Healthcare

CAREFULLY SPEAKING®

A Risk Management Resource for Aging Services | 2021 Issue 1

Resident Falls: A Collaborative Strategy for Risk Mitigation

For almost two decades, CNA has been publishing reports on aging services liability trends and patterns, utilizing a large pool of professional closed claims data. One finding that has remained consistent over time is the high frequency of resident falls, suggesting that past loss-reduction efforts in this area have been less than fully successful. As a result, there has been a shift away from traditional risk management approaches that assign aging services facilities sole responsibility for safeguarding residents. The industry is moving toward a more collaborative model whereby all involved parties – including administrators, front-line staff, residents and families – are kept apprised of the resident's susceptibility to falls and together develop a care or service plan built upon shared goals and realistic expectations.

No risk management philosophy can completely prevent falls. However, by emphasizing transparency and encouraging cooperation and active engagement on the part of all stakeholders, aging services organizations can better manage care and outcome expectations while helping ensure that residents receive the attention and assistance they need. This mutual approach can pay significant dividends in terms of increased resident and family satisfaction and reduced likelihood of litigation.

In this issue…

This edition of *Carefully Speaking*® summarizes common fall-related allegations and preventive measures, emphasizing that an effective fall- and fracture-reduction program can help curb the rise in claim severity. It also presents the following five essential strategies to help facilities evolve toward a shared, proactive vision of reducing falls and associated liability:

1. **Ongoing family collaboration** in safety initiatives and care planning.
2. **Effective expectations management** for residents and families.
3. **Enhanced documentation** of falls history.
4. **Reduction of resident noncompliance** and consequent unwitnessed falls.
5. **Consistent placement procedures,** as well as sound policies regarding transfer to a more suitable setting, when necessary.

A self-assessment questionnaire on pages 11-15 is designed to help administrators examine their current approach to managing resident and family expectations and creating an enterprise-wide culture of safety.

Common Allegations and Appropriate Countermeasures

As noted in past CNA closed claims reports, *failure to monitor residents*, *improper care by staff* and *unsafe residential environment* are perennial fall-related allegations for aging services settings. The following checklist highlights these common allegations and offers related preventive tactics, which may be adapted to your unique environment of care. Many of the suggestions included here apply equally to skilled nursing (SN), assisted living (AL) and independent living (IL) settings, while others are geared to SN and AL settings only.

Allegation	Risk Reduction Measure	Present? Yes/No
"Failure to monitor" refers to a situation where staff failed to prevent a fall, although they knew or should have known that the resident was at risk. **Examples:** • **Lack of monitoring** due to low staffing levels. • **Inadequate staff interaction** with resident. • **Insufficient observation,** resulting in the resident attempting to ambulate independently and ending up on the floor. • **Failure to instruct the resident to call for assistance,** or failure to respond in a timely manner after being summoned by the resident. • **Delay in noticing decline in resident's physical condition** or in notifying physician of observed changes.	**Ensure that staffing levels are appropriate** in relation to both resident census and resident acuity.	
	Clearly explain the types of services offered by the facility and the degree of resident supervision.	
	Perform initial comprehensive assessments to ensure that residents are receiving a suitable level of care or services.	
	Document the date and results of resident re-evaluations, including significant changes in physical, cognitive or psychological functioning.	
	Remain alert to subtle changes in resident condition, and be ready to promptly notify resident's physician and family members.	
	Promptly modify resident care or service plans in response to changing health conditions and service needs.	
	Include expected time frames associated with anticipated clinical outcomes when creating resident care plans.	
	Remind staff to monitor residents at potentially hazardous moments, including toileting, bathing and other personal care activities.	
	Conduct and document consistent, proactive rounding, including interacting with residents, in order to identify resident needs.	
	Monitor residents consistently as indicated in care plans, using appropriate alarm-free devices.	
	Encourage the use of medical alert pendants/bracelets and/or residential panic buttons.	
	Perform and document all resident safety checks as ordered, regardless of the presence of family or visitors.	
	Cultivate staff decision-making skills, using mock scenarios designed to help them quickly prioritize and manage simultaneous requests.	
	Assess and document staff competence in terms of monitoring and promptly responding to the clinical and service needs of residents.	
	Monitor the residential environment to ensure that safeguards are in place and functioning effectively.	

