

MANAGER

**All the King's
Men:
Management's
Role in Falls
Mitigation**

318-1101

DVD Length: 60 minutes

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Target Audience

The target audience for this activity includes nurses and long term care administrators.

Learning Objectives

After completion of this activity, the participant should be able to:

1. discuss steps in a fall management process.
2. discuss initial fall assessment components and implication for care planning.
3. describe interventions and selection criteria in a falls management process.
4. discuss the post-fall investigation and the CQI process.

All the King's Men: Management's Role in Falls Mitigation

Abstract

Until the healthcare industry begins to look to residents for the answer to falls rather than external devices, healthcare professionals cannot be successful in preventing falls. Healthcare workers should make it their goal to determine why residents move to get up and help them accomplish their own goals. Healthcare workers should stop trying to make the resident live in "our" world - the medical model world of long term care - and create an environment that focuses on the social aspects of living. Long term care staff try to help residents live in "our" world with alarms, special mattresses, and signs. None of those items address what residents are trying to do or help them get it done. Adopting the social model approach helps staff learn the resident's motives for moving. This philosophy works in any room in the facility because it is resident-specific, not location-specific. This program helps facility management create an effective, efficient falls management process that addresses the social and medical needs of the residents who fall. The presenter discusses ways to identify the steps that must be taken, the procedures that must be addressed, and the people who must be involved. A total facility falls management process helps ensure that falls are properly managed.

Discussion Questions

1. Discuss the need to include all staff in each step of the falls process.
2. Discuss the role of the family in obtaining needed information about the resident.
3. Describe available alternatives when using the five magic tools.
4. Examine the use of the quality assessment (QA) data regarding falls.
5. Discuss how the strength of hoarding can be used to help the resident feel more content.

Bibliography

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- National Citizen's Coalition for Nursing Home Reform, (1993). *Avoiding Physical Restraint Use: New Standards in Care*. Washington, DC: NCCNHR.
- Thomas, W. (1999). *The Eden Alternative Handbook*. Sherburne, NY: Summer Hill Company, Inc.

Post Test

All the King's Men: Management's Role in Falls Mitigation

1. When creating a falls management process, its philosophy must be reflected in your facility's mission/vision/purpose statement.
 True False
2. Which staff need to be a part of the falls management process?
 - a. Nurses
 - b. Administrators
 - c. Maintenance
 - d. Housekeeping
 - e. All of the above
3. Pre-admission visits are helpful to:
 - a. find answers to the five magic tools.
 - b. see where the resident has been sleeping.
 - c. determine the resident's favorite chair.
 - d. discover what the resident did all day.
 - e. All of the above.
4. Roadblocks to implementation of a falls process fall into one of which three categories?
 - a. Knowledge, money, and families
 - b. Knowledge, will, and the system
 - c. Knowledge, administration, and equipment
5. Involvement of the families as partners from pre-admission through the resident's stay usually increases family trust of the facility's actions.
 True False
6. Initiation of a falls management process requires:
 - a. planning
 - b. commitment
 - c. a system for feedback and evaluation
 - d. All of the above
7. Review the revisions and/or changes in falls interventions must be made immediately when a fall occurs.
 True False
8. Equipment needed to facilitate a successful falls management program could include:
 - a. a book about falls
 - b. file folders and papers
 - c. comfortable chairs
 - d. full size beds
 - e. All of the above.
9. The plagues of the elderly, as defined by Dr. Thomas, are:
 - a. financial ruin, displacement, and boredom.
 - b. loss of physical strength, loss of their sense of humor, and loneliness.
 - c. boredom, loneliness, and helplessness.
 - d. helplessness, worry, and frustration.
10. The falls oversight committee's primary focus is:
 - a. selecting individualized interventions for specific residents.
 - b. looking at the entire picture to determine the system problems that are leading to falls.
 - c. gathering data for the QA reports.
 - d. reviewing each fall and finding out what staff did wrong.

Answer Key
All the King's Men: Management's Role in Falls Mitigation

1. True
Because a successful falls management program must include a belief in utilizing the social model that philosophy must be a part of the facility's statement of belief which is addressed in either the mission, vision, or purpose statement. (video)
2. e
All staff play a role in successful falls mitigation. (video)
3. e
When a social model is in place, the social aspects of a person's life can be easily identified by visiting his or her home. (video)
4. b
All problems encountered when setting up a falls management process fall into one of these three categories. (video)
5. True
When people are a part of any process, they feel they can trust the other people in the process. Families can identify individual staff and know they care enough leave their facility and travel to the resident's home to gather information on how to best care for the resident. (video)
6. d
The fall management system must be set up with planning of the process; commitment from owners, administrators, and management; and a system to determine if the system is working or needs revision. (video)
7. True
Review and revision in falls interventions must be made:
 - By the individuals present when the fall occurs;
 - With the information available at the "fall scene"
 - Using knowledge that is lost once the resident has been moved and the "fall scene" has been changed by any staff action. (video)
8. e
Learning how to think out of the medical model box and into the social model allows all of these ideas to be effective interventions. (video)
9. c
Dr. Thomas has set forth these three plagues. (video)
10. b
The oversight committee must focus on the broad aspects of the falls management process and not get bogged down in trying to determine specific interventions for specific residents. Often, the system issues must be corrected before falls management can be totally effective. These system issues must be identified if they are to be addresses. (video)

Diana F. Waugh

PROFESSIONAL EXPERIENCE

- WAUGH CONSULTING, Waterville, Oh.; Private Practice** 5/99----
- Nursing Home Consultant
- Conduct seminars on geriatric care such as behavior management, falls mitigation, restorative care, restraint freedom
 - Work with professional health care workers in areas such as staff retention, teamwork, self-esteem, leadership
 - Consult on standards of practice in long term care
- THE HERITAGE, Findlay, Oh, Nursing Facility** 5/00--5/01
- Internal Consultant
- Work with clinical issues to increase quality of care
 - Set up systems in all areas of facility
 - Teach seminars for staff
 - Propose and implement unique approaches to resident care
- LIFE CARE CENTERS OF AMERICA, Cleveland, Tn; Nursing Homes** 5/99---5/00
- Regional Director of Clinical Services, Lake Region
- Develop and implement role of RDCS in Lakes Region
 - Work to ensure quality resident care in seven (7) centers across three (3) states
 - Operationalize a regional CQI program
 - Create programs that make Lakes Region facilities industry leaders
- WESTHAVEN SERVICES CO Perrysburg, OH; Institutional Pharmacy** 6/92-4/99
- Director of Education, Division of Quality Assurance/Client Education
- Creation, implementation of program of continuing education, long term care settings
 - Securance of Ohio Board of Nursing status as an Approver of Nursing CE
 - Creation of Advisory Committee for educational needs assessment
 - Implementation of a continuing education network
 - Chair of the Forms Committee
 - Consultation, compliance and clinical issues to 200+ nursing facilities in 3 states
 - National educator on restraint elimination, behavior management, falls mitigation
- NOVACARE, INC., Valley Forge, PA; Contract Rehabilitation Service** 12/91-6/92
- District Manager
- Supervision a mixture of therapists, PT, OT, Speech
 - Operation and growth of rehabilitation business
 - Implementation of clinical experience sites with collegiate therapy programs
 - Establishment of educational programs
- WESTHAVEN SERVICES, Perrysburg, OH** 8/88-12/91
- LTC Consultant, Division Quality Assurance/Client Education
- Interpretation of regulatory mandates
 - Provision of clinical expertise in areas of long term care needs
 - Taught educational offerings, in facility and seminar settings
- BRIARFIELD OF SYLVANIA, Sylvania, OH; Nursing Home** 6/87-8/88
- Director of Nursing
- Operation of nursing department and nursing budget for 109 bed ICF
 - Implementation of innovative staff retention and staffing model

