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Fall Pocket Guide:
Risk and Defensibility

Introduction

Falls are a leading cause of bodily injury for the elderly, as demonstrated by the following data from the Centers for Disease Control and Prevention:

- *Every year, one of three persons 65 years or older suffers a fall*, resulting in 2.5 million emergency department visits.
- *One of five falls causes serious harm*, such as broken bones or a head injury.
- *At least 250,000 older persons are hospitalized every year for hip fractures*, and more than 95 percent of these injuries are caused by falling (usually sideways).
- *Fall injuries result in $34 billion in direct costs every year*, with hospital costs accounting for two-thirds of the total.

As a major hazard for residents of aging services settings, falls also constitute a significant source of liability exposure for organizations. According to the CNA Aging Services Claims Report 2016, *Using Evidence to Achieve Excellence: Engage, Lead, Succeed*, resident falls account for 42.7 percent of the closed claims analyzed, far more than any other allegation. The study also shows that the average total cost (i.e., indemnity payment and expenses) of a fall-related closed claim during this five-year period is $186,589.

Clearly, falls are an abiding challenge for aging services organizations, requiring a risk management program that addresses both *risk* and *defensibility* factors. Risk refers to the likelihood of a particular adverse event or claim occurring, while defensibility gauges the organization's ability to successfully manage a claim that has been filed.

The better an organization understands its risk exposures, the more it can improve its practices, processes and procedures, thus reducing its risk exposure and enhancing its legal defensibility. Risk management activities both complement and strengthen the quality and safety aspects of a fall prevention and management program.

This fall pocket guide is designed to encourage a proactive, systematic approach to enhancing resident safety by minimizing the likelihood of resident falls and mitigating their consequences. It addresses such key risk areas as managing expectations, educating residents and families, improving documentation and creating an organization-wide culture of safety. After reviewing and completing the tools and exercises, teams are encouraged to develop the next steps in improving their fall and risk management programs.

This guide contains various sample forms and tools that serve as a reference for organizations seeking to address and evaluate risk exposures associated with resident falls. The content of these materials is not intended to represent a comprehensive discussion or listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the forms/tools to suit your individual practice and resident needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

Fall *Risk* Assessment and Prevention

Questionnaire: Expectations Management

Claims are often the result of failure to effectively manage resident and family expectations. The following questions can help indicate areas of potential improvement in terms of communication and resident education. After answering these questions with a *yes* or *no* response, consider what steps can be taken to address identified lapses and strengthen the process of managing expectations.

COMMUNICATION
Do staff members communicate with residents and families in their primary language and respect cultural traits and preferences?
Are interpreters available when necessary, and are they fully qualified and credentialed?
Are questions and complaints elicited from residents, families and team members, in order to avoid communication breakdowns?
Are resident and family council meetings held on a regular basis, and is there widespread participation?
Do staff members and providers …
▪ Initiate discussions with residents? (*"Take a moment to tell me what is bothering you right now."*)
▪ Work to identify problems? (*"It seems to me your main concern is about fear of falling."*)
▪ Encourage feedback? (*"What other issues do you wish to discuss, or questions you would like to ask?"*)
▪ Acknowledge emotions and unspoken concerns? (*"Help me understand your feelings about safety and mobility."*)
▪ Negotiate a practical course of action? (*"Let's talk about how we can work together to help you stay safely on your feet."*)
▪ Highlight small accomplishments? (*"I see that you have been able to get around the facility by yourself."*)
▪ Confront noncompliance directly? (*"If you don't take your medications daily, the odds of falling and hurting yourself will only increase."*)

COMMUNICATION (CONTINUED)

Do staff members and providers ask residents and families to restate major points, in order to confirm that they understand our messages?

Do staff and providers ask open-ended questions, i.e., "What questions do you have?" rather than "Do you have any questions?"

When staff and providers talk to residents and families, do they sit rather than stand, to create better rapport and prevent the appearance of being in a hurry?

Are staff trained to communicate with difficult and noncompliant residents, and is their proficiency monitored and addressed if necessary?

