

# Improving Patient Safety in Long-Term Care Facilities



## Module 3.

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### Falls Prevention and Management



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**Student  
Workbook**

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# Improving Patient Safety in Long-Term Care Facilities

## Student Workbook

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## Module 3

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## Falls Prevention and Management

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This student workbook is from the third module of a three-module set of training materials. Module 1 is concerned with detecting changes in a resident's condition, and Module 2 focuses on communicating changes in a resident's condition. For information on ordering additional copies of this student workbook or other materials in this set, please contact the AHRQ Publications Clearinghouse at 800-358-9295 or [ahrqpubs@ahrq.hhs.gov](mailto:ahrqpubs@ahrq.hhs.gov).

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# Falls Prevention and Management

## Student Workbook

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# Falls Prevention and Management

## Student Workbook

### Learning Objectives: Knowledge and Performance Objectives

#### Knowledge Objectives

Participants will learn:

- › Why falls are an important safety issue.
- › Risk factors for falls.
- › Which residents are at high risk of falling.
- › How falls can be prevented.
- › How nursing assistants and licensed nurses can work together to prevent falls.

#### Performance Objectives

Participants will be able to:

- › Describe nursing interventions to prevent falls, initiated by either:
  - o A nursing assistant.
  - o A licensed nurse.
- › Use particular interventions for particular risk factors.
- › Work as a member of a nursing team to:
  - o Choose intervention(s) for a particular case.
  - o Assess whether an intervention is effective.





# Session 1

## Introduction

### Case Study: Mr. P

Mr. P is an 84-year-old man who has been a resident at the nursing center for the last 2 years. He has moderate dementia, and his blood pressure falls when he stands up too fast, making him dizzy. Until recently he shared a room at the nursing center with his wife, but she passed away earlier this year. Since that time, he has been more depressed and has had difficulty sleeping. On admission to the nursing center, he used a walker to get around, but now he mostly uses a wheelchair, and he is less able to do his own toileting and grooming. His safety awareness is poor, and he has had many falls. Most of the falls have happened at night after his private duty caregiver has gone home.

**What are his risk factors for falling? How might you, as his nursing assistant, help protect him from having an injurious fall during the night?**

We all try to provide the highest possible level of care to our residents. Their safety is a priority for us. Safety means avoiding, preventing, and lessening the effects of harm and injury while residents are in a health care setting.<sup>1</sup> Within nursing centers, one of the biggest safety challenges is preventing falls. Research shows that three of every four nursing center residents fall each year, and the average resident has two to three falls per year. Most nursing centers have more than 100 falls per year.<sup>2,3,4</sup>

At the same time, another priority is the resident's quality of life. We try to respect a resident's right to make choices that make him or her happy, to have

<sup>1</sup> Key Facts About Patient Safety. Boston, MA: National Patient Safety Foundation; 1997. Available at <http://www.npsf.org/for-patients-consumers/patients-and-consumers-key-facts-about-patient-safety/>. Accessed January 30, 2012.

<sup>2</sup> Rubenstein LZ, Robbins AS, Josephson KR, et al. The value of assessing falls in an elderly population: A randomized clinical trial. *Ann Intern Med* 1990; 113(4):308-316.

<sup>3</sup> Rubenstein LZ. Preventing falls in the nursing home [comment]. *JAMA* 1997; 278(7):595-596.

<sup>4</sup> Rubenstein LZ, Josephson KR, Robbins AS. Falls in the nursing home. *Ann Intern Med* 1994; 121:442-451.

### Mr. P

- › What are his risk factors for falling?
- › How might you, as his nursing assistant, help protect him from having an injurious fall during the night?

respect, and to have privacy.<sup>5</sup> In settings in which older people both live and receive health care, it can be difficult for care providers to meet both of these goals of safety and quality of life at the same time. This is particularly true in nursing centers, where residents' ability to make choices may be affected by dementia, and their ability to keep themselves safe may be affected by frailty (being in a weakened condition).

According to the National Center for Injury Prevention and Control, "fall prevention takes a combination of medical treatment, rehabilitation, and environmental changes."<sup>6</sup> The Center found that the most effective interventions – things care providers can do – include:

- › Educating staff members about risk factors and prevention strategies for falls.
- › Making environmental changes designed to prevent falls.
- › Reviewing medicines to see which have side effects that might cause falls.
- › Assessing patients after a fall to identify and treat their risk factors for the future.

