**Prevention of Falls**
**Learner's Guide**

**Goal:**
You will learn about the effects of falls on the elderly, the factors that increase the risk of falls, and steps you can take to help prevent or decrease the chances of falls happening. You will also learn about the use of restraints in relation to falls.

**Objectives:**
1. At the end of this session, you will be able to:
2. Discuss some of the effects of falls on the elderly.
3. Identify internal and external causes of falls.
4. Identify risk factors for falls.
5. Describe ways to prevent falls.
6. Explain when a restraint can and cannot be used and risks of restraint use.
7. Develop a specific plan to prevent or decrease future falls.

**Take note:** Review your organization's policies and procedures on fall prevention, including risk assessment and treatment after a fall; restraint usage; planning for restraint removal; documentation; and communication among staff of preventive measures for at-risk-for-falls residents.

**Learning Strategies:**

To complete this lesson, follow these steps:
1. Read the materials provided in each unit of this lesson.
2. Complete the practice exercise or question for each unit.
3. Complete each activity unless instructed otherwise.
4. Read the lesson review.
5. Complete the final content assessment.

After completing all of these steps, print two copies of the completed activity forms; one to give to your education coordinator and one to keep for yourself.

**Related Topics:**  
Accident Prevention  
Bowel and Bladder Incontinence Management  
Caring for the Resident with Dementia  
Sensitizing Staff to Growing Old

**Introduction:**

Falling used to be considered a natural part of growing old. We now know that falls are not part of the normal aging process although incidents of falling do seem to increase with age. Twenty-five percent of persons age 65-74 living outside long-term
care communities fall each year. At age 75, this increases to 33%. Persons living in long-term care organizations fall more often. This is probably because they are frail with more medical problems. About 50% of older adults in organizations fall every year with at least 40% of those who fall do so multiple times. The combination of age-related changes and multiple interacting risk factors double jeopardizes older adults by increasing the probability of both falls and fractures. Falls for the frail elderly can result in serious injury or even death.

This training session will acquaint the caregivers in the long-term care community with information about residents who are at risk for falling. It will also discuss steps to prevent falls.

**Unit 1: Goal:**

You will learn about the effects of falls on the elderly and the internal and external factors that contribute to falls.

**Effects of Falls**

About 25% of all falls result in serious injury among the elderly. Serious injury includes head injuries, fractures, and soft tissue injury such as internal bleeding, sprains, and lacerations.

Falls are one of the most common reasons older adults are admitted to hospitals or long-term care communities. Persons responsible for the care of older adults often feel guilty when a fall occurs, as if they were not giving adequate care. Their response is often to restrict the older adult’s activities and independence.

Falls are embarrassing and painful for older adults. Many studies confirm that falls and fractures contribute to long-term functional decline and impairment. For example, as many as 75% of those who are independent before a hip fracture can neither walk independently nor achieve their previous level of independent living within one year of the fracture. Another example from the studies shows that 18-33% of older people who fracture a hip die within a year. Deaths are rarely a direct result of the fall, but from its accompanying effects, such as infections and immobility. A person 80 years or older is eight times more likely to die from fall complications than someone 60 or younger. This information shows how important it is to reduce the risk factors for falling as much as possible and still encourage the resident to be independent and mobile.

Fall victims often develop fear of falling, called “fallaphobia”. This fear can result in:

- Decreased activities.
Increased dependence and feelings of helplessness, which can lead to depression.
- Loss of function.
- Decreased socializing with others.
- Decreased quality of life.

Situational fear of falling occurs when fear of falling is associated with the performance of a particular activity such as bathing, toileting, or walking outside. People with situational fear of falling usually avoid the associated activity or become quite anxious when forced to participate in the feared activity.

Falls result in high costs to the resident in terms of pain, suffering, and money. Caregivers pay a high price in the increased time it takes to care for the older adult who has fallen. What's more, it is estimated that $7 billion per year is spent to care for older adults who have fallen.

**Internal and External Causes of Falls**

Federal regulations (F323) require that organizations see that “each resident receives adequate supervision and assistance devices to prevent accidents.” While falls are not a normal event for the older adult, there are many factors that make falls more likely for the older adult.