Do staff and providers pause at the end of discussions, thus allowing residents and families to have the last word?

Are residents asked about their goals, and are their responses taken seriously?

Do staff and providers solicit resident input about falls, e.g., by asking "What else can we do to help you prevent a fall"?

Do staff and providers explain to residents and families how team-based care works and how it differs from private duty nursing?

Are marketing/advertising materials and resident agreements reviewed by legal counsel to detect presence of unrealistic expectations, promises or guarantees?

RESIDENT EDUCATION

Are residents and families oriented to the fall prevention program?

Do staff and providers educate residents and families on fall prevention and management, and explain that the possibility of falls can be reduced but not eliminated?

Are barriers to communication assessed and documented in the resident healthcare information record, including low general and/or health literacy, cognitive impairment and limited English?

Do providers utilize the "teach-back" technique to ensure understanding of proposed treatments, services and procedures, and is use of this method documented in the resident healthcare information record?

Has the organization considered the benefits of hiring a health coach, health navigator and/or case manager? (See "Case Management: Six Principles to Enhance Care Delivery," CNA *Vantage Point®*, 2013–Issue 2.)

Upon admission, are all residents provided written information concerning their right to make decisions about their care, including the right to refuse recommended treatment?

RESIDENT EDUCATION (CONTINUED)
Are residents asked to explain in simple language the fall prevention and management information they have been given, including:
▪ *Basic risks* related to falling?
▪ *Recommended interventions*, as well as associated risks, benefits and alternatives?
▪ *Resident responsibilities* associated with the recommended intervention(s)?
Are open-ended questions used to gauge residents' resistance to change?
Are 10-point scales used to identify resident priorities? For example, "On a scale of 1 to 10, how important is it for you to …?"
Do providers ask residents and families to repeat back critical instructions, and are their responses noted in the resident healthcare information record?
Are staff and providers prepared to address noncompliance among residents and families?
Prior to discharge, is a detailed fall prevention plan developed to facilitate a safe and orderly transition to the home or another care setting?
Does the discharge summary …
▪ *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)?
Do discharge instructions include discussions about the resident's fall history, as well as the plan of care?
CULTURE OF SAFETY
Has a safety culture assessment been completed and any corrective actions taken and evaluated?
Is leadership motivated to make changes and willing to support change efforts?
Are staff motivated to make changes and do they understand why change is necessary?
Are leadership efforts visible to staff, families and residents?

Checklist: Fall Risk and Defensibility

The following checklist is designed to help organizations evaluate their fall risk and defensibility. After completing the checklist with *yes* or *no* responses, formulate an action plan for identified lapses on the form provided.

RISK	YES/ NO	DEFENSIBILITY	YES/ NO
Organizational culture empowers employees regarding resident safety.		*A formal customer services program is in place,* which emphasizes the need to convey realistic expectations.	
Fall risk assessments are conducted upon admission, on a quarterly basis, with any change in condition and after each fall.		*A written risk management plan has been developed,* addressing fall prevention and other critical issues.	
The facility's staffing ratio for resident care is sufficient to enable provision of high-quality, individualized care.		*Written fall prevention protocols are in effect,* covering both assessment and interventions.	
There is an active Quality Assurance/Risk Management/ Resident Safety Committee, which addresses resident falls.		*All fall risk assessments are accurately documented* and included in the resident healthcare information record.	
Fall prevention strategies are in place, encompassing visual identifiers, bowel and bladder training, equipment to mitigate falls, assessment time frames, etc.		*Fall prevention protocols are regularly audited* for effectiveness and staff adherence.	
All clinical and non-clinical staff participate in fall prevention training, as do volunteers, residents and families.		*Marketing documents undergo legal and leadership review* to ensure that they contain accurate descriptions and convey realistic expectations.	
Resident care plans address fall risks and include individually tailored preventive measures.		*Clinical fall risks and preventive measures are documented* in residents' care plan.	
A consulting pharmacist reviews resident medications, participates in med-pass audits and reports findings to the Quality Assurance Committee.		*Medication management protocols are in written form* and consistently implemented.	