Allegation	Risk Reduction Measure	Present? Yes/No
"Improper care" refers to failure to incorporate fall management and prevention measures into the care or service plan, meet a reasonable standard of care, and/or adopt appropriate policies and procedures. **Examples:** • **Lack of monitoring** due to low staffing levels. • **Lapses in adherence to care plans,** especially in terms of providing residents who need them with walkers, wheelchairs and other necessary ambulation aids. • **Insufficient assists when transferring residents or helping them ambulate,** e.g., ignoring the need for a two-person assist as specified in the care plan.	**Establish clear expectations** regarding the level of care and types of services to be provided.	
	Include discharge criteria in the resident contract, and also describe the process for transferring residents when their condition and needs change to the point of exceeding organizational capabilities.	
	Implement a mandatory staff orientation program that reviews basic expectations in the area of fall management and prevention.	
	Provide regular in-service education on fall management and prevention, including training in proper use of lifts, slings and other equipment used to transfer residents.	
	Train staff members to respond swiftly to signs of a worsening medical condition or any other changes in resident status.	
	Complete comprehensive resident assessments upon admission, with an emphasis on mental status, frailty, balance and history of falls.	
	Conduct re-assessments every six months (or more frequently if required by state law) and after any significant change in condition, in order to ensure that residents are at the appropriate level of care.	
	Periodically evaluate fall-related risks and interventions, taking into consideration medications taken and other aspects of treatment, as well as the resident's physical and mental condition.	
	Adhere strictly to resident care plans, especially in regard to transfer and ambulation safety requirements.	
	Use lifts, transfer devices and assistive equipment correctly and in accordance with resident care plans and manufacturer recommendations.	
	Educate residents and families about fall mitigation and management techniques in use at the facility.	
	Establish an organization-wide safety culture, adopting measures to hold staff accountable for failure to follow fall-related protocols.	
	Monitor compliance with facility policies and procedures for resident transfers, including proper use of resident lifts, transfer devices, fall prevention sensors and other equipment.	
	Track fall-related incidents and monitor the effectiveness of correction plans.	
	Work to reduce staff turnover, which can have a significant negative impact on quality of resident care or services.	

Allegation	Risk Reduction Measure	Present? Yes/No
"Unsafe environment of care" refers to defective fall-prevention equipment, uneven lighting, poorly maintained floors and/or staffing levels too low to allow for two-person assists. **Examples:** • **Falls that occur at the bedside,** on stairs and outdoor walkways, and in bathrooms, hallways and dining rooms, due to poor maintenance and resultant unsafe surfaces. • **Falls due to disrepair of wheelchairs,** walkers and other assistive ambulatory devices. • **Improper use of resident transfer belts, hoists and lifts** due to inadequate training, as well as accidents caused by poor maintenance. • **Failure to provide needed mobility assistance to residents** due to insufficient staffing.	**Address "aging in place" safety issues in resident contracts,** following consultation with legal counsel, and emphasize that falls are an inherent risk even in the best-managed facilities.	
	Develop individualized resident safety goals that reflect the facility's service and monitoring capabilities and incorporate effective safety measures.	
	Include certified nursing assistants in resident care planning, in order to benefit from their uniquely close connection to residents and families.	
	Focus care plan interventions on the places where falls are most likely to occur – such as bedside, bathrooms and dining rooms – and include the following simple but effective practices:	
	• Lock wheelchairs prior to transfers.	
	• Maintain chairs and beds at minimum recommended height.	
	• Place assistive devices within easy reach of residents.	
	• Keep pathways to restrooms free of obstacles.	
	• Require use of nonskid footwear.	
	Instruct residents to ask for assistance if needed, to the extent they are capable of doing so.	
	Permit staff members to access resident care plans at the point of care, using handheld electronic devices.	
	Train staff members to collaborate in providing residents with needed one-on-one attention, even when more than one resident is calling for help.	
	Instruct staff in proper lift and transfer technique, and audit the resident healthcare information record for compliance with policies and procedures.	
	Use visual reminders to alert staff and others of residents at higher risk for falls, within the parameters of laws and regulations pertaining to resident privacy.	
	Maintain a safe indoor environment by keeping halls and walkways obstacle-free, using contrasting colors on floors and walls, avoiding sudden loud noises in common areas, and banning carpeting or fabric patterns that may distract attention or cause dizziness.	
	Maintain a safe outdoor environment by frequently checking external lighting, as well as such areas as paths, sidewalks, parking lots and swimming pools.	
	Conduct regular equipment checks and document preventive maintenance.	

Basics of Fall and Fracture Prevention and Response

A review of CNA aging services closed claims between 2015 and 2020 reveals a nearly 6 percent increase in claim severity, reflecting a decrease in claims below $100,000 and an increase in claims settling for over $250,000. In terms of fall-related claims, SN facilities historically have experienced lower severity than AL facilities. However, this gap has narrowed, with SN and AL settings recently experiencing similar loss severity levels.

