



# Fall Risk Management

## Evidence-Based Best Practices

### **Overview:**

Falls present a serious health problem for persons aged 65 and over. Falls are the leading cause of injury and the most frequent cause of death from an injury in this age group, with over 35,000 fall-related deaths reported in 2019.<sup>1</sup> Not all falls result in injury, but out of those that do, 10-25% are severe.<sup>2</sup>

Adults that sustain fall-related injuries not only experience pain and suffering but may develop functional decline. This places them at greater risk for future falls. In addition, they may no longer be able to perform activities of daily living or engage in social events, which diminishes their quality of life.<sup>3</sup>

To effectively reduce falls, one must realize that they are multifactorial in nature. They may involve individual risk factors as well factors related to the person's environment and the practices of the facility in which they reside. To promote an effective fall prevention program, a facility must systematically assess these risk factors, target them with interventions to mitigate risk, monitor for effectiveness, and revise them as needed.

Achieving an effective fall management program requires a no-blame culture with strong leadership and the necessary financial/human resources.

### **Assessment:**

Fall risk assessments are completed within 24-hours of admission, with changes of condition, after a fall, and quarterly. Documentation includes evaluation/documentation of the following areas to identify the presence of fall risks:

- Fall history (repeat faller)
- Gait and balance (instability)
- Lower extremity strength (weakness)
- Medication regimen (presence of high-risk medications and polypharmacy)
- Orthostatic (postural) blood pressure measurements, with documentation of the actual values (drop of 20mmHg systolic or 10mmHg diastolic lying or sitting to standing; or pulse decrease of 10 BPM sitting or standing to lying)

- Underlying mental and physical conditions (vision impairment, urinary incontinence, vitamin D deficiency, dementia, arthritis, cardiac conditions, syncope, neuropathy, myopathy, foot conditions)
- Footwear characteristics (soft or slippery soles, reduced sole contact, high heels, low collar)
- Environmental issues (assistive device ill-fitting, not working, or not used properly; inadequate supervision; slippery or uneven floor; furniture or toilet not at proper height; no grab bars, hallway with no handrails; lighting too bright or dim; loose cords)

#### After a fall:

- A post-fall investigation is initiated within 24 hours. This includes an assessment with rereview/re-evaluation and documentation of the above areas that can present fall risks.
- In addition, the NF should investigate the fall, including:
  - Check and document vital signs (with orthostatic vitals), symptoms, neuro exam, injuries, and notify representative and physician
  - Interview witnesses to the fall
  - Collect details on **who, what, when, where, why** (what doing and feeling, time of day, location, circumstances)
  - Determine causal factors (cognitive state, presence of acute illness, condition symptoms, recent meds or med changes, environmental factors)

#### **Care Plan:**

A comprehensive care plan is completed within 24-hours of admission, with changes of condition, after a fall, and at least annually, and includes:

- Person centered goals (based on person's priorities, preferences, limitations, etc.), and measurable objectives/timeframes for achieving goals
- Planned interventions that target risk factors identified with the fall risk assessment
- Review/updating of interventions based on the findings of reassessments and post-fall investigations/fall causal factors
- Interdisciplinary team (IDT) involvement in identifying interventions to prevent falls/care planning
- Documented efforts to involve the person and/or their representative in care planning.

#### **Outcomes:**

Monitoring, data collection, and analysis to ensure:

- Individualized interventions identified in the care plan are implemented.
- Monitoring and evaluation of intervention effectiveness is done.
- Care plans are revised as necessary.
- Meaningful measures are used:
  - Facility fall rate
  - Number of people who fall each month
  - Number of people with two or more falls each month (repeat fallers)

- Number/percent of falls with serious injury each month (define serious)
- Percent fall assessments completed within 24 hours of admission/readmission
- Percent care plans containing fall interventions as needed
- Percent care plans with fall interventions up to date (revised as necessary)

**System:**

An effective fall prevention system includes:

- Written policies and procedures related to the overall management of the fall management program (assessment, care planning/interdisciplinary involvement, outcomes), as well as supporting policies.
- A communication and reporting system to notifying facility leadership/staff and tracking falls of people living in the facility.
- Training for new and existing staff and education for residents and families regarding fall prevention.
- An Interdisciplinary Care Team (IDT) that participates in review, revision, and monitoring of care plans and the effectiveness of the fall management program.
- Availability of multidisciplinary resources to provide comprehensive evaluation when needed for people who live in the facility.
- Procedures established/followed for maintaining equipment in safe operating condition and training people/staff on fitting and use.
- Procedures established/followed for proactive monitoring to ensure a safe environment (environmental rounds, observing for adequacy of supervision, reporting and addressing identified risks quickly).
- Systematic collection/analysis of data to monitor the program and improvement through intervention, revising care plans and modifying facility practices.

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<sup>1</sup> Centers for Disease Control and Prevention. [Older Adult Fall Prevention](#). CDC Web site.

<sup>2</sup> Rubenstein LZ. Falls in older people: epidemiology, risk factors and strategies for prevention. *Age Ageing*. 2006;35(Suppl 2):ii37-ii41.

<sup>3</sup> Becker C, Rapp K. Fall prevention in nursing homes. *Clin Geriatr Med*. 2010 Nov;26(4):693-704.