RISK	YES/ NO	DEFENSIBILITY	YES/ NO
Resident falls are reported and investigated promptly by an inter-disciplinary team.		*Residents and families are educated about fall prevention*, and this effort is documented.	
Resident clinical rounds are conducted frequently, as are environment of care rounds.		*The fall prevention protocol is reviewed* on at least an annual basis.	
Robust window restrictors are installed, if these are permitted by local fire marshal regulations.		*The physical environment is evaluated for fall hazards on a regular basis* and the safety rounding process is documented.	
Fall rates are calculated, tracked and trended for ongoing fall prevention program evaluation.		*All records are retained* in accordance with the facility's document retention policy and state requirements.	

Develop an action plan to address any "No" responses.

ITEMS NEEDING ACTION:	PROPOSED ACTION(S):	RESPONSIBLE INDIVIDUAL(S):	COMPLETION TIMELINE:
1.			
2.			
3.			
4.			

Self-assessment Tool: Fall Prevention Program

Approximately half of all aging services residents experience a fall during the course of a year, making falls one of the most frequent sources both of injuries and professional liability claims. Reducing both the number and consequences of resident falls should be a top priority for every aging services provider.

The following self-assessment tool is designed to help facilities evaluate the effectiveness of their fall prevention program, as well as to spur team discussion and action. Questions are organized by functional discipline and appropriate respondent.

CLINICAL (To be completed by director of nursing)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK PREVENTION		
Does the fall assessment process include all relevant indicators, such as …		
- Fall history?		
- Vestibular (i.e., balance) and gait evaluation?		
- Vision assessment and eyeglass/bifocal use?		
- Medications?		
- Weight loss and hydration?		
- Comorbidities?		
- Pain?		
- Cognitive level?		
- Use of appliances and assistive devices?		
Are resident fall assessments conducted and documented …		
- Upon admission?		
- At least quarterly?		
- With any change in condition?		
- After a fall?		

CLINICAL (To be completed by director of nursing)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK PREVENTION (CONTINUED)		
Are higher-risk residents identified with a falling star/leaf, color-coded wristband or other similar tag?		
Are staff trained to respond promptly to all alarms, and are response times monitored?		
Are proactive bowel and bladder training programs in place for residents who need them?		
Is delirium included as a risk factor in the fall assessment protocol?		
RISK MANAGEMENT		
Is "resident fall" clearly defined by the organization for reporting and quality improvement purposes?		
Are unwitnessed resident falls addressed by written policy and procedure?		
Does the fall prevention program include …		
- Avoidance of restraints, unless clinically indicated and deemed necessary by a qualified healthcare professional?		
- Rehabilitation consultations?		
- Pharmacy consultations?		
- Dietary consultations?		
- Care plans that accurately reflect the resident's risk of falling and interventions taken?		
- Documentation of falls and interventions in the resident health-care information record?		
- Assignment of higher-risk residents to rooms near the nursing station?		

CLINICAL (To be completed by director of nursing)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK MANAGEMENT (CONTINUED)		
- Wearing of emergency call pendants?		
- Teaching residents to dangle their legs before rising from bed?		
Are clothing-related safety guidelines in place to ensure that residents are …		
- Checked to make certain that pant legs do not touch the floor?		
- Instructed not to wear slip-on tops or other clothing that is pulled over the head?		
- Prohibited from walking around in bare feet, socks or unfastened shoes?		
Are resident shoes evaluated on a regular basis to ensure that they fit well and have low, unworn heels and thin, hard, non-slippery soles?		
Are incident reports completed on a timely basis following falls?		
Is there a written refusal of care policy and procedure, which includes a form for residents or family members to sign?		
Is noncompliance with the care plan documented in the resident's healthcare information record?		

ENVIRONMENTAL SAFETY (To be completed by maintenance director)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK PREVENTION		
Do safety inspections occur regularly, and are results documented?		
Are floor and step surfaces assessed throughout the facility, including stairways, hallways and bathrooms?		
Is there an NOAA weather radio in the office to monitor changing weather conditions?		