### Facts About Falls

- › One of the biggest safety challenges is preventing falls.
- › Three of every four nursing center residents fall each year.
- › Most nursing centers have more than 100 falls per year.
- › There are many interventions that providers can use to reduce the number of falls.
- › Nursing staff must have the knowledge and skills to prevent injury from falls.

To prevent injury from falls, all nursing staff need knowledge and skills. Licensed nurses have assessment skills and knowledge about medications that make them key to this process. Nursing assistants and other front-line workers spend more time with the residents and also have skills that they contribute to the nursing team. Front-line workers deliver most of the hands-on care that residents receive, so their insight on how to prevent falls in the context of residents' daily activities is unique and valuable.

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<sup>5</sup> Slater L. Person-centeredness: A concept analysis. *Contemp Nurse* 2006; 23(1):135; 2006.

<sup>6</sup> Injury Prevention and Control: Home and Recreational Safety; Falls in Nursing Homes. Centers for Disease Control and Prevention; 2011. Available at [www.cdc.gov/homeandrecreationalafety/falls/nursing.html](http://www.cdc.gov/homeandrecreationalafety/falls/nursing.html). Accessed January 25, 2012.

## A Safe and Enjoyable Environment

Care providers can help keep residents safe by helping to create and maintain a safe environment. That means:

- › **Being aware.** Being aware means that we are alert to the needs of our residents. We are “tuned in” and tend to their needs. To do this, we need to learn to watch residents, noticing and thinking clearly about what is going on with them.
- › **Responsiveness.** When we notice something that might affect a resident’s safety, it is our job to respond and do what is needed to protect the resident. A response is not complete until there has been followup. In other words, response is not a one-time thing. It may have several steps, or it may need to be repeated, until the issue is resolved.
- › **Sharing and teamwork.** Being alert and responding to our residents’ needs is only possible when we work as a team. We should understand the jobs of our coworkers and create teams that include workers with other jobs and skills. We should be available to assist our coworkers at any time. We can respond more completely to our residents’ needs together than by ourselves.
- › **Reporting and supporting.** We all feel terrible when a resident falls. We might wonder if we could have done something different, or worry that we let the resident and the team down. Also, we might feel frustrated that the environment was not safer.

Often, when a change occurs that might signal illness in a resident, that change has nothing to do with a mistake or a problem in the care system; it is simply that the resident is frail and unsteady. But even if you think a mistake may have happened, you must report the change. The resident can’t be helped if no one knows there might be a problem.

- o **Learning by talking with team members.** Reporting changes helps keep residents as safe as possible. Residents are most protected from harm or injury when providers openly report anything that might affect a resident’s well-being.

We need to see how things work, notice when they aren’t working right, learn how to fix problems, and learn how to recover when things do go wrong. An experienced care team has seen things go wrong in the care system. They have learned how to avoid those situations and, when they do happen, to fix them as well as they can.

Perhaps most importantly, they have learned to communicate openly with each other when something might affect a resident's well-being. This may not be easy. When things go wrong (adverse events) or look as if they are about to (near-misses), we may feel embarrassed and worry that if we report the problem our job performance could be questioned or we might get punished. Also, we don't want to get anyone else in trouble. This is particularly true if a supervisor needs to be involved. As a result, things that might affect a resident's safety may go unreported or not be discussed.

We learn best when we talk about how things might or did go wrong. Learning is much harder if we can't see what happens when things go wrong for others or can't get feedback when it happens to us. Everyone – residents and staff – does better when people support discussion and learn from near misses and adverse events.

- o **Avoiding blame helps.** We all care about the residents in our nursing center. To make sure they stay safe, we have to openly share experiences – good and bad. Blame prevents open communication. A situation in which a care provider's actions are not well-intended may happen; that person may have to be identified and possibly removed from the setting. But that is very unusual. Usually, when things go wrong it is because a provider was too tired, distracted, didn't know how things work, or the teamwork was not smooth. Sometimes, there is a situation that can be called "an accident waiting to happen." This kind of problem can be fixed best if discussion is encouraged, and the care team works together to find a solution.
- o **Fixing "accidents waiting to happen."** Hazards in the environment can – by themselves or in combination with other factors – cause falls. To prevent falls, we have to be aware of our environment. We have to notice hazards in the environment and eliminate those hazards ourselves. We should take action to eliminate the hazards if we can, or if not, we should work with the person who can eliminate them.
- o **Expect teamwork.** Caring means speaking up. But you also need your team to hear you in a helpful way. Residents expect and deserve a safe environment and often cannot speak or do for themselves, so it is up to members of their care team to speak for them and to be a team that hears and responds positively. While that's sometimes easier said than

