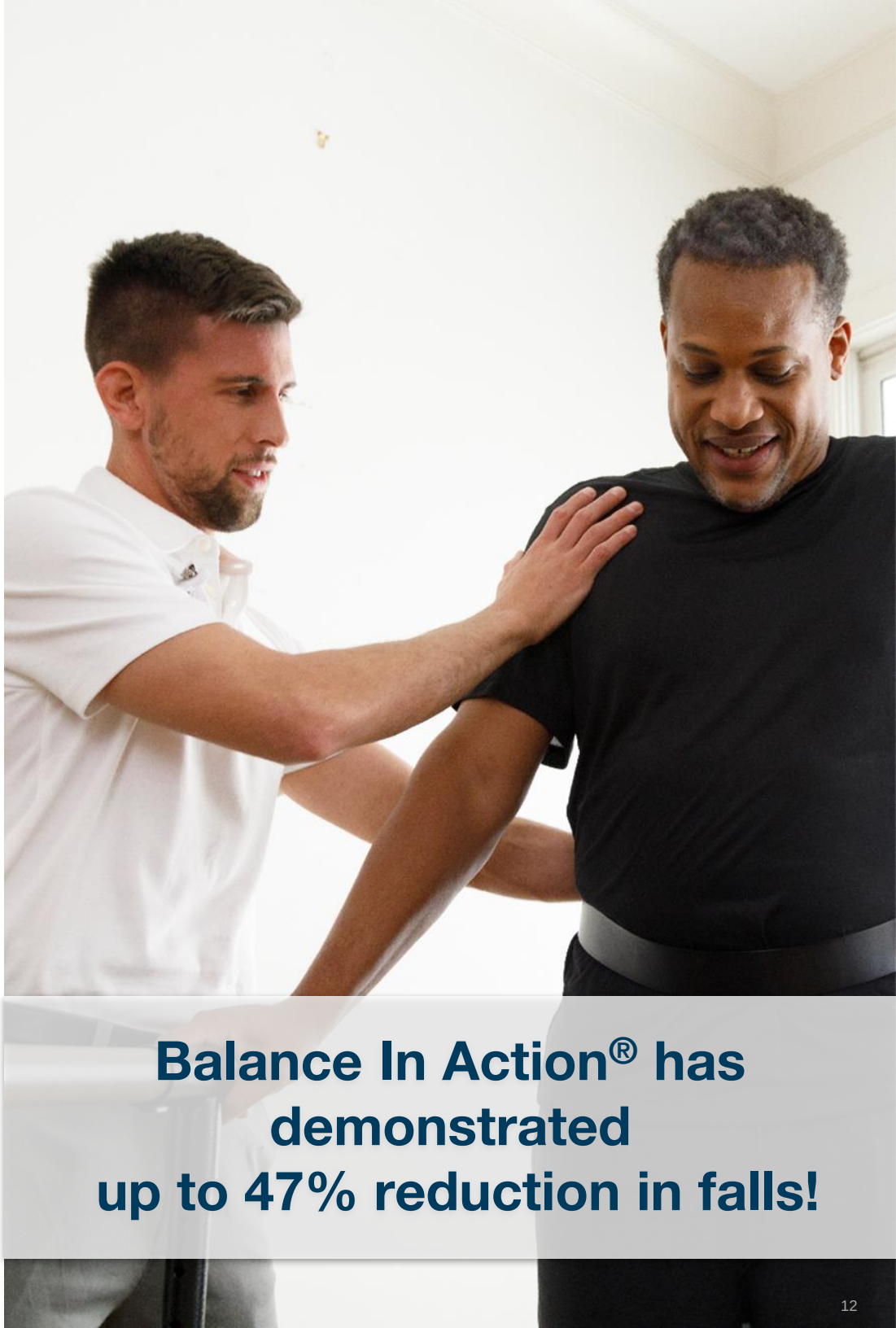
Falls Prevention: Balance In Action®

Balance In Action® (BIA) as our evidence-based falls prevention and management program for individuals at risk of falls in any care setting.

Program Components

- ✓ Education for rehab and center staff to establish effective interdisciplinary falls management and prevention approaches.
- ✓ Implementation of a process and systems for communication and collaboration across all care settings to identify and address fall risk factors and ensure program carryover.
- ✓ An evidence-based exercise program that can be used with individuals, groups, and at home.



Balance In Action® has demonstrated up to 47% reduction in falls!