PROFESSIONAL/SERVICE ORGANIZATIONS

GROW Coalition, co-founder
Regulations Committee, PC3, chair
Resource Subcommittee, Person Centered Care Coalition
Communication Art, INC. Board Member
AMDA
ACHCA
Ohio Health Care Association
Association of Philanthropic Homes, Housing and Services for the Aging
Riverside Hospital Alumni Association
University of Toledo Alumni Association
Northwest Ohio Gerontological Association
ONA/ANA
Professional Services Committee, Omnicare, Inc.
Committee on Continuing Nursing Education, Ohio Board of Nursing, Chair
Alzheimer's Association, Northwest Ohio Chapter, Board of Trustees
Memory Walk Chair
State of Ohio Nurse Aide Curriculum Revision Committee
Waterville Playshop
Waterville Chamber of Commerce
Waterville Village Council
Waterville Board of Zoning Appeals, Chair
Waterville Foundation Board

EDUCATION/EDUCATIONAL AWARDS

Eden Associate, The Eden Alternative -1998
BSN, University of Toledo, Toledo, OH. - 1976
Graduated magna cum laude; elected to Phi Kappa Phi.
Diploma, Riverside Hospital School of Nursing, Toledo, OH. - 1965
Graduated with highest academic average; received Outstanding Nursing
Student award.
Licensed RN in Ohio

AWARDS

Outstanding Young Woman of the Year, Toledo, OH
Citizen of the Year, Waterville, OH

ALL THE KING'S MEN Falls Mitigation

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for the

Indiana State Department of Health FALL MANUAL

released

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presented by

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ALL THE KING'S MEN

FALLS MANAGEMENT PROCESS

In order to develop and implement an effective falls prevention program, each facility will need to establish a structured process. After decisions are made, staff must be trained and appropriate follow-up carried out to assure the process is followed.

BUT FIRST WHERE HAVE WE BEEN?

How do you see your role in falls mitigation?

What does the Falls Qa Data Show? How have you utilized it?

What global interventions have been put into place based on that data?

What is the role of your falls committee?

When a resident falls, who is responsible for determining the changes to the care plan, if any are required?

How does that information get disseminated? Is there a mechanism so that every employee working the next shift knows the change/addition in the interventions?

If I asked all staff why folks are still falling, what would they say?

Are social interventions offered? Name three you see in place today.

Are social interventions valued? Relate one instance where you rewarded another staff member for trying to use a social intervention. Preferably this would be a front line staff member, a charge nurse or a floor nurse.

Do you feel your falls SHOULD be less? Why? Why not?

Do you feel your falls COULD be less? Why? Why not?

Who on the staff is doing a great job as part of the solution? How have you utilized their talents with the remaining staff in education, example, hands on demonstration?

Who on staff continues to be part of the problem? Why? What is stopping them from becoming part of the solution?

Has the pre-admission assessment proved successful? Why? Why not?

What percentage of your residents have on devices that work by psychological intimidation called alarms?

What are you doing to reduce the use of alarms?

FALLS MANAGEMENT KEYS TO SUCCESS

****HUMANS DESERVE FREEDOM**

****PREVENTION IS 9/10TH OF THE CURE!!!!**

****FALLS PREVENTION IS THE RESPONSIBILITY OF THE ENTIRE STAFF**

****FOCUSING ON PREVIOUS FALLS WILL NEVER REDUCE YOUR FALLS RATE**

****A CALM, CONTENTED, RESIDENT DOESN'T GET INTO THE SITUATION THAT WILL ENCOURAGE FALLS**

****PERSONAL AND BED ALARMS ARE ONLY AS EFFECTIVE AS THE RESIDENT'S ROOMMATE'S RESPONSE TIME.**

****FALLS ARE A RESULT OF THE THREE PLAGUES OF THE INSTITUTIONALIZED ELDERLY:**

BOREDOM

LONELINESS

HELPLESSNESS

THE ULTIMATE FALLS REDUCTION BELIEF

****ANSWERS TO FALLS MITIGATION LIES IN YOUR ABILITY TO LOOK INSIDE OF THE RESIDENT'S REALITY - - - - NOT SOLELY AT EXTERNAL "THINGS"**

OUR GOAL MUST BE

TO DETERMINE THE RESIDENT'S GOAL FOR MOVING OR GETTING UP AND THEN HELPING THEM MEET IT.

THE FIVE MAGIC TOOLS

KNOWING WHAT THE RESIDENT LIKES TO:

- SEE**
- SMELL**
- TASTE**
- TOUCH**
- HEAR**

LEADS TO INDEPENDENT RESIDENT ACTIVITIES THAT KEEP RESIDENT OCCUPIED AND LESS LIKELY TO ACT IN A MANNER THAT LEADS TO FALLING.

Keys to Success, continued....

STRENGTHS OF THE CONFUSED ELDERLY

REPETITIVE, NON-THINKING BEHAVIORS

PHYSICAL ACTIVITY

SENSE OF RHYTHM

HOARDING

LONG TERM MEMORY

HUMOR

CHAIR RELATED ISSUES

WHAT IS THE RESIDENT'S FAVORITE CHAIR?

WHAT DID YOU FIND DURING YOUR PRE-ADMISSION VISIT TO THEIR HOME?

ARE THEY USING IT?

CAN YOU GET IT HERE FOR THEM?

WILL YOU ALLOW IT TO COME IN HERE?

WHY ARE RESIDENTS IN WHEELCHAIRS?

BED RELATED ISSUES

WHERE HAS THE RESIDENT BEEN SLEEPING?

WHAT DID YOU FIND DURING YOUR PRE-ADMISSION VISIT TO THEIR HOME?

HAVE YOU MADE ARRANGEMENTS FOR THEM AT YOUR FACILITY TO SLEEP IN THE SAME KIND OF PLACE THEY WERE SLEEPING AT HOME? WHY NOT?

CAN THE RESIDENT IDENTIFY THE EDGE OF THE BED?

WHY IS THE RESIDENT GETTING UP IN THE NIGHT?

WHY ARE YOU TRYING TO KEEP THEM IN BED?

ALL THE KING'S MEN

MULTIDISCIPLINARY TEAM'S KEYS TO SUCCESS Falls Management Process

VALUES

- ◊ Demonstration of management beliefs
- ◊ "Card carrying" affirmation of support of a person centered approach to falls management
- ◊ Staff responsibilities included in orientation and subsequent in-services

ASSESSMENT

- ◊ Utilize all team members to determine
 - At least two answers to what the person likes see, smell, taste, touch, hear
 - Person's ability to identify edge of bed
 - Behavioral patterns that make the person unsafe
 - Person's favorite chair
 - Where the person has been sleeping
 - Person's Night time sleep and behavior patterns
- ◊ Functional Age

CARE PLAN

- ◊ Components that must be stated in the person's care plan:
 - Equal parts of social and medical aspects
 - Functional Age
 - Use of all life style factors
 - Behavior that has or might prompt a fall
 - Three (3) statements that can be used:
 - to elicit a calm, happy person response
 - to divert the person's attention
- ◊ Determine how to share social data with all staff that interact with person

INCIDENT INVESTIGATION

- ◊ Establish and empower an "Immediate Response Team"
- ◊ Respond slowly in a calm, in control manner with as few employees as possible
- ◊ Don't destroy the evidence before the incident investigation is complete
- ◊ Ask in the present tense:
 - What are you doing?
 - Where are you going?
 - What do you need?
- ◊ Inclusion of any new interventions in care plan

ANALYSIS

- ◊ Responsibility of QI group work
- ◊ System issue focused
- ◊ Sharing of findings with staff
- ◊ Utilization of findings in changing facility systems

EXAMPLE

FALLS MANAGEMENT PROMISE

I promise to do my part to reduce the number of falls our residents experience.

I know that the word "intervention" simply means "something we do to help keep them from falling."

I understand an intervention can be as simple as:

- Put the resident in the orange recliner, or
- Give the resident a cookie and an ice tea, or
- Take them to the bathroom right after each meal, or
- Don't leave them in their wheeled chair sitting in the bedroom looking at their bed

I understand it is up to me to observe the residents and offer interventions that might help keep that resident be safer.

I know that there is no single intervention that will work for all residents.

