PROCESS GUIDELINE FOR EVALUATION OF FALLS/FALL RISK
October 1, 2001

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Assessment/Problem Recognition		
1. Is there documentation that an assessment for resident specific fall-related risks was begun within 24 hours of admission, fall, or significant change.	Problem definition includes several components: 1) identifying individuals with a history of falling, 2) identifying the likelihood of falling subsequently, 3) identifying factors that may make falling more likely, and 4) identifying individuals who may be at risk for serious consequences of falling such as a high risk of injury. Begin trying to identify possible causes within 24 hours.	Falling is not associated with normal aging. Often, falling can be reduced markedly or prevented. Best practice focuses assessment on identifying individuals who have fallen and those who may be at risk for falling. Within 24 hours of admission or a fall or significant change, collection of information relevant to determining a fall risk or problem is begun. The investigation may take time, because a number of conditions or situations can cause falling. The investigation is not necessarily completed right away.
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	The Minimum Data Set (MDS) contains some -- but not all -- information relevant to defining and managing a fall risk or problem. Because falling is a common high-risk problem in the long term care population, you should consider fall-related issues even if it is not time to do an MDS. Use this information to rapidly identify prominent risk factors and minimize immediate risks without resorting to the use of physical restraints.	As you collect information, you can try to decide if there is a fall problem or risk. Facilities will find additional relevant information in the Resident Assessment Profile (RAP) Key Guidelines and in the tables and references at the end of this tool.

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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 Director's Association (AMDA) Falls and Fall Risk Guidelines, Tables 1 & 2].	The Resident Assessment Protocols (RAPs) give some clues to the possible categories and causes of falls. You should refer to the RAPs for such clues. However, regulations cannot and do not tell you how to decide exactly what is causing a fall or fall risk in a specific individual. Therefore, go as far as you need to beyond the information in the RAP to draw relevant conclusions and take proper actions.	Recognize that some individuals have a relatively low risk of falls, and that risk prediction is not always exact; that is, sometimes low-risk individuals may fall and some high-risk individuals may not. However, in individuals with a history of falls or at risk for falls, a facility can identify factors that may be associated with an increased risk of injury from subsequent falls.
4. Is there documentation that the physician or physician extender has been notified if there is a significance of falls or falls risk in this resident?	If necessary to manage falls and identify causes properly, review the situation with a physician, Nurse Practitioner (NP) or Physician's Assistant (PA-C) who is trained to understand how to use resident-specific information to identify why that person is falling and what to do about it. You will not review every fall with a physician, NP or PA-C.	If you can readily determine a cause (for example, the individual tripped over something) or if a simple intervention can address the probable cause, then you may not need to consult the physician, NP or PA-C. Many disciplines (CNAs, nurses, dieticians, social workers) may make and document observations (sleeping, eating, social patterns), but only some of them may be qualified to determine the significance of those observations. Physicians may not be present to make observations, but are trained to analyze them.
5.a) For residents who have fallen previously, is there documentation of a review of circumstances under which the fall occurred,	Sources of information such as hospital discharge summaries, review of current medications, and a history obtained from the resident or family are all helpful.	Collecting and documenting information helps to identify whether the resident may have suffered any serious consequences of the fall, such

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		as fracture or serious internal head injury
5.b) And documentation of evaluation for potential immediate and delayed consequences?	Delayed consequences are not uncommon and may occur within several days after the fall; occasionally they can occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks later after an actual fall. Each facility needs to ensure that staff are aware of, and respond to, delayed consequences of falling.	Even if there are no immediate consequences of a fall, document follow up for at least 48 hours and consider late consequences if there is a significant change in function, mental status, or level of consciousness within several weeks of a fall.
Diagnosis/Cause Identification		
6. Are the risk factors relative to this specific resident identified and documented in the RAP? These may include: **History** a) Previous or multiple falls	Fall history should include any co-existing symptoms, modifying factors, location, timing, and context. Often, several factors (medical condition, medications, activities, safety awareness, etc) are involved simultaneously.	Not all individuals in your facility will have the same amount or frequency of action or documentation. However, an effective risk assessment should allow anticipation of risks correctly more often than not. Falling has causes, and history of falls (especially in the preceding 90 days) is a strong predictor of future falls. Often, identifying and correcting causes can reduce or eliminate falling.
External Factors b) Currently taking medications commonly associated with injury from falls	See AMDA Falls Guidelines Table 2, consider antianxiety/hypnotic agents, anticholinergics, anticoagulants, antidepressants, antihypertensives, cardiovascular and diuretics, among others.	If the cause is unclear, or there is a possibility of a significant medical cause such as an adverse drug reaction (ADR), or the individual continues to fall despite previous interventions, involve a physician, NP or PA-C. They need to review the situation, and include some discussion of possible medical causes. If the physician, NP or PA-C does not write a note, a nurse or other appropriate individual should