**INTERNAL (IN BODY) FACTORS**

Physical changes are those changes that occur within the body. Some common changes in the aging adult include:

- **SENSORY CHANGES:**
  - Decreased vision
    - Need for increased lighting
    - Cataracts
    - Blind spots
    - Decreased depth perception
    - Increased glare sensitivity
    - Difficulty seeing curbs, steps, and flooring changes
  - Decreased hearing
    - Peripheral (at the edges) sensation changes
    - Decreased knowledge of where body parts (especially feet) are located
    - Decreased reaction time
    - Decreased ability to maintain balance

- **HEART and BLOOD VESSEL (cardiovascular) CHANGES:**

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- Abnormal heart rhythms
  * Drop in blood pressure when position is changed
  * Dizziness
  * Drop attacks (sudden onset of falls) with leg weakness without loss of consciousness
  * Fainting, usually due to decreased circulation to the brain

✓ MUSCLES and BONES (musculoskeletal) CHANGES:
  - Decreased strength and mobility
  - Decreased balance and coordination
  - Decreased ankle flexibility and strength
  - Gait changes (decreased speed, length of step, and height of steps)
  - Muscle loss and weakness
  - Disease conditions (osteoarthritis, arthritis, and stooped posture)

✓ NERVE (NEUROLOGICAL) CHANGES
  - Tremors
  - Gait and balance disturbance
  - Slowed reaction time
  - Increased tiredness
  - Increased pain
  - Disease conditions (Parkinson’s disease, strokes, multiple sclerosis)

✓ KIDNEY AND BLADDER (UROLOGICAL) CHANGES:
  - Incontinence—for many reasons
  - Medicines that increase urine output

✓ NUTRITIONAL CHANGES:
  - Anemia
  - Fluid or mineral imbalances
  - Malnutrition

✓ ACUTE ILLNESS:
  - Falls are often a first alert to illness
  - Confusion and falls may be early signs of an infection or other acute medical problem

Psychosocial issues include those issues that change a person’s social functioning or how he or she copes with life:

  - Emotional or mental health problems include stress, confusion (sundowning), and memory loss
  - Behavioral and thinking ability problems include confusion, depression, anxiety, dependency, agitation, denial, fear of falling, and concern about falling
  - Changes in living arrangements may include a recent move to a long-term care setting or a new room.

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Medication problems include the kind, number and interactions of the medications a person takes:
  o Multiple medication usage to treat chronic health conditions
  o Interactions and side effects of medications can cause:
    ▪ a drop in blood pressure with changes in position
    ▪ dizziness
    ▪ changes in ability to think clearly

EXTERNAL (OUT OF THE BODY) FACTORS

Physical factors include:
  • How far did the resident walk without assistance?
  • Did the resident attempt to walk to the bathroom?
  • Does the resident have problems with standing balance?
  • Were there hazards in the resident's bedroom such as throw rugs, overbed tables, and lack of a clear pathway to the bathroom or the door to the hallway?

Individual factors include:
  • Does the person have a history of falling (including falls without injuries)?
  • What were the events leading up to the fall? What was the person doing? Was there any warning? Where did it occur? How? What time of day?
  • What happened after fall?

Other factors include:
  • Floor textures (deep pile increases problems), color (dark colors and speckled and multi-toned patters are often difficult to see), glare (high glare looks wet), wetness of surface (slippage is a problem), loose or uneven floor surfaces
  • Assistive devices that are inappropriate or improperly fitted
  • Lack of supervision by caregivers or slow response to call lights
  • Furniture or wheelchair not comfortable or feet do not touch the floor or foot rests
  • Footwear: high-heeled shoes or poor-fitting shoes, socks or hose worn alone, leather soles (can promote slipping), rubber crepe soles (may stick to linoleum)
  • Stairs (handrails and edges must be marked)
  • Lack of railings to hold on to in hallways, bathrooms, and showers
  • Color of walls. Cool colors, greens and blues, are difficult to distinguish from each other
  • Signage on hallways and doors should be easy to read and at eye level.

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Identifying Risk Factors for Falls

There are several tools for doing fall risk assessments. The important factor when doing fall risk assessments is that the **same tool be used every time** so that changes in the resident’s condition can be tracked over time. Another benefit of using the same tool is that staff can quickly figure out a resident’s risk for falls. Factors included in these tools are:

- Vision problems
- Lowering of blood pressure with position change
- Reduced leg strength
- Impaired gait and balance
- Use of ambulation assistive devices
- Bladder problems
- Changes in thinking ability
- Medication usage
- Signs and symptoms of acute infection
- Length of time in the organization
- Falls in the past six months

A past fall is usually a reliable predictor of another fall. It is very important to assess the risk factors of each resident at the time of admission, on a routine basis, when there is a change of health condition, and after each fall.

