Fall Management and Prevention Tool Kit

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Policy & Procedures

Assessing Falls and Their Causes

Purpose

The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Identify the resident's current medications and active medical conditions.
3. Assemble the equipment and supplies as needed.

General Guidelines

1. Falls are a leading cause of morbidity and mortality among the elderly in nursing homes.
2. Fear of falling may limit an individual's participation in activities.
3. Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors.
4. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Equipment to assess vital signs, such as stethoscope; sphygmomanometer or electronic blood pressure device; and oral or rectal thermometer;
2. Tools to assess resident's level of consciousness and neurological status, if necessary;
3. First aid kit, if necessary;
4. Resident's medical chart; and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

After a fall:

1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities.
2. Obtain and record vital signs as soon as it is safe to do so.
3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.
4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.
5. Notify the resident's attending physician and family in an appropriate time frame.
    a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone.
    b. When a fall does not result in significant injury or a condition change, notify the practitioner routinely (e.g., by fax or by phone the next office day).

SAMPLE

6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record.
7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings.
8. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services.

Defining Details of Falls:

1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred.
2. For each individual, distinguish falls in the following categories:
   a. Rolling, sliding, or dropping from an object (e.g., from bed or chair to floor);
   b. Falling while attempting to stand up from a sitting or lying position; or
   c. Falling while already standing and trying to ambulate.

Identifying Causes of a Fall or Fall Risk:

1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc.
2. Evaluate chains of events or circumstances preceding a recent fall, including:
   a. Time of day of the fall;
   b. Time of the last meal;
   c. What the resident was doing;
   d. Whether the resident was standing, walking, reaching, or transferring from one position to another;
   e. Whether the resident was among other persons or alone;
   f. Whether the resident was trying to get to the toilet;
   g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or
   h. Whether there is a pattern of falls for this resident.
3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found.
4. As indicated, the attending physician will examine the resident or may initiate testing to try to identify causes.
5. Consult with the attending physician or medical director to confirm specific causes from among multiple possibilities. When possible, document the basis for identifying specific factors as the cause.
6. If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.).

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Performing a Post-Fall Evaluation:

1. After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results of this effort.
2. If the individual has no difficulty or unsteadiness, no further evaluation is needed at that time.
3. If the individual has difficulty or is unsteady in performing this test, additional evaluation may be initiated as warranted.

Performing a Post-Fall Evaluation:

When a resident falls, the following information should be recorded in the resident's medical record:

1. The condition in which the resident was found (e.g., "resident found lying on the floor between bed and chair").
2. Assessment data, including vital signs and any obvious injuries.
3. Interventions, first aid, or treatment administered.
4. Notification of the physician and family, as indicated.
5. Completion of a falls risk assessment.
6. Appropriate interventions taken to prevent future falls.
7. The signature and title of the person recording the data.

Reporting

1. Notify the following individuals when a resident falls:
   a. The resident's family;
   b. The Attending Physician (timing of notification may vary, depending on whether injury was involved);
   c. The Director of Nursing Services; and
   d. The Nursing Supervisor on duty.
2. Report other information in accordance with facility policy and professional standards of practice.

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References	
MDS Items (CAAs)	Section G; Section J; Section N; (CAA 5; CAA 11; CAA 17)
Survey Tag Numbers	F689
Related Documents	Falls and Falls Risk, Managing Report of Incident/Accident (MP5415)
Version	1.3 (H5MAPR0026)

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Falls - Clinical Protocol

Assessment and Recognition

1. The physician will help identify individuals with a history of falls and risk factors for falling.
   a. Staff will ask the resident and the caregiver or family about a history of falling.
   b. The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days).
   c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause.
2. In addition, the nurse shall assess and document/report the following:
   a. Vital signs;
   b. Recent injury, especially fracture or head injury;
   c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.;
   d. Change in cognition or level of consciousness;
   e. Neurological status;
   f. Pain;
   g. Frequency and number of falls since last physician visit;
   h. Precipitating factors, details on how fall occurred;
   i. All current medications, especially those associated with dizziness or lethargy; and
   j. All active diagnoses.
3. The staff and practitioner will review each resident's risk factors for falling and document in the medical record.
   a. Examples of risk factors for falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension, and medical conditions affecting the central nervous system.
   b. After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur.
4. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness or hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant).
   a. Falls often have medical causes; they are not just a "nursing issue."
5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.
6. Falls should be categorized as:
   a. Those that occur while trying to rise from a sitting or lying to an upright position;
   b. Those that occur while upright and attempting to ambulate; and
   c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor.
7. Falls should also be identified as witnessed or unwitnessed events.

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Cause Identification

1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall.
   a. Often, multiple factors contribute to a falling problem.
2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors.
   a. After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling.
   b. Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling.
3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable.

Treatment/Management

1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.
   a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing).
2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).

Monitoring and Follow-Up

1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved.
   a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.
2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.
   a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.
   b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented.

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3. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall.
4. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors.
5. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable.

SAMPLE

References	
MDS Items (CAAs)	Section G; Section J; (CAA 5; CAA 11)
Survey Tag Numbers	F689
Other References	AMDA. Falls and Fall Risk Clinical Practice Guideline. Columbia, Maryland. American Geriatrics Society. AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons. Available at http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations. Viewed on 4/6/13. Guideline for the prevention of falls in older persons. J Amer Geriatr Soc 2001,49:664-672. Tinnetti ME, Williams CS. Falls, injuries due to falls, and the risk of admission to a nursing home. N Engl J Med 1997;337:1279-1284. Tinnetti ME, Speechley M, Ginter SF. Risk factors for falls among elderly persons living in the community. N Engl J Med 1988;319:1701-1707.
Related Documents	Falls and Fall Risk, Managing
Version	1.3 (H5MACL0017)

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Falls - Fall Risk, Managing

Policy Heading

Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

Policy Interpretation and Implementation

Definition

According to the MDS, a fall is defined as:

Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

Challenging a resident's balance and training him/her to recover from loss of balance is an intentional therapeutic intervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall.

Fall Risk Factors

1. Environmental factors that contribute to the risk of falls include:
   a. wet floors;
   b. poor lighting;
   c. incorrect bed height or width;
   d. obstacles in the footpath;
   e. improperly fitted or maintained wheelchairs; and
   f. footwear that is unsafe or absent.
2. Environmental factors that contribute to the risk of falls include:
   a. fever;
   b. infection;
   c. delirium and other cognitive impairment;
   d. pain;
   e. lower extremity weakness;
   f. poor grip strength;
   g. medication side effects;
   h. orthostatic hypotension;
   i. functional impairments;
   j. visual deficits; and
   k. incontinence.

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3. Medical factors that contribute to the risk of falls include:
   a. arthritis;
   b. heart failure;
   c. anemia;
   d. neurological disorders; and
   e. balance and gait disorders; etc.

Resident-Centered Approaches to Managing Falls and Fall Risk

1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.
2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once).
3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc.
4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period.
5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.
6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.
7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.
8. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.

Monitoring Subsequent Falls and Fall Risk

1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.
2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved.
3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

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4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.

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References	
MDS Items (CAAs)	483.10(i); 483.25(d)
Survey Tag Numbers	F584; F689
Related Documents	Fall Risk Assessment
Version	1.2 (H5MAPL0313)

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Falls - Risk Assessment

Policy Statement

The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.

Policy Interpretation and Implementation

1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time.
2. The nursing staff will ask the resident and/or his/her family about any history of the resident falling.
3. The nursing staff, attending physician, and consultant pharmacist will review for medications or medication combinations that could relate to falls or fall risk, such as those that have side effects of dizziness, ataxia, or hypotension.
4. The staff will look for evidence of a possible link between the onset of falling (or an increase in falling episodes) and recent changes in the current medication regimen.
5. The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose to falls.
6. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis).
7. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition.
8. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout.
9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.