ENVIRONMENTAL SAFETY (To be completed by maintenance director)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK MANAGEMENT		
Is campus lighting adequate, indoors and out?		
Are sturdy handrails present in hallways and bathrooms?		
Are floor mats used for wiping wet shoes?		
Are spills immediately mopped, as well as melt spots?		
Are snow removal protocols in place, and is their effectiveness monitored?		
Are leaves promptly removed from footpaths and parking areas?		
Do carpets have low pile and tacked-down edges?		
If scatter rugs must be used, are they backed with non-skid material and never placed at the top or bottom of stairs?		
Are skid-proof or rubber strips placed near sinks and other areas with potential puddles?		
Have elevated doorjambs been eliminated to prevent tripping?		
Are floor patterns carefully chosen to reflect changes in floor level?		
Are all electrical cords tacked down and extension cords prohibited?		
Are pathways and traffic areas free of obstacles and clutter that may be tripped over?		
Are floors tested for coefficient of friction?		
Are stairs free of objects and clutter, and are they:		
- Built without overhanging treads?		
- Checked regularly for looseness or unevenness?		

ENVIRONMENTAL SAFETY (To be completed by maintenance director)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK MANAGEMENT (CONTINUED)		
- Free of torn or curled carpeting, if carpeted?		
- Equipped with non-skid treads, if wooden?		
- Equipped with well-marked and lighted edges?		
- No more than six inches high?		
- Equipped with handrails on both sides?		
Are stairwell doors alarmed to signal potential resident elopements?		
Do corridors have handrails installed at proper height, where needed, as well as …		
- Benches placed at regular intervals?		
- Bright, glare-free lighting, day and night?		
- Non-skid, non-slip surfaces?		
Are closets and storage areas free of clutter and piles, which could fall and cause accidents?		
Are laundry chutes locked when not in use?		
Is furniture checked for stability on an ongoing basis?		
Is furniture positioned in a non-obstructing pattern, providing a clear route for foot traffic?		
Are furniture and counters at an appropriate height to minimize stretching or bending?		
Do chairs and couches provide good body support and allow residents to sit with their legs at a 90-degree angle?		
Are chair arms long enough to provide full support when sitting down and getting up?		
Do chairs have non-slip "feet," especially in examination and treatment areas?		

ENVIRONMENTAL SAFETY (To be completed by maintenance director)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK MANAGEMENT (CONTINUED)		
Are procedure tables equipped with proper safeguards, such as side rails, grip handles and step risers?		
Is bed height correct for residents, permitting their feet to touch the floor with their knees at a right angle?		
Are body-length pillows placed on the sides of beds to create safe barriers against falls?		
Do beds have a support rail for transitions in and out of bed?		
Are bed wheels always locked properly when the bed is not being moved?		
Is shelving within reach and sturdily affixed to the wall?		
Do shelving and countertops have rounded edges for safety in case of slips or falls?		
Do all drawers and doors open easily and stay closed?		
Are wheelchair seats sufficiently cushioned to prevent irritation?		
Are wheelchairs always locked properly when in place, and do they have anti-rollback devices?		
Do bathrooms have grab bars in baths and near toilets, as well as …		
- Hand-held showers?		
- Non-skid mats or flooring surfaces in baths/showers?		

ENVIRONMENTAL SAFETY (To be completed by maintenance director)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK MANAGEMENT (CONTINUED)		
- Seats in baths/showers?		
- Support rails on toilets?		
- Weight-bearing towel rods?		
- Emergency call cords?		
- Elevated toilets with contrasting black seats?		
Is special attention paid to outdoor fall hazards, including …		
- Changes in elevation (e.g., stairs, doorways, uneven terrain)?		
- Shadow-full light contrast?		
- Low or unstable chairs and benches?		
- Unpaved paths and parking lots?		
- Shifting weather conditions?		
- Transitional areas (e.g., entrances, garages, patios)?		
Is lighting designed with an eye for safety, including the use of …		
- Glare-free, 60 to 100 watt, non-fluorescent bulbs?		
- Backlit light switches located near doors?		
- Motion-detector switches, where appropriate?		
- Bedside lights within easy reach?		
- Automatic nightlights in bathrooms?		
- Non-glare paint?		

