Resident Falls
EDUCATION GUIDE

• FACTS
• PREVENTION
• RESPONDING
• TOOLS AND REFERENCES
• ADDITIONAL RESOURCES
Falls Examples:

Washington – A 74-year-old nursing home resident fell and fractured her ankle and sustained a neck injury. She was diagnosed with central cord syndrome secondary to her fall and was placed in a cervical halo. The nursing home was subsequently sued and agreed to a $900,000 settlement.

New York – A nursing home was sued because they allegedly failed to provide monitoring or a call system for an incontinent and disoriented 63-year-old resident with an unsteady gait. The resident slipped in his own urine and fractured his hip. The verdict resulted in a $1,766,142 judgment against the facility.

Florida – A 95-year-old nursing home resident fell and fractured her hip. The nursing home was subsequently sued and agreed to a $225,000 settlement.

Kentucky – A resident fell while in a shower chair and fractured her hip. Surgery could not be performed due to concerns of a blood clot. The resident was confined to her bed prior to the accident. A $125,000 settlement was reached.

North Carolina – While a CNA was assisting a resident with a transfer, the resident fell and fractured her leg. The nursing home was subsequently sued and agreed to a $125,000 settlement.

Arkansas – A resident with Alzheimer’s disease fell twice while in a nursing home for only five days. The first fall occurred while she was in another resident’s room; she sustained bruises. The second fall occurred as she was trying to get out of her bed, which resulted in a non-permanent head injury. A $164,000 settlement was reached.

RESIDENT FALLS – CLARIFICATION:

Current Centers for Medicare and Medicaid Services (CMS) policy regarding falls includes:

a. A fall is defined as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface.

b. An episode where a resident lost his or her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.

c. The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.

d. When a resident is found on the floor, the facility is obligated to investigate and try to determine how he or she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall occurred.

e. The distance to the next lower surface (i.e., the floor) is not a factor in determining whether a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall.

The point of accurately capturing occurrences of falls on the Minimum Data Set is to identify and communicate resident problems and potential problems, so that staff will consider and implement interventions to prevent falls and injuries from falls. In the instance of a resident rolling off a mattress that is close to the floor – even though this is still recorded as a fall – it might be true that staff have already assessed and intervened, and that placing a bed close to the floor to avoid injuries from falls is the intervention that best suits this individual resident.

Consider these alarming statistics:

• Resident falls are the greatest medical malpractice exposure.

• 10 to 20 percent of all nursing home residents fall each quarter. The average is 2.6 falls per person per year. This is twice the rate of elders living in the community.

• The greatest risk is during the first week after admission to a senior living community.

• 87 percent of all fractures among the elderly are due to falls. Falls account for 40 percent of all nursing home admissions.

• Individuals who have fallen before are two to three times more likely to fall again.

• Likely traveling to the bathroom, a resident’s bedroom is the most frequent location of a fall.

• According to the Centers for Disease Control, accidents are the seventh leading cause of death for persons over 65, and two-thirds of these deaths are directly related to falls and their consequences.

• One of five hip fracture patients die within a year of their injury, due to complications.

Federal nursing home regulations require that “the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.” (F323)

According to CMS guidelines for determining immediate jeopardy related to failure to prevent neglect, surveyors are instructed to investigate “repeated occurrences, such as falls, which place the individual at risk of harm without intervention.”
Why Should I Be Concerned?

While most residents are admitted to nursing homes because of memory concerns, falling or safety issues, falls are the number one cause of facility-incurred injuries facing nursing homes today. These injuries can lead to adverse resident outcomes, expensive litigation and liability exposure. At a minimum, injuries from falls increase the care required from staffing resources and strain facility and family relationships.

Every facility must have an organized fall prevention program, so employees understand their role and responsibility in identifying and minimizing the risk of resident falls.

Falls Examples Continued:

Wisconsin – A resident fell while in the bathroom and sustained a facial fracture. She was taking a blood thinner and died of a subdural hematoma a few months later. A $200,000 settlement was reached.