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		document enough to show that there was a substantive discussion with them.
c) Recent medication change	Should trigger a review of all medications	The newly added medication may be, in and of itself, increasing symptoms associated with falls, or it may be interacting with other medications the resident receives.
d) Potential multiple medication interactions	Is best accomplished with the assistance of the consultant pharmacist and/or the medical provider.	The mechanism of action, effectiveness, metabolic breakdown and toxicity of medications may be affected by concurrent medication administration.
e) Appliances or devices	(e.g., cane, walker, crutch, footwear, gait belt, wheelchair, mechanical lifts, pacemaker, restraints, reduction of restraint without alternatives)	Resident gait and balance, as well as devices to assist mobility should be examined to determine structural soundness and appropriateness. Statistically, gait and balance impairment is the second most frequent cause of falls in the elderly. Watch the resident rise from a chair without using his or her arms, walk several paces, and return to a sitting position. Consider sitting as well as standing balance as a precursor to further evaluation.
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. Review of environmental factors with front line staff as well as the safety committee, maintenance, and housekeeping may provide insight into alternatives for bed use, floor mats, transfer bars, anti-tipping devices for wheelchairs, wandering patterns, lighting, alarms,	Many environmental factors associated with falls are discovered and eliminated by the investigation of the fall itself by staff, standard safety committee QA projects and survey readiness reviews. Pilot studies of new products and interventions (night lights, non-skid products) are helpful.

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	placement of furniture, signs or memory triggers and restraints.	
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)	When someone falls, collect specific information – for example, time of day and what the individual was doing when they fell – that may help to identify patterns and causes.

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Internal Factors h) Cardiovascular	(e.g., cardiac dysrhythmia, hypotension, lightheadedness, dizziness, vertigo, syncope) Advise residents with orthostatic hypotension to rise first to sitting position after lying down, and to stand slowly.	Some conditions may predispose to orthostatic hypotension. Others, such as urosepsis may result in risk factors for falls such as dizziness, dehydration or delirium.
i) Neuromuscular/functional	(e.g., loss or decline in use of arm/leg movement, balance/gait disorder, proprioception, CVA, chronic/acute conditions with instability, weakness, weight loss, decline in functional status, incontinence, Parkinson's, reflexes, seizure disorder). Gait/balance instabilities/decline should be investigated for underlying illness, or neurological/ musculoskeletal conditions, and evaluated by rehabilitative and restorative therapies.	Musculoskeletal problems can impair strength, balance and biomechanics. Even fear of repeat falls may cause decreased mobility and deconditioning. Executive functioning, and the ability to sequence steps to a process, may require simplification.
j) Orthopedic	(e.g., joint pain, arthritis, hip fracture, amputation, osteoporosis and activity tolerance)	Decreased body mass (muscle, fat and subcutaneous tissue) to absorb impact and changes from osteoporosis may result in increased opportunity for serious injury from a fall, such as fracture of the hip, wrist and spine. Hip protectors may minimize trauma with artificial padding.
k) Perceptual	(e.g., impaired vision [cataracts, macular degeneration, glaucoma] and impaired hearing [neurosensory, presbycusis])	Poorly fitting, as well as incorrect eye-wear and hearing aids are potential factors in falls. Consider also that falls may be symptomatic of an underlying condition change, such as stroke, or adverse drug reaction.
l) Cognitive/Behavioral	(e.g., delirium, decline in cognition or safety-awareness, decision-making capacity, confusion, depression, dementia, change in LOC, exacerbation in behavioral pattern, combativeness, refusal of intervention. Resident compliance is not necessarily, and of itself, an adequate	A resident's noncompliance with the plan of care is not necessarily by itself an adequate explanation or justification for continued falling, because there may be another underlying cause in