References	
MDS Items (CAAs)	§483.10(i) Safe Environment; §483.25(d) Accidents.
Survey Tag Numbers	F584; F689
Related Documents	Falls and Fall Risk, Managing
Version	1.2 (H5MAPL0311)

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Neurological Assessment

Purpose

The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition.

General Guidelines

1. Neurological assessments are indicated:
   a. Upon physician order;
   b. Following an unwitnessed fall;
   c. Following a fall or other accident/injury involving head trauma; or
   d. When indicated by resident's condition.
2. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP).
3. Any change in vital signs or /neurological status in a previously stable resident should be reported to the physician immediately.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Flashlight;
2. Stethoscope and sphygmomanometer;
3. Thermometer;
4. Watch with second hand; and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Wash and dry your hands thoroughly.
2. Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached.
3. Perform neurological checks with the frequency as ordered or per falls protocol.
4. Determine resident's orientation to time, place, and person.
5. Observe resident's patterns of speech and speech clarity.
6. Take temperature, pulse, respirations, and blood pressure.
   a. Use oral thermometer only if safe with this type of resident.
   b. Respirations are increased and shallow with ICP.
   c. Pulse usually increases with ICP.
   d. Blood pressure usually increases with widening pulse pressure with ICP.
7. Check pupil reaction:
   a. Darken room.
   a. Open eyelid with your fingers.
   a. Turn on flashlight and observe size and reaction of pupil.
   a. Repeat for the other eye.

SAMPLE

8. Determine motor ability:
9. Have resident move all extremities.
10. Ask resident to squeeze your fingers. Note strength bilaterally.
11. Have resident plantar and dorsiflex. Note strength bilaterally. Ask resident if he/she has any numbness or tingling in legs/feet/toes and document accordingly.
12. Determine sensation in extremities. Rub resident's arms at the same time to see if resident has decreased sensation in either arm. Check sensation in lower extremities also and document accordingly.
13. Check gag reflex with tongue depressor, if safe for resident.
14. Have the resident smile to determine if there is any facial drooping and document accordingly.
15. Check eye opening, verbal, and motor responses using the Glasgow Coma Scale. Record observations.
16. Reposition the bed covers. Make the resident comfortable. Use seizure precautions if indicated.
17. Place the call light within easy reach of the resident.
18. Clean reusable equipment according to the manufacturer's instructions.
19. Clean the bedside stand.
20. If the resident desires, return the door and curtains to an open position and if visitors are waiting, tell them they may now enter the room.
21. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time the procedure was performed.
2. The name and title of the individual(s) who performed the procedure.
3. All assessment data obtained during the procedure.
4. How the resident tolerated the procedure.
5. If the resident refused the procedure, the reason(s) why and the intervention taken.
6. The signature and title of the person recording the data.

Reporting

1. Notify the physician of any change in a resident's neurological status.
2. Notify the supervisor if the resident refuses the procedure.
3. Report other information in accordance with facility policy and professional standards of practice.

SAMPLE

References	
MDS Items (CAAs)	Section I; Section J; Section O; (CAA 11)
Survey Tag Numbers	F636
Related Documents	Neurological Evaluation Flow Sheet (MP5435)
Version	1.1 (H5MAPR0199)

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Prevention

Getting to Know Me - Resident Questionnaire

As caregivers in long-term care, we strive to provide quality care to our residents while ensuring they are provided a safe environment. By getting to know our residents' background and preferences, it allows us to prepare, plan, anticipate, and hopefully prevent any adverse events. Below are examples of questions that can be asked of a resident to assist with potentially identifying unique ways to prevent adverse events, such as falls. Consider using this questionnaire pre-admission, admission, quarterly and as needed to assist with developing a person-centered approach to fall prevention and management.

If the resident is unable to answer these questions, the questions may be asked to family/friends to gain further knowledge and background.

Describe home as you remember it (city, suburb, farm, ranch, etc)

Would you say you are outgoing or introverted?

Do you have any lifestyle habits you enjoy (naptime, exercise, smoking, housework)?

Do you have a specific evening routine (warm milk, wine, personal care, bathing, etc)?

Do you typically eat breakfast?

What's your typical lunch routine? What time do you generally eat lunch?

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What was your line of work (duties/responsibilities/shift/accomplishments)?

What are your hobbies/interests?

Do you enjoy movies, music, reading in a quiet environment?

Did you have any pets (allergic, afraid)?

What do you need to have a good night's rest?

What is your favorite time of year?

Do you prefer to do things alone, in small groups, or large groups?

Did you ever serve in the military? Immediate relatives serve?

Do you have any favorite foods or snacks?

What brings you comfort? Discomfort? Are you a night owl or do you prefer early morning hours?

Anything else you would like to share?

With these questions will come prompts for potentially preventing falls. For example, if the resident worked night shift, they may prefer to sleep most of the day and be awake at night. If staff are unaware, the resident will be awaken earlier than routine, be fatigued at bedtime, but have an internal clock that prompts them to be awakened at night. This could cause increased weakness/drowsiness resulting in unsteady gait, potential poor impulse control, and possibly a fall. If we get to know our residents, we are more equipped to intervene and prevent falls/injuries.

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RESOURCE

Algorithm

for Fall Risk Screening, Assessment, and Intervention

As a healthcare provider, you are already aware that falls are a serious threat to the health and well-being of your older patients.

More than one out of four people 65 and older fall each year, and over 3 million are treated in emergency departments annually for fall injuries.

The CDC's STEADI initiative offers a coordinated approach to implementing the American and British Geriatrics Societies' clinical practice guideline for fall prevention. STEADI consists of three core elements: **Screen**, **Assess**, and **Intervene** to reduce fall risk.

The **STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention** outlines how to implement these three elements.

Additional tools and resources include:

- Information about falls
- Case studies
- Conversation starters
- Screening tools
- Standardized gait and balance assessment tests (with instructional videos)
- Educational materials for providers, patients, and caregivers
- Online continuing education
- Information on medications linked to falls
- Clinical decision support for electronic health record systems

CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steadi.

You play an important role in caring for older adults, and you can help reduce these devastating injuries.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2019

STEADI Stopping Elderly Accidents, Deaths & Injuries

STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community-Dwelling Adults 65 years and older

START HERE

1 SCREEN for fall risk yearly, or any time patient presents with an acute fall.

Available Fall Risk Screening Tools:

- **Stay Independent: a 12-question tool** [at risk if score ≥ 4]
  Important: If score < 4, ask if patient fell in the past year
  (If **YES** → patient is at risk)
- **Three key questions** for patients [at risk if **YES** to any question]
  Feels unsteady when standing or walking?
  Worries about falling?
  Has fallen in past year?
  » If **YES** ask, "How many times?" "Were you injured?"

SCREENED NOT AT RISK

PREVENT future risk by recommending effective prevention strategies.