I also know that each of our residents are people, just like me, and there is no one intervention that will work all of the time.

I will continue to look for interventions that are very specific for each resident and add them to that resident's falls intervention list.

As a nursing assistant, I will review the intervention list for all updates each time I come on duty. I will use the interventions that are listed and share them with staff members who aren't in the nursing department.

When I am involved in a situation where a resident falls, I will not return the resident to the same situation they were in before they fell.

I realize the resident's safety starts with me.

Signature _____ Date _____

Sample Fall Risk Assessment

adapted from the Ohio Falls Work Group work, 1999

Resident _____ Attending Physician _____ Room/Unit _____

Complete fall risk assessment upon admission, readmission and according to facility policy. Check appropriate responses. If a resident has any one the the conditions checked consider proceeding to care planning.

___ Admission ___ Readmission ___ Other

FALLS HISTORY

___ None/no history of falls ___ Fall(s) in last 90 days/#of fall(s) ___
___ Fall(s) in last 30 days/#of fall(s) ___ ___ Fall(s) in last 180 days/# of fall(s) ___

Circumstances surrounding fall(s) _____

LIFE STYLE FACTORS

What does the resident like to.....

Hear _____
Smell _____
Touch _____
Taste _____
See _____

Resident can identify edge of bed ___ Yes ___ No

Behavioral patterns that make resident unsafe, e.g. need to be independent, pacing, other? _____

What is the resident's favorite chair? _____

Where has the resident been sleeping?
If bed, include size _____

Night time sleep and behavior patterns _____

INTERNAL RISK FACTORS

Cardiovascular

___ None
___ Orthostatic hypotension (systolic BP change > 20mm Hg drop standing and lying
Lying _____ Sitting _____ Standing _____
___ Cardiac dysrhythmia
___ Pacemaker - last date checked _____

Diagnostic indicators, e.g. PVD, other _____

Neuromuscular Function

Body movement problems (gait and balance). Assess resident's gait and balance while
1) standing with both feet on the floor for 30 seconds unsupported, 2) Walking forward, 3) Walking through a doorway and turning:

___ No Difficulty with tasks	___ Decline in functional status
___ Partial or total loss of balance while standing	___ Poor muscular coordination
___ Partial or total loss of balance while walking	___ Unsteady gait
___ Jerking movements or instability	___ Transfer difficulties
___ Gait pattern changes when walking	___ Hemiplegia/hemiparesis
___ Loss of arm/leg movement	___ Other _____

Diagnostic indicators, e.g., CVA, Parkinson's, seizure disorder, other _____

Continued

Resident _____ Attending Physician _____ Room/Unit _____

Orthopedic

___ Joint Pain ___ Hip Fracture ___ Other fracture ___ Missing limb(s)

Diagnostic indicators, e.g. osteoporosis, arthritis, other _____

Perceptual Deficits

___ None ___ Impaired hearing ___ Impaired vision ___ Dizziness/vertigo/syncope/BPPV

Mental Status

___ Comatose ___ Inability to understand or follow directions
___ Oriented at all times ___ Impaired judgment/decision-making
___ Confusion/disorientation at all times ___ Signs of depression/anxiety
___ Periods of confusion/disorientation ___ Hallucinations/delusions
___ Lack of familiarity with surroundings ___ Decline in cognitive skills

Diagnostic indicators, e.g. delirium, manic depression/bi-polar disease, Alzheimers or other dementia _____

Medications (If any medications are checked, complete fall medication review)

___ Antianxiety ___ Antiparkinson ___ Hypoglycemic ___ Antihistamine
___ Hypnotic ___ Antipsychotic ___ Analgesic ___ Anticoagulant*
___ Antihypertensives ___ Anticonvulsant ___ Laxatives ___ Non
steroidal
___ Antidepressant ___ Diuretics ___ Narcotics Anti-inflammatory

*Not a medication that leads to falls, but increases risk for injury when fall occurs.

EXTERNAL FACTORS

___ Restraints/devices/enablers (including side rails) _____
___ Use of mobility devices when ambulating? What? _____
___ Using correctly ___ Using incorrectly, Explain _____
___ Appliances that contribute to fall potential , e.g. splints, O2 tubing, slings, other _____
___ Clothing/Footwear that contribute to falls potential _____
___ Other environmental conditions that contribute to falls potential _____

SUMMARY Indicate fall risk potential, identifying factors that can be managed, controlled or removed by staff intervention. If fall risk potential exists take to care planning. Include interventions that manage, control or remove the risk factors identified. _____

Nurse Completing Assessment _____ Date _____

MEDICATION REVIEW

Resident _____ Attending Physician _____ Room/Unit _____

This form is designed to be completed by the nurse with input from the pharmacist. This pharmacist input could occur through communication via phone or fax. The sections to be completed with the help of a pharmacist are denoted by the designation "Pharmacy."

MEDICATIONS	YES	NO	NA	COMMENTS
Person receives one or more of the following medications:				
Analgesic				
Antianxiety Agent				
Anticonvulsant				
Antidepressant				
Antihistamines				
Antihypertensive				
Antiparkinson Agent				
Antipsychotic Agent				
Diuretic				
Hypoglycemics				
Muscle Relaxant				
Nonsteroidal Anti-Inflammatory				
Sedative/Hypnotic				
MEDICATION CONSUMPTION ISSUES	YES	NO	NA	COMMENTS
Has the dosage form changed?				
Is the person taking the med at different times each day?				
Is the med being crushed sometimes and not others?				
Is a non-crushable med being crushed?				
Is the med being given either with food or without food as directed?				

TIME OF FALL RELATED TO MEDICATION ADMINISTRATION	YES	NO	NA	COMMENTS
Was a "potential causer" PRN med taken within the last 12 hours?				
Are any bedtime meds interfering with sleep, and possibly causing bedtime sedation?				
Are multiple sedative medications given at bedtime causing hangover effects at time of fall?				
What is the peak action time of a suspected med? (Pharmacist)				
What may be the cumulative effect of the peak action of several meds? (Pharmacist)				
What are the peak action times of antidiabetic meds? (Pharmacist)				
What are the blood glucose readings at these peak action times?				
DOSE CHECK OF NEW MEDS	YES	NO	NA	COMMENTS
Is this a typical geriatric dose (Pharmacist)				
If dose is high, was dose gradually achieved? If higher, was size of resident taken into consideration? (Pharmacist)				
POST WITHDRAWAL MED EFFECTS	YES	NO	NA	COMMENTS
Was a recently discontinued med stopped abruptly?				
Should the recently discontinued med have been tapered? (Pharmacist)				
Is the side effect of the discontinued med similar to the side effects of a new overlapping med? (Pharmacist)				

VITAL SIGNS	YES	NO	NA	COMMENTS
Are the blood pressures noted during typical times of incidents?				
Does the blood pressures fluctuate at different times of the day?				
Does blood glucose fluctuate during the day?				
What were blood pressures within a week before fall?				
If diabetic, what were blood glucose readings one week before the fall?				
SIDE EFFECTS EVALUATION	YES	NO	NA	COMMENTS
Is the description of the person's condition before the fall clear?				
Is a suspected med side affect a likely factor?				
RECOMMENDATIONS				
Recommend continuation of current med regime? (Pharmacy)				
Recommend changes to the current med regime as follows: (Pharmacy)				
Resident _____ Attending _____ Physician _____ Room/Unit _____				

INCIDENT INVESTIGATION

SAMPLE

RESIDENT _____ ROOM _____ DATE/TIME OF FALL _____

DIRECTIONS

According to facility policy, the incident investigation shall be completed immediately following any resident incident. This fall incident investigation shall not be made part of the resident's medical record. The investigation is completed as part of the facility's continuing quality assurance program. Information in this investigation should be used to revise the resident's plan of care. If medications are suspected as a contribution factor in the case of a fall, a review of the medications should be completed. **Items noted below with a star * should be appropriately documented in the resident's clinical record. All other items should be reviewed and acted upon solely at the discretion of the nursing facility.**

IMMEDIATE ACTION

*The following items should be documented in the resident's clinical record:

- Physician contacted Family contacted
- Administration contacted, according to facility policy
- Resident first-aid and treatment
- Neuro-checks
- Vital signs: BP (standing and sitting), temperature, pulse and respiration
- Signs/symptoms of injuries such as pain, bleeding, abrasions, contusions, bruises, swelling, reddened areas, etc.
- Medical conditions that may have contributed to incident, such as chronic recurrent illness, acute conditions, or signs/symptoms of unknown origin
- The position of the resident upon discover
- Resident and witness statements

INVESTIGATION

***What the resident was doing when incident occurred:**

Standing Sitting Transferring In Bed Walking Reaching Other _____

***Where was the resident when the incident occurred:**

Own Bedroom Another bedroom Another bathroom Hall Dining Room Lounge
 Own Bathroom Other _____

***What was the resident's state of mind when the incident occurred:**

Oriented/ No Problem Judgment Impaired Non-communicative Confused/Disoriented
 Unable to understand others Unknown

Has there been a change in mental status in the last week before fall? Yes No

If "Yes" please investigate cause.