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Individual Fall Risk Management Program

Identify	Collaborate	Address
✓Identification and stratification of fall risk factors for each individual resident	✓Collaborate as an inter-professional team to discuss a comprehensive plan for addressing the fall risk factors for both prevention and intervention	✓Evaluate and treat any fall risk factors within your scope of practice

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Fall Risk Factors

- ❑ History of Fall
- ❑ Balance Deficit
- ❑ Diabetes
- ❑ >4 Medications
- ❑ Gait Deficit
- ❑ Visual Impairment
- ❑ Depression
- ❑ Orthostatic Hypotension
- ❑ Muscle Weakness
- ❑ Female
- ❑ Pain
- ❑ Arthritis
- ❑ Impaired ADLs
- ❑ Cognitive Impairment
- ❑ Incontinence
- ❑ Age >80

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After A Fall:

- ✓ Investigate thoroughly
- ✓ Discuss with the IPP team
- ✓ Update the individualized fall risk management program

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Interprofessional Collaboration

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Interprofessional Fall Risk Management Program

Develop systems to track and communicate:

- Individual fall risk factors
- Interprofessional plan to mitigate risk / key members involved in plan
- Quarterly therapy screens

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Interprofessional Fall Risk Management Program - Example

Risk Factor	Potential Interventions	Lead Team Members	Support Team Members
>4 medications or benzodiazepines Or Inappropriate use of OTC	Reconcile medications	MD/Pharm D to reconcile medications and insure patient on lowest effective dose MD/Pharm D for patient education	Rehab/Nursing to identify if patient taking inappropriate medications; identify and report possible side effects affecting fall risk SW/Pharmacy to ensure patient is able to pay for medications and take appropriately Patient/Caregiver to follow medication regimes
ADL Impairment	Assessment of impairment Treat appropriately to match interventions to root cause(s) of impairment - may be physical, cognitive, visual, etc	OT	ST: comprehensive cognitive assessment assessment findings and suggested corrective/compensatory strategies shared with care team Rehab/Nursing: support consistent strategies and interventions

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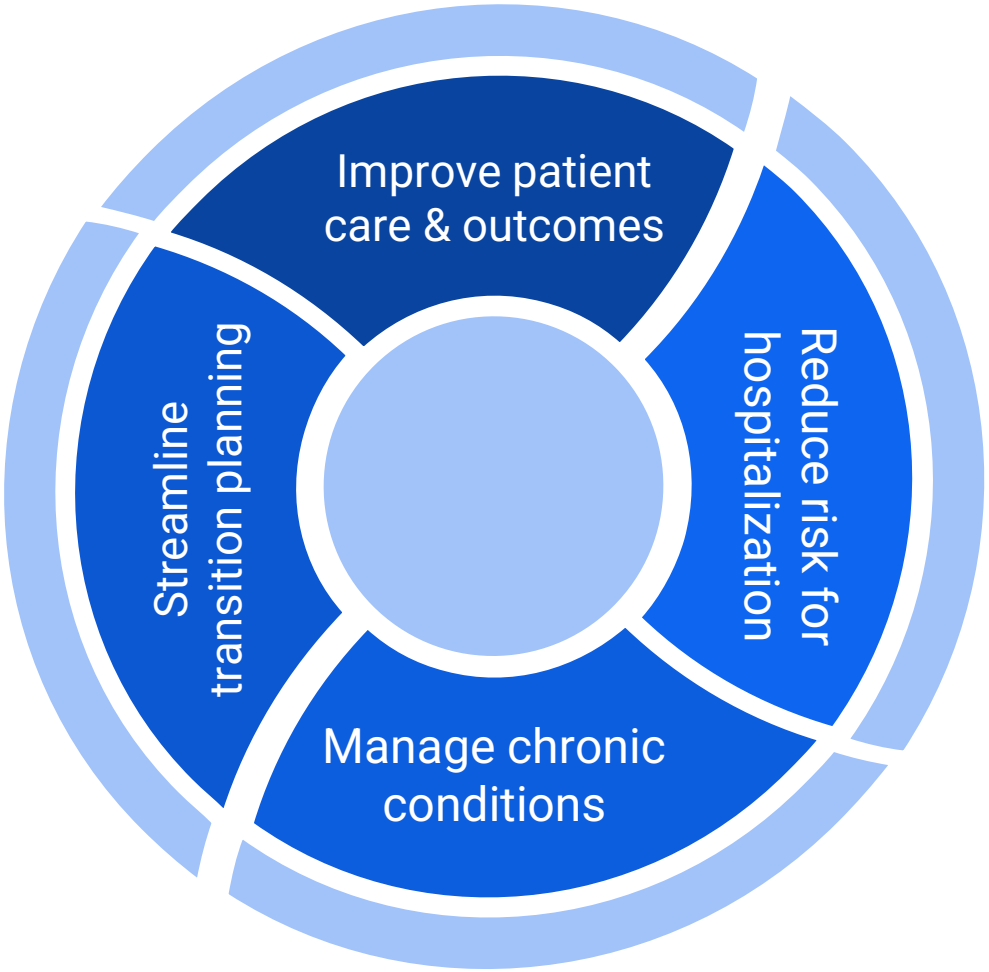
Goals: Interprofessional Fall Risk Management