Preventing a Fall

To help prevent falls, nursing homes should implement policies and procedures that include the following elements:

1. **Risk Assessments** – Many falls are predictable. Therefore, a fall risk assessment should be completed in all of the following circumstances: within 24 hours of admit, quarterly, with any condition change and after any fall. In about one-third of falls, a single potential cause can be identified; in two-thirds, more than one risk factor will likely be involved.

Intrinsic risk factors include:

- Circulatory or heart problems (e.g. dysrhythmia, hypotension, CHF, anemia, CVA, etc.);
- Neurological or functional problems (e.g. Parkinson’s disease, seizure disorder, Multiple Sclerosis, traumatic brain injury, muscle weakness, etc.);
- Orthopedic problems (e.g. arthritis, previous hip fracture, osteoporosis, missing limb, joint pain, etc.);
- Sensory or perceptual deficits including vision impairment, hearing changes, dizziness, vertigo, etc.;
- Normal aging changes in one’s gait due to loss of muscle mass and strength, including decreased limb coordination and ability to raise feet very high;
- Psychological and cognitive factors, such as depression, apathy, delirium, Alzheimer’s disease or other dementia, schizophrenia, wandering, anxiety, etc.;
- Medications, such as analgesics, anticonvulsants, antidepressants, antihypertensives, sedatives, antianxiety, antipsychotics, etc.;
- Pain, fear of falling, sleep disorders and incontinence; and
- Headache, fatigue, dehydration, infection, etc.

Extrinsic risk factors – observe how the resident:

- Transfers to and from bed or chairs;
- Ambulates;
- Uses the bathroom handrails; and
- Uses assistive devices, such as walkers or canes.

Example of Effective Fall Prevention Tactics:

A woman brought her elderly mother to a small nursing facility. The woman's mother was slightly forgetful and did not have the strength to ambulate independently, but could transfer and propel herself in a wheelchair. As the admitting nurse talked to the daughter, she asked if her mother had experienced any recent falls. The daughter stated that she had a “few close calls recently, while attempting to transfer herself from the wheelchair.” The daughter proceeded to say that she “solved the problem by giving her mother her father’s old cane to use when transferring herself.” Later, when the nurse assessed the woman, she noticed that her ankles were bruised and that she kept one foot behind the wheelchair’s foot pedal as she watched television. The nurse contacted the new resident’s physician and received orders for a pedal sling to be placed in front of the legs of the wheelchair to keep her feet from getting tangled behind the pedals again. The resident was also evaluated by a physical therapist, who replaced the woman's cane with a walker that would provide a wider base of support and she was placed in a gait strengthening program.

Continued on page 4
Preventing a Fall

Example of Effective Fall Prevention Tactics:

A resident was admitted to a nursing home with a diagnosis of congestive heart failure and dementia. He was confused, had an unsteady gait and relied on his wife to propel him in a wheelchair for mobility. His wife told the admitting nurse that she was no longer able to care for him in their home because he had frequent periods of restlessness, especially at night, and would attempt to transfer himself without asking for assistance, and fall. The nurse assessed the resident, discussed her findings with his physician and obtained the following orders:

- The resident’s evening diuretic was changed to an earlier time.
- A urinalysis test was ordered to determine if he had a possible urinary tract infection that may be contributing to his restlessness.
- Physical therapy was asked to evaluate and develop a restorative exercise program for him.
- The resident’s bed was lowered and surrounded by a mat.
- A geri-hip brief was purchased to provide padded hip protection, in the event of a fall.