In view of the increasing number of serious injuries and costly claims associated with resident falls, facilities should evaluate their safety measures in this area and initiate a fall-reduction program aimed at preventing fractures and other serious injuries. Such a program should incorporate the following elements, among others:

- **Educate staff** regarding the high correlation between falls and fractures.
- **Perform fall assessments** upon admission/readmission and on a quarterly basis thereafter, as well as following falls and significant changes in condition.
- **Assemble an interdisciplinary team to identify risk factors and suitable interventions,** comprising representatives from nursing, physical therapy, medical disciplines, dietary services, environmental services and materials management.
- **Develop and implement individualized care plans** to manage falls and mitigate potential injury.
- **Engage relatives in the care-planning process,** in order to obtain input and ensure that family members have reasonable care or service expectations.
- **Consider physiological factors predisposing residents to falls,** utilizing data-driven clinical tools. (See "Artificial Intelligence and Fall Reduction," at right.)
- **Employ tools and equipment that effectively minimize fracture risk,** such as transfer belts and boards, walking belts, lifting cushions and slider sheets.
- **Utilize therapeutic principles of care to improve resident functioning and mobility,** such as physical and occupational therapies.
- **Examine residents who complain of pain or exhibit symptoms possibly indicating a fracture,** documenting the assessment and all follow-up actions taken in the resident healthcare information record.
- **Require staff to monitor residents after a fall,** in order to detect delayed signs or symptoms of fracture, concussion or other injury.
- **Notify primary care providers and family members of falls,** and document calls made in the resident healthcare information record or other administrative record.
- **Educate staff regarding resident transfers,** and monitor their compliance with facility protocols and individual care plans.
- **Regularly review resident care plans with the interdisciplinary team** to ensure that fall-reduction services remain appropriate and effective.
- **Track and trend the occurrence of fractures,** and monitor the effectiveness of corrective measures taken.

Artificial Intelligence and Fall Reduction

Data-driven tools can reveal the risk factors that predispose residents to injurious falls. Innovative artificial intelligence (AI) systems that rely on wearable sensors, cameras and other analytic tools are now being used to detect a variety of fall-related warning signs, including but not limited to baseline gait speed, stride length, grip strength, heart-rate variability, hydration levels and muscle mass.

Predictive analytics also are being applied to electronic health record data, noting the frequency of nursing calls and alarm use, as well as observing patterns in resident reactions to medications. These applications are transforming care and service plans from static documents into tools that can predict potential falls well before danger signals become apparent to staff.

Another advantage of AI systems is that they release staff members from the time-consuming task of collecting and interpreting resident data, thereby permitting caregivers to focus on monitoring and attending to residents who are at highest risk of falling. (For an example of how one facility successfully adopted AI tools, see Reagan, T. "Carlton Senior Living Reduces Memory Care Falls 31% with AI Tech." *Senior Housing News*, August 19, 2019.)

Five Elements of a Collaborative Safety Culture

1. Engage families in safety initiatives.

By promoting a mutual, enterprise-wide safety culture, organizations help ensure that leaders, staff, residents and families agree upon basic safety goals and work together in an atmosphere of trust, shared decision-making and candid communication. An important first step is to consult residents and families about their needs and concerns, in order to include them in the ongoing process of creating a safe and caring environment.

The following questions can serve as a starting point for enhancing collaboration:

- **Is there an emphasis on mutual respect and appreciation among all stakeholders,** including ownership, senior management, front-line staff, and residents and their families, as evidenced by an active family council, a responsive complaint-management program and ample opportunity for all parties to share in the care-planning process?
- **Is administrative staff readily accessible to residents and their families,** and do members of the leadership team conduct safety rounds in residential areas?
- **Prior to admission, are documented discussions held with prospective residents and families regarding the most appropriate care setting,** in order to help them understand the differences between types of facilities, be aware of service limitations and maintain reasonable expectations?
- **Is the fall-reduction program highlighted in the resident handbook,** and are discussions regarding resident and family participation in risk-mitigation efforts documented in the resident healthcare information record?
- **Does the organization promote social outreach for prospective residents and their families,** including resident/family orientation sessions, educational sessions on reducing falls and ongoing discussion of the aging process?
- **Are residents and families educated on fall-reduction efforts in an ongoing manner** through newsletters, social media forums and family council meetings?
- **Is there transparency and accountability after falls and other injurious events,** in order to improve processes and strengthen credibility with residents and families?
- **Do residents and family members participate in the facility's quality assurance and performance improvement (QAPI) committees?** (See "Boosting Fall-related QAPI Efforts: Family Engagement Is Key" on page 7.)
- **Does the organization have a dedicated process by which residents and families report safety-related issues,** and do administrators acknowledge their concerns in a timely manner?
- **Do residents and family members know how to report their concerns,** and are they promptly informed of actions taken in response?