done – especially on sensitive matters that we think might cause blame – it’s something we all have to learn to do together. Often it helps just to expect that kind of teamwork. Thinking beyond blame to expecting teamwork and problem solving makes it much easier to speak up, be heard, and respond positively together.

As we do this work, we can also keep in mind that residents want to do things that give them happiness, respect, and independence. Most people like to be able to move around and take care of themselves. For people who are weak, confused, and fall easily, it can be hard to be happy and safe. So watching and helping to make sure that people are as safe as they can be without making them unhappy is our goal.

## Knowing When a Fall Has Occurred

A person can end up on the ground for many reasons. Experts have defined a fall as an “unintentional change in position, coming to rest on the ground or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).” That is, a person falls down, is not pushed down, and does not collapse from a sudden medical condition like a stroke.

It is important to determine whether the resident has fallen down because of another medical problem that caused a loss of consciousness like a stroke or a seizure. Falls are more likely to be part of another problem when the person has no history of falling and few risk factors for falling. If the person has many risk factors for falling, it may be that the fall is the main problem.

### Is it a fall?

- › A fall is an unintentional change in position, coming to rest on the ground or the next lower surface that does not result from:
  - Being pushed down.
  - Collapsing from a sudden medical condition.

## Risk Factors for Falls

A risk factor for falling is one that, in clinical studies, has been found to present frequently in people who fall. Research shows that there are several key risk factors for falls among nursing center residents. Many residents have more than one risk factor. The more risk factors a person has, the more likely he or she is to fall.<sup>7</sup>

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<sup>7</sup> Tinetti ME, Kumar C. The patient who falls. JAMA 2010; 303(3):258-266.

There are two main groups of risk factors. The first group has to do with the person who falls; maybe the person has poor vision or dizziness when he or she gets up too fast. The second group of risk factors has to do with the environment.

## Risk Factors Related to the Resident

The most important risk factors for falls having to do with the resident are:

- › **Previous falls.** If residents have fallen in the past, or if they have a pattern of falling, they are much more likely to fall in the future.
- › **Diminished strength.** Residents may not be strong enough to counter the tendency to fall. Strength is measured by the ability to stand and walk unaided, commonly called the “Get Up and Go Test.” Loss of strength in the lower limbs is especially common in residents who fall. Anyone who walks with a cane or a walker has diminished strength in the lower limbs and is at risk for falling.
- › **Gait and balance impairments.** Even if residents can walk unaided, they may have abnormal patterns of steps, or they may have difficulty in maintaining their balance. Such gait and balance problems are always suspect in a resident who falls and are an important risk factor for falling.
- › **Medications.** Taking certain medications has been shown to result in an increased risk of falls.<sup>8</sup> In particular, the use of sedatives and hypnotics, antidepressants, and benzodiazepines has been found to be associated with falls. Often, however, eliminating such medications is not an option.
- › **Alzheimer’s disease or dementia.** Many nursing center residents suffer from Alzheimer’s disease or dementia, which may put them at additional risk. In general, people who have dementia are more likely to fall than people who don’t, and they are more likely to be injured in a fall. When people with dementia move about when they are not being watched and do not have help,

### Resident Risk Factors for Falls

- › Previous falls.
- › Diminished strength.
- › Gait and balance impairments.
- › Medications.
- › Alzheimer’s disease or dementia.
- › Vision impairment.

<sup>8</sup> Woolcott JC, Richardson KJ, Wiens MO, et al. Meta-analysis of the impact of nine medication classes on falls in elderly persons. Arch Intern Med 2009; 169(21):1952-1960.

they are at greater risk for falling. Also, when their behavior is agitated or disruptive, they are more likely to fall. People with dementia are also more likely to fall in the late afternoon or during the night.

- › **Vision impairment.** Problems with vision are common in nursing center residents, and vision problems make residents more likely to fall.