***What time was it when the incident occurred:**

Day of Week _____ Time of Day _____ am/pm Phase of moon _____ Last meal time _____
Last Toileting time _____ Last incontinence episode _____

ENVIRONMENTAL FACTORS

*A summary of environmental factors that contributed to the incident is present. Yes No If "NO" interview staff and get information into record as late entry.

Has there been a change in the environment? No Yes, please investigate

Floor Surface

Unknown No problem Loose rug, tiles Thick pile carpet
 Clutter Patterned carpet Slippery/glare Threshold > 1/2"
 Uneven surfaces Other _____

Stairs

Unknown No problem Low lighting Objects on stair
 Tread Loose Top/bottom not identified Other _____

Lighting

Unknown No problem Inadequate Glare Too much Other _____

Handrail

Unknown No problem Not accessible Difficult to grip Loose
 Other _____

Bathroom

Unknown No problem No Grab bar Grab Bar loose Floor slippery
 Other _____

Chair

Unknown No problem No armrest Unlocked wheels Poor construction
 No problem Lack of 3 right angles when seated Other _____

Bed

Unknown No problem Too narrow Overlay Too low
 No problem Unlocked wheels Lack of 3 right angles when seated
 Siderails Other _____

Clothing and Shoes

Unknown No problem Tripped person Loose/ill-fitting shoes Walking in stocking feet
 Other _____

Other factors contributing to incident

None Restraint Lift Staff Other device, List _____

RESIDENT SPECIFIC CARE PLAN IN PLACE, FOLLOWED AND DOCUMENTED

Appropriate safety precautions and devices Yes No NA
Positioning devices Yes No NA
Toileting program Yes No NA
Rehab/restorative program Yes No NA
Behavioral program Yes No NA
Other, list _____

ACTION PLAN

Review incident report Review nurses notes Educate resident about safety concerns
 Educate resident about ways to fall Review and revise care plan Communicate changes to staff

CONCLUSION/SUMMARY

Individual Completing Investigation _____ Date _____

RESIDENT _____ ROOM _____ PHYSICIAN _____

State of Michigan
Department of Community
Health
Bureau of Health Systems

***Process Guideline for
Evaluation of
Falls/Fall Risk***

PROCESS GUIDELINE FOR EVALUATION OF FALLS/FALL RISK

October 1, 2001

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>Assessment/Problem Recognition</p> <p>1. Is there documentation that an assessment for resident specific fall-related risks was begun within 24 hours of admission, fall, or significant change.</p>	<p>Problem definition includes several components: 1) identifying individuals with a history of falling, 2) identifying the likelihood of falling subsequently, 3) identifying factors that may make falling more likely, and 4) identifying individuals who may be at risk for serious consequences of falling such as a high risk of injury. Begin trying to identify possible causes within 24 hours.</p>	<p>Falling is not associated with normal aging. Often, falling can be reduced markedly or prevented. Best practice focuses assessment on identifying individuals who have fallen and those who may be at risk for falling. Within 24 hours of admission or a fall or significant change, collection of information relevant to determining a fall risk or problem is begun. The investigation may take time, because a number of conditions or situations can cause falling. The investigation is not necessarily completed right away.</p>
<p>2. Did the MDS include any triggers for fall risk? [On the MDS version 2.0 these include: Wandering (E4aA= any of 1,2,3 checked); Dizziness (J1f = checked); History of Falls (J4a or J4b checked); Use of Anti-Anxiety Drugs (O4b = any of 1-7 checked); Use of Antidepressant Drugs (o4c – any of 1-7 checked); or Use of Trunk Restraint (P4c – either 1-2</p>	<p>The Minimum Data Set (MDS) contains some -- but not all -- information relevant to defining and managing a fall risk or problem. Because falling is a common high-risk problem in the long term care population, you should consider fall-related issues even if it is not time to do an MDS. Use this information to rapidly identify prominent risk factors and minimize immediate risks without resorting to the use of physical restraints.</p>	<p>As you collect information, you can try to decide if there is a fall problem or risk. Facilities will find additional relevant information in the Resident Assessment Profile (RAP) Key Guidelines and in the tables and references at the end of this tool.</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>checked]]</p> <p>3. Have major risk factors for falls and serious consequences of falls been considered? [See Falls RAP Key Guidelines (i.e., multiple falls, internal risk factors, external risk factors, medications, appliances and devices, environmental and situational hazards). Additional examples of conditions representing risk factors for falls may be found in the American Medical Director's Association (AMDA) Falls and Fall Risk Guidelines, Tables 1 & 2].</p>	<p>The Resident Assessment Protocols (RAPs) give some clues to the possible categories and causes of falls. You should refer to the RAPs for such clues. However, regulations cannot and do not tell you how to decide exactly what is causing a fall or fall risk in a specific individual. Therefore, go as far as you need to beyond the information in the RAP to draw relevant conclusions and take proper actions.</p>	<p>Recognize that some individuals have a relatively low risk of falls, and that risk prediction is not always exact; that is, sometimes low-risk individuals may fall and some high-risk individuals may not.</p> <p>However, in individuals with a history of falls or at risk for falls, a facility can identify factors that may be associated with an increased risk of injury from subsequent falls.</p>
<p>4. Is there documentation that the physician or physician extender has been notified if there is a significance of falls or falls risk in this resident?</p>	<p>If necessary to manage falls and identify causes properly, review the situation with a physician, Nurse Practitioner (NP) or Physician's Assistant (PA-C) who is trained to understand how to use resident-specific information to identify why that person is falling and what to do about it. You will not review every fall with a physician, NP or PA-C.</p>	<p>If you can readily determine a cause (for example, the individual tripped over something) or if a simple intervention can address the probable cause, then you may not need to consult the physician, NP or PA-C. Many disciplines (CNAs, nurses, dieticians, social workers) may make and document observations (sleeping, eating, social patterns), but only some of them may be qualified to determine the significance of those observations. Physicians may not be present to make observations, but are trained to analyze them.</p>
<p>5.a) For residents who have fallen previously, is there documentation of a review of circumstances under which the fall occurred,</p>	<p>Sources of information such as hospital discharge summaries, review of current medications, and a history obtained from the resident or family are all helpful.</p>	<p>Collecting and documenting information helps to identify whether the resident may have suffered any serious consequences of the fall, such</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>5.b) And documentation of evaluation for potential immediate and delayed consequences?</p>	<p>Delayed consequences are not uncommon and may occur within several days after the fall; occasionally, they can occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks later after an actual fall. Each facility needs to ensure that staff are aware of, and respond to, delayed consequences of falling.</p>	<p>as fracture or serious internal head injury Even if there are no immediate consequences of a fall, document follow up for at least 48 hours and consider late consequences if there is a significant change in function, mental status, or level of consciousness within several weeks of a fall.</p>
<p>Diagnosis/Cause Identification 6. Are the risk factors relative to this specific resident identified and documented in the RAP? These may include: History a) Previous or multiple falls</p>	<p>Fall history should include any co-existing symptoms, modifying factors, location, timing, and context. Often, several factors (medical condition, medications, activities, safety awareness, etc) are involved simultaneously.</p>	<p>Not all individuals in your facility will have the same amount or frequency of action or documentation. However, an effective risk assessment should allow anticipation of risks correctly more often than not. Falling has causes, and history of falls (especially in the preceding 90 days) is a strong predictor of future falls. Often, identifying and correcting causes can reduce or eliminate falling.</p>
<p>External Factors b) Currently taking medications commonly associated with injury from falls</p>	<p>See AMDA Falls Guidelines Table 2, consider antianxiety/hypnotic agents, anticholinergics, anticoagulants, antidepressants, antihypertensives, cardiovascular and diuretics, among others.</p>	<p>If the cause is unclear, or there is a possibility of a significant medical cause such as an adverse drug reaction (ADR), or the individual continues to fall despite previous interventions, involve a physician, NP or PA-C. They need to review the situation, and include some discussion of possible medical causes. If the physician, NP or PA-C does not write a note, a nurse or other appropriate individual should</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>5. b) And documentation of evaluation for potential immediate and delayed consequences?</p>	<p>Delayed consequences are not uncommon and may occur within several days after the fall; occasionally they can occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks later after an actual fall. Each facility needs to ensure that staff are aware of, and respond to, delayed consequences of falling.</p>	<p>as fracture or serious internal head injury Even if there are no immediate consequences of a fall, document follow up for at least 48 hours and consider late consequences if there is a significant change in function, mental status, or level of consciousness within several weeks of a fall.</p>
<p>Diagnosis/Cause Identification</p>		
<p>6. Are the risk factors relative to this specific resident identified and documented in the RAP? These may include: History a) Previous or multiple falls</p>	<p>Fall history should include any co-existing symptoms, modifying factors, location, timing, and context. Often, several factors (medical condition, medications, activities, safety awareness, etc) are involved simultaneously.</p>	<p>Not all individuals in your facility will have the same amount or frequency of action or documentation. However, an effective risk assessment should allow anticipation of risks correctly more often than not. Falling has causes, and history of falls (especially in the preceding 90 days) is a strong predictor of future falls. Often, identifying and correcting causes can reduce or eliminate falling.</p>
<p>External Factors b) Currently taking medications commonly associated with injury from falls</p>	<p>See AMDA Falls Guidelines Table 2, consider antianxiety/hypnotic agents, anticholinergics, anticoagulants, antidepressants, antihypertensives, cardiovascular and diuretics, among others.</p>	<p>If the cause is unclear, or there is a possibility of a significant medical cause such as an adverse drug reaction (ADR), or the individual continues to fall despite previous interventions, involve a physician, NP or PA-C. They need to review the situation, and include some discussion of possible medical causes. If the physician, NP or PA-C does not write a note, a nurse or other appropriate individual should</p>