Interventions – After the resident has been carefully assessed, individualized interventions should be implemented according to the resident’s needs. While interventions can be as simple as close observation, they also may include:

- Provide a bowel and bladder program. Cue or assist the resident to the bathroom every two hours, before or after activities, meals, or as needed by each individual resident.
- Review medications. The resident’s physician or pharmacist should monitor any medications that are associated with falls to determine if they can be eliminated, reduced or given at a more opportune time. He or she also should check for any overlapping drug therapy, synergistic reactions or need for routine orthostatic hypotension monitoring.
- Evaluate for acute illnesses that may increase restlessness (e.g. urinary tract infection, hypoxia, transient ischemic attacks, etc.).
- Evaluate assistive devices. All walkers, canes, wheelchairs and other devices should be evaluated to ensure they are the appropriate type, height and weight. The resident also should be evaluated to ensure they know how to use the devices and they have the cognitive ability to use them correctly.
- Adjust environmental risk factors. Check the resident’s footwear (sturdy, rubber-soled shoes are best), keep pathways clear of clutter, lock brakes on beds/wheelchairs before transferring a resident, and make sure the toilet seat is at an appropriate height.
- Provide adequate nutrition, hydration and supplements throughout the day as needed.
- Provide meaningful activities. Work with the Activities Department to find what interests the resident and keep items accessible near the nurse’s station or in the resident’s room. Encourage regular exercise.
- Provide restorative care programs for walking, exercising and strengthening. Keep the resident properly positioned in the bed, chair or wheelchair.
- Utilize gait belts while assisting residents with ambulation and transfers to minimize injuries should a resident begin to fall. Lifts should be used with residents that require extensive assistance. In-service training for staff should be provided that includes return demonstrations.
- Consult therapies. A physical or occupational therapist may need to evaluate the resident and make recommendations regarding positioning devices, restorative programs or appropriateness for restraint usage (e.g. wedge cushions, etc.).
- Provide adequate lighting in resident rooms, bathrooms and common areas.
- Provide added supervision, as able. Seat the resident near the nurse’s station during the day and encourage socialization. Alert staff to never leave the resident unsupervised when out of bed.
- Plastic grips can be used to assist the resident from sliding forward while in a wheelchair.
- Provide protective wear such as elbow or knee pads, geri-hips, etc.
- Consider a Merry Walker to allow more independence.
- Encourage and assist residents to have their vision checked at least annually.
• Consider lowering the resident’s bed if he or she is anxious, confused or unable to ask or wait for staff to assist with transfers. Use a mat beside the bed as an additional cushion and store it when the bed is unoccupied.

• Consider placing all newly admitted residents on a fall prevention program for approximately one week, or until the resident is acclimated to his or her new surroundings.

• Upon admission, select a roommate with similar sleep/wake patterns. Offer slow, repeated orientation to room, roommate, etc.

• Create a room/bed area that most closely represents the resident’s home environment (e.g., bed facing same direction to the bathroom so the resident gets in and out the same way).

• Check 4 P’s often:
  – Position – does the resident need assistance to redistribute pressure points?
  – Pain control
  – Personal toileting needs
  – Placement of personal items, so they are easy for the resident to reach.

• Set the bed to an appropriate height, and mark the measurement on the wall for staff to assess when in the resident’s room.

• Create a color contrast to background areas with items, such as dark toilet seats, call-lights, etc. for clearer visual cues.

• Provide and ensure that residents receive as much uninterrupted sleep as possible.

3 Communication – Once a resident has been identified as being at risk for falling and interventions have been implemented to minimize the risk, everything should be documented in the resident’s chart and communicated to those involved with the resident’s care. Be sure to include:

• The resident’s care plan. This should list all interventions that are used to minimize the potential for a fall. The interdisciplinary team, resident, physician and responsible party or power of attorney for health care decisions should be involved with this process. Review the resident’s care plan, including interventions, after each fall. Update as needed.

• Assignment sheets. All direct-care staff should know which residents are at risk for falling and the interventions needed to prevent an occurrence. A written assignment sheet may be helpful if the facility experiences a significant turnover in staff and agency help is used. Update assignment sheets promptly when needed.