## Risk Factors in the Environment

Things like poor lighting or a cluttered room can make it more likely that a person will fall. Factors related to equipment that is being used may increase a resident's fall risk. For example, the walker may not be stable, or the wheelchair lock may be hard to use. Falling risk also can be related to how care is organized. For example, perhaps not all members of the team are aware that the resident tends to wander at night. This may be because they do not read one another's notes or talk much at change of shift.

Nursing center residents often fall for reasons that have little to do with their health or behaviors.

Nursing assistants and licensed nurses know that factors in the environment are extremely important causes of falls. Risk factors for falls having to do with the environment include:<sup>9</sup>

- › Design problems. Inaccessible call buttons, inadequate lighting, and uneven, wet, or slippery floors.
- › Lack of space. Small or overcrowded rooms that can be difficult to navigate.
- › Obstacles. Wheelchairs, linen carts, medicine carts, and cleaning equipment left in crowded rooms or hallways.
- › Equipment misuse or malfunction. Examples include wheelchairs that do not lock or Hoyer lifts that are not properly operated.
- › Staffing and organization of care. Inadequate staffing may leave residents who are likely to fall without proper supervision.

### Environmental Risk Factors for Falls

- › Design problems.
- › Lack of space.
- › Obstacles.
- › Equipment misuse or malfunction.
- › Staffing and organization of care.

<sup>9</sup> Hill EE, Nguyen TM, Shaha M, et al. Person-environment interactions contributing to nursing home resident falls. *Res Gerontol Nurs* 2009; 2(4):287-296.

## Session 2

### Limiting Falls that Cause Injury

Residents in long-term care settings are likely to fall. Often, the price of too much caution is lost quality of life; a resident may want to dance, or garden, or go on an outing, and taking the risk of falling may be worth it to the resident. In the past, we thought that using restraints to keep a resident tied to his or her bed or chair would protect them. Mostly, it so deprived them of their quality of life that residents often got into dangerous situations trying to get out of the restraints. So, now we accept that some falls are inevitable, even in an optimal care environment. However, what we can do is eliminate needless falls and limit the injuries from falls that do occur. Communication and teamwork are a necessary part of achieving these goals, but restraints are not.

#### Communicate

There are many things that the care team can do routinely to limit injurious falls. First and foremost is to have clear and consistent communication between nursing assistants and licensed nurses about which residents are at risk for falls. Any resident who has a pattern of falls is at risk of falling again. After the licensed nurse has assessed a resident for fall risk it is important to communicate the results of the assessment to the nurse's front-line coworkers. Nursing assistants are better equipped to guard against falls when they know which residents – especially new residents or those in transition back from hospital stays – are going to need a special “fall watch.”

Many care teams have found it useful to place a symbol on the resident's chart or in his or her room to alert the entire team that that person is at risk for falls. These are all care routines that only work well when there also is good communication.

#### Work as a Team

Teamwork between nursing assistants is also essential to falls prevention. Nursing assistants should know which residents need assistance in ambulating, transferring, or simply standing. Any of these can result in a fall. To help prevent falls, never leave a resident alone during a transfer (bed to chair, wheelchair to toilet, etc.). When nursing assistants work in a two-person team to provide



more support for a resident during the transfer (“the two-person assist”), safety is further improved. All this requires team work. Team members need to know when another team member needs help.

## Avoid Restraints

Although in some cases it may seem that restraints could help keep a resident safe, the research shows that exactly the opposite is true. Using restraints does not help to prevent falls. In fact, restraints can actually cause falls when residents attempt to get out of them or slide down through them.<sup>10</sup> Posey vests, pelvic restraints, and lap trays on geri-chairs all contribute to falls and to injuries that occur with falls.

## Assessing and Decreasing Fall Risk

An important job for licensed nurses is to assess residents’ risk of falling. This is best done using a protocol or instrument that asks the licensed nurse to look at or test several features about the resident.

The Hartford Institute for Geriatric Nursing recommends the Hendrich II Fall Risk Model.<sup>11,12</sup> Other instruments include the Comprehensive Falls Risk Screening Instrument,<sup>13</sup> the Falls Assessment portion of The Falls Management Program,<sup>14</sup> the Vanderbilt Fall Prevention Program for Long-Term Care,<sup>15</sup> and the Timed Up and Go Test.<sup>16</sup> These and other resources are shown in the Appendix.