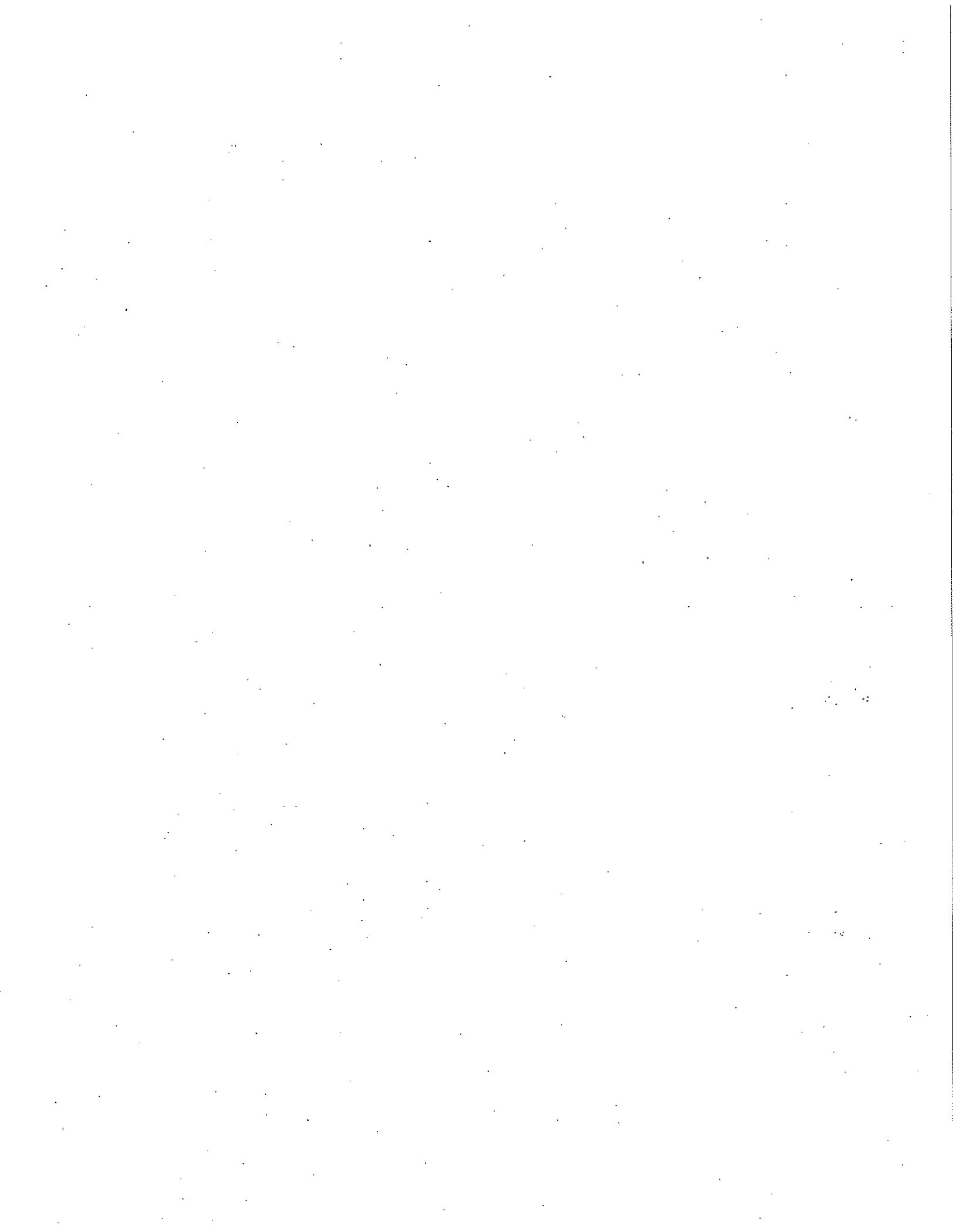
CARE STEP PROCESS	EXPECTATIONS	RATIONALE
		document enough to show that there was a substantive discussion with them.
c) Recent medication change	Should trigger a review of all medications	The newly added medication may be, in and of itself, increasing symptoms associated with falls, or it may be interacting with other medications the resident receives.
d) Potential multiple medication interactions	Is best accomplished with the assistance of the consultant pharmacist and/or the medical provider.	The mechanism of action, effectiveness, metabolic breakdown and toxicity of medications may be affected by concurrent medication administration.
e) Appliances or devices	(e.g., cane, walker, crutch, footwear, gait belt, wheelchair, mechanical lifts, pacemaker, restraints, reduction of restraint without alternatives)	Resident gait and balance, as well as devices to assist mobility should be examined to determine structural soundness and appropriateness. Statistically, gait and balance impairment is the second most frequent cause of falls in the elderly. Watch the resident rise from a chair without using his or her arms, walk several paces, and return to a sitting position. Consider sitting as well as standing balance as a precursor to further evaluation.
f) Environmental factors	(e.g., glare, poor lighting, slippery or wet floors uneven surfaces, patterned carpet, foreign objects, new environment). See AMDA Falls Guideline Table 4. Review of environmental factors with front line staff as well as the safety committee, maintenance, and housekeeping may provide insight into alternatives for bed use, floor mats, transfer bars, anti-tipping devices for wheelchairs, wandering patterns, lighting, alarms,	Many environmental factors associated with falls are discovered and eliminated by the investigation of the fall itself by staff, standard safety committee QA projects and survey readiness reviews. Pilot studies of new products and interventions (night lights, non-skid products) are helpful.