Strong partnerships with families depend upon awareness of their experiences, beliefs, attitudes and unspoken assumptions. Leadership should regularly ask family members about their interactions with staff, solicit their ideas about resident safety, assess their overall level of satisfaction, and obtain their feedback about organizational policies and safety measures. (To help organizations compile this vital information, Consumer Assessment of Healthcare Providers and Systems offers a family member survey tool, which can be downloaded for use in family outreach initiatives.)

2. Establish mutual goals and expectations.

Highly mobile and independent residents are generally regarded by family members as less vulnerable to falls and associated injuries. Thus in AL and IL settings, well-meaning relatives often attribute a loved one's injury to staff inattentiveness, instead of the natural progression of underlying disease and/or aging. The process of establishing realistic expectations with residents and families should start early in the pre-admissions process with a clear, simply stated description of available services, safety measures in place, the level of care and supervision provided, and – perhaps most importantly – resident selection criteria.

Marketing materials and admissions staff should emphasize that AL and IL settings are not appropriate environments for residents who are at a heightened risk for falls, prone to aggressive behavior, in need of two-person assistance or suffering from serious medical problems requiring skilled nursing.

In **AL and IL settings**, well-meaning **relatives often attribute** a loved one's **injury to staff inattentiveness**, instead of the **natural progression** of underlying **disease and/or aging**.

Boosting Fall-related QAPI Efforts: Family Engagement Is Key

When residents and family members participate in quality assurance and performance improvement (QAPI) meetings, they join in the facility's decision-making process and become a potentially important source of ideas for improvement. Their input can influence other residents to respond more positively to safety and quality initiatives, helping create an upward spiral of enhanced safety and trust.

The following strategies can help aging services organizations incorporate residents and families into their existing QAPI structure, thus promoting useful, two-way dialogue about shared goals:

- **Prepare a one-page document describing the role and responsibilities of QAPI participants,** including necessary time commitments and requirements for handling sensitive information.
- **Ask residents and family members with a long-term connection to the facility to participate in the QAPI process,** as well as staff members who …
  - **Interact well with residents** and respect their perspective.
  - **Have a demonstrated interest in working with others** to improve the level of care.
  - **Have good communication skills** and a willingness to consider a range of views.
  - **Are comfortable speaking candidly** in a group setting.
- **Review beforehand all data to be discussed in QAPI meetings,** removing any resident-identifying information before sharing it with residents and family members and refraining from discussing identifiable cases.
- **Take attendance at meetings,** noting the names of participating residents and family members in the minutes.
- **To encourage input, prepare questions in advance for residents and family members,** such as ...
  - **How can we encourage use of ambulation aids** and otherwise improve resident compliance with safety measures?
  - **How can we reduce resident falls in higher-risk areas of the facility,** such as bathrooms, dining areas, recreational spaces and exercise rooms?
  - **In your experience, are staff members quick to respond** to calls for assistance from residents?
  - **What do you think about motion-detector sensors?** Are they a help or hindrance?
- **Following meetings, conduct debriefing sessions with staff** to discuss questions asked, suggestions made and other family input, as well as to recommend ways to increase participation.
- **Solicit feedback from residents/family members who attended QAPI meetings** and discuss their comments and questions at future meetings.
- **Follow up with participating residents/family members** by communicating any changes made as a result of QAPI discussions.

When **residents and family members** participate in **quality assurance and performance improvement** (QAPI) meetings, **they join** in the facility's **decision-making process** and become a potentially important source of **ideas for improvement**.

If a resident presents with a history of falling in the home, be honest about the fact that no safeguards can completely eliminate the risk of future falls. Reinforce realistic expectations by inserting language into admission agreements, care or service plan summaries, and other communications that reiterates the realities of the care environment, as in the following example for AL and IL settings:

> *"We are licensed as a residential care facility for the elderly. Our licensing regulations do not permit us to use restraints on our residents, nor is the use of restraints consistent with our philosophy of care. We encourage our residents to participate in physical activities to the extent of their capabilities. As a result, falls and other injuries will occur from time to time. If you are not comfortable with this type of an environment, we suggest that you consider a higher level of care."**

In addition, during the pre-admissions process, inform residents and families about the relationship between chronic conditions, the aging process and the occurrence of falls. Educational efforts should continue throughout the residential stay, focusing on the extent of disease progression and presence of comorbidities that may adversely affect a resident's fall risk. Also encourage families to actively participate in the facility's fall-mitigation program, in order to reiterate that all parties share the responsibility for lowering slip and fall risk. Document all discussions and family involvement in the resident healthcare information record.

