

RESIDENT ASSESSMENT PROTOCOL: FALLS

(Adapted from MDS 2.0)

I. PROBLEM

Falls are leading cause of morbidity and mortality among the elderly who reside in nursing facilities. Approximately 50% of residents fall annually, and 10% of these falls result in serious injury, especially hip fracture. Most elders are afraid of falling and this fear can limit their activities. Falls may be an indicator of functional decline and the development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections. External risk factors include medication side effects, the use of appliances and restraints, and environmental conditions. This RAP provides a systematic approach to the evaluation of a fall and assessment guidelines to assist staff in identifying common fall risk factors and developing care plan interventions.

II. TRIGGERS

Potential for additional falls or risk of initial fall suggested if one or more of following present:

- Fell in past 30 days [J4a = checked]
- Wandering (Risk) [E4aA = 1,2,3]
- Use of trunk restraint (Risk) [P4c = 1,2,]
- Use of antidepressant drugs (Risk) [O4c = 1-7]
- Fell in past 31-180 days [4b = checked]
- Dizziness (Risk) [J1f = checked]
- Use of antianxiety drugs (Risk) [O4b = 1-7]

III. GUIDELINES

To reach a decision on a care plan, begin by reviewing whether or not one or more of the major risk factors listed on the RAP Key are present. Clarifying information on the nature of the risk or type of issue to be considered for the RAP KEY items follows.

Multiple Falls: Is There a Previous History of Falls, or Was the Fall an Isolated Event?

Refer to the MDS, reports of the family, and incident reports.

Internal Risk Factors

Review to determine whether or not the items listed on the RAP KEY under the following headings are present. Each of these represents an underlying health problem or condition that can cause falls and may be addressed so as to prevent future falls.

- Cardiovascular
- Neuromuscular/Functional
- Orthopedic
- Perceptual
- Psychiatric or Cognitive

External Risk Factors

These risk factors can often be modified to reduce the resident's risk of falls.

Medications – certain drugs can produce falls by causing related problems (hypotension, muscle rigidity, impaired balance, other extrapyramidal side effects [e.g., tremors], and decreased alertness). These drugs include: antipsychotics, antianxiety/hypnotics, antidepressants, cardiovascular medications, and diuretics.

- Were these medications administered prior to or after the fall?
- If prior to the fall, how close to it were they first administered?

Appliances and Devices:

- If the resident who falls (or is at risk of falling) uses an appliance, observe his/her use of the appliance for possible problems.
- Review the MDS and the resident's record to determine whether or not restraints were used prior to the fall and might have contributed to the fall, (e.g., causing a decline function or an increase in agitation).

Environmental/Situational Hazards – many easily modifiable hazards (e.g., poor lighting, patterned carpeting, poorly arranged furniture) in the environment may cause falls both in relatively healthy and in frail elderly residents.

For Those, Who Have Fallen Previously, Review the Circumstances Under Which the Fall Occurred

Attempt to gather information on most recent fall. Needed information includes:

- Nature of problem
- Time of day, time since last meal
- Was resident doing usual or unusual activity?
- Was he/she standing still or walking? Reaching up or down? Not reaching?
- Was resident in a crowd of people? Responding to bladder/bowel urgency?
- Was there glare or liquid on floors? Foreign objects in walkway? New furniture placement or other changes in environment?

- Is there a pattern of falls in any of the above circumstances?
- If you know what the resident was doing during the fall, have her/him perform that activity and observe (protect resident to ensure that a fall does not occur during this test).
- Lack of staffing failure to supervise.

Take Necessary Vital Signs

- At time of fall, obtain supine and upright blood pressure and heart rate. If the resident does not have a serious injury such as a fracture of the hip or lower extremity.
- When reproducing circumstances of a fall (e.g., if the resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the residents eats).
- Measure blood pressure and heart rate when the resident is supine and 1 and 3 after standing; note temperature and respiratory rate.

For Residents at Risk of Future Falls, Review Environmental/Situational Factors to Determine Whether or Not Modifications are Needed

- Observe resident's usual pattern of interaction with his/her environment – the way he/she gets out of bed, walks, turns, gets in and out of chairs, uses the bathroom. Observations may reveal environmental solutions to prevent falls.
- Observe him/her get out of bed, walking 20 feet, turn in a 360° circle, standing up from a chair without pushing off with his/her arms (fold arms in front), and using the bathroom.

FALLS RAP KEY TRIGGER-REVISION

Potential for additional fall risk of initial fall suggested if one or more of following present:

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| • Fell in past 30 days [J4a = checked] | • Fell in past 31-180 days [J4b = checked] |
| • Wandering [E4aA = 1,2,3] | • Dizziness [Jlf = checked] |
| • Use of trunk restraint [P4c = 1,2] | • Use of anti-anxiety drugs [O4b = 1-7] |
| • Use of anti-depressant drugs [O4c = 1-7] | |

GUIDELINES

Review risk factors for falls to identify problems that may be addressed/resolved:

- **Multiply Falls. [J4a, J4b]**
- **Internal Risk Factors.**
 - **Cardiovascular:** Cardiac Dysrhythmia [Ile] **lightheadedness, syncope*
 - **Neuromuscular/Functional:** Loss of Arm or Leg Movement [G4b,d], Decline in Functional Status [G9], Incontinence [H1], Hypotension [Ili], CVA [Ilt], Hemiplegia/Hemiparesis [Ilv], Parkinson's [Ily], Seizure Disorder [Ilaa], Syncope [Jlm], Chronic/Acute Condition Makes Unstable [J5a, J5b], Unsteady Gait [Jln] **balance disorder, CVA, weakness, weight loss,*
 - **Orthopedic:** Joint pain [J3g], Arthritis [Iml], Fracture of the Hip [Iln, J4c], Missing Limb (e.g. Amputation) [Inn], Osteoporosis [Ilo]
 - **Perceptual:** Impaired Hearings [Cl], Impaired Vision [D1,D2], Dizziness/Vertigo [Jlf]
 - **Psychiatric or Cognitive:** Delirium [B5], Decline in Cognitive Skills [B6], Manic Depression [Ifff], Alzheimer's [Ilq], Other Dementia [Ilu] **change in LOC, exacerbation of behavioral pattern, combativeness, refusal of intervention(determine underlying cause)*
- **External Factors.**
 - **Medications:** Psychotropic Meds [O4a,b,c,d], Cardiovascular Meds [from record] and Diuretics [O4e] **antianxiety/hypnotic agents, anticholinergics, anticoagulants, antidepressants, antihypertensive*
 - **Appliances/Devices** (time started): Pacemaker [from record], Cane/Walker/Crutch [G5a], Devices and Restraints [P4a,b,c,d,e] **footwear, gait belt, wheelchair, mechanical lift, pacemaker,*
 - **Environmental/Situational Hazards and , if relevant, Circumstances of Recent Fall(s): [Review of situation and environment]** Glare, Poor Illumination, Slippery Floors, Uneven Surfaces, Patterned Carpets, Foreign Objects in Walkway, New Arrangement of Objects, Recent Move Into/Within Facility, Proximity to Aggressive Resident, Time of day, Time Since Meal, Type of Activity, Standing Still/Walking in a Crowded Area/Reaching/Not Reaching, Responding to Bladder/Bowel Urgency. ** lack of staffing, failure to supervise, abuse/neglect*

*additional factors from other sources