Following a fall, it is important to investigate and determine the cause of the fall. Think of the word **SPLATT** to help you remember some of the factors to analyze. **SPLATT** stands for:

- Symptoms experienced at time of fall
- Previous number of falls or near-falls
- Location of fall
- Activity engaged in at the time of the fall
- Time (hour of the day) of fall
- Trauma (physical, psychological) associated with fall

Acute illness like a bladder infection or pneumonia may first be signaled by a fall. Other subtle changes with acute illness may include mental status changes, complaints of “weak legs” or “not feeling right,” or behavioral changes such as decreased eating, increased agitation, or increased confusion. Noticing these changes may prevent the person from falling. After a fall the resident should not be moved until an assessment for injury has been completed by the nurse. Look over the area also to determine what caused the fall. Often, the environment gives good clues to the cause. You must follow through by completing an incident report and by following all your organization’s policies and procedures.

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Unit 1: Practice Activity

Assign the list of the
Factors                                    Type of Factor:
Cataracts                                  Internal Factors
Dizziness                                  External Factors
Anemia
Activities
Floor Texture
Footwear

Unit 2:

Goal:
You will learn about ways to prevent falls and to identify who is at risk for falls. You will learn about physical and chemical restraints and the regulations and precautions concerning restraints.

Ways to Prevent Falls

All caregivers must work to prevent falls. Each caregiver must know which residents are at risk for falls. Some organizations have special codes or signs outside the resident's room or on the bed. Things such as stars or ribbons of a certain color can quickly help all caregivers identify who is at risk for falls. Having accessible information on how each resident transfers or ambulates at the bedside helps with the safety of both workers and residents. Most falls from the bed, chair, or wheelchair occur at the busiest times of the day, such as at mealtimes, or when residents are getting up in the morning, or at bedtime.

Other ideas for fall prevention:

General:
- Recognize that restraint use does not decrease falls and should only be a last resort.
- Encourage the use of assistive devices such as walkers and canes.
- Group high-risk residents together during periods of short staffing (mealtimes or meetings).
- Seat residents who fall frequently close to the watchful eyes of staff.
- Mark sure clothing does not hang lower than the ankles.

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Caregiver measures:
- Place the call light within reach, and answer it promptly.
- Toilet the resident on a regular basis or when restless.
- Stay with confused residents while they are in the bathroom.
- Stay in close vicinity of alert residents who need assistance transferring off and on the toilet.
- Make sure the residents wear proper footwear at all times—proper shoes during waking hours and, perhaps, non-skid socks for those residents who get up after going to bed.
- Have residents sit on the side of the bed until they get their bearings before standing, especially if on medications for blood pressure.
- Keep the resident awake during the day, if possible, so that he or she will sleep at night instead of wandering. If napping occurs, it should be in the early afternoon.
- Walk with residents one on one when possible rather than restricting their mobility.
- Walking residents to meals instead of using a wheelchair meets their need for exercise.
- Rub the resident’s back to calm and soothe, bringing on sleep.
- Report to the next shift those residents who have the risk for falling.
- Allow residents time to sit to receive medications.
- Keep frequently used items near resident.
- Orient/re-orient residents to their surroundings.
- Provide bed or chair alarms to alert the staff that someone at risk for falls is trying to get up.
- Chair and bed alarms are mentioned in the Federal Guidance to Surveyors. However, there is the caveat that included in the guidance. “While alarms can help to monitor a resident’s activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace supervision.” Development of a comprehensive fall reduction program with accurate assessment of residents at risk for falls, resident specific care plan interventions and comprehensive education of staff has been shown to be effective.
- While they are awake, place high-risk residents in view of staff.
- Make sure the resident receives enough fluids each day. Usually six to eight glasses of fluids are required daily by adults. Know the resident’s usual routine so you can anticipate when he or she will need assistance with ambulation.

Environmental measures:
- Keep the bed in a low position.
- Observe for unsafe situations (especially clutter), furniture that moves, and furniture that sticks out.
- Leave a night light on in the room.
- Place a bedside commode near the resident.

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• It may be necessary to place mattresses on the floor or on a very low frame with padding.
• Provide good lighting and low-glare surfaces.
• Maintain firmly attached carpet and non-skid strips near areas that might get wet or in areas near beds where residents may step while wearing socks or stockings.
• Elevate toilet seats and other chairs.
• Place a rubber mat or non-skid strips in tubs or showers.

Activity measures:
• Maintain a regular program of exercise to improve strength, muscle tone, and mobility.
• Encourage residents to attend your organization’s scheduled activities.
• Provide interesting activities for the residents to do in their rooms.
• Encourage wandering residents to sit in rocking chairs so they can use up some of their energy.