OPERATIONAL (To be completed by administrator/ risk manager)	PRESENT? YES/NO	ACTION(S) NEEDED
RISK PREVENTION		
Are residents, families and staff educated on an ongoing basis about fall prevention and management techniques?		
Are staff educated about the potential side effects of medications, as well as drug interactions that can precipitate falls?		
RISK MANAGEMENT		
Are post-fall huddles conducted with team members and the resident?		
Are injurious falls promptly written up using incident report forms?		
Is there a formal fall investigation process, which is carefully documented?		
Does each shift provide a report on resident falls, as well as near misses and identified hazards?		
Is the potential for polypharmacy determined using an interdisciplinary quality improvement/risk management process that includes pharmacist consultation?		
Are fall data tracked, trended and reported to the designated committee?		
Are fall data and analysis translated into an action plan to reduce falls and mitigate injuries?		
Does the organization monitor fall-related costs against national norms?		

Formula: Calculating Fall Rates

Fall rates should be calculated at least quarterly, based upon the information from incident reports and daily census. Follow these steps:

1. Count the number of falls during designated time frame (monthly or quarterly) from the incident reporting system.
2. Determine total number of beds occupied.
3. Divide the number of falls by the number of occupied beds.
4. Multiply the result by 1,000.

EXAMPLE:

The incident reporting system indicates there were 15 falls during the month of August (31 days).

1. Determine the total number of occupied beds by identifying your census for each day of the month, at the same time of the day. In this case, the unit's occupancy was 30 each day. Multiply: 30 x 31 days. The total occupied beds was 930.
2. Divide number of falls by total occupied beds: 15/930=0.016
3. Multiply your previous result by 1,000: 0.016 x 1,000=16.
4. Answer: Fall rate was 16 falls per 1,000 occupied bed days, or 1.6%

Source: www.AHRQ.gov

Analyze calculated fall rates over time, asking the following questions, among others:

- Does the fall rate vary significantly over time?
- Is there a rising or declining trend in falls?
- Do changes in the fall rate correlate with different policies, practices or personnel?
- Are fall-related costs increasing or decreasing?

Enhancing Documentation, Response and *Defensibility*

Informed Refusal Documentation Form

"Informed refusal" is the counterpart of informed consent, an acknowledgement by residents or family that, before rejecting any care recommendations, they have been thoroughly advised of potential consequences. The following standard form is designated to help organizations appropriately document that they have fully disclosed the risks, benefits and potential ramifications of accepting or declining recommended treatments and safety measures, including fall prevention/management programs.

Each resident's capacity to understand and make decisions about treatment issues should be evaluated and documented in the resident healthcare information record. If residents are incapable of making an informed refusal, they must be represented by a family member or other individual granted power of attorney.

INFORMED REFUSAL

1. I and/or my guardian and family members have been advised by the medical and clinical team of my proposed care/service plan.
2. I and/or my guardian and family members have been given the opportunity to participate in the care/service planning process.
3. The proposed care/service plan has been fully explained to me and/or my guardian and family members, and I/we understand the…
   - *Nature of the recommended therapy and/or treatment.*
   - *Purpose of and need for the recommendations.*
   - *Possible alternatives to the recommended therapy and/or treatment.*
   - *Potential consequences of forgoing the recommended therapy and/or treatment.*
4. I/we understand that in choosing to exercise my right to refuse therapy and/or treatment, I may be endangering my health or life.
5. My/our reason for declining *[insert therapy or treatment being declined]* is as follows:

_____

_____

_____

6. *[The following release is optional.]* I/we assume the risks and consequences attendant upon my freedom of choice, and release for myself, heirs, executors, administrators or personal representatives those healthcare professionals who have designed/consulted on my plan of care/service from any and all liability for ill effects that may result from my choice.
7. I/we acknowledge that I/we have read this document in its entirety, that I/we fully understand it and that all blank spaces have been completed or crossed off prior to my/our signing.