- Educate patient on fall prevention
- Assess vitamin D intake
  If deficient, recommend daily vitamin D supplement
- Refer to community exercise or fall prevention program
- Reassess yearly, or any time patient presents with an acute fall

SCREENED AT RISK

2 ASSESS patient s modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

Evaluate gait, strength, & balance
Common assessments:
- Timed Up & Go
- 30-Second Chair Stand
- 4-Stage Balance Test

Identify medications that increase fall risk
(e.g., Beers Criteria)

Ask about potential home hazards
(e.g., throw rugs, slippery tub floor)

Measure orthostatic blood pressure
(Lying and standing positions)

Check visual acuity
Common assessment tool:
- Snellen eye test

Assess feet/footwear

Assess vitamin D intake

3 INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk
- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed
- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk
- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely
- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed
- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed
- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified
- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Vitamin D deficiency observed or likely
- Recommend daily vitamin D supplement

Comorbidities documented
- Optimize treatment of conditions identified
- Be mindful of medications that increase fall risk

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s)

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Fall Risk and Prevention in Long-Term Care

Risk Factors for Falls

Intrinsic (Patient) Factors

- Balance and Gait Impairment
- Visual Impairment
- Orthostatic Hypotension
- Medication
- Cognitive Impairment

Extrinsic (Environmental) Factors

- Physical Disabilities
- Instrument Usage (wheelchair, walker, etc.)
- Home and Room Hazards

Non-Medication Falls Prevention Strategies

- Environmental-Related Prevention
  - Ensure trip hazards and other obstacles are minimized in patient room
  - Address effectiveness of instrument usage
- Condition-Related Prevention
  - Assess and treat neurologic, gait and balance disorders
  - Assess for orthostatic hypotension and treat if indicated
    - Midodrine and fludrocortisone are common treatments
  - Evaluate other cardiovascular causes
    - Carotid stenosis (common in elderly), arrhythmias, other

Medication Considerations in Falls

- Geriatric and chronically ill patient's response to medications differs from the general population
  - Physiologic and body composition changes alter drug absorption, metabolism, and elimination
  - Organ function decline (kidney and liver) slows metabolism and elimination
  - Increased medication utilization increases risk of drug interactions

Medications Implicated in Falls

Causative Medications

- Opioids
- Psychotropics
- Anticholinergics
- Muscle Relaxants
- Antidepressants and Antiepileptics

Worsen Fall Injury

- Antiplatelets
- Anticoagulants

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Medication Management Strategies in Falls Prevention

- Quality medication reconciliation
- Medication assessment and risk evaluation
    - Beer's Criteria and STOPP/START Criteria
    - Address polypharmacy and identify de-prescribing opportunities
- Assess cognition and mood and identify untreated conditions
- Mitigate fall injury severity
    - Increase bone density
    - Evaluate risk/benefit of antiplatelets and anticoagulants

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Investigation
(When A Fall Occurs)

Post-Fall Interview

A post-fall interview/investigation is a process that can be done while you are completing a physical assessment of the resident. This is a data-collection process that will aid you in deciding on an immediate intervention to help prevent another fall, guide you in documenting a comprehensive nurses note, and help the interdisciplinary team (IDT) in conducting a root cause analysis to find a permanent intervention to care plan.

Observation - This is what you see visually at the time of fall. (Did you see the fall? If no, immediately perform neuro check)

- Where is the resident found? What position is the resident in? What are they wearing (street clothes, gown, non-skid footwear?)
- Is there anything around the resident? (i.e., items on floor, assistive device, spilled drink)
- Any visible injuries?
- Is the lighting poor?
- Is the resident soiled? Were they incontinent? Bowel or bladder?

Interview - These are questions that you will ask staff and the resident.

Staff

- When was the resident last toileted?
- Had they noticed a change in the way the resident had been acting? (Increased confusion, change in bowel/bladder pattern, poor appetite, change in sleeping pattern, etc)

Resident

- What happened?
- What were you trying to do?

All the information that you obtain in this process should be documented quoting the resident verbatim, if possible.

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Immediate Fall Interventions

For the bedside nurse

Each fall event requires a new intervention. At the time of the fall, an immediate intervention needs to be put in place. This requires that you be familiar with the current interventions in place for the resident. After performing the post fall investigation and interview, you should have the information needed to implement the immediate intervention. Think of the immediate intervention as something tangible that staff can do to assist in keeping the resident from falling again.

For example:

Investigation	Intervention
The resident was incontinent at the time of assessment.	Toilet check and/or change every hour x four hours, then every two hours thereafter.
The resident was attempting to self-transfer from wheelchair to bed after a meal.	Lay the resident down immediately following meals.
The resident's remote fell on the floor, and he was attempting to reach it.	Ensure resident's remote is within reach on the over-the-bed table.

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Immediate Fall Interventions

For the IDT/Nurse Manager (PPT/Eductation)

An immediate intervention should be put in place by the nurse during the same shift that the fall occurred.

When investigation of the fall circumstances is thorough, it is usually clear what immediate action is necessary. For example, if the resident falls on the way to the bathroom because of urgency and poor balance, interventions related to toileting and staff assistance would be appropriate. However, if the resident is found on the floor between the bed and the bathroom and staff do not look for clues, such as urine or footwear or ask the resident questions, immediate care planning is much more difficult.

Some examples of immediate interventions are:

- Increased toileting with specified frequency of assistance from staff;
- Increased assistance targeted for specific high-risk times;
- Increased monitoring using sensor devices or alarms;
- Increased staff supervision targeted for specific high-risk times;
- Pain management;
- Protective clothing (helmets, wrist guards, hip protectors);
- Safe footwear; and
- Low bed/mat.

Documentation of the immediate response on the medical record is important. Missing documentation leaves staff open to negative consequences through survey or litigation.

Resource: Chapter 2. Fall Response | Agency for Healthcare Research and Quality (ahrq.gov)

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Post-Fall Nurses Note

A complete and comprehensive nurses note aides in determining the root cause of a fall and in preventing future falls.

The note should include:

- Head-to-toe assessment performed by the licensed nurse (including vital signs and neuro checks if fall was unwitnessed or the resident hit his or her head).
- Results of the post-fall interview/investigation.
- Notification of medical doctor and family of fall.
- Any new orders received and notification of the family for these orders.
- What immediate intervention was put in place.

Follow your facility's policies and procedures for documenting a fall. Thorough documentation helps ensure that appropriate nursing care and medical attention are given.

SAMPLE

Writer called to resident's room by CNA. Upon entry to room, resident observed laying on floor beside bed on left side with left arm under torso. Resident in bed clothes with non-skid socks in place on bilateral feet. Resident states that he was attempting to get to bathroom to turn off light. Head-to-toe assessment performed and neuro checks initiated with all findings WNL for resident. Resident denies pain but does voice discomfort to left upper arm. Resident assisted back to bed by three staff and positioned for comfort. Call light and water within reach and bathroom light turned off. MD notified of fall and complaints of left upper arm discomfort. Order received for STAT 2-view x-ray of left upper arm. Mobile x-ray company notified. Call placed to daughter, Sarah, to inform of fall and new order. Sarah denied questions and thanked writer for call. Immediate intervention of keeping bathroom light off after putting resident to bed for the night implemented and communicated to unit staff at this time.

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Neurological Assessment Flow Sheet

Instructions: Record the date and time of each assessment, then proceed as follows:

- **Level Of Consciousness** – Check (√) the appropriate response
- **Pupil Response** – Check (√) PERRLA if applicable; enter the appropriate code for each eye if not equal.
- **Motor Functions**
  - **Hand Grasps** – Enter the appropriate code.
  - **Extremities** – Check (√) the appropriate column(s).
- **Pain Response** – Check (√) the appropriate column.
- **Vitals** – Record blood pressure, temperature, pulse, and respirations in the appropriate columns.