When a Restraint Can and Cannot Be Used

A restraint is anything that restricts the resident’s movement and which the resident cannot easily remove. Federal regulations require that restraints be used only as a last resort. F221 states: “The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptom.”

Before a restraint can be used, the nurse must conduct a thorough assessment and the doctor must order the restraint for a specific medical reason. The best thing to do is to figure out why a fall happens and then try to eliminate the cause. The preventive steps discussed in the last section should be tried before using a restraint.

When a decision is made to use a restraint, it should be the least restrictive type and be used for the shortest possible time. Restraints cannot be used for the convenience of the staff (in place of resident monitoring) or because the family of the resident requests that a restraint be used.

It is not so much the device that is defined as a restraint as it is the ability of the individual to easily remove the device. For example bedrails can either help the resident be more independent or keep the resident in bed. The caregiver must know the purpose for the bedrail for that resident. A Merry Walker allows the resident to freely move about, but can the resident get out of it when he or she wants to? If not, it is a restraint—but a least restrictive restraint. A cushion, beanbag, or positioning device that keeps the person from getting up out of a chair is a restraint if the resident cannot get up when he or she wants to. It may be a positioning device if it does not
interfere with the movement of the resident. Each organization must know when a
device is a restraint and when it is not.

When a long-term care community begins to use a restraint, it must have a plan for
how it will quit using it. Staff must be able to give excellent reasons for its continued
use.

In recent years, great strides have been made to decrease the use of restraints. More
falls happen at first when restraints are removed, but the seriousness of injuries has
decreased. Deaths from restraints occur every year. This is a devastating event for the
family and the organization. **Persons who are restrained must be checked
frequently—every 5-30 minutes** (check your organization’s policies and procedures).
The restraints must be removed at least every two hours. During this time, the
resident should be taken to the restroom and should receive some form of exercise.
Remember that this does not prevent serious problems from happening. The standard
of care desired by all homes is very little or no use of restraints.

A **chemical restraint** is a mind-altering medication used for discipline or convenience
and not required to treat a medical condition. These medications can cause
drowsiness, dizziness, or lowering of blood pressure, all of which can cause falls. After
a fall, the resident’s drugs should be reviewed to see if they are contributing to falls.

Using restraints can cause major problems for the resident. These include:
- Loss of mobility, which leads to constipation and incontinence, decreased bone
  strength, slowing of all body systems, decreased range of motion, decreased
  ability to ambulate, and skin breakdown.
- Loss of independence.
- Loss of dignity.
- Social isolation.
- Increased agitation or depression.
- More serious injury if a fall does occur.
- Death from strangulation.

**Unit 2: Practice Activity**
True or false: It is the job of every caregiver to work to prevent falls.

True
False
**Lesson Summary**

Falling is *not* a normal part of growing old, although the likelihood of falling does increase with age. There are both internal and external reasons that falls occur. It is important to conduct a fall assessment at the time of admission, on a routine basis, whenever the resident’s condition changes, and following a fall. With this information the care team can develop a plan to minimize a fall occurrence. Physical and chemical restraints should only be used as a last resort as there are substantial risks to their use. Caregivers have a duty to prevent resident falls. Each caregiver must be aware and protect the resident from harm. You do make a difference in the care of a resident.

To continue with this lesson, please complete the following individual or group activities.
Prevention of Falls
Individual/Group Activity

Activity 1:
Restraint Usage

 Directions: If there is a resident in your organization who has a restraint, answer the following statements or questions about that resident. If you are working alone, write down your answers and give them to your organization’s education coordinator. If you are working in a group, share your answers with your group.

1. What strategies do you use to keep this resident from having to be restrained?

2. What additional measures could staff take so that this resident’s restraint usage could be decreased or removed?

3. Has this resident fallen even when the restraint has been used? If so, what other options could be tried to eliminate restraint usage? If the resident has not fallen, can the restraint be eliminated or reduced in type or length of time used?
Activity 2:  
Falls and Restraints  

Directions: Identify a resident in your organization who has fallen in the last month and answer the following statements or questions. If you are working alone, write down your answers and give them to your organization’s education coordinator. If you are working in a group, share your answers.

1. List possible reasons why this resident has fallen.

2. What could you do as a staff member to try to prevent this resident from falling again?

3. What time of the day does the resident usually fall? What activity is he or she doing?

4. What measures have not worked to eliminate falls with this resident?

5. What measures have been most successful in decreasing this resident’s falls?

Note: Provide a list of residents who have fallen in the month prior to inservice so that staff members have this information available to them.
Activity 3:

**Directions:** With the education coordinator or your supervisor, demonstrate the proper application of all restraints used in your organization. (This takes the time of a supervisor or educational coordinator and is, therefore, optional).
Lesson Assessment

Directions: Click on the best answer.

