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 in 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.]	a. Previous or multiple falls			
External Factors:	b. Currently taking medications commonly associated with injury from falls (see AMDA Falls Guideline Table 2, consider antianxiety/hypnotic agents, anticholinergics, anticoagulants, antidepressants, antihypertensives, cardiovascular and diuretics, among others)			
	c. Recent medication change (should trigger review of all medications)			
	d. Potential multiple medication interactions			
	e. Appliances or devices (e.g., cane, walker, crutch, footwear, gaitbelt, wheelchair, mechanical lifts, pacemaker, restraints, reduction of restraint without alternatives)			
	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.]			
	g. Situational Factors (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)			
Internal Factors:	h. Cardiovascular (e.g., cardiac dysrhythmia, hypotension, lightheadedness, dizziness, vertigo, syncope)			
	i. Neuromuscular/functional (e.g., loss or decline in use of arm or leg movement, balance and gait disorder, CVA, chronic or acute conditions with instability, weakness, weight loss, decline in functional status, incontinence, Parkinson's, seizure disorder)			
	j. Orthopedic (e.g., joint pain, arthritis, hip fracture, amputation, osteoporosis)			
	k. Perceptual (e.g., impaired vision, impaired hearing)			
	l. Cognitive/Behavioral (e.g., delirium, decline in cognition, confusion, depression, dementia, change in LOC, exacerbation in behavioral pattern, combativeness, refusal of intervention. Resident noncompliance is not necessarily, and of itself, an adequate explanation or justification for continued falling, because underlying causes may occur in conjunction with noncompliance.)			

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.]			
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.			

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