• In-service training. Provide orientation and periodic training for nursing and direct-care staff regarding your fall prevention program. Include discussions on various medications, diseases and disorders associated with falls.

4 Quality Assurance and Performance Improvement (QAPI) Auditing – Develop a safety committee composed of members from administration, nursing, environmental services, Medical Director and other pertinent parties. They should conduct environmental tours to identify hazards, check equipment, review incident reports, and recommend plans for improvement.

Example of an Effective Response:
As a nursing home’s Safety Committee met to analyze the month’s incident reports involving resident falls, they determined that many of them occurred just after meals as wheelchair-bound residents waited in the dining room for their turn to be transferred to their rooms. During this time, the CNAs were busy transferring individual residents and providing care when they got to the room, which limited the supervision of the residents left in the dining room to the CNA present at the time. The nurses were also in and out of the dining area as they passed medications and provided treatments, but there was always someone at the nurse’s station that could answer phones and update the resident’s records. The committee felt that a major contributing factor to the high number of resident falls during this time was the lack of consistent supervision by the nursing staff. The only person that could provide that type of supervision was the person at the nurse’s station, which was not within sight of the dining room. The residents couldn’t be transported to the area next to the nurse’s station, which was not within sight of the dining room. The residents couldn’t be transported to the area next to the nurse’s station to wait, because there wasn’t enough room. The committee looked at the layout of the facility and noticed a huge room that had been an old beauty shop next to the nurse’s station. It was currently being used for storage. The room was big enough to hold all of the residents as they waited, and if an opening could be cut in one of the walls, the individual at the nurse’s station could easily supervise the residents. The committee took their idea to the facility’s manager and owner, who immediately began a remodeling project. As a result, the residents acquired a supervised place where they could socialize or watch television as they wait to be transferred to their room. The number of resident falls drastically decreased.
Despite your best efforts, resident falls will still likely occur. Be proactive. Develop policies and procedures that address how to respond to these situations before they occur.

Procedure for Responding to a Resident Fall:

1. Ensure the resident’s safety by keeping the resident comfortable, yet immobile, as a licensed nurse performs a head-to-toe assessment. Some areas to be evaluated include:
   - Vital signs – Evaluate neurological signs if the resident’s head was struck during the fall;
   - Skin breaks, swelling or discoloration;
   - Verbal complaints of pain or grimacing;
   - Range of motion of extremities;
   - Asymmetry of extremities or lengthening of a limb; and
   - Anything abnormal about the appearance or behavior of the resident.

First aid should be provided promptly, as necessary. Fractures may not be readily apparent after a fall. If the nurse suspects a fracture or serious injury, he or she should convey this concern as soon as possible to the resident’s physician.

2. Notify the resident’s physician and responsible party as soon as possible, and follow through with any new treatment orders.

3. Provide follow-up assessments for the next 72 hours in order to identify any change in the resident’s condition as a result of the fall. Neurological checks should be done, per facility policy, for any suspected head injury or unwitnessed fall involving a resident with a history of confusion. Orthostatic blood pressures also should be taken when appropriate.

4. Once the resident’s immediate needs have been attended to, document the incident by reporting the facts. Record all objective data including the time the resident was discovered, the resident’s condition, who was notified and when, the follow-up treatment (including diagnostic tests, nursing and medical interventions), as well as the resident’s current condition and response to interventions. Also record any subjective data concerning the fall, such as comments made from the resident and witnesses verbatim and attribute them accordingly. Always avoid opinions, assigning blame, inferences or vague statements. Include enough detail to accurately paint a picture of what you’re attempting to describe. An incident report should be completed – according to facility policy. The incident report is not part of the resident’s legal or medical record.

5. The nursing staff should notify the facility’s supervisor of the fall so he or she can direct the staff to implement interim interventions to protect the resident from another fall or injury. This information should be documented in the resident’s chart and plan of care.

6. If the facility has access to a therapy department, the therapist should screen the resident for an evaluation and follow-up treatment.