1. Changes inside the older adult’s body make him or her more susceptible to all of the following EXCEPT: (unit 1)
   a) decreased vision.
   b) loss of muscle mass.
   c) an improperly fitted walker.
   d) gait and balance disturbances.

2. Floor surfaces that increase the likelihood of a fall include: (unit 1)
   a) high-glare finish
   b) carpet with deep pile
   c) dark colored, speckled, multi-toned flooring
   d) all of the above

3. Restraints can be: (unit 2)
   a) Merry Walkers®
   b) Pillows or wedges
   c) Tie restraints and beanbags
   d) Chemicals (use of medications)
   e) All of the above

4. Which is NOT a correct statement?
   a) Restraints are a last resort to prevent falls.
   b) It is the job of every caregiver to prevent falls.
   c) Persons who fall can develop a “fear of falling”.
   d) Falling is a natural consequence of growing older.

5. The fear of falling can result in (unit 1)
   a) loss of function.
   b) eventual depression.
   c) decreased participation in activities.
   d) increased dependence on caregivers.
   e) any of the above.

6. Sensory changes that can contribute to the older adult falling include: (unit 1)
   a) decreased ability to see.
   b) decreased ankle flexion.
   c) sudden drop in blood pressure.
   d) bowel and bladder incontinence.
7. Which factors would contribute to the resident being at risk for falling? (unit 1)
   a) Irregular pulse rate.
   b) Wearing new shoes.
   c) Complaints of being tired.
   d) Move to a different room.
   e) Any of the above

8. The use of restraints can cause all of the following EXCEPT: (unit 2)
   a) Skin breakdown.
   b) A sense of security.
   c) Constipation or incontinence.
   d) Increased agitation or depression.

9. Which option should NOT be used to prevent a resident's fall? (unity 2)
   a) Toileting on a regular basis.
   b) Leaving a night light on in the room.
   c) Placing frequently used items within reach.
   d) Offering caffeine containing beverages to drink.

10. A fall risk assessment is done (unit 2)
   a) on admission.
   b) after each fall.
   c) on a routine basis.
   d) when there is a change in health condition.
   e) all of the above.
Prevention of Falls  
Presenter’s Guide

Purpose:
Falling used to be considered a natural part of growing old. We now know that falls are not part of the normal aging process although incidents of falling do seem to increase with age. Twenty-five percent of persons age 65-74 living outside long-term care communities fall each year. At age 75, this increases to 33%. Persons living in long-term care communities fall more often. This is probably because they are frail with more medical problems. About 50% of older adults in community’s fall every year with at least 40% of those who fall, do so multiple times. The combination of age-related changes and multiple interacting risk factors double jeopardizes older adults by increasing the probability of both falls and fractures. Falls for the frail elderly can result in serious injury or even death.

This training session will acquaint the caregivers in the long-term care community with information about residents who are at risk for falling. It is also an opportunity to discuss steps to prevent falls.

Goal:
The participant will learn about the effects of falls on the elderly, the factors that increase the risk of falls, and steps to take to help prevent or decrease the chances of falls from happening. The use of restraints in relation to falls will be discussed.

Objectives:
At the end of this training session, the participant should be able to:
Explain the potential effects of falls on the elderly.
Identify internal and external causes of falls.
Identify risk factors for falls.
Identify ways to prevent falls.
Explain when a restraint can and cannot be used and the risks of restraint use.
Develop a specific plan to prevent or decrease future falls.

Related Topics:  
Accident Prevention  
Bowel and Bladder Incontinence Management  
Caring for the Resident with Dementia  
Sensitizing Staff to Growing Old

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Learning Activities:

To complete this session, participants should:
Attend a lecture/discussion about prevention of falls at the organization (presented either by designated staff or a guest speaker) and/or read the Prevention of Falls Learner’s Guide.
View a videotape that discussed falls, the prevention of falls, and the use of restraints (optional).
Discuss specific residents in the organization (while maintaining confidentiality), and incorporate appropriate interventions into their plans of care.
Have the opportunity to see various restraints and practice proper application techniques (optional).
Complete the Lesson Assessment.
Review organization policies and procedures on fall prevention including risk assessment and treatment after a fall; restraint usage; planning for restraint removal; documentation; and communication among staff of preventative measures for at-risk-for-falls residents.