Date	Time	Level of Consciousness				Pupil Response			Motor Functions								Pain Response			Vitals				Initials/Title
		A	D	S	C	PERRLA	RT	LT	Hand Grasps	MA	RU	LU	RL	LL	U	AB	A	I	AB	BP	T	P	R	
Every 15 Minutes x 1 Hour																								
Every 30 Minutes x 1 Hour																								
Every Hour x 4 Hour																								
Every 4 Hours x 24 Hours																								

Consciousness	Pupil Response	Hand Grasps	Extremities	Pain Response
A – Alert D - Drowsy S – Stuporous C - Comatose	PERRLA - pupils equal, round and reactive to light and accommodation B – Brisk S - Sluggish NR - Nonreactive PP – Pinpoint DL – Dilated FX- Fixed	= - Hand grips equal R>L – Right grasp greater than left L>R – Left grasp great than right U – Unable to follow commands AB - Absent	MA - Moves all extremities RU - Moves right arm LU - Moves left arm RL - Moves right leg LL - Moves left leg U - Unable to follow commands AB - Absent	A - Appropriate pain response I - Inappropriate pain response AB - No pain response

Name- Last, First	Attending Physician	Record No.	Room/Bed

Assessing PERRLA

A neurological assessment or neuro check should be done when a resident hits his or her head or if it is unknown if they hit their head (unwitnessed fall). A key component is the assessment of the resident's pupils. A change from baseline could identify the resident has a potential head injury and should be referred for additional testing.

PERRLA is an acronym for **P**upils **E**qual **R**ound **R**eactive to **L**ight and **A**ccommodation.

What You Need

- A penlight
- Piece of paper

How To Perform

- **Equal**: Check that pupils are equal in size.
- **Round**: Check that each pupil is round.
- **Reactive to Light**: Dim light or use paper above eyes to decrease room light.
    - Shine the penlight over one of the resident's eyes and observe the pupils.
    - Hold the light for three seconds.
    - Turn off the penlight. Observe the pupil for dilatation.
    - Repeat on the other eye.
- **Accommodation**: Utilize your penlight off and in the vertical position.
    - Slowly bring the penlight closer and closer to the resident's nose and observe and note how the pupils react as the penlight gets closer.

Determining Results

- Healthy pupils should be in the center of the iris and are about the same size (approximately 3-5mm) that look like circles with even borders. Pupils should open and close in response to light and should respond equally. If an abnormal assessment finding is identified, please notify the provider and document per facility policy.

Reference: Perrla Eyes Examination, what it is and how it is done: Perrla Eyes. Perrla Eyes | Perrla Eye, Eyes Exam, and Eyes Assessment. (2022, December 21). https://perrlaeyes.com/

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SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

Before Calling the Physician / NP / PA/other Healthcare Professional:

- □ Evaluate the Resident/Patient: Complete relevant aspects of the SBAR form below
- □ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
- □ Review Record: Recent progress notes, labs, medications, other orders Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
- □ Have Relevant Information Available when Reporting e.g., medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are _____

This started on ____ / ____ / ____ Since this started it has gotten: □ Worse □ Better □ Stayed the same

Things that make the condition or symptom worse are _____

Things that make the condition or symptom better are _____

This condition, symptom, or sign has occurred before: □ Yes □ No

Treatment for last episode (if applicable) _____

Other relevant information _____

BACKGROUND

Resident/Patient Description

This resident/patient is in the facility for: □ Long-Term Care □ Post-Acute Care □ Other: _____

Primary diagnoses _____

Other pertinent history (e.g., medical diagnosis of CHF, DM, COPD, isolation for infection or communicable disease)

_____

Medication Alerts

□ Changes in the last week (describe) _____

□ Resident/patient is on (*Warfarin/Coumadin*) Result of last INR: _____ Date _____ /_____ /_____

□ Resident/patient is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)

Resident/patient is on: □ Hypoglycemic medication(s) / Insulin □ Digoxin

Allergies _____

Vital Signs

BP _____ Pulse _____ (or Apical HR ____) RR _____ Temp _____Weight _____ lbs (*date* ____ /____ /____)

CHF, edema, or weight loss: last weight before _____ on _____ /_____ /_____

Pulse Oximetry (*if indicated*) _____ % on □ Room Air □ O2 (_____)

Blood Sugar (*Diabetics*) _____

Resident /Patient Name _____

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

Resident/Patient Evaluation

Note: Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition check the box for "not clinically applicable to the change in condition being reported".

1. Mental Status Evaluation (*compared to baseline; check all changes that you observe*)

- ☐ Altered level of consciousness (*hyperalter, drowsy but easily aroused, difficult to arouse*)
- ☐ Increased confusion or disorientation
- ☐ Memory loss (new or worsening)
- ☐ New or worsened delusions or hallucinations
- ☐ Other symptoms or signs of delirium (*e.g. inability to pay attention, disorganized thinking*)
- ☐ Unresponsiveness
- ☐ Other (*describe*)
- ☐ **No changes observed**

Describe symptoms or signs _____

2. Functional Status Evaluation (*compared to baseline; check all that you observe*)

- ☐ Decreased mobility
- ☐ Needs more assistance with ADLs
- ☐ Falls (*one or more*)
- ☐ Swallowing diffi culty
- ☐ Weakness (*general*)
- ☐ Other (*describe*)
- ☐ **No changes observed**

Describe symptoms or signs _____

3. Behavioral Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Danger to self or others
- ☐ Depression (*crying, hopelessness, not eating*)
- ☐ Social withdrawal (*isolation, apathy*)
- ☐ Suicide potential
- ☐ Verbal aggression
- ☐ Physical aggression
- ☐ Personality change
- ☐ Other behavioral changes (describe)
- ☐ **No changes observed**

Describe symptoms or signs _____

4. Respiratory Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Abnormal lung sounds (rales, rhonchi, wheezing)
- ☐ Asthma (with wheezing)
- ☐ Cough (☐ Non-productive ☐ Productive)
- ☐ Inability to eat or sleep due to SOB
- ☐ Labored or rapid breathing
- ☐ Shortness of breath
- ☐ Symptoms of common cold
- ☐ Other respiratory changes (describe)
- ☐ **No changes observed**

Describe symptoms or signs _____

5. Cardiovascular Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Chest pain/tightness
- ☐ Edema
- ☐ Inability to stand without severe dizziness orlightheadedness
- ☐ Irregular pulse (new)
- ☐ Resting pulse >100 or <50
- ☐ Other (describe)
- ☐ **No changes observed**

Describe symptoms or signs _____

6. Abdominal / GI Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Abdominal pain
- ☐ Abdominal tenderness
- ☐ Constipation (date of last BM ____ / ____ / ____)
- ☐ Decreased/absent bowel sounds
- ☐ Distended abdomen
- ☐ Decreased appetite/fluid intake
- ☐ Diarrhea
- ☐ GI Bleeding (*blood in stool or vomitus*)
- ☐ Hyperactive bowel sounds
- ☐ Jaundice
- ☐ Nausea and/or vomiting
- ☐ Other (*describe*)
- ☐ **No changes observed**

Describe symptoms or signs _____

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

7. GU/Urine Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ New or worsening incontinence
- ☐ Painful urination
- ☐ Urinating more frequently or urgency with or without other urinary symptoms
- ☐ Blood in urine
- ☐ Decreased urine output
- ☐ Lower abdominal pain or tenderness
- ☐ Other (*describe*)
- ☐ **No changes observed**

Describe symptoms or signs _____

8. Skin Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Abrasion
- ☐ Blister
- ☐ Burn
- ☐ Contusion
- ☐ Discoloration
- ☐ Itching
- ☐ Laceration
- ☐ Pressure ulcer/pressure injury
- ☐ Puncture
- ☐ Rash
- ☐ Skin tear
- ☐ Splinter/sliver
- ☐ Wound (*describe*)
- ☐ Other (*describe*)
- ☐ **No changes observed**

Describe symptoms or signs _____

9. Pain Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**

Does the resident have pain?

- ☐ No
- ☐ Yes (*describe to the side*)

Is the pain?

- ☐ New
- ☐ Worsening of chronic pain

Description/location of pain: _____

_____

_____

Intensity of Pain (*rate on scale of 1-10, with 10 being the worst*): _____

Does the resident show non-verbal signs of pain (for residents with dementia)?