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	explanation or justification for continued falling, because underlying causes may occur in conjunction with noncompliance.	conjunction with noncompliance. Maximizing dignity and quality of life while focusing on minimizing falls risk should be a focus.
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 medication, 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. Examine the resident, and explain any decision not to at least try to adjust likely risk factors such as multiple medications associated with dizziness or postural hypotension. If the physician does not participate sufficiently to allow you to identify causes or address relevant issues, inform the medical director for involvement as necessary until a satisfactory review has occurred.	Continue to collect and evaluate information until you have either identified the cause of the falling or determined that the cause cannot be found or that finding a cause would not change the outcome or how you manage the situation.
8. If this resident was **not** evaluated to identify the causes of falling or fall risks, does the facility explain <u>why</u> the resident was not further evaluated OR why identifying causes would not have changed the management.	Use the information collected to try to identify why the individual fell or is at risk for falling. Or, explain why you could not or did not try to do so, or why you concluded that doing so would not have made any difference. Carefully document reasons for decision not to treat, or for choosing one approach over another.	There is no requirement for any specific evaluations or tests, but if a resident continues to fall despite certain interventions or has a history of recurrent falling within several months just prior to admission, the physician would do a more thorough evaluation. A work-up may not be indicated if the resident is terminal, if it would not change the management course, or if the burden of the workup is greater than the potential benefit or the resident or proxy refuse it.
Treatment/Problem Management		
9. Does the care plan contain cause-	When causes are identifiable and potentially correctable,	If the systematic evaluation of the

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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?	interventions should be based on identified or suspected causes. If not, indicate why such causes could not or should not be treated It is not enough just to say, "because that's what the doctor ordered". Show how you decided that certain interventions were indicated while others were not.	resident's fall (risk) identifies several possibilities for interventions, it is reasonable to try one first, and document the rationale. While the physician does not have to always write a note, someone may need to answer such questions. Since the survey may occur long after the events, it makes sense to have such discussions and documentation at or near the time that these decisions are made.
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, and gait and balance disorders should be considered initially.	It is appropriate to prioritize approaches to preventing and managing fall risk and falling. That is, you may try only one of the possible interventions first, if it is based on a systematic evaluation and related conclusions about likely causes. If falling recurs despite the initial approach, then try other interventions unless you can explain why nothing else was relevant.
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?	Document how you decided on the specific cause(s), or concluded that certain things contributed to the fall while others were not relevant. Falls that start after a change in medication regime should trigger a review of the entire medication regimen. If a resident is receiving medications that are often associated with falling, and no adjustments are attempted in those medications, document how you determined that the resident did not have lethargy, dizziness, or postural blood pressure changes that might indicate that medications played some role.	Many medications can cause dizziness, which is associated with increased risk of falling. If a medication is suspected to be a possible cause of a person's falling, then the initial intervention might be to taper or stop that medication before trying anything else. The physician, direct care staff and pharmacist should be involved with review of drug regimen. Titration of