Overheads:
1. Falls = Serious Injuries
2. Fear of Falling
3. Internal Factors
4. External Factors
5. Fall Risk Factors
6. SPLATT
7. Fall Prevention
8. Risks of Restraint Use

Answers to Quiz:

1. Answer: c
Rationale: The other answers are changes that happen with aging.

2. Answer: d
Rationale: All options are correct statements.

3. Answer: e
Rationale: All options are a form of restraint depending on its use.

4. Answer: d
Rationale: Falling is not a natural consequence of growing older. There are other factors that contribute to falling.

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5. Answer: e  
*Rationale:* When an individual is afraid of falling, he will try to protect himself by limiting his activities which leads to options a, b, c, and d.

6. Answer: a  
*Rationale:* Option a is the only sensory change option.

7. Answer: e  
*Rationale:* Any of the options could contribute to the resident falling.

8. Answer: b  
*Rationale:* Restraints do not provide a sense of security; most often it is very frightening for the resident.

9. Answer: d  
*Rationale:* Caffeine acts as a stimulant and also increases urine formation causing the resident to need toileting more often. This increased urine formation leads to dehydration.

10. Answer: e  
*Rationale:* All options indicate a proper time to complete a fall assessment.
More Information:
The following are resources your staff can read for more information about falls and fall prevention, or these materials can be used as resources if your staff members are presenting an inservice.

**Articles**


**Books**


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**Videotapes**

*Assisting with ambulation.* (27 minutes)

This program demonstrates how to help a resident walk in a way that maximizes strength and minimizes fatigue, muscle strain, and injury. It stresses the importance of proper body mechanics and explores devices that assist ambulation (2001) $129 purchase. 1-800-233-9910 or [www.insight-media.com](http://www.insight-media.com).

*Balancing Act—Your fall prevention program.* (24 minutes)

Creating and sustaining an effective and proactive falls prevention program is made easy by adding this video and trainer’s guide. Balancing Act teaches why falls happen, how to assess a resident upon admission, what interventions to adopt, and how to identify and document the facts and circumstances surrounding a fall. (2000) $159 purchase. 1-888-337-8808 or [www.healthpropress.com](http://www.healthpropress.com).

*Everyone wins: Quality care without restraint* (6-video set). (Available from AAHSA 1-800-508-9442)

*Falls in older people.*


*Fall risk management* (18 minutes). Available from ITT Hartford Insurance Group, Hartford Plaza (Caledonia Building) Hartford, Connecticut, 06115

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Fear of falling: A matter of balance. (17 minutes)

Older people often restrict their activities because they think it will reduce risk of falls. However, this restricted activity often leads to physical deconditioning that can actually increase fall risks. This video empowers older adults to overcome the fear of falling and take active steps to reduce the risk of falling. Includes 140-page Facilitator’s Manual with step-by-step strategies for fall prevention. $159 purchase, $45 rental. 1-800-799-8491 or tnf@terranova.org.

Resident Safety: Prevention of Falls and Injuries. (20 minutes)

Resident safety is the responsibility of all staff. This video describes proper procedures and techniques for preventing resident falls and injuries. (1999). $259 purchase. Available from Insight Media. 1-800-233-9910 or www.insight-media.com.

Quality Indicator: Resident Function. 3-tape series includes demonstrations and interactive discussion. Each video is 20 minutes in length. The purchase price for each is $150 or rental for $75. The series may be purchased for $400. To order call 1-800-328-7450 or visit www.videopress.org.

1. Improving Function—Improving Life. Join Dr. Resnick and an exercise trainer as they demonstrate to nursing assistants an exercise program based on ADLs that will strengthen muscle and bones, improve balance, and increase range of motion. Research shows that participation in this type of exercise program improves function, decreases falls and provides a better quality of life.

2. The Nursing Assistant’s Role as Cheerleader and “Personal Trainer.” Despite the benefits of exercise, it’s often difficult to motivate older individuals to participate in exercise. Dr. Resnick teaches nursing assistant “tricks of the trade: to motivate older individuals to exercise at their optimal levels. If an exercise program is to succeed, nursing assistants will need these motivational skills.

3. Function—A Quality Indicator: The CNA’s Role. This program specifically looks at function as a quality indicator used in the survey process and discusses what is evaluated in the area of resident function. Through demonstrations, the program teaches nursing assistants how to optimize function rather than simply getting functional tasks completed.