- ☐ No
- ☐ Yes (*describe*) _____

(restless, pacing, grimacing, new change in behavior)

Other information about the pain: _____

10. Neurological Evaluation

- ☐ **Not clinically applicable to the change in condition being reported**
- ☐ Abnormal Speech
- ☐ Altered level of consciousness *(hyperalert, drowsy but easily arousable, difficult to arouse, unarousable)*
- ☐ Seizure
- ☐ Weakness or hemiparesis
- ☐ Dizziness or unsteadiness
- ☐ Other neurological symptoms *(describe)*
- ☐ **No changes observed**

Describe symptoms or signs _____

Advance Care Planning Information *(the resident/patient has orders for the following advanced care planning)*

☐ Full Code ☐ DNR ☐ DNI (*do not intubate)* ☐ DNH (*do not hospitalize)* ☐ No Enteral Feeding

☐ Other Order or Living Will (*specify*) _____

Other resident/patient or representative preferences for care

_____

_____

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

APPEARANCE

Summarize your observations and evaluation: _____

_____

_____

REVIEW AND NOTIFY

Primary Care Clinician Notified: _____ Date: ___/___/___ Time (am/pm):_____

Recommendations of Primary Clinicians *(if any)* _____

_____

_____

a. Check ALL that apply

Testing

- ☐ COVID Test
  If yes, check all that apply:
  - ☐ Viral PCR (Nasal Swab)
  - ☐ Viral PCR (Saliva Swab)
  - ☐ POC Antigen Test
  - ☐ Antibody Test
- ☐ Blood tests
- ☐ EKG
- ☐ Urinalysis and/or culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other (describe) _____

Interventions

- ☐ New or change in medication(s)
- ☐ IV or subcutaneous fluids
- ☐ Increase oral fluids
- ☐ Oxygen (if available)
- ☐ Other (describe) _____

- ☐ Transfer to the hospital (non-emergency) *(send a copy of this form)*
- ☐ Call for 911
- ☐ Emergency medical transport

Nursing Notes *(for additional information on the Change in Condition)* _____

_____

_____

_____

Name of Family/Health Care Agent Notified: _____ Date: ___/___/___ Time (am/pm):_____

Staff Name (RN/LPN/LVN) and Signature _____

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FALL INCIDENT REPORT

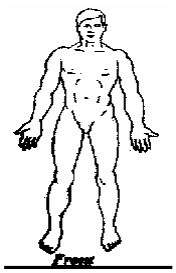
MR#_____ **Last Name**_____ **First Name**_____
Room#_____ **Date**_____ **Time**_____**am/pm**
□**Resident** □**Employee** □**Visitor** **Type:** □**Fall** □**Behavior** □**Other** (Specify)**:**_____

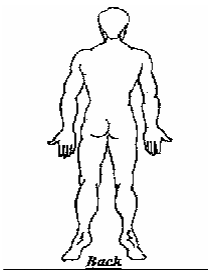
Physical Assessment:
Position resident found in? (Describe in detail)**:** _____

Describe mobility/ROM of extremities following incident:_____

Is assessed mobility/ROM ability changed? (Check)**:** □ **No** □ **Yes** (Describe)**:** _____

Injury (Check): □ None □ Laceration □ Skin Tear □ Abrasion □ Hematoma □ Swelling □ Other
(Describe/Locate on Diagram): _____





Vital Signs (time):
B/P Lie _____B/P Stand _____B/P Sit_ _____
Pulse _ _____Temp _____Resp _____
Other:_____

Other (time):
BG Accu Check_____
Pulse Oximetry _____
Neuro Check _____

Treatment (Check All That Apply)
□ Examined at Hospital: _____ □ Admitted to Hospital: _____
□ Xray Done (Results): _____ □ First Aid Administered: _____

Name of Person(s) Administering Treatment: _____

Physician Notified: _____ **Time:** _____**am/pm** **Response Time:** _____**am/pm**
Family/Other Notified: _____**Time:** _____**am/pm** **Response Time:** _____**am/pm**

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Investigation

Exact Location of Incident: □ Resident's Room □ Hallway □ Bathroom □ Nursing Station □ Lobby □ Shower Room □ Dining Room □ Other (Specify room #, hallway, bathroom, shower etc.):

_____

□ Incident Witnessed **Name of Witness** _____

□ Incident Un-Witnessed **Person Who Discovered Incident:** _____

Description of Incident: _____

_____

_____

_____

Person(s) Involved, Statements About Incident: _____

_____

_____

What Was Involved Person Attempting To Do: □ Getting Out of Bed □ Standing Still □ Walking □ Propelling in W/C □ Reaching for Object □ Transferring To/From Chair/W/C □ Going to the Bathroom □ Incontinence B/B Noted □ Other (Specify):_____

_____

Equipment Involved: □ Walker □ Cane/Crutch □ Wheelchair □ W/C Wheels Locked □ W/C/Wheels Unlocked □ Geri-Chair □ G/C Back Reclined □ G/C Back Upright □ G/C Wheels Locked □ G/C Wheels Unlocked □ Bed □ Half Bedrails □ Full Bedrails □ Bedrails Up □ Bedrails Down □ No Bedrails □ Other (Specify):_____

Environment: □ Wet Floor □ Wet Floor Sign in Place □ No Sign □ Object on Walkway □ Poor Lighting □ Rug in Walkway □ Clutter/Liquid in Walkway □ Footwear (Specify)_____ □ New Admit □ Recent Room Move □ Call Light in Reach □ Call Light Not in Reach □ Bed/Chair Alarm On □ Bed/Chair Alarm Off □ Other _____

Diagnosis/Conditions □ Vision Deficit □ Hearing Deficit □ Hx of Falls □ Hypotension □ CVD □ Wt. Loss □ Cognitive Deficit □ Dehydration □ Hx CVA □ New Fx □ Parkinson's □ SOB □ Hypertension □ Diabetes □ Neuropathy □ ↓ in ADL's □ Other (Specify):_____

Meds: □ Diuretic □ Antidepressant □ Hypnotic □ Anti-anxiety □ Psychotropic/Antipsychotic □ Cardiovascular □ Medication Chg. □ 9+ Medications □ Other (Specify):_____

Why Did This Incident Occur? (Opinion): _____

_____

What Was Done Immediately? (To Prevent Reoccurrence):_____

_____

Name of Person(s) Completing Report: _____

_____

REVIEW SIGNATURES:

Administrator_____ **Date**_____**DON** _____**Date**_____

QI_____**Date**_____**Med. Dir**_____**Date** _____

(Form should be reviewed at next IDT/QAPI- completeness, accuracy & appropriate interventions)

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Interventions
(IDT Review)

Interdisciplinary Team Fall Documentation

The interdisciplinary team (IDT) is a crucial component to successful management and implementation of falls prevention programs.

Writing an effective IDT note post-fall should include the following:
INCIDENT - What happened?
INVESTIGATION - How did it happen?
INTERVENTION - What action should be taken to prevent future occurrences?

Example:
IDT NOTE: Resident had an unwitnessed fall on (Date) in the dining room. Small skin tear measuring 2cmx1cmx<0.1cm noted to right shin [INCIDENT]. Head-to-toe physical assessment completed, vital signs obtained, and neurochecks initiated. Upon observation and resident interview, resident reports he was ambulating to dining room and slipped and fell. Resident was observed wearing house slippers in facility [INVESTIGATION]. Resident was encouraged to wear appropriate footwear when ambulating outside of his room and staff were educated to remind resident if necessary. Skin tear was cleaned, reapproximated and dry dressing applied. MD, POA, and DON notified. No new orders given at this time. Care plan updated. Will continue to monitor as needed [INTERVENTION].