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<sup>10</sup> Capezuti E, Strumpf N, Evans LK, et al. Relationship between physical restraint removal and falls and injuries among nursing home residents. *J Gerontol A Biol Sci Med Sci* 1998; 53A(1):M47-M52.

<sup>11</sup> Gray-Micelli D. Falls: Nursing Standard of Practice Protocol: Fall Prevention. New York, NY: New York University College of Nursing, Hartford Institute for Geriatric Nursing; 2008. Available at [http://consultgerirn.org/topics/falls/want\\_to\\_know\\_more](http://consultgerirn.org/topics/falls/want_to_know_more). Accessed January 30, 2012.

<sup>12</sup> Hendrich AL, Bender PS, Nyhuis A. validation of the Hendrich II Fall Risk Model: A large concurrent case/control study of hospitalized patients. *Appl Nurs Res* 2003; 16(1):9-21.

<sup>13</sup> Fabre JM, Ellis R, Kosma M, et al. Development and validation of the Comprehensive Falls Risk Screening Instrument. *Phys Occup Ther Geriatr* 2010; 28(2):181-194.

<sup>14</sup> The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities. Rockville, MD: Agency for Healthcare Research and Quality; 2010. Available at <http://www.ahrq.gov/research/ltc/fallspc/fallspcmanual.htm>. Accessed January 30, 2012.

<sup>15</sup> Taylor JA. The Vanderbilt Fall Prevention program for long-term care: Eight years of field experience with nursing home staff. *J Am Med Dir Assoc* 2002; 3(3):180-185.

<sup>16</sup> The Timed Up and Go Test for Fall Assessment. Available at [http://www.patientsafety.gov/SafetyTopics/fallstoolkit/media/timed\\_up\\_and\\_go\\_test-07-15-04.pdf](http://www.patientsafety.gov/SafetyTopics/fallstoolkit/media/timed_up_and_go_test-07-15-04.pdf). Accessed January 30, 2012.

To help prevent falls, check on your residents frequently and be alert for any furniture, equipment, or other items that might make a fall likely – fixing risks as you see them. Ask yourself: “Is this resident getting enough of the right exercises and ambulating enough?” If not, consider what else could be done to help the patient avoid a fall.

### Review a Checklist – HEAR ME

Often, it is useful to have a mechanism to help you remember all of the things you need to think about. Here is a list of things to remember that fit into a handy memory aide: “HEAR ME.” Remembering these “HEAR ME” tips can help you prevent falls in your nursing center.

- › Hazards in the environment should be noticed and eliminated.
- › Educate residents about how to accomplish their activities in a safe way.
- › Anticipate the needs of residents. As you get to know your residents, you will learn their routines and habits and the times they will need your help. You can use that knowledge to “be there” almost before the residents know they need help.
- › Round frequently to learn residents’ needs. Rounding – going from patient to patient to see how they are doing – is the activity that lets you “keep an eye” on each of the residents and accommodate his or her needs in a timely way.
- › Materials and equipment should be in working order, and they should be used correctly.
- › Exercise and ambulation with residents is vital to maintaining their fitness and preventing falls. Occupational and physical therapy, if available, can be very helpful.

#### HEAR ME

- › Hazards in the environment.
- › Educate residents.
- › Anticipate residents’ needs.
- › Round frequently.
  
- › Materials and equipment.
- › Exercises and ambulation.

### Responding to a Near Fall or Fall

Everyone on the care team has a role to play in responding to a nursing center resident’s near fall or fall. There are four steps to responding effectively.

**1. Observe and evaluate.**

When you see that a resident has fallen, what do you observe? Is first aid or other additional care required? If so, your first priority is to make sure the resident gets that care as quickly as possible. You should always alert the attending professional (whether a licensed nurse, nurse practitioner, or doctor) according to the guidelines for notification that are the policy of your nursing center.

**2. Investigate and document.**

Once the resident's condition has been addressed, it is important to investigate the circumstances in which the fall took place. Try to notice and list everything that may have contributed to the fall, including the resident's individual risk factors, environmental factors, and factors in care or equipment. Then you need to document what you have found. In most nursing centers, this involves completing an incident report.