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
g) Situational factors	<p>placement of furniture, signs or memory triggers and restraints. (e.g., recent transfer, time of day, time since meal, proximity to other residents, type of activity, responding to toileting urgency, lack of staffing, failure to supervise, abuse/neglect)</p>	<p>When someone falls, collect specific information – for example, time of day and what the individual was doing when they fell – that may help to identify patterns and causes.</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>Internal Factors h) Cardiovascular</p>	<p>(e.g., cardiac dysrhythmia, hypotension, lightheadedness, dizziness, vertigo, syncope) Advise residents with orthostatic hypotension to rise first to sitting position after lying down, and to stand slowly.</p>	<p>Some conditions may predispose to orthostatic hypotension. Others, such as urosepsis may result in risk factors for falls such as dizziness, dehydration or delirium.</p>
<p>i) Neuromuscular/functional</p>	<p>(e.g., loss or decline in use of arm/leg movement, balance/gait disorder, proprioception, CVA, chronic/acute conditions with instability, weakness, weight loss, decline in functional status, incontinence, Parkinson's, reflexes, seizure disorder). Gait/balance instabilities/decline should be investigated for underlying illness, or neurological/musculoskeletal conditions, and evaluated by rehabilitative and restorative therapies.</p>	<p>Musculoskeletal problems can impair strength, balance and biomechanics. Even fear of repeat falls may cause decreased mobility and deconditioning. Executive functioning, and the ability to sequence steps to a process, may require simplification.</p>
<p>j) Orthopedic</p>	<p>(e.g., joint pain, arthritis, hip fracture, amputation, osteoporosis and activity tolerance)</p>	<p>Decreased body mass (muscle, fat and subcutaneous tissue) to absorb impact and changes from osteoporosis may result in increased opportunity for serious injury from a fall, such as fracture of the hip, wrist and spine. Hip protectors may minimize trauma with artificial padding.</p>
<p>k) Perceptual</p>	<p>(e.g., impaired vision [cataracts, macular degeneration, glaucoma] and impaired hearing [neurosensory, presbycusis])</p>	<p>Poorly fitting, as well as incorrect eye-wear and hearing aids are potential factors in falls. Consider also that falls may be symptomatic of an underlying condition change, such as stroke, or adverse drug reaction.</p>
<p>l) Cognitive/Behavioral</p>	<p>(e.g., delirium, decline in cognition or safety-awareness, decision-making capacity, confusion, depression, dementia, change in LOC, exacerbation in behavioral pattern, combativeness, refusal of intervention. Resident compliance is not necessarily, and of itself, an adequate</p>	<p>A resident's noncompliance with the plan of care is not necessarily by itself an adequate explanation or justification for continued falling, because there may be another underlying cause in</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>7. Did the physician or physician extender participate in the evaluation of this resident to identify the causes of falls or fall risks to the extent that a likely medical cause or no cause was identified?</p>	<p>explanation or justification for continued falling, because underlying causes may occur in conjunction with noncompliance.</p> <p>The responsibility for changes in the resident's medical plan of care is contingent on a review of medication, adverse drug reactions or interactions, lab values, screening for gross vision and gait/balance deficiencies, assessment of lower limb joints, neurological and cardiovascular systems, etc. Examine the resident, and explain any decision not to at least try to adjust likely risk factors such as multiple medications associated with dizziness or postural hypotension. If the physician does not participate sufficiently to allow you to identify causes or address relevant issues, inform the medical director for involvement as necessary until a satisfactory review has occurred.</p>	<p>conjunction with noncompliance. Maximizing dignity and quality of life while focusing on minimizing falls risk should be a focus.</p> <p>Continue to collect and evaluate information until you have either identified the cause of the falling or determined that the cause cannot be found or that finding a cause would not change the outcome or how you manage the situation.</p>
<p>8. If this resident was not evaluated to identify the causes of falling or fall risks, does the facility explain why the resident was not further evaluated OR why identifying causes would not have changed the management.</p>	<p>Use the information collected to try to identify why the individual fell or is at risk for falling. Or, explain why you could not or did not try to do so, or why you concluded that doing so would not have made any difference. Carefully document reasons for decision not to treat, or for choosing one approach over another.</p>	<p>There is no requirement for any specific evaluations or tests, but if a resident continues to fall despite certain interventions or has a history of recurrent falling within several months just prior to admission, the physician would do a more thorough evaluation. A work-up may not be indicated if the resident is terminal, if it would not change the management course, or if the burden of the workup is greater than the potential benefit or the resident or proxy refuse it.</p>
<p>Treatment/Problem Management</p>		
<p>9. Does the care plan contain cause-</p>	<p>When causes are identifiable and potentially correctable,</p>	<p>If the systematic evaluation of the</p>

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
<p>specific interventions to prevent or minimize resident fall risk, falls and complications from falls OR has the facility modified the care plan to accommodate the expectation of a continued risk, when cause-specific interventions or adjustments cannot be accomplished?</p>	<p>interventions should be based on identified or suspected causes. If not, indicate why such causes could not or should not be treated. It is not enough just to say, "because that's what the doctor ordered". Show how you decided that certain interventions were indicated while others were not.</p>	<p>resident's fall (risk) identifies several possibilities for interventions, it is reasonable to try one first, and document the rationale. While the physician does not have to always write a note, someone may need to answer such questions. Since the survey may occur long after the events, it makes sense to have such discussions and documentation at or near the time that these decisions are made.</p>
<p>10. Is there documentation that the physician or physician extender helped identify, or authorized, cause-specific interventions in this resident's care plan, if indicated?</p>	<p>It is possible that no cause of falling may be identified despite a comprehensive evaluation. If cause cannot be readily identified, then adverse drug reactions, and gait and balance disorders should be considered initially.</p>	<p>It is appropriate to prioritize approaches to preventing and managing fall risk and falling. That is, you may try only one of the possible interventions first, if it is based on a systematic evaluation and related conclusions about likely causes. If falling recurs despite the initial approach, then try other interventions unless you can explain why nothing else was relevant.</p>
<p>11. If this resident falls, (without another obvious cause) is there physician or physician extender documentation of a trial adjustment of medications or medication combinations commonly associated with falls to judge their possible effect on falling OR an explanation as to why this could not be attempted?</p>	<p>Document how you decided on the specific cause(s), or concluded that certain things contributed to the fall while others were not relevant. Falls that start after a change in medication regime should trigger a review of the entire medication regimen. If a resident is receiving medications that are often associated with falling, and no adjustments are attempted in those medications, document how you determined that the resident did not have lethargy, dizziness, or postural blood pressure changes that might indicate that medications played some role.</p>	<p>Many medications can cause dizziness, which is associated with increased risk of falling. If a medication is suspected to be a possible cause of a person's falling, then the initial intervention might be to taper or stop that medication before trying anything else. The physician, direct care staff and pharmacist should be involved with review of drug regimen. Titration of</p>