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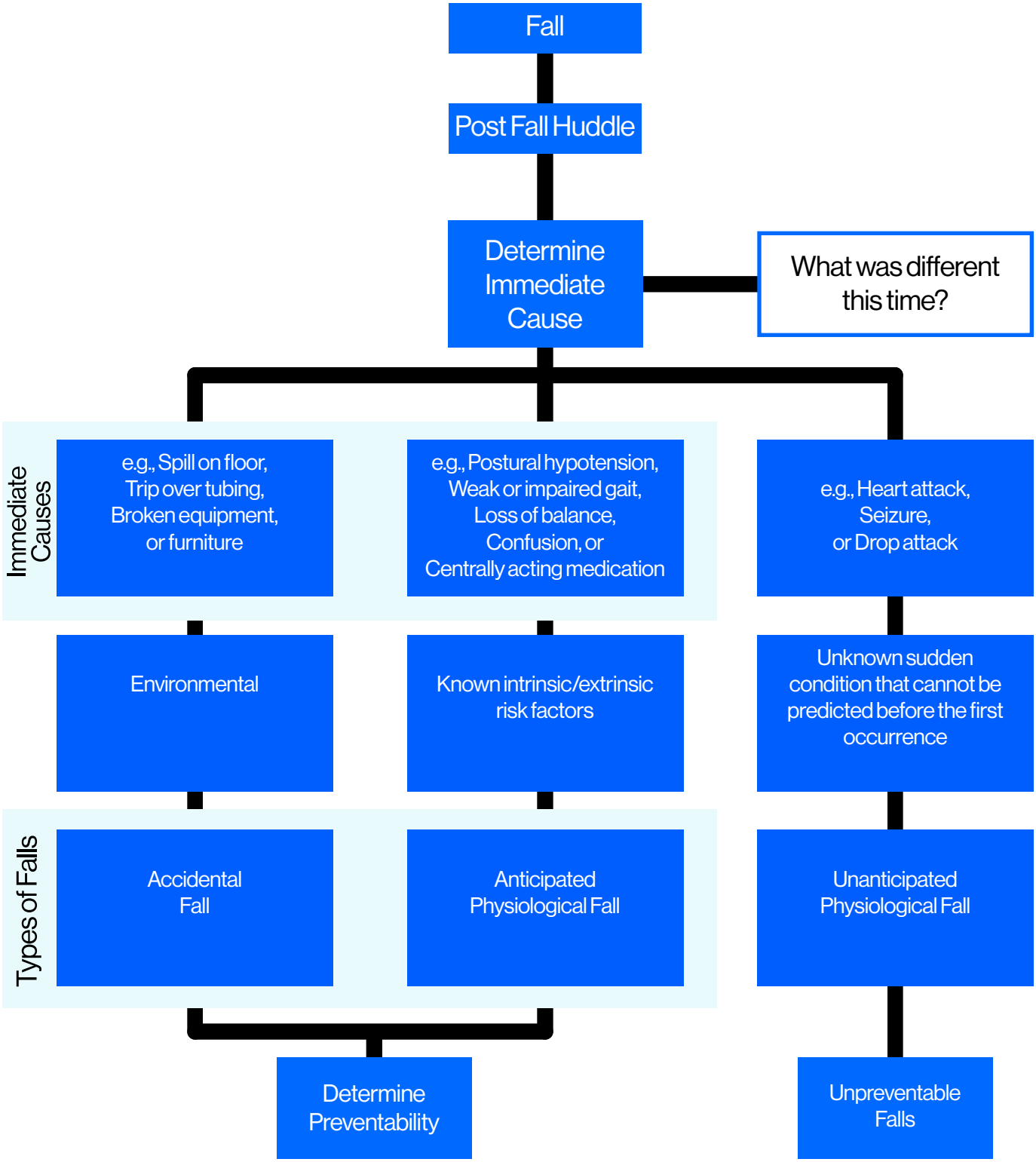
Decision Tree for Types of Falls



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Root Cause Analysis Worksheet: Five Whys Method

Define the Problem:

Why is it happening?

1. → Why?

2. → Why?

3. → Why?

4. → Why?

5.

Tip: Don't list five different reasons for the problem. Instead, dig deeper into the one reason.

Tip: If the last answer is something that can't be controlled, return to the previous answer. Individuals should not be blamed. Instead, the "why" is being examined to determine a solution/resolution.

Action to begin implementing:

The Civil Monetary Penalty Quality Improvement (CMPQI) Reinvestment Program funds this quality improvement project.

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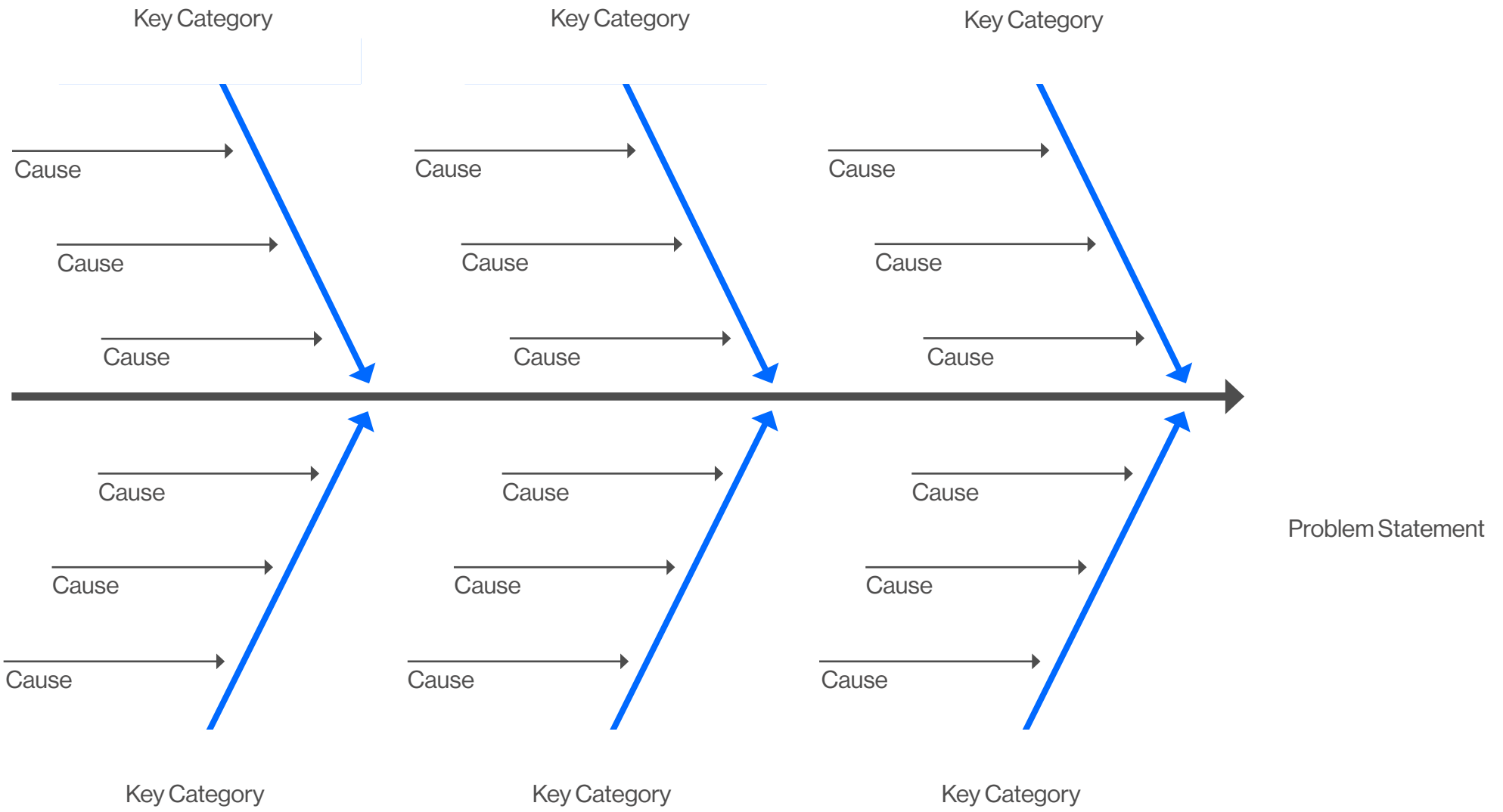
Fishbone Diagram

1. Define the problem. Type or write this in the problem statement box to the far right.
2. Decide on key categories of the problem. Write or type these categories inside the rectangular boxes.
3. Brainstorm all the possible causes of the problem. Ask “Why does this happen?” Write or type these causes as a branch of the appropriate category. Causes can be written in several places if they relate to several categories. Continue to ask “Why?” and generate deeper levels of causes.



