TIPS Question:

Do you have any suggestions on how to deal with a resident who is at risk for falls because he tries to self-ambulate? He has the ability to remove his TABS monitor. He scored 8/30 on the Folstein MME. Issues:

- pain #9th rib
- very brittle bones
- anosognosia
- constipation
- emotionally sensitive
- climbs out of bed - one/two side rails up
- removes incontinence product/urinates on bed/floor
- family/staff are concerned

Response:

In your TIPS question, you have listed several issues. My suggestion, especially when you are first beginning to use the template, is to focus on one issue at a time, and work through the template from that perspective. You will find other solutions/strategies for the issue you are not focusing on also come to light as part of the P.I.E.C.E.S. assessment process. I've chosen self-ambulation as one issue to focus on as a START in the assessment process. It does not diminish the importance of investigating other challenging behaviours such as removing incontinence product and urinating on the floor, but allows you to focus your assessment in one area as a starting place. Remember too, that P.I.E.C.E.S. is built on a foundation of Partners in Care so as you work through the template questions, involve other team members including family in dialogue. Your U-First! wheel is a tool that can assist you in fostering this dialogue.

In terms of the P.I.E.C.E.S. template, your search may look something like this:

Question 1: The behavioural concern is self-ambulation.

Question 2: It has the potential for affecting this resident i.e. through falls, and staff/family acknowledge being fearful for his safety.

Question 3: Risk occurs in the area of falls and resultant fractures being imminent. The degree of risk for falls would depend on many factors including balance, muscle strength, posture, reaction time, etc.

Question 4: In separating our fear of falls, with actual potential, you can capture some objective data from many areas, e.g. retrospective chart review for previous falls, examining the ABCs of the falls, using the DOS to record behaviour when this resident does try to self ambulate, climb over bed rails or do other behaviours at risk for falls

Question 5 and 6: In exploring possible causes to the falls, one can use the P.I.E.C.E.S. acronym to really delve into the individual cause of falls risks and then think through to question six for possible strategies for care and falls reduction. I've included some things to consider. Your team's knowledge of your resident will allow you to work through this process in a much more individualized manner.

P: Are there drugs that cause an increase in confusion, dizziness, weakness? Can these medications be decreased? What factor does pain have on his restlessness and desire to get up and move? Is there a disease process that makes him more at risk for fracture or falls such as osteoporosis or Parkinson's? Have we done all we can to offset these risks medically?

I: Can he be cued to call for assistance? Does his constipation cause him to get out of bed, looking For a place to defecate? On behaviour charting, is there a pattern between the two? If getting up on his own often followed by urinating on the floor, and is this improved by an increase in the number of times he is toileted?

E: What is the resident's reaction to having any barriers to his movement? Is he emotionally sensitive? What do you know about the causes of this and what soothes this resident? What do family/staff think about his risk for agitation verses his risk for falling?

C: What is the extent of his ability to ambulate attended and unattended? Are there factors that cause this ability to fluctuate such as time of day?

E: Is the environment the safest it can be? Would hip protectors decrease the risk of self-ambulation? What risk is any type of restraining device including lap trays that might be used?

S: What did this gentleman do for a living? Did it involve walking?

As you can see, I have offered more questions than actual strategies. The focus is the individual, and their entire situation. We could look up falls prevention strategies, but unless we seek to incorporate these with an individualized approach that seeks to understand the behaviour through the person, the strategies will always fall short.

Another reference you may find useful can be found on the RNAO website:
http://www.rnao.org/bestpractices/completed_guidelines/BPG_Guide_C1_Prevent_Falls.asp

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*