**3. Implement an individualized care plan.**

Once the team reaches a conclusion about the causes of the resident's fall, nursing should add an individualized approach for falls to the resident's care plan. This approach may call for one or many interventions. If the falls continue, a group involving several disciplines beyond nursing, such as physical therapy and the doctor, may need to meet with the nursing staff to address the problem.

An individualized care plan for falls is not a one-time solution. Licensed nurses and other staff must revisit the plan to make sure it is effective in preventing additional falls and injuries from falls. If the plan is not effective, a new one should be devised.

**4. Develop a falls management program.**

Beyond individualized care plans, nursing centers can develop a falls management program aimed at falls prevention across the nursing center. Staff must be able to document how many falls are occurring in a given time period and why those falls are occurring. With this information at hand, the team can design a menu of interventions and a process for individualizing interventions. In one nursing center, for example, lack of easy access to call buttons may be a major issue in falls; in another, falls may result from insufficient ambulation and exercise. When such trends come to light, nursing centers can make organization-wide changes in services or care processes that will help prevent falls.<sup>17</sup>

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<sup>17</sup> Taylor JA, Parmelee P, Brown H, et al. Model quality improvement program for the management of falls in nursing homes. *J Am Med Dir Assoc* 2007; 8(3, Suppl 1):S26-S36.

## After a Fall

There are many interventions that can be tried to limit the risk of future falls. Here are some things that staff should think about and discuss with the nurse practitioner or doctor.

### Things about the environment, including:

- › Keep frequently needed items (glasses, water, blankets, call lights, telephone) close to a resident where they can be reached safely.
- › Rearrange residents' room furniture to reduce hazards.
- › Add safety equipment.

### Things about the resident, including:

- › Take the resident to the bathroom often.
- › Review medications.
- › Consider which balance exercise programs are best for the resident.
- › Evaluate and, if needed, adjust assistive devices.

### Examples of Fall Prevention Interventions

To reduce fall risk consider:

- › Things about the environment (e.g., rearrange the resident's furniture).
- › Things about the resident (e.g., review medications).
- › Things about the equipment or care plan (e.g., monitor blood pressure frequently).
- › Things about the nursing center (e.g., provide education on falls prevention).

- › Assess the resident's gait and consider gait training.

### Things about equipment or the care plan, including:

- › More frequent blood pressure monitoring.
- › More frequent toileting.
- › Safer footwear.
- › Lower beds.
- › Use of bedrails.

### Things about how the nursing center operates, including:

- › Falls surveillance.
- › Multidisciplinary falls assessment.
- › Changing staffing schedules to provide increased monitoring.
- › Providing education on falls prevention to staff and/or residents.

A comprehensive facility assessment may be necessary to make all the needed changes.

Usually, more than one intervention is tried, perhaps by adding one at a time or perhaps several all together. Each plan should be tailored to the individual. That is, each change should be made to address a reason that this particular resident may be falling. So, knowledge of the resident's history, and observations about how this particular resident came to fall, are critical in selecting the appropriate intervention.

## Conclusion

### In Summary

Falls prevention aims to balance patient safety and personal freedom to do things. The goal is to maintain and maximize quality of life, while minimizing each individual resident's risk of having a fall resulting in an injury. This is best done in an environment where it is easy to report, and everyone supports discussions about what happens and how to make things better.

**Not every fall is just a fall.** All falls need to be investigated. But, some falls are due to a stroke or a seizure or dizziness. The licensed nurse needs to make an assessment and talk it over with the nurse practitioner or doctor. A falls assessment may be relevant only after the medical cause has been taken care of, perhaps in a hospital or at another care level.

**There are many risk factors for falls.** If a fall occurs, after taking care of the resident, assessing the resident again for risk factors is an important way of reducing the chance of another fall. The risk factors for falls are many, and they relate to individual residents and their environment. Important risk factors about the individual include a history of previous falls, diminished lower limb strength, gait or balance impairments, and use of certain medications. Important environmental risk factors include design problems, lack of space, obstacles, equipment misuse or malfunction, and inadequate staffing and organization of care.

#### Things to Remember

- › Not every fall is just a fall.
- › There are many risk factors for falls.
- › Using the HEAR ME tips can help reduce falls.
- › Appropriate interventions can minimize future falls.