Date: _____ Time: _____

Signature of resident or guardian: _____

WITNESSES:

Signature of family member or other witness: _____

Signature of family member or other witness: _____

Policy and Procedure Template Guide

Useful, well-drafted, regularly reviewed policies and procedures are an essential component of any risk control program, including fall prevention initiatives. By formalizing organizational standards and expectations, written policy statements can help promote quality of care, clarify staff roles and responsibilities, and strengthen the legal defense of the healthcare facility in the event of litigation.

The following generic template can help streamline the policy development process, while helping ensure that no important information is omitted. Of course, actual organizational protocols should be tailored to specific needs, capabilities and resources.

I. HEADER

The header section includes:

- *Policy title*, which should be brief and descriptive.
- *Policy number*, to track updates.
- *Policy status* (i.e., in effect, since revised or obsolete).
- *Date* on which the policy was approved, reviewed and/or revised.
- *Area or unit* that drafted the policy and to which it applies.

II. PURPOSE

The purpose section summarizes the policy's objectives and explains why it is necessary to take this action.

III. DEFINITIONS

The definitions section explains technical terms for the benefit of novice readers and contextualizes potentially ambiguous words.

IV. POLICY

The policy section provides a historical, legal and/or ethical framework for the new or revised protocol and describes intended outcomes.

V. PROCEDURE

The procedure section is designed to do the following:

- *Outline* the basic processes involved.
- *Identify* the participants and their specific responsibilities.
- *Instruct readers* in a step-by-step manner as to how the policy is to be implemented.
- *Refer to other guidelines*, documents and other materials needed to implement the policy.

VI. RELATED POLICIES AND FORMS

The related policy section cites key background information, including:

- *Companion policy statements* that help clarify the issues.
- *Relevant federal and state laws*, plus accreditation and regulatory standards.
- *Standardized forms* used to implement the policy/procedure.

VII. REVIEW

The review section lists necessary reviewers – e.g., department or unit managers, executive leadership, the medical director, governing board members and chair of the policy and procedure review committee. It also schedules the steps of the approval process and contains a signature block to document reviewers' approval.

Fall Documentation Audit Tool

RISK CONTROL CRITERION	PRESENT? YES/NO	ACTION(S) NEEDED
PRE-FALL		
An accepted screening tool is used to assess fall risk, with evaluation results documented in the resident healthcare information record and care plan.		
Fall assessments are documented upon admission, following any change in condition and at least quarterly.		
Residents are asked about previous falls and near-falls, and answers are noted in their healthcare information record.		
Residents are examined for evidence of confusion, disorientation and memory lapses, as well as other signs of impaired cognitive status.		
Visual acuity is checked and signs of impairment are noted, including decreased night vision, altered depth perception, decline in peripheral vision and glare intolerance.		
A history of acute illness is obtained, including strokes, seizures, orthostatic hypotension, urinary tract infections and febrile states.		
Chronic degenerative illnesses are documented, including arthritis, cataracts, dementia and diabetes.		
Use of medications affecting the central nervous and/or cardiovascular system is noted in the resident healthcare information record, including tricyclic antidepressants, benzodiazepines, anticonvulsants, sedatives, hypnotics, antihypertensives, hypoglycemics, diuretics and vasodilators.		

RISK CONTROL CRITERION	PRESENT? YES/NO	ACTION(S) NEEDED
PRE-FALL (CONTINUED)		
Residents vulnerable to falls are identified and fall risk is flagged in the resident healthcare information record.		
Residents are monitored as needed in compliance with the care plan, and monitoring efforts are documented.		
Fall prevention measures and equipment are evaluated for effectiveness, including lowered beds, bed alarms, call bells, enhanced lighting, non-slip flooring, etc.		
POST-FALL		
Resident accounts of falls are documented with direct quotes indicated by quotation marks.		
All physician and family notifications, orders and communications are documented, including post-fall transfers to acute care facilities.		
Resident assessments are updated following a fall.		
Post-fall clinical interventions are documented, as are revised resident care plans.		
Incident reports are not mentioned in the resident healthcare information record, in order to protect confidentiality.		
Fall incidents are tracked and trended by a quality and safety advisor so that processes can be continually enhanced.		