For additional ideas on how to convey service capabilities and limitations, negotiate shared goals, strengthen adherence to fall-management plans, and increase family/resident participation and satisfaction, see "Questionnaire: Establishing and Managing Resident/Family Expectations" on pages 11-15.

If a **resident** presents with a **history of falling** in the home, be honest about the fact that **no safeguards can completely eliminate the risk** of future falls.

* Goldman, J. "Creating Realistic Expectations," a legal update from Hanson Bridgett LLP.

3. Assess fall risk frequently.
Residents require a detailed fall risk assessment upon admission, including an initial screening for risk factors and any history of falls. For most settings, reassessment should occur on a quarterly basis or more frequently if the resident suffers a fall, experiences changes in physical or cognitive status, or is readmitted from an acute care setting.

Standard assessment formats should include these basic documentation parameters:

- **Resident's background,** including living situation prior to admission and length of stay in previous healthcare facilities.
- **Resident's awareness of his or her own safety needs,** along with an understanding and acceptance of any limitations.
- **Family's perception of resident's needs,** including knowledge of physical and mental deficits that may affect safety.
- **History of falls prior to and following admission,** including number of falls in the past 12 months, dates and details of occurrences, assistive devices used at the time of falls, treatment required for prior falls, current major risk factors and noticeable fear of falling.
- **Resident's knowledge of fall risk factors,** including efforts to educate residents and their family members on medical conditions and comorbidities that can predispose residents to falls.
- **Medications taken and associated side effects,** such as impaired balance, tremors, lightheadedness and excessive drowsiness, as well as knowledge of these effects by the resident and family.
- **Vision problems,** including poor acuity, cataracts, altered depth perception, reduced contrast sensitivity and decreased night vision.
- **Gait and balance disturbances** due to Parkinson's disease and other neurological conditions affecting muscle tone and gait.
- **Lower-limb joint ailments,** such as arthritis and related conditions that can limit range of motion.
- **Medical conditions,** including dehydration, dizziness, history of fractures and musculoskeletal issues.
- **Cognitive impairment** due to depression, anxiety or dementia, and awareness of these deficits by family members.
- **Bowel and bladder dysfunction,** noting incontinence, the use of diuretics or an urgent need to use the bathroom.
- **Physical limitations,** such as confinement to a chair.
- **Habitual risk factors,** such as smoking and alcohol use, which can weaken bones.

The following measures can further aid staff in their efforts to capture fall information and craft mutually agreed-upon care/service plans with residents and their families:

- **Expand the number of interviews.** By holding documented discussions with family members, former and present providers, and caseworkers involved in the care of prospective residents, admissions staff can gain a more complete, balanced and accurate idea of the applicant's mobility deficits.
- **Conduct face-to-face discussions.** Every effort should be made to conduct documented in-person interviews with residents, as well as family members and other supportive individuals.
- **Encourage a relative or other companion to participate in care planning.** By including someone close to the resident in the process, staff can learn about a resident's fall history and present susceptibility to falls, more effectively solicit resident and family feedback, and impart information to the family about fall risks and mitigation efforts.
- **Communicate regularly with current care providers.** By maintaining open, two-way channels of communication with healthcare providers, staff help ensure that vital information does not slip through cracks in the care-planning process or go overlooked in day-to-day care.

4. Promptly address resident noncompliance with fall mitigation measures.

Sound care/service planning and timely intervention may limit the occurrence and impact of spontaneous falls. However, not all residents will comply with fall safety expectations, no matter how carefully they are explained. In such cases, caregivers and family members must work together to determine underlying reasons for resident noncompliance, which may indicate that the resident …

- **Has not been educated** about fall-related risks, including the impact of medication side effects on the occurrence of falls.
- **Fails to comprehend the underlying medical issues** that may lead to injurious falls.
- **Misunderstands staff directives** due to a hearing deficit, cognitive barrier, or other physical or mental condition.
- **Is embarrassed to ask for aid,** use assistive devices or summon help following an unwitnessed fall.
- **Forgets to comply consistently** with safety requirements due to cognitive impairment.