Meet Brenda:

- Recently moved to supportive care environment
- Multiple falls
- Changes in routine
- Limited social interaction
- New complaints of pain
- “Wobbly”

Interprofessional Collaborative Practice for:

- Nursing?
- Therapy?
- Life Enhancement?

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Considerations for Persons with Dementia

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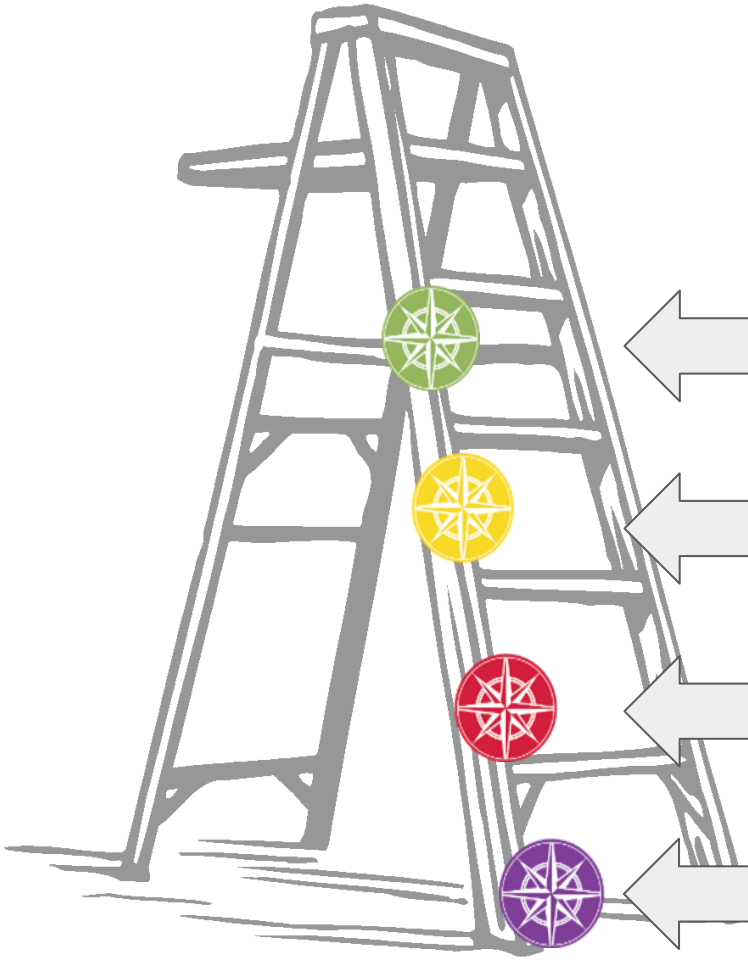
Progression of Dementia



Preclinical AD: no symptoms, possible biological changes in the brain

Early Stage / Mild Dementia

Middle Stage / Moderate Dementia

Late Stage / Severe Dementia

End Stage

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Managing Fall Risk Factors: **MCI / Early**

- Address problem-solving and reasoning
- Implement memory compensatory strategies
- Encourage socialization and involvement
- Manage function of sensory systems

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Managing Fall Risk Factors: **Middle / Moderate Dementia**

- Use errorless learning & Spaced Retrieval
- Identify & implement daily routines
- Support mental and emotional well-being
- Simplify instructions
- Allow 30 seconds to process
- Use written and visual systems

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Managing Fall Risk Factors: **Late / Severe Dementia**

- Anticipate needs
- Support communication with gestures
- Allow up to 90 seconds to process language
- Maintain positive nonverbal body language
- Maintain daily routines to support success

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Managing Fall Risk Factors: **End Stage**

- Dependent on others for survival
- Support communication with gestures
- Responds to sensory: touch, music
- Maintain positive nonverbal body language