Fall Management Competencies

The effectiveness of a fall prevention program depends upon the competence and commitment of all staff members. Staff members must communicate clearly, work together effectively, and understand their own and their colleagues' roles and responsibilities.

The following recommendations help organizations ensure that staff members are proficient in basic core competencies regarding falls prevention:

- *Staff regularly participate in fall prevention education and training sessions*, and their attendance is documented.
- *Staff can identify major fall risk factors* and take steps to minimize risk.
- *Staff can access fall-related policies and procedures* and refer to them when necessary.
- *Staff implement fall precautions* at all times.
- *Fall prevention and management input is solicited* from all staff, residents and family members.
- *Staff continually assess and monitor resident comorbidities, changes in resident conditions and other health-related risk factors*, e.g., urinary tract infection, dehydration, elevated blood sugar, polypharmacy, etc.
- *Staff carefully document all resident assessments*, as well as fall prevention and management efforts.
- *Staff reassess residents regularly* to determine whether existing fall prevention care plans remain pertinent, and update them as needed.
- *Staff select appropriate assistive devices* to promote fall prevention.
- *Staff conduct post-fall reviews* via "huddles" and other communication techniques.
- *Staff revise the fall care plan* when a resident's condition changes.
- *Staff report all unwitnessed falls*, which should be fully investigated.

Conducting Root Cause Analysis

SCENARIO

Following lunch, the skilled nursing facility resident was found on his bathroom floor. He reported that he had rung his bell for help, but nobody came before he fell. He was transferred to the hospital, where he underwent surgery to treat a femoral fracture.

The resident returned to the skilled nursing facility a week later for physical therapy and rehabilitation. He had declined significantly during the hospital stay and now experienced confusion as well as stiffness of the extremities. His readmission care plan included use of a wheelchair at all times when out of bed, use of bed and wheelchair fall alarms, help with all personal care needs and two-person transfer assistance.

Despite receiving nursing and rehabilitation care, the resident continued to weaken rapidly. Three weeks later, he developed a urinary tract infection, septic shock and hypotension. He was readmitted to the hospital but did not respond to treatment. The family consented to a Do Not Resuscitate order, and the resident died shortly thereafter.

ANALYSIS

STEP 1 *Assemble a multidisciplinary team* to review the event and identify what went wrong.

STEP 2 *Decide which disciplines are most relevant* and should participate in the process.

STEP 3 *Analyze the data*, asking the following questions, among others:

- When and where did the event occur?
- Who was on duty at the time of the incident?
- Have other similar incidents happened at that time or in that area?
- What fall prevention safeguards were in place at the time of the incident?
- Was the resident considered at heightened risk for falls?
- Did the resident's care plan specifically address fall prevention?
- What is the usual response time when a resident rings a bell?

STEP 4 *Discern the root cause of the event* by suggesting initial reasons why the fall occurred, then asking "Why?" or "How come?" multiple times until the team agrees on underlying causes, such as staffing issues, process flaws or lapses in training.

STEP 5 *Determine if existing fall policies and procedures had been followed*, and if they are unlikely to prevent a recurrence.

STEP 6 *Reach a consensus regarding the changes that should now occur* to prevent this type of fall from happening again.

Post-fall Huddle Worksheet

This outline is designed to help organize a post-fall team discussion and review, under the direction of the facility's quality assurance and improvement committee.

F-A-L-L HUDDLE WORKSHEET

(Insert institutional quality confidentiality language. This worksheet is not part of the resident healthcare information record.)

FRAME OBSERVATIONS.

Elect a recorder to compile and record objective findings in a statement below. This step will help ensure that participants focus on the same key facts and findings.