When caring for uncooperative residents with impaired decision-making capacity, even basic expectations must be carefully articulated. Standardized educational materials and other teaching and memory aids can help improve compliance and foster rapport with residents and family members. But if written reminders fail to improve the situation, a discussion should be held with the resident and family regarding mutual concerns and expectations. If appropriate, present the option of a negotiated risk agreement (see Quick Links for a resource on this topic) or, if necessary, transfer the resident to a setting providing closer supervision.

When encountering noncompliant residents and their relatives, note all steps taken to address the problem in the resident healthcare information record or other administrative record. In the event of a fall, the following measures, among others, should be implemented and documented:

- **Notify the resident's family and physician** in a timely fashion.
- **Perform a post-fall assessment,** describing details of the incident, immediate causes and contributing risk factors, including resident noncompliance and organizational response.
- **List witnesses to the fall** in the investigative report, and summarize their accounts of the occurrence.
- **Describe the resident's functional status and medical condition before and after the fall,** including current assessments, treatments and response to interventions.
- **Identify any medical equipment that may have contributed to the fall,** such as recliners, hoists, lifts, or unsecured wheelchairs or beds.
- **Observe the presence of any clutter in the living environment,** such as excess movable furniture and other pathway-blocking obstacles.
- **Note assistive device utilization,** as well as non-use of recommended equipment.
- **Gather all physician notifications, orders and other pertinent handoff documentation,** in the event of transfer to an acute care facility.
- **Track and trend unwitnessed falls,** in order to assess and improve resident monitoring and post-fall response.

With respect to claim defensibility, the importance of adhering to the written care plan cannot be overstated. Failure to execute a care plan as written and to document resident noncompliance with safety directives may have costly consequences for aging services facilities.

5. Select residents carefully and be prepared to transfer them to higher-acuity settings when necessary.
Underlying frailties and chronic medical conditions constitute a risk factor for all aging service settings, potentially contributing to injurious falls. Given the rise in acuity levels in AL and IL settings, facilities and providers in those settings have a duty not only to screen prospective residents and place them in the most appropriate setting, but also to transfer them when their needs exceed facility capabilities.

Leadership can reduce the likelihood of risky and potentially costly mismatches by performing full assessments of residents' functional and cognitive status before making placement-related decisions. Organizations can further protect themselves by clearly explaining to families how levels of care differ, helping them discern and articulate the needs and desires of their loved ones, and clearly explaining transfer-related policies.

No matter how transparent the admission process, the decision to transfer aging residents to a higher-acuity setting may lead to conflict with residents and family. The following measures can help smooth the resident transfer process:

- **Draft unambiguous written policies regarding transfer,** emphasizing that residents can no longer remain at a facility when the level of care is unsafe or inappropriate. If applicable, note that state regulations impose a duty to transfer residents when necessary.
- **Educate residents and families during the admissions process,** and periodically thereafter, regarding the obligation to transfer some residents to a higher level of care when their condition changes.
- **Ask the family to select a single spokesperson** to serve as liaison between facility and family regarding major questions and concerns, including transfer recommendations.
- **Offer to coordinate a conference call among family members** to help talk them through issues and resolve differences.
- **Retain an ombudsman or a professional mediator** to address underlying sources of family conflict, explain the rationale for the transfer and help the parties arrive at consensus.

Open, two-way, straightforward communication with families is an essential risk management tool, especially at critical times such as admission and discharge. (For guidance in evaluating and enhancing facility-family rapport, see "A Nursing Home Self-Assessment Survey on Patient Transitions and Family Caregivers," issued by the Next Step in Care campaign.)

Notwithstanding many risk control efforts and safety campaigns over the years, falls remain a major hazard for residents and a substantial source of complaints, lawsuits and liability for aging services facilities. Increasingly, the industry has come to realize the critical importance of instituting a collaborative approach to fall reduction. By encouraging family involvement and cooperation, proactively cultivating realistic expectations, and establishing and communicating sound transfer policies, leadership can reduce potential conflict, strengthen trust, and help ensure that staff and family members sustain a sharp, shared focus on keeping residents healthy, well cared for and on their feet.

Open, two-way, straightforward **communication with families** is an essential **risk management tool**, especially at **critical times** such as **admission and discharge**.

Questionnaire: Establishing and Managing Resident/Family Expectations

For many families, the decision to place a loved one in an aging services setting is not an easy one. Weighed down by conflicting emotions and perceptions, family members may not agree about their relative's condition or needs, or comprehend the nature and limitations of the facility. Clear, honest and compassionate communication with residents and family members can help reduce the potential for misunderstandings, friction and grievances.

