A technical reference bulletin by the Risk Control Services Department of the Glatfelter Insurance Group

Glatfelter Healthcare Practice℠
A Division of Glatfelter Insurance Group

RISK COMMUNIQUÉ

Fall Prevention and Management

Each year, one in every three adults age 65 and older falls. These falls can result in moderate to severe injuries such as hip fractures and head traumas, and could increase the risk of early death. Incident data from insured hospices, home care and senior living organizations demonstrates that resident falls tend to be one of the most frequently reported incident types.

Research done by the Veterans Administration's National Center for Patient Safety identified risk factors associated with the likelihood of an individual falling. These factors can be present whether the individual is receiving care in an acute hospital setting, a nursing home or assisted living facility, or in their own home. The research categorized the risk factors into extrinsic (factors outside of the patient's body) and intrinsic (patient's internal, psychological factors).

Extrinsic Factors:

- Potentially hazardous activities (generally related to the patient's need to maintain their independence).
- Clutter.
- Time of day.
- Lighting.
- Spills / wet floors.
- Loose electrical cords.
- Unsecured rugs.

Intrinsic Factors:

- Age.
- Muscle and strength weakness.
- Gait and balance disorders.
- Visual disturbances.
- Cognitive impairment / mental status alterations.
- Dizziness / vertigo.
- Postural hypotension.
- Incontinence.
- Poly-pharmacy.
- Chronic disease.

From this list, it is likely that a large proportion of individuals may have at least one intrinsic factor that might make them at risk of a fall. Start fall prevention activities at the time of admission to help identify and mitigate extrinsic factors in the environment. This starts with a documented safety assessment of the care setting. It is also important to identify resident specific intrinsic factors that may impact the potential for a fall and develop an individualized plan of care addressing fall prevention activities. In this process, include identification of equipment and/or technology that could assist in controlling the identified intrinsic factors (i.e. electric bed, walker, shower chair, etc.).

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Fall Risk Examples

Falls in the bathroom:
Falls in a bathroom setting or when the resident is attempting to get to the bathroom are a common incident type. Many of these falls actually occur because patients request privacy and the caregiver is trying to respect that need. Unfortunately, it often ends with an injured patient. No matter how many times the caregiver may say "wait for me and I will help you back to bed," individuals wanting to maintain their independence may try to get up on their own.

Organizations that have initiated late evening and night toileting rounds programs have found some success in decreasing the number of falls on those shifts. Educating the resident and their family of the importance to consider the resident's safety and accept assistance is an important fall prevention activity. Also, consider the need for raised toilet seats or a bedside commode to help reduce falls.

Another frequent fall location is in the bath or shower. It is important that the caregiver assess the environment before beginning the bathing process. Safety and assistive devices such as shower mats, grab bars and shower chairs can be helpful. Also consider whether a bed bath would be the safest alternative.

Falls while ambulating, transferring or transporting:
It is important that the caregiver assess the resident's level of independence including their ability to stand and assist with transfers or to ambulate on their own. Fall prevention should be an ongoing process since the resident's ability may change over time. Sometimes there will be improvement, but oftentimes there will be a decline in their abilities. Focus staff education on how to correctly transfer residents and when necessary, how to carefully assist them to the floor to help prevent a serious injury if a fall cannot be avoided.

A higher level of supervision and attention is advisable when there is knowledge of a history of prior falls. Identifying factors that contributed to the prior fall(s) can help provide an environment that limits the potential for another fall.

Caregiver judgment is a factor in resident safety. This is especially true when residents are being transported in a wheelchair. Secure residents in a wheelchair with a lap belt when taking them on longer rides in an outdoor setting. It is helpful if the individual pushing the wheelchair is aware of the environment and avoids hazardous conditions on the path, sidewalk or roadway.

In Summary
A good fall assessment program is an important loss control measure to help avoid falls. The risk of a fall is present whether care is provided on a continuous or an intermittent basis. The risk of a fall with serious injury may be higher in a care setting with limited ability to control the environment and a lack of 24-hour supervision (such as senior independent living), but falls with serious injury can happen in any setting.

Assess residents at the time of their admission as to their risk to fall, with reassessment on a regular basis since the risk level may change (i.e. due to health status or medications). When a resident is identified as a risk to fall, include fall prevention measures in their plan of care. This might consist of making equipment such as electric patient beds, shower chairs, walkers, canes or bed/chair alarms available in the care setting. Identify residents who have been assessed as a fall risk so that staff takes appropriate precautions when working with the resident in any setting.