_____

_____

_____

ASK *"HOW COME?"*

Next, ask "How come it happened?" five times in a row, addressing each question to the previous answer. Record each answer below.

1. How come? _____

_____

2. How come? _____

_____

3. How come? _____

_____

4. How come? _____

_____

5. How come? _____

_____

LOOP BACK.
Next, look at answer number 5 and ask "How come it happened?" Continue this reverse process, ending with Answer 1. Record answers here.

1. How come? _____

_____

2. How come? _____

_____

3. How come? _____

_____

4. How come? _____

_____

5. How come? _____

_____

LISTEN TO THE ANSWERS UNTIL PARTICIPANTS ARE IN AGREEMENT.
Record investigative findings and recommendations below.

_____

_____

Date/time completed

_____

Participant signatures (Print name and title)

_____

_____

Adapted from: www.isixsigma.com, www.mindtools.com.

Testing Knowledge and Taking Action

Fall Prevention Test

QUESTIONS FOR GROUP DISCUSSION – *TRUE* OR *FALSE?*

1. ____ A resident fall with injury usually results in a lawsuit.
2. ____ Approximately 25 percent of fall-related liability claims focus on the quality of the documentation within the resident healthcare information record.
3. ____ Charting all care at the end of the shift is an acceptable practice.
4. ____ Incomplete information in the resident healthcare information record can be difficult to defend.
5. ____ If a resident falls, document in the resident healthcare information record that an incident report was completed.
6. ____ If a late entry regarding a resident fall is to be made in the healthcare information record, it should be labeled as such.
7. ____ Resident fall assessments are completed only upon admission and on a quarterly basis thereafter.
8. ____ Proactive bowel and bladder training is a critical fall prevention strategy.
9. ____ Use of assistive lifting devices can contribute to falls.
10. ____ Contaminants, cleaning products, general wear and tear, and use of chemical coatings and sealants can all affect the slipperiness of a floor or step.
11. ____ It is appropriate to place quotation marks around residents' comments in healthcare information records and incident reports.

ANSWERS

1. (F) Not all falls with injuries result in claims, especially if the resident is generally satisfied with the care provided and documentation is adequate.
2. (F) Many liability determinations hinge on the quality of documentation.
3. (F) Charting should be performed contemporaneously with care.
4. (T) Missing information can give the impression of deficient care.
5. (F) Incident reports should never be part of the resident healthcare information record.
6. (T) Late entries should be identified as such in the record.
7. (F) Resident fall assessments should be conducted upon admission, quarterly, following any change in condition and after a fall.
8. (T) Toileting programs have been shown to decrease the risk of falls.
9. (T) As incorrect use of assistive lifting devices can result in falls, policies and procedures must be followed when utilizing them.
10. (T) Floor and stair surfaces are a significant fall risk factor.
11. (T) Direct quotations are a useful means of capturing facts and strengthening legal defensibility.

Next Steps

WHAT ARE THE NEXT STEPS FOR YOUR FALL PREVENTION PROGRAM?

GOALS	STRATEGIES	EVALUATION*
1.		
2.		
3.		
4.		
5.		

* Does the fall rate vary significantly over time? Is there a rising or declining trend in resident falls? Do changes in the fall rate correlate with different policies, practices or personnel? Are fall-related costs increasing or decreasing?

Additional Resources

Fall Prevention Resource Publications

- CNA *Carefully Speaking*, Republished 2015. "Policy and Procedure: Developing Effective Protocols for Aging Care Settings."
- CNA *Carefully Speaking*, 2014–Issue 1. "Risk Assessments: How They Help, Why They Matter."
- Important Facts about Falls, from the Centers for Disease Control and Prevention, updated September 29, 2016.
- "Keeping Your Customer Safe: Controlling Slips, Trips and Falls," from CNA, 2015.
- "Practical Resources to Aid in Safeguarding Residents and Minimizing Risk," from CNA, 2015.
- Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care, from the Agency for Healthcare Research and Quality, 2013.

For more information, please call us at 866-262-0540 or visit www.cna.com/healthcare.