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Suggested Resident Interventions to Manage Falls

Fall From Bed

Resident Able to Transfer:	Resident Unable to Transfer Self:
• Make sure bed is locked and in lowest position • Provide a night light • Clear path to the bathroom – no obstacles or trip hazards • Call light within reach and secured • Learn which side a resident normally gets in and out of bed and position accordingly • Non-skid footwear • Placement of assistive device (within reach but not an obstacle) • Increase daytime activity and limit napping • Reduce noise in the facility • Assess for bed mobility bars or need for removal • Assess for need for pain medications • Offer fluids and snack between meals and at bedtime • Measure orthostatic vital signs • Keep eyewear in reach/encourage resident to wear glasses • Evaluate flooring to reduce glare • Use signs with large letters or pictures • Install contrasting-colored call lights • Promote adequate hydration • Educate resident to change positions slowly and sit on edge of bed prior to standing • Ensure correct height of bed (mark on footrest or wall)	• Frequent rounding by frontline staff with the four Ps: pain, potty, personal items, position (also offer oral fluids if appropriate) • Bedside table with needed items within reach • Contour mattress • Body pillows for positioning • Assess for bed mobility bars or need for removal • Toileting schedule • Install contrasting-colored call lights • Increase daytime activity and limit napping • Reduce noise in the facility • Assess for need for pain medications • Mat beside bed (with beveled edges) • Offer fluids and snacks between meals and at bedtime • Use quality incontinent briefs to allow residents to sleep uninterrupted during the night • Low bed • Consider bed/chair alarms to determine pattern or trend

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Fall For Ambulatory Residents

Assess reason for fall in order to choose appropriate intervention.

- Observe flooring to ensure clean, dry, and in good repair
- Appropriate footwear (shoes should be slip resistant with tread on the bottom, low even heels)
- Monitor, remind resident regarding appropriate use of assistive devices
- Refer to podiatrist for podiatry associated problems
- Use gripper socks when shoes cannot be worn
- Provide proper footcare and frequent assessment
- Remind, monitor resident's ability to maneuver change in flooring (e.g., carpet to tile)

Residents With Multiple Falls

- Know the resident's personal history and preferences before trying a new intervention
- Trending of falls for individual (time of day, reason for fall, location of fall, etc.)
- Consider room change to move resident closer to nurses' station or move the bed to be closer to bathroom
- Keep resident in view during high-risk times, if possible
- Refer to therapy
- Discuss at stand up, leadership rounds with interdisciplinary team
- Restorative programs
- Ask family/friends to visit at high-risk times as "partners in caring"
- Incorporate feedback from direct caregivers to assist with determining appropriate interventions
- Communicate planned interventions to all team members
- Monitor implementation of interventions
- Involve activities directors for interventions and resident engagement
  - Tai Chi/exercise/movement groups for resident with frequent falls
  - Favorite TV programs, radio shows for high-risk times
  - Hydration group – activity during high-risk times
  - Resident-specific activity for staff to use
  - Schedule activities for residents at their high-risk times
- Assess medical condition/medication as possible causal factors
  - Examples:
    - Pain Management with consideration of pain assessment for cognitively impaired
    - Blood sugar fluctuations
    - Blood pressure fluctuations (Orthostatic)
    - UTI or other infectious process
    - Timing of medications in relation to falls
    - Address polypharmacy and identify de-prescribing opportunities
    - Evaluate risk/benefit of antiplatelets and anticoagulants

Fall From Wheelchair

Assess reason for fall in order to choose appropriate intervention – e.g., reaching, attempting to transfer or stand, leaning too far forward, sliding out of chair, etc.

- Assess for pain
- Keep wheelchair unlocked if the resident has the need to move
- Rocking chair
- Activity programming/engagement – exercises, TV programs, etc.
- Offer snacks, fluids between meals
- Toileting schedule
- Restorative programming
- Assess that wheelchair is appropriate size, need for footrests, brake extenders, or anti-rollback device
- Assess for drop seat if necessary or alternate cushion
- Assess for anxiety or contributing behaviors (involve Social Services for interventions)

Fall In Bathroom

Assess reason for fall in order to choose appropriate intervention.

- Observe flooring to ensure clean, dry, and in good repair
- Toilet at regular intervals
- Consider applying non-skid strips
- Use adequate handrail support
- Provide raised toilet seat
- Use easy-to-manage clothing
- Increase staff assistance
- Install contrasting-colored toilet seats

Falls With Cognitively Impaired Residents

Assess reason for fall in order to choose appropriate intervention.

- Observe flooring to ensure clean, dry, and in good repair
- Toilet at regular intervals
- Consider applying non-skid strips
- Use adequate handrail support
- Provide raised toilet seat
- Use easy to manage clothing
- Increase staff assistance
- Install contrasting-colored toilet seats

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Fall Care Plan Template Examples

Focus/Problem	Goals	Interventions
I have a potential for falls related to: [reference items triggered on fall risk assessment tool], diagnoses and medications that could directly relate to falls, and clinical details i.e. movement, paralysis, incontinence.	I will have my risk for falling minimized through next review.	I will receive education related to potential fall risks. [If Brief Interview for Mental Status (BIMS) allows education] I will receive education related to fall preventive measures.

Focus/Problem	Goals	Interventions

I have had an actual fall with [SPECIFY: minor injury, serious injury] related to:	I will resume usual activities without further incident through next review. My [SPECIFY: injured areas] will resolve without complication through next review.	• Nursing will check my range of motion [Specify # times daily.]
		• Nursing will continue interventions on my at-risk plan.
		• For no apparent acute injury, nursing will determine and address the causative factors to my fall.
		• I need nursing to observe/ document/report to my physician as needed for 72 hours for signs and symptoms, such as:
		  • Pain, bruises, and/or change in mental status
		  • New onset of confusion, sleepiness, inability to maintain posture, and/or agitation.