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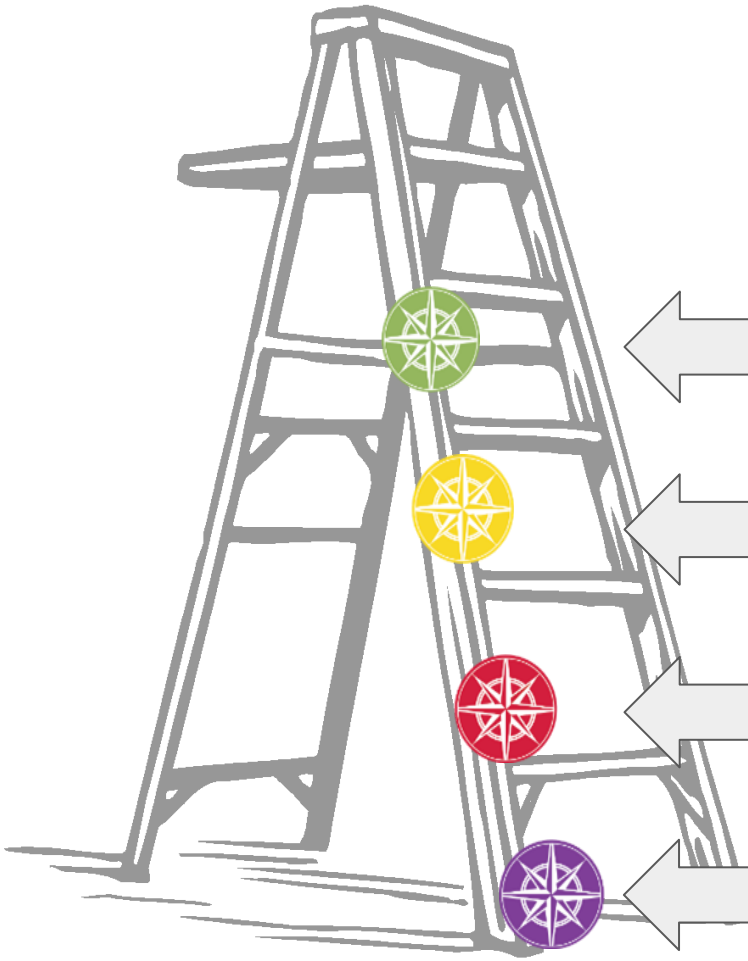
Example: Music, Movement, & Dementia



May sing or dance (with modification as needed), may express song/genre preferences

May sing or hum well-known chorus, may shuffle, tap foot, or clap hands to the beat

May show increased alertness, participate in assisted clapping, or sing a few words

May open/close eyes, smile/frown, have increased body movements

Social Circles

It is our pleasure to support residents in active living. We are able to go beyond rehabilitation therapy services and traditional wellness programs to offer additional enhanced lifestyle and well-being opportunities within the community.

Our Powerback team members will evaluate resident interest and design opportunities for “Social Circles.” According to the US National Library of Medicine National Institutes of Health, “Participation in community activities (eg, sports and hobby groups or volunteer organizations) is believed to be associated with better health status in the older population.” Examples of Social Circles include a cooking club or a men’s group.

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Mobility

Pre Dementia

Can learn new assistive device

Educate on physical limitations & healthy exercise habits

Early Stage Mild Dementia

Benefits from structure and routine for physical activities

Introduce new devices with additional support

Middle Stage Moderate Dementia

New devices must be meaningful due to loss of ability to learn

Remove obstacles

Late Stage Severe Dementia

May stop suddenly at flooring changes

Will not notice barriers below the knee

May require wheelchair

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Activities of Daily Living (ADLs)