7. As soon as possible, a complete and thorough investigation should be completed to determine contributory causes for the fall and what actions should be taken to minimize the risk of a future fall. New interventions should match the causative agents of the fall as identified by the root cause analysis. Members of the resident’s care plan team should review this plan and make revisions, if needed. This information should be communicated to the resident’s family and appropriate nursing staff.

8. A new MDS assessment may need to be initiated. The CAA summary should list all the interventions that have been attempted or considered, so the reader is aware of the facility’s ongoing efforts to prevent the resident from falling.

9. The information obtained from the fall investigation should be included in the facility’s safety and Quality Assurance meetings for analysis, tracking and trending purposes. Random audits should be performed periodically during all shifts to ensure interventions are effectively being implemented.

Now that fall response tactics are in place, staff training and continued education is critical. In-service training should be provided to all staff during orientation and periodically after. A written copy of these plans should be kept near the nurse’s station for easy access.
## Tools and References to Help You

### Documentation

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3634HH</td>
<td>Fall Risk Assessment Form</td>
</tr>
<tr>
<td>3606/2P</td>
<td>Fall Risk Discipline Trigger Form</td>
</tr>
<tr>
<td>CFS 6-17HH/HF</td>
<td>Fall Risk Evaluation Form</td>
</tr>
<tr>
<td>1911P</td>
<td>Fall(s) Care Area Assessment (CAA) Form</td>
</tr>
<tr>
<td>CFS 6-18/2P</td>
<td>Incident/Accident Report Form</td>
</tr>
<tr>
<td>1161P</td>
<td>Interdisciplinary Post-Fall Assessment Form</td>
</tr>
<tr>
<td>3091</td>
<td>Resident Fall Tracking Log Form</td>
</tr>
<tr>
<td>3714HH/HF</td>
<td>Side Rail Assessment Form</td>
</tr>
</tbody>
</table>

### Signage

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5996DS</td>
<td>“Attention High Fall Risk” Door Hanger Sign</td>
</tr>
<tr>
<td>6509DS</td>
<td>“Attention High Fall Risk” Magnetic Sign – 2” x 9”</td>
</tr>
<tr>
<td>6510DS</td>
<td>“Attention High Fall Risk” Magnetic Sign – 3” x 5”</td>
</tr>
</tbody>
</table>

### Education & Training

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8943</td>
<td>Falls in Older People: Prevention and Management (Book)</td>
</tr>
<tr>
<td>8500</td>
<td>Fall Prevention Program</td>
</tr>
<tr>
<td>1862</td>
<td>MDS 3.0 User’s Manual, Updateable</td>
</tr>
<tr>
<td>1766</td>
<td>Survey Guide</td>
</tr>
<tr>
<td>7723DV</td>
<td>Transfer and Ambulation Video</td>
</tr>
</tbody>
</table>

### Chart Labels/Alert Bands

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L-2183</td>
<td>“Fall Precautions” Label</td>
</tr>
<tr>
<td>L-2071</td>
<td>“Fall Precautions” Label with a graphic</td>
</tr>
<tr>
<td>05-5065-YFR</td>
<td>Fall Risk Condition Alert Band – Yellow</td>
</tr>
<tr>
<td>L-2065</td>
<td>Fall Risk Condition Alert Label – Yellow</td>
</tr>
<tr>
<td>L-2109</td>
<td>“High Fall Risk” Label</td>
</tr>
<tr>
<td>L-4811</td>
<td>Side Rail Indicator Label</td>
</tr>
<tr>
<td>L-2800</td>
<td>Star Label – Blue</td>
</tr>
<tr>
<td>L-2801</td>
<td>Star Label – Red</td>
</tr>
<tr>
<td>L-2802</td>
<td>Star Label – Yellow</td>
</tr>
<tr>
<td>L-2803</td>
<td>Star Label – Green</td>
</tr>
</tbody>
</table>