SAMPLE

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Focus/Problem	Goals	Interventions
I have had an actual fall and am at risk for fall-related injury secondary to: history of falls [fall specifics if necessary]; diagnoses and medications that could directly relate to falls; and/or clinical details such as movement, paralysis, and/or incontinence.	I will be free from [significant] injury from a fall through next review.	• I will have my personal items within easy reach including my call light. • I will wear my adaptive devices as needed [eye glasses, contacts, hearing aides]. • My bed will be kept in the lowest position. • My bed will be kept at wheelchair height. • I will utilize enabler bar(s) during transfers. • I will utilize proper non-skid footwear when transferring/ambulating. • I need my nurse to complete a fall risk assessment in order to identify my risk. • I will participate in therapy as ordered. • Nursing staff will educate me/my family about safety reminders and what to do if a fall occurs. • I will be encouraged by staff to participate in activities that promote exercise, physical activity for strengthening, and improve mobility. • I utilize [specify: chair/bed] electronic alarm(s). Ensure device is in place as needed. • I need nursing to review information on past falls and attempt to determine cause of falls, record possible root causes, and alter or remove any potential causes if possible. • I need staff to anticipate and meet my needs. • I will need staff to ensure my call light is within reach. • I need help making sure I have the proper assistive devices and that I am using them properly. • I need reminders to reinforce my safety awareness [i.e. lock brakes before transfers, sit on side of bed for a few minutes before transferring] • If staff notices I am having side effects from medications that may increase my risk for falls, they will notify my physician. • If staff notices I am having a change in my status that may increase my risk for falls, they will notify my physician. • I will allow staff to offer and assist me with toileting upon rising, before/after meals, with routine care rounds, and as needed. • If I have a fall, I need my nurse to discuss with my physician and representative. [List individualized fall prevention measures and devices ordered]

SAMPLE

Tools

Fall Compliance Audit Tool

Date and Time								
Name								
Room #								
Incident Report Completed								
Nurses Note								
Notifications								
Immediate Intervention								
Neuro Checks								
Fall Assignment								
New Order?								
IDT Note								
New Intervention								
Care Plan Updated								
Kardex/CNA Sheet Updated								
Initials								

*Recommended Best Practice: Using your facility floor plan, track and trend fall occurrences to determine if pattern can be identified. Attach floor plan to audit tool.

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Monthly Fall Tracking Log

DATE	TIME	RESIDENT	INJURY	LOCATION							REPORTED BY	NOTES
				Bedroom	Bathroom	Hallway	Dining Room	Common Area	Outdoors	Other		
											TOTAL FALLS	

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Inter-Disciplinary Team (IDT) Daily Rounding (Care Rounds) Program Overview

Purposeful daily rounding is a best practice intervention to routinely meet resident needs, ensure safety, and proactively address problems before they occur.

Daily

1. Each resident is assigned a care partner. During the daily IDT meeting, new admission residents will be assigned to a care partner.
2. A list will be kept with assigned care partners and their residents. Provide resident and/or representative with name and contact information of care partner.
3. Assigned care partners will complete morning rounds upon arriving to the facility each day.
4. Assigned care partners will be provided with necessary updates regarding resident, such as upcoming appointments, preferences, safety interventions, etc.
   -Suggested to print/provide interventions from care plans weekly.
5. Care partners will share major events/happenings in the residents' lives, such as birthdays, anniversaries, death of a loved one, upcoming surgery, etc.
6. Care partners will complete a log with reference questions, topics, and observations that were completed.
7. Care partners will share pertinent updates during administrative meetings to assist with person-centered care, identify potential hazards, such as fall risks, noted resident concerns, or identified changes of condition.
8. IDT team will utilize these reports to ensure the most appropriate plan of care is in place for each resident.

Monthly

1. Each month, the facility administrator will ensure that the care partner paperwork is completed, reviewed, and collected.
2. Each month, the assigned care partners will contact resident family members and document encounters. Pertinent information from these contacts will be shared with the IDT and followed up with accordingly.
3. The care partner paperwork is reviewed with the IDT and discussion occurs regarding communications with residents, staff/caregivers, and/or resident family members.

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INTER-DISCIPLINARY TEAM (IDT) CARE ROUNDING TOOL

Resident Observation	Yes/No	Follow-Up Needed
Resident appears neat, clean, and well groomed? (hair combed, mouth clean, clean clothes, shaved per preference, nails clean and trimmed?)		
Resident is wearing appropriate non-skid footwear?		
Fall interventions in place?		
Positioning devices/wound interventions in place?		
Oxygen tubing dated and bag in place for when not in use?		
Foley catheter tubing and bag not touching floor? Placed in position below bladder? Dignity bag covering?		
Tracheostomy supplies at bedside per care plan?		
Head of bed elevated per care plan?		
Resident's glasses, dentures, braces, and/or splints in place?		
How does the resident's mood appear today?		
Are there any complaints or non-verbal signs and symptoms of pain?		
Resident Communication	**Yes/No**	**Follow-Up**
How are you feeling today?		
Inquire about meals – how was breakfast (lunch/dinner)? Did you enjoy the food?		
When was your last bath/shower? Are you receiving them per your preference?		
Have you had any missing items recently? Were they found or replaced?		
How have the staff been treating you? Have the staff ever been rude to you?		
Do you feel safe?		
Are you comfortable voicing any concerns you might have?		

Room/Environment Observation	Yes/No	Follow-Up
No odors present?		
Room furniture clean and free of clutter?		
Floor is clean and free of clutter?		
Fresh water present and within reach?		
Call light within reach?		
Oxygen concentrator filter is clean?		
Personal care items are put away?		
Bedpans and urinals are bagged and stored properly?		
No medications or treatment supplies at bedside?		
If on isolation, appropriate signage and supplies are present?		
Staff Observation	**Yes/No**	**Follow-Up**
Staff are wearing name tags?		
Staff knock before entering rooms?		
Staff are pulling privacy curtains prior to providing care?		
Staff are performing hand hygiene appropriately?		
Staff are speaking kindly and explaining procedures before performing them?		

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Fall With Injury Reportable Guide

Activity	Completed
Reported in Gateway no later than 24 hours after incident.	
Documentation	
Nurses note addressing fall and resident assessment in EMR.	
Documentation completed with accurate assessment to include anticoagulant use, accu-check, if applicable.	
A tangible immediate intervention was put into place and documented.	
Notification of physician and responsible party completed.	
IDT note completed with root cause of fall and new care planned intervention.	
Care Plan updated with new intervention.	
Resident care sheet/profile reviewed to ensure interventions in place.	
Evaluated resident's room to ensure that interventions were actually in place.	
Neuro-checks initiated immediately and completed with not documentation holes.	
If x-rays ordered, are they present in the chart with timely physician notification documented.	
Orders present to check interventions every shift as indicated.	
Statements	
Obtain written statements from staff who provided care to resident leading up to fall.	
Education	
Provided education to staff and documented disciplinary action, if applicable	
Follow Up	
Investigation summary and timeline written and placed in soft file.	
Five day follow up completed and submitted in Gateway.	
If resident is hospitalized, resident was reevaluated upon return to facility for new fall risk, needed new fall interventions, and any new interventions needed related to injury.	

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Possible F-tags Related to Falls

According to The State Operations Manual, these F-tags are a few that can be related to falls. During a survey one deficiency can lead to another due to an oversight in a system.

F-Tag	Description
F552	Right to be Informed/Make Treatment Decisions
F553	Right to Participate in Planning Care
F580	Notification of Changes
F646	MD/ID Significant Change Notification
F635	Admission Physician Orders for Immediate Care
F655	Baseline Care Plan
F656	Develop/Implement Comprehensive Care Plan
F689	Free of Accident Hazards/Supervision/ Devices
F700	Bedrails
F726	Competent Nursing Staff
F865	QAPI Program/Plan, Disclosure/Good Faith Attempt
F867	QAPI/QAA Improvement Activities
F909	Resident Bed
F910	Resident Room

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Stop And Watch - Early Warning Tool

If you have identified a change while caring for or observing a resident/patient, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

STOP

Seems different than usual; Symptoms of new illness
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities

AND

Ate less
No bowel movement in 3 days; or diarrhea
Drank less

WATCH

Weight change; swollen legs or feet
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

_____ _____

Patient / Resident *Nurse Response* *Date and Time (am/pm)*

_____ _____

Your Name *Nurse's Name*

_____

Reported to *Date and Time (am/pm)*

Credit to Pathway Interact
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