CARE STEP PROCESS	EXPECTATIONS	RATIONALE
12. Is there evidence to demonstrate that the care plan has been implemented?	Potential or actual falls should be addressed in the resident's individual care plan, either as a primary item, or in conjunction with risk factors associated with increased falls.	<p>medication or revision of administration times may help to manage pain, tremors, cogwheeling, incontinence, dehydration, etc. while minimizing fall risk.</p> <p>Discussion of resident risk factors and fall history in care conferences will be helpful in evaluating the implementation of care plans.</p>
Monitoring		
13.a) Does the facility document monitoring of the resident's response to interventions?	Evaluate the progress of individuals who have fallen or have a fall risk.	Adjust the resident's plan of care as necessary to reflect the implementation of new or modified interventions. Rationale documents thought processes.
13.b) and document a periodic review of approaches for applicability to the current situation?	If the resident stops falling, and you believe that the underlying cause has been corrected, then you might reconsider periodically whether the interventions are still needed.	Since causes sometimes can be corrected and do not recur, it is often reasonable to try to stop specific interventions, to see if they are still needed. It would not necessarily be problematic if a resident fell again, if you had based the decision on relevant evidence.
14. Does the care plan document that previously selected interventions were re-evaluated if falling continued (until falls stopped or declined markedly), OR document that the physician or physician extender helped to identify or verify likely reasons why falling continued despite interventions?	Consider the resident's response to each intervention on a timely basis. A facility should use root cause analysis but is not obligated to pursue all possible interventions. Consider any possible reasons for falling besides those already identified until falls stop or markedly decline, or indicate why another cause is unlikely or why finding a cause is not likely to change the outcome or the interventions. Reconsider interventions, try alternatives or explain why you believe that the current approach was	If falls continue despite initial measures, it could be because different or additional causes exist, because the underlying causes are not readily correctable, because the cause cannot be identified, or because the interventions are insufficient. Use basic quality improvement approaches to monitor falls in your

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
	<p>appropriate despite recurrent falls. A facility should be able to provide some justification for a decision not to pursue additional interventions in residents who continue to fall.</p>	<p>facility and to determine areas for improvement. Review falls to look for trends and patterns such as a particular unit or time of the day, patients who are taking certain medications or medication combinations. You can also use the results of your reviews as part of your quality improvement activities to look for processes and practices that might be improved. Compare your results over time to see if various changes in processes and practices have affected your results.</p>
<p>15.a) After a fall associated with injury, does the facility document notification of the physician or physician extender?</p>	<p>Provide staff with a clear written procedure that describes what to do when a resident falls. Notify the physician and family in appropriate time frame. With no significant injury or change of condition, the physician may be notified routinely (by fax or phone the next day).</p>	<p>A written policy and procedure, available at the work site, ensures a more systematic approach to unexpected events.</p>
<p>15.b) and document that actual consequences were addressed, based on prominence of signs and symptoms, with re-evaluation until stable</p>	<p>Record vital signs (heart rate/rhythm), evaluate for possible injuries (especially to the head, neck, spine and extremities) such as pain, swelling, bruising, decreased mobility or range of motion, and administer appropriate first aid. When the assist in restoring dignity. Use available information to begin critical thinking. A resident with existing osteoporosis, or taking anticoagulants may be more likely to have a serious consequence of falling. Describe the situation accurately and objectively (position of the resident initially and on impact, momentum of the fall, any events or complaints that occurred before the fall etc).</p>	<p>See AMDA Falls and Fall Risk Guidelines Tables 3 and 5. For individuals who fall repeatedly, where the causes cannot be controlled, try to identify ways to reduce the seriousness of injuries from falling. It is not always possible to predict with certainty who will be injured or how severe the injury might be. It is also desirable to note the absence of significant findings, which helps to demonstrate that the resident is being monitored appropriately.</p>
<p>15.c) and document observation for possible delayed consequences of a fall</p>	<p>Delayed consequences are not uncommon and may occur within several days after the fall; occasionally they can</p>	<p>Even if there are no immediate consequences of a fall, document</p>

CARE STEP PROCESS (late evidence of fracture, subdural hematoma, etc.) for at least 48 hours?	EXPECTATIONS	RATIONALE
16. Is there documentation of staff awareness of policy/procedures for resident falls?	<p>occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks after an actual fall. Each facility needs to ensure that staff are aware of, and respond to, delayed consequences of falling.</p> <p>Protocols will help educate and train your staff about how to address falling and fall related issues (steps the staff and practitioners should follow, expected time frames, who is responsible for what, etc). Your protocol should include the basic steps listed in the accompanying process guideline. The details of those steps can be specific to your facility; for example, who does what or when they should do it.</p>	<p>follow up for at least 48 hours and consider late consequences if there is a significant change in function, mental status, or level of consciousness within several weeks of a fall.</p> <p>For details of the above steps, refer to the OBRA guidelines, the process guidelines and materials listed in the tables and references. The panel that helped create this document felt that these reflected appropriate recommendations based on current evidence and consensus. Therefore, the department recognizes that policies and protocols that follow the recommended guidelines are a proper foundation for your facility's practices. Surveyors may ask you for evidence to support approaches that differ significantly from those recommended in these materials.</p>

**Documentation Checklist: Process Guideline for
Evaluation of Falls/Fall Risk
October 1, 2001**

Resident: _____

Date: _____

Facility assessment or MDS Triggers indicate that this resident may be at risk for, or has experienced a fall. This checklist can be used to guide and document appropriate care process used in response to this concern:

A fall is considered to be a sudden, unplanned movement to the ground from a higher elevation. Each facility should have a specific protocol identifying the time frame for performing a falls risk assessment. The facility should examine resident-specific fall-related issues, even if they have not yet completed the MDS.

For some residents, falling or fall risk is not relevant, or is a low priority. Facilities may prioritize considerations of fall risk or approach to falling in specific residents if it is based on a systematic approach. If the facility concludes that fall risk is not relevant, it should be able to produce some evidence to support that conclusion (i.e., a comatose resident would not require additional documentation).

If a concern for falls is triggered during the survey process, the facility will be given the opportunity to demonstrate that it has followed the steps in this checklist, as evidence to support an appropriate care process related to falls and fall risk. Evidence of appropriate care process will be considered in determining whether an adverse event (a negative outcome), or the potential for an adverse event, related to falls and fall risk can be attributed to a deficient facility practice. If attributable to a preventable (avoidable) deficient facility practice, this checklist may also be used in analyzing the severity of the deficiency, if a citation should result.

F-tags, which are typically associated with falls, are provided for each of the Tables. Other tags may also be appropriate.

NOTE: Items #7, 10, 11, 13, 15(a), denote physician or physician-extender participation.

MDS/Fall RAP Key Guidelines -- Fall Assessment and Problem Definition

May relate to F Tag: 272 (Assessment), 309 (Quality of Care)	Yes	No	NA
1. Is there documentation that an assessment for resident-specific fall-related risks was begun within 24 hours of admission, fall, or significant change?			
2. Did the MDS include any triggers for fall risk? [On the MDS Version 2.0 these include: Wandering (E4aA = any of 1,2,3 checked); Dizziness (J1f = checked); History of Falls (J4a or J4b checked); Use of Anti-Anxiety Drugs (O4b = any of 1-7 checked); Use of Antidepressant Drugs (O4c = any of 1-7 checked); or Use of Trunk Restraint (P4c - either 1-2 checked)]			
3. Have major risk factors for falls and serious consequences of falls been considered? [See Falls RAP Key Guidelines (i.e., multiple falls, internal risk factors, external risk factors, medications, appliances and devices, environmental and situational hazards). Additional examples of conditions representing risk factors for falls may be found in the American Medical Directors Association (AMDA) Falls and Fall Risk Guideline, Tables 1 & 2.]			
4. Is there documentation that the physician or physician extender has been notified if there is a significance of falls or fall risk in this resident?			
5.a) For residents who have fallen previously, is there documentation of a review of circumstances under which the fall occurred,			
5.b) and documentation of evaluation for potential immediate and delayed consequences?			