The following questions are designed to help organizations identify their strengths and weaknesses in terms of resident safety, communication and expectations management. After answering these questions, consider what steps can be taken to address identified lapses, enhance transparency and minimize risk.

Measure	Present? Yes/No	Action Needed
Culture of safety		
Has the concept of "safety culture" been defined by the organization, and has a safety culture assessment been performed?		
Is every effort made to develop a culture conducive to resident safety and to ensure that staff members embrace this culture?		
Are needed changes championed by leadership, and are their efforts in this area visible to staff, families and residents?		
Are staff members made aware of why change may be necessary, and are they willing to support culture-change efforts?		
Are respectful relationships formed with residents and families, and is this rapport cultivated over time?		
Transparency in admissions		
Are selection criteria clearly defined, and do they relate to activities of daily living, ambulation, medication management, need for supervision and mental status?		
Are marketing materials written with the goal of accurately describing organizational capabilities and limitations, thereby cultivating realistic expectations?		
Are marketing/advertising materials and resident agreements reviewed by legal counsel to eliminate exaggerated or unrealistic descriptions, promises or guarantees?		
Are marketing and admissions staff trained to discuss service limitations and degree of supervision at each level of care?		
Are prospective residents carefully evaluated in terms of their overall functional level and their suitability for different levels of care?		
Are service offerings and expectations discussed with residents and families before and soon after admission, as well as throughout the resident's stay?		
Are both residents and families given a clear understanding of services that are *not* available at the chosen level of care (e.g., assisted living, independent living, etc.)?		
Are resident retention criteria included in admission agreements, so that residents and families have a clear understanding of the types of occurrences and changes in condition that may result in transfer to another level of care?		

Measure	Present? Yes/No	Action Needed
Transparency in admissions (continued)		
Are transfer criteria and protocols explained to residents and family members, and do they acknowledge in writing that they understand and agree to these policies?		
Are residents and families informed that falls cannot always be averted, and that changes in health status are inherent to the aging process?		
Are residents assessed by clinical staff before rooms are assigned to ensure that they are being admitted to the appropriate level of care?		
Are facility policies regarding use of private nurses, nurse's aides and sitters communicated to residents and family members, and are available options presented during the admissions process?		
Are changing care and monitoring needs addressed in resident contracts as part of the facility's commitment to helping residents age in place safely?		
Resident/family education		
Are residents and families properly oriented to the fall-management program, and is this orientation documented?		
Are residents and families educated by staff about fall management and related protocols, and is it explained to them that the possibility and harmfulness of falls can be reduced but not eliminated?		
Are barriers to communication assessed and documented in the resident healthcare information record, where applicable, including cognitive impairment, low general and/or health literacy, and limited English fluency?		
Are residents asked to restate in simple language the fall-prevention/ management information they have been given, including the following:		
• **Common causes of falls,** as well as potential consequences?		
• **Recommended interventions,** as well as associated risks, benefits and alternatives?		
• **Resident and family responsibilities and expectations** related to fall prevention and mitigation?		
Are open-ended questions used to assess resident attitudes and better understand any perceived resistance to change?		
Are 10-point scales employed to identify resident priorities? (For example, "On a scale of 1 to 10, how important is it for you to walk outdoors on a daily basis?")		
Are residents and families asked to repeat back critical instructions, and are their responses noted in the resident healthcare information record, where applicable?		
Are resident and family expectations discussed throughout the resident's stay in an ongoing, proactive and documented manner?		

Measure	Present? Yes/No	Action Needed
Communication		
Are resident meetings held on a regular basis, and is there widespread participation?		
Are residents and families encouraged to articulate their own goals and preferences regarding ambulation and transfer, before staff members offer suggestions?		
Are questions and complaints elicited from residents and families, in order to avoid misunderstandings and prevent initially small problems from developing into major ones?		
Are residents and families taught how team-based care works and how it differs from private-duty nursing?		
Are staff members and providers trained to communicate proactively with residents and family, including …		
• **Initiating discussions with residents?** ("Take a moment to tell me if anything is bothering you right now.")		
• **Clearly articulating problems?** ("It seems to me your main concern is about fear of falling.")		
• **Encouraging feedback?** ("Are there other issues you wish to discuss or questions you want to ask?")		
• **Acknowledging emotions and unspoken concerns?** ("I know the topic of falling can cause worry.")		
• **Negotiating a practical course of action?** ("I have some ideas about how we can work together to help you stay on your feet.")		
• **Soliciting suggestions from residents about fall prevention?** ("What else can we do to help you stay on your feet?")		
• **Highlighting small accomplishments?** ("I see that you have been able to get around the facility safely by yourself.")		
• **Confronting noncompliance directly?** ("If you don't call for assistance when walking to the bathroom, the odds of falling and hurting yourself will significantly increase.")		

