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PharMerica Follow Up
Steps to Fall Prevention Webinar

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Thank you for attending our recent webinar on January 17th. Our expert speakers Rebecca Wingate and Dr. Elizabeth Shauen Howard would like to share additional educational content on this important topic.

Follow Up Questions & Answers

Q. What is the rationale for the monitoring of the level of albumin and prealbumin in the blood?

A. Malnutrition has a substantial clinical and socioeconomic significance; it increases rates of complications in hospitalized patients and healthcare-associated costs. Its prevalence has been estimated in hospitals of Western countries to be 30–50% and in long-term care facilities up to 85%. Serum visceral proteins such as albumin and prealbumin have traditionally been used as markers of the nutritional status of patients. Easily added to a metabolic panel, the current consensus is that laboratory markers could be used as a complement to a thorough physical examination. Weight loss alone will not point to nutritional status.

Q. Is sliding out of bed intentionally considered a fall?

A. No. First rule out the word intentional. People who are living with dementia are prone to falling out of bed. In fact, 28% of severe falls in memory care communities happen when a resident is rolling out of bed or transferring to or from a bed. There are a number of factors that contribute to people living with dementia falling out of bed. Those living with cognitive impairment may become unaware of their physical limitations. They often will attempt to get out of bed even though they may lack the ability to walk on their own, leading to a fall or roll out of bed onto the floor. In addition, incontinence is very common in people living with dementia; however, the instinct to get up and go to the bathroom remains. This very often causes people to try to get up on their own and try to navigate to the restroom in a darkened room while sleepy.

If this is actually intentional behavior, it is not a fall but self-injurious behavior. Because adult self-injury behaviors can be very ingrained, it can be challenging to find other coping techniques. For adults, self-injury may be one of the few parts of their lives in which they feel complete control.

Q. How can we limit the risk of polypharmacy when med monitoring requires intensive staff supervision, not always there for the SNF environment?

A. I see medication management different than managing polypharmacy. I believe polypharmacy is a function of process in each facility or building. Creating the expectation that upon admission, hospitalization, or medication change, the medication regimen is reviewed and the consultant pharmacist is involved in that review. Medication management is far more difficult. To ensure sufficient quantity with script management, if non-licensed care givers are involved in administration then there are a host of remote/tele-monitoring we have designed to support the success of administration. This in itself could be a whole topic of discussion on best practice and proven ways to execute medication oversight.

Polypharmacy is an ongoing process in the medication regimen review. The prescriber and IDT team require continuous awareness of potential adverse events the patient is at risk of when taking medications as clinically indicated and justified for the medical condition being treated as diagnosed.

For more learning opportunities for the long-term care industry, view our upcoming webinars.

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Direct Care Provider Education: "I HATE FALLING"

- **I** Inflammation of joints or joint deformity

- **H** Hypotension (orthostatic blood pressure changes)
- **A** Auditory and visual abnormalities
- **T** Tremor (Parkinson's disease/other tremor causes)
- **E** Equilibrium/balance problems

- **F** Foot problems
- **A** Arrhythmia, cardiac issues
- **L** Leg-length discrepancy
- **L** Lack of conditioning (general weakness)
- **I** Illness
- **N** Nutrition (weight loss)
- **G** Gait disturbance

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