RAP -- Fall Assessment and Problem Analysis

May relate to F Tag: 221 (Restraints), 323 (Accidents), 324 (Supervision and Assistive Devices), 329 (Unnecessary Drugs), 498 (Proficiency of Nurse Aides)	Yes	No	NA
6. Are the risk factors relative to this specific resident identified and documented in the RAP? These may include:			
History: [Fall history should include any co-existing symptoms, modifying factors, location, timing and context.]			
External Factors:			
Internal Factors:			

<p>7. Did the physician or physician extender participate in the evaluation of this resident to identify the causes of falls or fall risks to the extent that a likely medical cause or no cause was identified? [The responsibility for changes in the resident's medical plan of care is contingent on a review of medications, adverse drug reactions or interactions, lab values, screening for gross vision and gait/balance deficiencies, assessment of lower limb joints, neurological and cardiovascular systems, etc.]</p>			
<p>8. If this resident was not evaluated to identify the causes of falling or fall risks, does the facility explain <u>why</u> the resident was not further evaluated OR why identifying causes would not have changed the management.</p>			

Care Plan -- Treatment and Management of Falls

May relate to F Tag: 279/280 (Comprehensive Care Plans), 309 (Quality of Care), 323 (Resident Environment), 324 (Adequate Supervision)	Yes	No	NA
9. Does the care plan contain cause-specific interventions to prevent or minimize resident fall risk, falls and complications from falls OR has the facility modified the care plan to accommodate the expectation of a continued risk, when cause-specific interventions or adjustments cannot be accomplished?			
10. Is there documentation that the physician or physician extender helped identify, or authorized, cause-specific interventions in this resident's care plan, if indicated? [It is possible that no cause of falling may be identified despite a comprehensive evaluation. If cause cannot be readily identified, then adverse drug reactions, gait and balance disorders should be considered initially.]			
11. If this resident falls, (without another obvious cause) is there physician or physician extender documentation of a trial adjustment of medications or medication combinations commonly associated with falls to judge their possible effect on falling OR an explanation as to why this could not be attempted?			
12. Is there evidence to demonstrate that the care plan has been implemented?			
13.a) Does the facility document monitoring of the resident's response to interventions?			
13.b) and document a periodic review of approaches for applicability to the current situation?			
14. Does the care plan document that previously selected interventions were re-evaluated if falling continued (until falls stopped or declined markedly), OR document that the physician or physician extender helped to identify or verify likely reasons why falling continued despite interventions? [A facility should consider other causes (root cause analysis) but is not obligated to pursue all possible interventions. A facility should be able to provide some justification for a decision not to pursue additional interventions in resident who continue to fall.]			
15.a) After a fall associated with injury, does the facility document notification of the physician or physician extender ?			
15.b) and document that actual consequences were addressed, based on prominence of signs and symptoms, with re-evaluation until stable? [See AMDA Falls and Fall Risk Guidelines Table 3.]			
15.c) and document observation for possible delayed consequences of a fall (late evidence of fracture, subdural hematoma, etc.) for at least 48 hours? [Delayed consequences are not uncommon and may occur within several days after the fall; occasionally they can occur several weeks later.]			
16.a) Is there documentation of staff awareness of policy/procedures for resident falls?			

Signatures of Person(s) completing form:

Signature

Date

Signature

Date

References

American Medical Directors Association & American Health Care Association Falls and Fall Risk Clinical Practice Guideline, 2003

Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Alert, Issue 14, July 12, 2000.

JSC, Ink. 1999 Update MDS User's Manual V 2.0, 1999 Watertown, Maine

Table 1
Conditions Representing Risk Factors for Fall

- ◆ Previous Falls
- ◆ Fear of falling
- ◆ Cardiac arrhythmias
- ◆ Transient ischemic attacks (TIAs)
- ◆ Stroke
- ◆ Parkinson's Disease
- ◆ Delirium
- ◆ Dementing illnesses
- ◆ Depression
- ◆ Musculoskeletal conditions such as myopathy and deformities
- ◆ Problems with mobility/gait
- ◆ History of fractures
- ◆ Orthostatic hypotension
- ◆ Incontinence of bowel or bladder
- ◆ Visual and auditory impairments
- ◆ Dizziness
- ◆ Dehydration
- ◆ Acute and subacute medical illnesses
- ◆ Use of restraints
- ◆ Hypoglycemia
- ◆ Polypharmacy (multiple medications)

Table 2
Medication Categories More Commonly Associated with Injury from Falling

- ◆ Anticoagulants
- ◆ Antidepressants
- ◆ Antiepileptics
- ◆ Antihypertensives
- ◆ Anti-Parkinsonian agents
- ◆ Benzodiazepines
- ◆ Diuretics
- ◆ Narcotic analgesics
- ◆ Non-steroidal anti-inflammatory agents (NSAIDs)
- ◆ Psychotropics
- ◆ Vasodilators

Table 3 (see attached page)

Table 4
Environmental Factors Associated with Falling

- ◆ Dim lighting
- ◆ Poor or weak seating
- ◆ Glare
- ◆ Use of full-length side rails
- ◆ Uneven flooring
- ◆ Bed Height
- ◆ Loose carpet or throw rugs
- ◆ Inadequate assistive devices
- ◆ Wet or slippery floor
- ◆ Inappropriate footwear
- ◆ Lack of safety railings in room or hallway
- ◆ Malfunctioning emergency call systems
- ◆ Lack of grab bars in bathrooms
- ◆ Poorly fitting or incorrect eye wear
- ◆ Poorly positioned storage areas

Table 5
Complications from Falling

- ◆ Abrasions, contusions, lacerations
- ◆ Ecchymosis (bruising)
- ◆ Hemorrhage (internal and external bleeding)
- ◆ Anemia, secondary to bleeding
- ◆ Concussion
- ◆ Subdural Hematoma
- ◆ Fracture, sprain or dislocation
- ◆ Fear of falling resulting in loss of confidence, decreased independence, and social isolation.

Table 3

Checklist for Assessing Fall Risk or Performing a Post-Fall Evaluation

	Assessing Fall Risk	Performing a Post-Fall Evaluation
Fall History	<ul style="list-style-type: none"> Review patient's history of falls 	<ul style="list-style-type: none"> Review patient's history of recent or recurrent falls.
Medications	<ul style="list-style-type: none"> Review patient's record for medications or combinations of medications that could predispose to falls. Stop or reduce the dosage of as many of these medications as possible. 	<ul style="list-style-type: none"> Review patient's records for medications or combinations of medications that could predispose to falls. Stop or reduce the dosage of as many of these medications as possible. Review patient's record for recent changes in the medication regimen that may have increased fall risk.
Underlying conditions	<ul style="list-style-type: none"> Assess patient for underlying medical conditions that affect balance or cause dizziness or vertigo. Assess heart rate and rhythm, postural pulse and blood pressure. Assess patient for orthostatic hypotension and conditions predisposing to it. Assess for underlying medical conditions that may increase the risk of injury from falls. 	<ul style="list-style-type: none"> Review status of medical conditions that predispose to falls or that could increase the risk of injury from falls. Assess patient for orthostatic hypotension and manage predisposing conditions.
Functional status	<ul style="list-style-type: none"> Assess level of mobility. Assess gait and standing/sitting balance. Assess lower extremity joint function. Assess ability to use ambulatory assistive devices (e.g., cane, walker). Review appropriateness and safety of any current restraints. Review activity tolerance. Assess for deconditioning. Review bowel and bladder continence status. 	<ul style="list-style-type: none"> Reassess patient for significant changes in gait, mobility and standing/sitting balance and lower extremity joint function. Reassess use of ambulatory assistive devices (e.g., cane, walker) and modify as indicated. Review appropriateness and safety of any current restraints. Assess for significant changes in activity tolerance. Review bowel and bladder continence status. Assess whether patient's footwear may have contributed to fall.
Neurological status	<ul style="list-style-type: none"> Assess patient for conditions that impair vision (e.g., cataracts, glaucoma, macular degeneration). Assess for sensory deficits, including peripheral neuropathies. Assess muscle strength, lower extremity peripheral nerves, proprioception, reflexes, motor and cerebellar function. 	<ul style="list-style-type: none"> Reassess visual and auditory impairments. Assess new or progressive neurological impairments.
Psychological factors	<ul style="list-style-type: none"> Review for impaired cognition, judgment, memory, safety awareness, and decision-making capacity. 	<ul style="list-style-type: none"> Reassess as indicated for significant changes in cognition, safety awareness, and decision-making capacity.
Environmental factors	<ul style="list-style-type: none"> Assess presence of environmental factors that could cause or contribute to falls. Assess whether patient's footwear may be contributing to fall risk. 	<ul style="list-style-type: none"> Review and modify environmental factors that could have caused or contributed to fall.