Measure	Present? Yes/No	Action Needed
Family councils		
Is a family council instituted and does it carry out important functions, such as …		
• **Addressing and resolving family and resident concerns** in a structured, documented and accountable manner?		
• **Offering ideas, suggestions and other constructive input** to organizational decision-makers?		
• **Educating families about internal policies, practices and new initiatives,** as well as state and federal laws and regulations?		
• **Welcoming and integrating new residents and their families to the facility,** via an ongoing peer-support system?		
• **Fostering trust between families and administrators** by enhancing communication and participation?		
• **Supporting and strengthening the facility** through social activity programming, fundraising and community advocacy?		
Are new residents and their families informed about the role and benefits of the family council in preventing misunderstandings and facilitating positive change?		
Is information about the family council made available to new and prospective residents through a dedicated website, emails to residents/families and regular orientation sessions?		
Are clear and accurate minutes kept of every council meeting, including the full names of participants, issues discussed, and decisions and suggestions made?		
Are council member comments and inquiries responded to in a thoughtful and courteous manner within a designated time frame?		
Are council inquiries responded to in writing, thus showing that the council is taken seriously by leadership?		
Noncompliance with fall-management measures		
Are staff members trained to respond effectively to hostile, manipulative or otherwise difficult residents/families, using role-playing scenarios and "real-life" techniques?		
Is an effort made to develop a mutually acceptable plan of care with noncompliant residents, taking the time to explain and document the potential consequences of failing to adhere to fall-mitigation recommendations?		
Are formal procedures established and implemented for managing residents who do not follow agreed-upon safety rules, including documentation of resident noncompliance and staff responses to it?		
Is staff proficiency in managing noncompliant residents monitored and are problems addressed, if necessary?		

Measure	Present? Yes/No	Action Needed
Resident transfer		
Has a formal policy been drafted that residents will be transferred to a higher level of care when necessary, i.e., when staff members observe that they are no longer safe in an independent or assisted living setting?		
Are residents and families educated regarding transfer policies and clinical criteria during the admissions process and periodically thereafter?		
Are residents continually monitored for signs that may indicate the need for transfer to a higher level of care, and is this monitoring included in the care/service plan?		
Are discussions regarding changing resident needs and safety considerations documented in the resident healthcare information record, and are summaries of these discussions conveyed in writing to residents and families?		
Prior to resident transfer, is a detailed fall-management plan developed to facilitate a safe and orderly transition? If the answer is yes, does this plan …		
• **Reflect input from the resident** and/or family members?		
• **Include a comprehensive assessment of the resident's condition** and care requirements?		
• **Address all resident needs and deficits** identified in the initial Resident Assessment Protocols and Minimum Data Set, as prepared upon admission?		
• **Explain why the transfer is in the resident's best interest** (e.g., because the new facility has care capabilities that the current setting lacks)?		
Complaint management		
Are residents and family members informed about reporting procedures in regard to care, treatment and resident safety issues?		
Has a formal complaint process been developed, and if the answer is yes, does the process include …		
• **Actively encouraging residents and their family members to share their concerns** with staff and leadership?		
• **Apologizing for inconvenience** or embarrassment caused by reported incidents?		
• **Documenting complaints** and resolving them immediately, if possible?		
• **Designating a staff member to investigate any complaints** that cannot be resolved immediately?		
• **Compiling facts via interviews with the resident** and/or family members, as well as any staff members involved?		
• **Formulating a solution** to address the resident's/family member's concern(s)?		
• **Following up with the resident/family** to ensure that the complaint has been satisfactorily resolved?		

Quick Links

- CNA *CareFully Speaking*® 2016-Issue 3, "Resident Falls: A Team Approach to Effective Intervention," which includes a fall-mitigation program self-assessment tool.
- CNA *CareFully Speaking*® 2018-Issue 2, "Strengthening Facility-Family Relationships: Transparency is Key."
- CNA *CareFully Speaking*® 2019-Issue 1, "Negotiated Risk Agreements: When and How Should They be Used?"
- CNA *CareFully Speaking*® 2020-Issue 2, "Documentation Deficiencies: Better Records Mean Stronger Defense."

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Allied Vendor Program

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