### Medical Supplies

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-CHXX</td>
<td>ComfiHips Hip Protector (Various sizes)</td>
</tr>
<tr>
<td>505-5000-5500</td>
<td>DMI Wheelchair Tray, Acrylic</td>
</tr>
<tr>
<td>505-4016-0400</td>
<td>DMI Wheelchair Tray, Hardwood</td>
</tr>
<tr>
<td>11-7084</td>
<td>Dynarex Bed Alarm Sensor Pad</td>
</tr>
<tr>
<td>11-7081</td>
<td>Dynarex Universal Bed/Chair Alarm</td>
</tr>
<tr>
<td>85-6016</td>
<td>Hipster III Impact Absorbing Pad Briefs</td>
</tr>
<tr>
<td>99-6023</td>
<td>Posey Beveled Floor Cushion</td>
</tr>
<tr>
<td>99-6024</td>
<td>Posey Economy Floor Cushion</td>
</tr>
<tr>
<td>99-5700</td>
<td>Posey Roll Guard</td>
</tr>
<tr>
<td>99-6820C</td>
<td>Posey Wedge Foam Pommel Cushion</td>
</tr>
<tr>
<td>99-252061</td>
<td>Skil-Care Gait Belt, Derlin Buckle</td>
</tr>
<tr>
<td>99-252011</td>
<td>Skil-Care Gait Belt, Metal Buckle</td>
</tr>
<tr>
<td>14-433EL</td>
<td>Smart Caregiver Cordless Chair/Bed Alarm</td>
</tr>
<tr>
<td>99-4381</td>
<td>Soft Belt</td>
</tr>
<tr>
<td>99-754330AL</td>
<td>Ultra-Cushion Alarm Cushion</td>
</tr>
<tr>
<td>99-754110AL</td>
<td>Ultra-Wedge Alarm Cushion</td>
</tr>
</tbody>
</table>

### Additional Resources

**Older Adult Falls Programs – Centers for Disease Control and Prevention (CDC)**
www.cdc.gov/HomeandRecreationalSafety/Falls/pubs.html
www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

**Falls and Older Adults – National Institutes of Health (NIH)**
nihseniorhealth.gov/falls/aboutfalls/01.html

**Falls Prevention – National Council on Aging (NCOA)**

**Prevention of Falls in Older Persons – American Geriatrics Society (AGS)**
Easy Ways to Order:
Phone (Toll-Free): 1.800.247.2343
Fax (Toll-Free): 1.800.222.1996
Email: edicustomerservice@briggscorp.com
Online: www.BriggsCorp.com

Satisfaction Guaranteed!
Every order you receive should meet your 100% satisfaction. If you are not completely satisfied, notify us within the terms of our Return Goods Policy and we will replace your unsatisfactory merchandise, issue a full credit for that merchandise or refund your money in full.

Order Today, Ship Today!
At Briggs, we don’t keep you waiting! With our nationwide computerized distribution system, when you place an order by 4:00 p.m. central time, you can be sure it will ship that same day via UPS or other ground service. And because we have two fully stocked distribution centers, most orders will arrive in no more than 2 days. On the rare occasion when an item is not readily available, you can be assured that our Procurement Department is securing the new inventory as rapidly as possible.

Feel Free to Take a Closer Look!
Just ask for a FREE sample and we’ll be glad to send one to you that same day (some restrictions may apply). Take your time and look the item over. When you are completely satisfied it’s what you want, give us a call at 1.800.247.2343 and place your order. And if you need additional copies of this guide or any other Briggs catalogs, manufacturer’s data sheets or technical specifications, we’ll get them to you fast.

We’ll Pick Up the Shipping Charges!
Whenever you order $300 or more of Briggs’ in-stock items, your entire order ships FREIGHT FREE (continental USA only). Order your medical supplies, documentation solutions and any other Briggs product on the same order – if the total exceeds $300, your entire order ships FREIGHT FREE via UPS or other ground service. Not applicable to drop-ship items.