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		medication or revision of administration times may help to manage pain, tremors, cogwheeling, incontinence, dehydration, etc. while minimizing fall risk.
12. Is there evidence to demonstrate that the care plan has been implemented?	Potential or actual falls should be addressed in the resident's individual care plan, either as a primary item, or in conjunction with risk factors associated with increased falls.	Discussion of resident risk factors and fall history in care conferences will be helpful in evaluating the implementation of care plans.
Monitoring		
13.a) Does the facility document monitoring of the resident's response to interventions?	Evaluate the progress of individuals who have fallen or have a fall risk.	Adjust the resident's plan of care as necessary to reflect the implementation of new or modified interventions. Rationale documents thought processes.
13.b) and document a periodic review of approaches for applicability to the current situation?	If the resident stops falling, and you believe that the underlying cause has been corrected, then you might reconsider periodically whether the interventions are still needed.	Since causes sometimes can be corrected and do not recur, it is often reasonable to try to stop specific interventions, to see if they are still needed. It would not necessarily be problematic if a resident fell again, if you had based the decision on relevant evidence.
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?	Consider the resident's response to each intervention on a timely basis. A facility should use root cause analysis but is not obligated to pursue all possible interventions. Consider any possible reasons for falling besides those already identified until falls stop or markedly decline, or indicate why another cause is unlikely or why finding a cause is not likely to change the outcome or the interventions. Reconsider interventions, try alternatives or explain why you believe that the current approach was	If falls continue despite initial measures, it could be because different or additional causes exist, because the underlying causes are not readily correctable, because the cause cannot be identified, or because the interventions are insufficient. Use basic quality improvement approaches to monitor falls in your

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	appropriate despite recurrent falls. A facility should be able to provide some justification for a decision not to pursue additional interventions in residents who continue to fall.	facility and to determine areas for improvement. Review falls to look for trends and patterns such as a particular unit or time of the day, patients who are taking certain medications or medication combinations. You can also use the results of your reviews as part of your quality improvement activities to look for processes and practices that might be improved. Compare your results over time to see if various changes in processes and practices have affected your results.
15.a) After a fall associated with injury, does the facility document notification of the **physician or physician extender**?	Provide staff with a clear written procedure that describes what to do when a resident falls. Notify the physician and family in appropriate time frame. With no significant injury or change of condition, the physician may be notified routinely (by fax or phone the next day).	A written policy and procedure, available at the work site, ensures a more systematic approach to unexpected events.
15.b) and document that actual consequences were addressed, based on prominence of signs and symptoms, with re-evaluation until stable	Record vital signs (heart rate/rhythm), evaluate for possible injuries (especially to the head, neck, spine and extremities) such as pain, swelling, bruising, decreased mobility or range of motion, and administer appropriate first aid. When the assist in restoring dignity. Use available information to begin critical thinking. A resident with existing osteoporosis, or taking anticoagulants may be more likely to have a serious consequence of falling. Describe the situation accurately and objectively (position of the resident initially and on impact, momentum of the fall, any events or complaints that occurred before the fall etc).	See AMDA Falls and Fall Risk Guidelines Tables 3and 5. For individuals who fall repeatedly, where the causes cannot be controlled, try to identify ways to reduce the seriousness of injuries from falling. It is not always possible to predict with certainty who will be injured or how severe the injury might be. It is also desirable to note the absence of significant findings, which helps to demonstrate that the resident is being monitored appropriately.
15.c) and document observation for possible delayed consequences of a fall	Delayed consequences are not uncommon and may occur within several days after the fall; occasionally they can	Even if there are no immediate consequences of a fall, document

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(late evidence of fracture, subdural hematoma, etc.) for at least 48 hours?	occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks after an actual fall. Each facility needs to ensure that staff are aware of, and respond to, delayed consequences of falling.	follow up for at least 48 hours and consider late consequences if there is a significant change in function, mental status, or level of consciousness within several weeks of a fall.
16. Is there documentation of staff awareness of policy/procedures for resident falls?	Protocols will help educate and train your staff about how to address falling and fall related issues (steps the staff and practitioners should follow, expected time frames, who is responsible for what, etc). Your protocol should include the basic steps listed in the accompanying process guideline. The details of those steps can be specific to your facility; for example, who does what or when they should do it.	For details of the above steps, refer to the OBRA guidelines, the process guidelines and materials listed in the tables and references. The panel that helped create this document felt that these reflected appropriate recommendations based on current evidence and consensus. Therefore, the department recognizes that policies and protocols that follow the recommended guidelines are a proper foundation for your facility's practices. Surveyors may ask you for evidence to support approaches that differ significantly from those recommended in these materials.