Pre Dementia

Effective Monitoring for Education/ Health Management

Early Stage Mild Dementia

Assist/Monitor IADLs

Provide Structured Environment for ADL Routine

Middle Stage Moderate Dementia

Cognitive Assist Required for Basic ADLs

Task Segmentation/Simplify Tasks

Familiar Routines

Late Stage Severe Dementia

Tap into Procedural Memory

Hand under Hand or Guiding Techniques

Managing Resistance to ADLs

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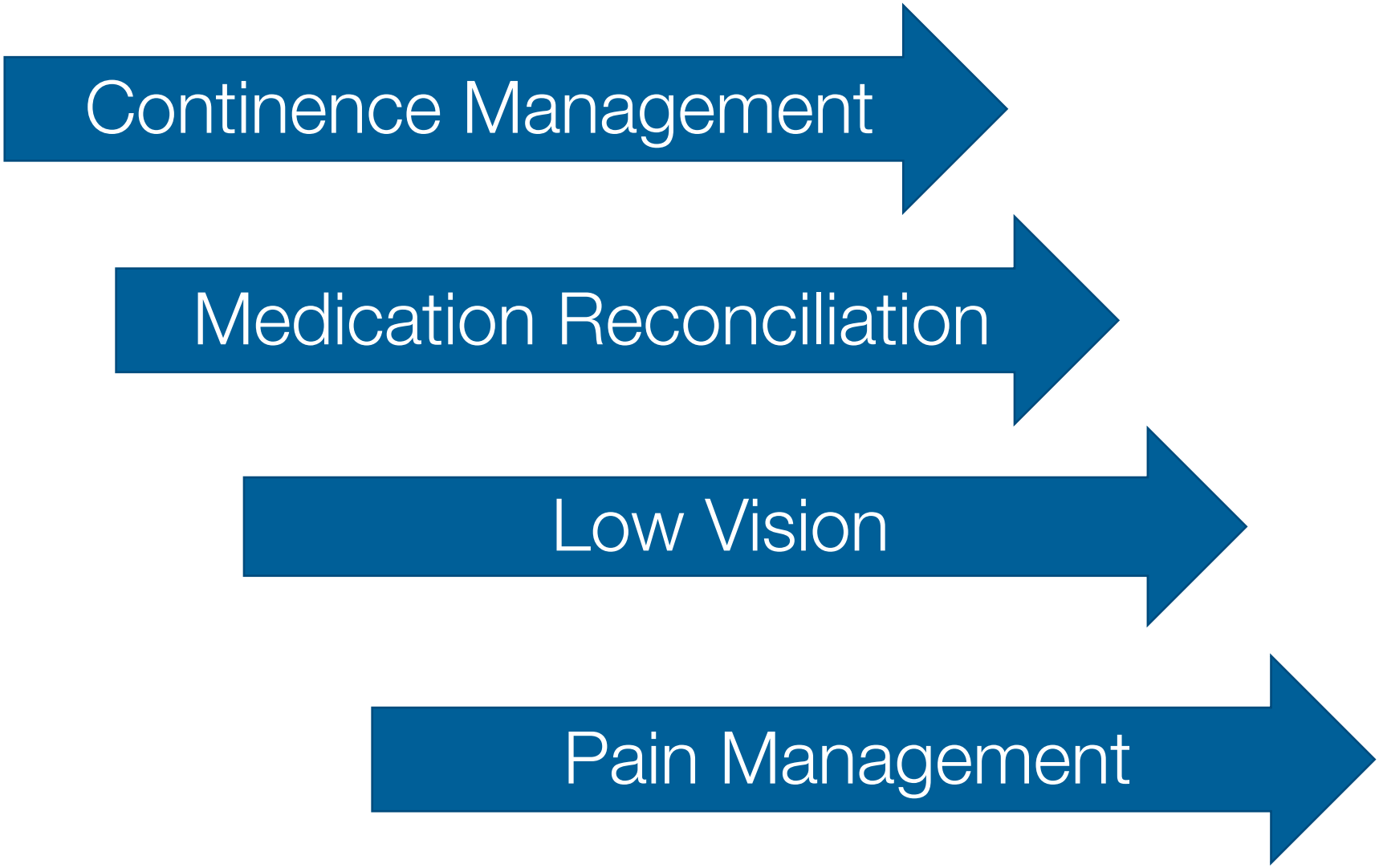
Additional Treatment Areas to Manage Fall Risk



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Depression, Dementia, & Fall Risk

- Increased fall risk for depression combined with medical conditions
- More than 50% of patients with dementia have one or more depressive symptoms
- Non-pharmacological interventions may include:
  - Routine Exercise
  - Engagement in meaningful activities
  - Validation Therapy

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Betty

Betty is an 85 yo female, whose spouse died a year ago and has 3 children, 6 grandchildren and 4 great grandchildren who all live close. Betty was a local librarian and was known for her love of cake decorating. After Betty retired, she was often found sharing a dessert with a friend over a cup of coffee or with one of her grandchildren that visit her after school. Betty was diagnosed with dementia a year ago and living alone with intermittent family support to assist with meals, medication/financial management and was walking independently and still able to care for her basic needs. Betty fell 2 weeks ago and suffered a hip fracture. She was admitted for PT/OT with a plan to discharge to a nearby ALF. She has fallen since her admission and was found near the bathroom without her walker. Rehab reports that she "knows" how to use her walker and can walk short distances with general supervision. She has been refusing therapy stating "I don't need that. Just leave me alone."

WHEN YOU'VE GOT QUESTIONS, WE'VE GOT ANSWERS.

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