As with any incident, should a fall occur, complete an incident report and post-incident analysis. The analysis can be used to evaluate the plan of care and to make revisions to address any additional fall prevention strategies that

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may be needed. Looking for trends or common factors in reported falls might provide strategies for safer delivery of resident care. It may not be possible to totally eliminate all fall events, but working to provide a safe environment, making wise decisions related to the delivery of care and educating the resident/family/caregivers about the risk of falls and prevention strategies may help in controlling this loss exposure.

Resources:

1. GHP Video: Patient Transfer
This 11 minute training video provides safety tips as well as demonstrations of correct patient transfers in a number of different scenarios. There is an emphasis on taking the time to prepare the patient and the environment before any transfers begin. The order form can be found at www.glatfelterhealthcarepractice.com.
2. The VA National Center for Patient Safety (www.patientsafety.gov)
3. The Institute for Healthcare Improvement (www.ihi.org)
4. Centers for Disease Control and Prevention (www.cdc.gov)

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SELF-EVALUATION CHECKLIST

FALL PREVENTION AND MANAGEMENT:

Item	Yes	No	Not Applicable/Comments
ASSESSMENT			
1. Are risk-to-fall assessments completed on all new admissions?			
2. Are family members/caregivers queried as to any history of falls prior to admission?			
3. Are risk prevention strategies incorporated into the plan of care and documented in the clinical record?			
4. Is there a method of easily identifying those residents who are assessed as at risk?			
5. Are there procedures for re-assessment on a periodic basis and for identified changes in care, including: • Medications • Mental status change • Physical status deterioration • Transfer to a new level of care			
6. Are residents instructed to ask for assistance before getting out of bed, or up from chair?			
7. Is a thorough physical assessment completed and documented subsequent to any patient fall? If there is evidence of a head injury is there a requirement for assessment by a physician and/or transport to the emergency department?			
8. Are families and caregivers informed of assessment findings and included in risk prevention strategies?			
ENVIRONMENTAL			
9. If a resident is identified as at risk to fall, are room modifications made to meet their needs?			
10. Are ambulatory residents evaluated for proper footwear?			
11. Is lighting adequate?			
12. Are floor level night lights available?			
13. Are beds kept at the lowest position when residents are not receiving care?			
14. Are floor pads available for residents as needed?			
15. Are full side rails prohibited?			
16. Is a call button/light kept within reach of resident?			
17. Are resident rooms uncluttered and pathways between bed and bathroom unobstructed?			
18. Do floors have non-skid surfaces with no rugs or other tripping hazards?			

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19. Are wheels on chairs or resident's beds locked to prevent sliding?			
20. Is Oxygen tubing, extension and other cords secured so as not to create a tripping hazard?			
21. Are personal items within reach?			
22. Do tubs, showers and floors around them have non-slip matting?			
23. Are handrails and/or grab bars provided in stairwells, hallways and bathrooms and are securely attached?			
24. Are floor spills cleaned up promptly?			
POLICIES/PROCEDURES			
25. Do written policies/procedures address: a. Assessment of risk to fall b. Development of fall prevention plan and implementation of mitigation strategies c. Evaluation of environment d. Reporting of all falls e. Post fall evaluation and treatment			
26. Is a toileting rounds program in place for evening and night shifts?			
27. Are policies/procedures reviewed periodically and revised as needed?			
RESPONSE PROCEDURES			
28. Do procedures outline immediate post-fall actions including requirements for assessment by nurse, physician and/or referral to ED?			
29. Is an incident report completed for all resident, staff and visitor falls?			
30. Does a patient record reflect actions taken including follow/up and monitoring for possible sequel?			
31. Are pharmacy and rehabilitative services involved in review of falls as needed?			
32. Is there a mechanism for review of all fall incidents as well as trending and analysis of aggregate data?			
STAFF EDUCATION/TRAINING			
33. Does staff receive training about fall risk factors and completion of fall assessment tools at orientation?			
34. Are fall prevention strategies addressed during new employee orientation for any staff having contact with residents (nursing, rehab, housekeeping, dietary, etc.)?			
35. Do annual in-service training sessions address fall prevention strategies?			
36. Is staff competence related to fall assessment and fall prevention strategies assessed on an ongoing basis?			

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