Restraint Reduction and Fall Prevention. (20 minutes)

This program (with self-learning packet) complies with the HCFA/CMS Rule, through its focus on individualized strategies in reducing the risk of falls and treatment without the use of restraints. Free with the purchase of this program: “Assessment of the Fallen Resident”. $295 purchase. Available from Envision, 1111 16th Avenue South, Nashville, Tennessee 37212, 615-321-5166, Fax: 615-321-5119, or www.EnvisionInc.net

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Restraint-Free Care. (21 minutes)

This video training program covers types of restraints, reasons restraints are used, myths about the elderly, problems from the use of restraints, and individualized care planning for restraint-free care. $275 purchase. Available from Envision, 1111 16th Avenue South, Nashville, Tennessee 37212, 615-321-5166, Fax: 615-321-5119, or www.EnvisionInc.net

Safety and Restraints. (20 Minutes)

Many accidents and falls can be prevented by knowledge of proper safety measures. This video describes such restraint alternatives as side rails and bed and wheelchair locks; discusses the safe use of such restraints as the vest restraint, extremity restraint, and finger-control mitten; and teaches appropriate techniques for applying restraints and monitoring restraint use. (2001) $199 purchase. 1-800-233-9910 or www.insight-media.com.

Web Sites:

www.aafp.org/afp/20000401/2173ph.html
What Causes Falls in the Elderly? How Can I Prevent a Fall?

www.aafp.org/afp/20000401/2159.html
Falls in the Elderly. Includes a resident information handout on the causes of falls and tips for prevention.

www.agingkansas.org/kdoa/lce/lce_index.html
Report of Falls Work Group

www.Borun.medsch.ucla.edu/modules/mobility_decline_prevention/
Mobility Decline Prevention.


www.hartmanonline.com/qualitycare/falls.html
Hartman Publishing Inc. offers publication titled “Preventing Falls in the Elderly”.

www.hartfordign.org/resources/education/tryThis.html
“try this” series on best practices in nursing care to older adults by the John A. Hartford Foundation Institute for Geriatric Nursing.

http://www.merck.com/pubs/mm_geriatrics
Click on “search the Book,” then enter “falls in the elderly,” then select Sec. 2, Ch 20.

www.niichro.com/inspired/ibe_7.html

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The Role of Exercise in Preventing Falls

www.ext.colostate.edu/pub/consumer/10242.html
Preventing Falls in the Elderly. Includes a number of websites and references.

www.hartfordign.org/programs/niche/kit-protocols.html
Click on “Preventing Falls in Acute Care” for protocols.

www.sgim.org/workshop01?pdf/handout16TinettiAssessmentTool/pdf
Tinetti Balance and Gait Tools

Note: Instructor should review F Tag 324 in Guidance to Surveyors in State Operations Manual before presenting this inservice.
FALLS = SERIOUS INJURIES

• Head injuries

• Fractures

• Soft tissue injuries
  o Internal bleeding

  o Sprains

  o Lacerations
FEAR OF FALLING

- Decreased activities

- Increased dependence and feelings of helplessness, leading to depression

- Loss of function

- Decreased socializing with others

- Decreased quality of life
INTERNAL FACTORS

SENSORY CHANGES:

- *Decreased vision*
  - Need for increased lighting
  - Cataracts
  - Blind spots
  - Decreased depth perception
  - Increased glare sensitivity
  - Difficulty seeing curbs, steps, floor

- *Decreased hearing*

- *Peripheral sensation changes*
  - Decreased knowledge of where body parts (especially feet) are located
  - Decreased reaction time
  - Decreased ability to maintain balance

(CONTINUED)
INTERNAL FACTORS

HEART & BLOOD VESSEL CHANGES:

- Abnormal heart rhythms
- Drop in blood pressure when position is changed
- Dizziness
- Drop attacks (sudden onset of falls) with leg weakness without loss of consciousness
- Fainting usually due to decreased circulation to the brain
MUSCLE & BONE CHANGES:

- Decreased strength and mobility
- Decreased balance and coordination
- Decreased ankle strength and flexibility
- Gait changes (decreased speed, length of step, and height of steps)
- Muscle loss and weakness
- Disease conditions (osteoporosis, arthritis, and stooped posture)

(CONTINUED)
NERVE CHANGES:

- Tremors
- Gait and balance disturbances
- Slowed reaction time
- Increased fatigue
- Increased pain
- Disease conditions (Parkinson’s disease, strokes, multiple sclerosis)

(CONTINUED)
KIDNEY & BLADDER CHANGES:

- Incontinence—due to many causes
- Medicines that increase urine output

NUTRITIONAL CHANGES:

- Anemia
- Fluid or mineral imbalances
- Malnutrition

ACUTE ILLNESS:

- Falls are often a first alert to illness
- Confusion or falls may be early signs of infection or other acute problem
PSYCHOSOCIAL ISSUES:

*Emotional or mental health problems:* stress, confusion (sundowning), memory loss

*Behavioral and thinking ability problems:* confusion, depression, anxiety, dependency, agitation, denial, fear of falling, concern about falling

*Living situation changes:* a recent move to a long-term care community or a new room.
MEDICATION PROBLEMS:

- Multiple medications to treat chronic health conditions

- Interactions and side effects of medications:
  - Drop in blood pressure with changes in position
  - Dizziness
  - Changes in ability to think clearly
EXTERNAL FACTORS

*Physical Factors include:*

- How far from home does the person go and how often?
- What are the patterns of activity?
- What types of activity does the person like to do?
- Which hazards exist where the person spends a lot of time (stairs, handrails, bathrooms, rugs, cabinets, and clutter)?

(CONTINUED)
Individual factors include:

- Does the person have a history of falling (including falls without injuries)?
  - What were the events leading up to the fall?
  - What was the person doing?
  - Was there any warning?
  - Where did it occur?
  - How did it happen?
  - What time of day?
- What happened after the fall?
Other factors include:

- Floor
  Textures
  Color
  Glare
  Wetness of surface
  Loose or uneven floor surfaces

- Assistive devices
  inappropriate
  improperly fitted

- Lack of supervision by caregivers or slow response to call lights

- Poor design of furniture; clutter

- Inappropriate footwear

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- Stairs (handrails and edges must be marked)

- Lack of railings to hold on to in hallways, bathrooms, and showers

- Signage must be at eye level

- Color of walls
FALL RISK FACTOR

- Vision problems
- Lowering of blood pressure with position change
- Reduced leg strength
- Impaired gait and balance
- Use of ambulation assistive devices
- Bladder problems
- Changes in thinking ability
- Medication usage
- Signs/symptoms of acute infection
- Length of time in an organization
- Falls in the past six months
SPLATT:

**S**ymptoms experienced at the time of the fall

**P**revious number of falls or near-falls

**L**ocation of fall

**A**ctivity engaged in at the time of the fall

**T**ime (hour of the day) of the fall

**T**rauma (physical, psychological) associated with a fall
FALL PREVENTION

GENERAL:

➢ Restraint use does not decrease falls, use only as a last resort.

➢ Encourage the use of assistive devices

➢ Group high-risk residents together

➢ Seat residents close to the nurses’ station.

➢ Make sure clothing is an appropriate length.

(Continued)
CAREGIVER MEASURES:

- Place the call light within reach—answer promptly

- Toilet resident on a regular basis or when the resident is restless.

- Stay with confused residents while they are in the bathroom.

- Assure that residents wear proper footwear at all times.

- Have residents sit on the side of the bed before standing, especially if on medications for blood pressure.
➢ Discourage napping during the day, especially late afternoon.

➢ Walk with residents one on one when possible rather than restricting their mobility.

➢ Walking residents to meals instead of using a wheelchair meets their need for exercise.

➢ Rub the resident’s back to calm and soothe, bringing on sleep.

➢ Report to next shift those residents who have the risk for falling.

➢ Allow residents to sit to take their medications.
- Keep frequently used items near the resident.
- Orient residents to their surroundings.
- Provide bed or chair alarms to alert the staff.
- Place high-risk residents in view of staff.
- Make sure the resident receives enough fluids each day.

(CONTINUED)
ENVIRONMENTAL MEASURES:

- Keep bed in a low position.
- Observe for unsafe situations.
- Identify which side rails are to be up.
- Leave a night light on in the room.
- Place a bedside commode near the resident.
- Place a mattress on the floor or on a very low frame with padding.
- Provide good lighting and low-glare surfaces.
➢ Maintain firmly attached carpet and non-skid strips

➢ Elevate toilet seats and other chairs.

➢ Place wall-mounted grab bars in hallways and bathrooms.

➢ Place a rubber mat or non-skid strips in tubs or showers.

ACTIVITY MEASURES:

➢ Maintain regular program of exercise to improve strength, muscle tone, and mobility.

➢ Encourage residents to attend your organization’s scheduled activities.
➢ Provide interesting activities for the residents to do in their rooms.

➢ Provide rocking chairs for residents who wander.
RISKS OF RESTRAINT USE

Loss of mobility leads to:

- Constipation
- Incontinence
- Decreased bone strength
- Slowing of all systems
- Decreased range of motion
- Decrease ability to ambulate

resulting in skin breakdown

- Loss of independence
- Loss of dignity
- Social isolation
- Increased agitation or depression
- More serious injury if a fall does occur
- Death from strangulation

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