**HEAR ME.** The HEAR ME tips can help staff remember to: address hazards in the environment, educate residents about safety, anticipate the needs of residents, engage in the practice of rounding to stay aware of residents' needs as they arise, and make sure needed materials are available and equipment is in working order. You will want to be sure that you know how to operate all available equipment, and that you encourage and assist residents to exercise so that their fitness and strength can be maintained.

**Minimizing further falls.** Interventions to minimize further falls usually involve several changes, and they should be tailored to the individual resident's reasons for falling. Nursing assistants and licensed nurses must cooperate to observe and evaluate the specific fall event, investigate and document the circumstances of the fall, implement and monitor an individualized care plan, and wherever possible, develop a falls management program.

## Pearls and Pitfalls

### Pearls

1. Awareness is a watchword in falls prevention. Only by carefully observing residents from our various trained viewpoints can we prevent falls. Only by remaining alert to the needs of residents, and meeting those needs in as timely a way as possible, can we contribute to the prevention of falls.

#### Pearls

- › Awareness is a watchword in falls prevention.
- › Teamwork is necessary to prevent falls.
- › Fall prevention requires active engagement.
- › You must go beyond an incident report to develop a revised care plan.

2. Teamwork is necessary to prevent falls. It is not the job of nursing assistants or licensed nurses alone to prevent falls. Each member of the nursing team, along with staff from other disciplines, must play a role in preventing falls and intervening in falls. Every fall presents an opportunity for the team to work together to improve care.

3. Risk factors are always present. We all have risk factors for falls. Older people in general, and nursing center residents in particular, are less able to compensate for those risk factors. This means that fall prevention requires active thought about each resident's risk factors and interventions tailored to those risk factors. Falls hardly ever have one single cause, but rather they require adjustments in multiple areas to prevent future falls.
4. Go beyond incident reports to help establish a revised care plan for falls that corresponds to the individual resident's needs and circumstances. Using nursing skills at all levels to develop a collaborative plan helps to prevent a particular resident's falls. Use the interdisciplinary team – rehabilitation, pharmacy, medicine, and dietary – to address issues that would benefit from their working together.

## Pitfalls

1. Not having a falls assessment for a resident is like allowing an “accident waiting to happen” to occur.
2. Failing to make a new falls assessment and care plan for a resident who has fallen misses an opportunity to reduce that resident's risk of falling again in the future.

### Pitfalls

- › Forgetting to do a falls assessment for a resident.
- › Failing to make a new falls assessment and care plan for a resident who has fallen.





# Appendix. Additional Tools and Resources

Fabre JM, Ellis R, Kosma M, Moore DS, McCarter KS, Wood RH. Development and validation of the Comprehensive Falls Risk Screening Instrument. *Phys Occup Ther Geriatr.* 2010; 28(2): 181-194.

Gray-Micelli, D. 2008. Falls: Nursing Standard of Practice Protocol: Fall Prevention. Hartford Institute for Geriatric Nursing. See [http://consultgerirn.org/topics/falls/want\\_to\\_know\\_more](http://consultgerirn.org/topics/falls/want_to_know_more); accessed August 27, 2010.

Hendrich AL, Bender PS, Nyhuis A. Validation of the Hendrich II Fall Risk Model: A large concurrent case/control study of hospitalized patients. *Appl Nurs Res.* 2003; 16(1): 9-21. See also <http://uprightfallprevention.com/index.php?view=h2model-main-overview>; accessed November 5, 2010.

Reducing Restraint Use. Advancing Excellence in America's Nursing Homes Campaign. <http://www.nhqualitycampaign.org/files/factsheets/Staff%20Fact%20Sheet%20-%20Reducing%20Restraint.pdf>; accessed November 18, 2010.

Taylor JA. The Vanderbilt Fall Prevention Program for long-term care: eight years of field experience with nursing home staff. *J Am Med Dir Assoc.* 2002; (3)3: 180-185.

The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities. February 2010. Rockville, MD, Agency for Healthcare Research and Quality. <http://www.ahrq.gov/research/ltc/fallspc/fallspcmanual.htm>; accessed August 27, 2010.

The Timed Up and Go Test for Fall Risk Assessment [http://www4.va.gov/ncps/SafetyTopics/fallstoolkit/media/timed\\_up\\_and\\_go\\_test-07-15-04.pdf](http://www4.va.gov/ncps/SafetyTopics/fallstoolkit/media/timed_up_and_go_test-07-15-04.pdf); accessed November 5, 2010.



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