Glatfelter HEALTHCARE

FALL PREVENTION AND MANAGEMENT

Each year, one in four adults suffer from one or more falls (National Institute on Aging, 2022). 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. The risk of falling rises with age (NIH, 2022). However, many falls can be prevented. This bulletin provides prevention strategies to help caregivers identify and mitigate fall risks.

RISK FACTORS

There are many factors that may cause a resident to fall. These factors may be present whether the individual is receiving care in an acute hospital setting, a nursing home, assisted living facility, or in their own home. Research has shown that potential causes may be categorized into extrinsic factors and intrinsic factors.

EXTRINSIC FACTORS

Factors that exist outside of the resident's body

- Clutter
- Time of day
- Lighting
- Slippery / wet floors
- Loose electrical cords
- Lengthy extension chords
- Scatter rugs

INTRINSIC FACTORS

Psychological factors that exist internally for the resident

- 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 these examples, 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. Identify fall risk and provide fall prevention activities at the time of admission to help identify and mitigate extrinsic factors in the environment. Begin 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. Include identification of equipment and/or technology that could assist in controlling the identified intrinsic factors (i.e. electric bed, walker, shower chair, etc.).

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 cause of falls. Many of these falls may be unwitnessed and are due to the residents' request for privacy and the caregiver providing that need. Unfortunately, it often ends with an injured resident. 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 strategy. Also, consider providing 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. Additionally, consider reassessing 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. Although improvements are not always likely, 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 when a fall cannot be avoided.

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

Caregiver judgment is a factor in resident safety. This is especially true for wheelchair transports of individuals. 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.

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 fall risk at the time of their admission, with reassessment on a regular basis to determine risk level changes (i.e. due to health status or medications). When a resident is identified as a risk to fall, include fall prevention measures and fall risk scoring in their care plan. This may include assistive 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 root cause analysis. Use the analysis to evaluate the plan of care and to revise and/or address any additional fall prevention strategies that 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 eliminate all fall events, but working to provide a safe environment, following the care plan and educating the resident/family/caregivers about the risk of falls and prevention strategies may help in controlling this loss exposure.

References

National Institute on Aging (NIH). (2022). Falls and fractures in older adults: Causes and prevention. Retrieved from: https://www.nia.nih.gov/health/falls-and-falls-prevention/falls-and-fractures-older-adults-causes-and-prevention

ADDITIONAL RESOURCES

Glatfelter Healthcare | Patient Transfer video
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/risk-control-training-videos

The VA National Center for Patient Safety
www.patientsafety.gov

The Institute for Healthcare Improvement
www.ihi.org

Centers for Disease Control and Prevention
www.cdc.gov

SELF-EVALUATION CHECKLIST

Name of Facility:______________________________ Date: ______________

Address: ______________________________

Completed by: ______________________________

FALL PREVENTION AND MANAGEMENT				
Item		Yes	No	Comments/Action
ASSESSMENT				
1.	Are all admissions assessed for fall risk?			
2.	Are family members/caregivers included in fall risk assessments upon admission?			
3.	Are fall risk assessments and prevention care plans documented in the resident's record?			
4.	Is there a method of easily identifying those residents who are assessed as at risk?			
5.	Are there processes in place for continued fall risk assessment(s) when a patient shows natural decline to include: • Medication change • Mental status change • Physical decline • Transfer to a higher level of care			
6.	Are residents educated on how to call for assistance before getting out of bed, or up from a chair?			
7.	Is a comprehensive assessment completed and documented post fall as well as proper follow up notification of a physician?			
8.	Are assessment findings shared with legal next of kin and/or designee?			
ENVIRONMENTAL				
9.	Are fall risk prevention strategies implemented as a result of fall risk scoring?			
10.	Are ambulatory residents educated on proper footwear?			
11.	Is lighting adequate?			

Item		Yes	No	Comments / Action
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 call buttons/lights within reach of residents?			
16.	Are resident rooms uncluttered and pathways between bed and bathroom unobstructed?			
17.	Are floors and common areas non-skid and free of scatter rugs to decrease trip hazards?			
18.	Are wheels locked on wheelchairs and beds to prevent sliding?			
19.	Is oxygen tubing, extension and other cords secured for fall precautions?			
20.	Are personal items within reach?			
21.	Do tubs, showers and floors around the resident have non-slip matting?			
22.	Are handrails and/or grab bars provided in stairwells, hallways and bathrooms and are they securely attached?			
23.	Are floor spills cleaned up promptly?			
POLICIES / PROCEDURS				
24.	Do written policies/procedures address: • Assessment of fall risk • Development of fall prevention plan and implementation of mitigation strategies • Assessment of environment • Reporting of all falls • Post fall evaluation and treatment			
25.	Is frequent rounding in place for evening and night shifts?			
26.	Are policies/procedures reviewed periodically and revised as needed?			

Item		Yes	No	Comments / Action
RESPONSE PROCEDURES				
27.	Do procedures outline immediate post-fall actions including requirements for assessment by nurse, physician and/or referral to ED?			
28.	Is an incident report completed for all falls by resident, staff and visitor?			
29.	Is proper documentation, physician orders, and care plan revisions completed status post fall?			
30.	Does the care plan reflect pharmacy, DME, and rehabilitative services status post falls as needed?			
31.	Is there a quality review to track and trend all fall incidents for data analysis and performance improvements?			
STAFF EDUCATION / TRAINING				
32.	Does patient facing staff receive training at hire and annually for fall risk factors and completion of fall assessment tools (nursing, rehab, housekeeping, dietary, etc.)?			
33.	Are there staff competencies for fall assessment and are fall prevention strategies assessed on an ongoing basis.			

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