MedPro Group
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Checklist

Fall Prevention in Senior Care

Falls are a common risk management and patient safety concern in senior care facilities. About half of the residents living in U.S. nursing facilities fall each year, and approximately 1 in 3 of those who fall will do so two or more times in a year.[1]

Falls are also a costly concern for senior care facilities. MedPro Group's closed claims data from 2016–2020 show that the average total dollars paid (expense plus any indemnity paid) to resolve allegations of failure to prevent resident falls was $100,000 for skilled nursing facilities, $102,600 for assisted living facilities, and $134,000 for independent living facilities.[2]

Falls can result in serious consequences for residents, including disability, poor quality of life, reduced function, increased risk of death, and more. For healthcare staff, falls can result in an increased workload (both in relation to patient care and documentation), poor satisfaction survey results, and litigation.

Although not all falls can be prevented, having a systematic process of assessment, intervention, and monitoring that results in minimizing fall risk is critical for senior care facilities. Additionally, a multifaceted approach to fall prevention that considers the unique needs and circumstances of individual residents is recommended. This checklist[3] may help senior care professionals evaluate their fall prevention program, identify best practices, and target aspects for improvement.

	Yes	No
Organizational Considerations		
Does your facility have a culture of safety, including:		
• Well-defined and documented safety protocols?	☐	☐
• Leadership support of safety initiatives through goal setting and resource allocation?	☐	☐

	Yes	No
Organizational Considerations (continued)		
• A nonpunitive approach to staff feedback and risk identification? • Transparency in communication with staff members? • Empowerment of staff to make decisions and changes that support quality improvement? • Measurement and trending of performance and quality indicators?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Does your facility have a fall risk program or policy in place for residents and family members?	☐	☐
Has your facility designated a team to evaluate fall risks, review incidents of falls, implement safety protocols, and monitor results?	☐	☐
Does the fall team include appropriate representatives from across the facility, such as a nurse leader, nursing assistants, an occupational therapist, and a facility engineer or maintenance manager?	☐	☐
Does your facility conduct an analysis of fall trends among your resident population that includes a review of times of day, recent changes in baseline behaviors, medication changes, exacerbation of chronic conditions, acute illnesses, sleep pattern disruptions, etc.?	☐	☐
Resident Care		
Is a comprehensive fall risk assessment completed for every resident as part of the admissions process?	☐	☐
Does the fall risk assessment take into account potential red flags for increased risk of falling, such as poor vision, issues with gait, weakness, and incontinence? Is a facility-wide screening tool in place that identifies incontinence?	☐	☐
Does the fall risk assessment include a review of medical history (including previous falls), a physical exam, and a functional assessment of each resident's ability to perform activities of daily living?	☐	☐
Are residents reassessed for fall risk quarterly, monthly, or sooner when appropriate (e.g., when a change in medication or health status occurs)?	☐	☐

	Yes	No
Resident Care (continued)		
Do staff members use the fall risk assessment to develop individualized care and interventions?	☐	☐
Are residents who are at high risk for falls easily identifiable (e.g., through the use of colored wristbands, signage in or directly outside their living areas, lists at nursing stations, etc.)?	☐	☐
Are residents' medications affecting their mobility, balance, or cognition reviewed as part of their fall risk assessments?	☐	☐
Does your facility consider pre-sleep activities (reading, relaxing music, aromatherapy, massage, etc.), sleep setting ambience (lighting, noise, door open or closed, etc.), and daily sleep/nap patterns for each resident?	☐	☐
For individual residents, does the facility consider lifelong hobbies, career history, family role, and community involvement to develop resident-centered care plans?	☐	☐
Are activities professionals made aware of which residents are at risk for falls so they can implement appropriate safety precautions during activities?	☐	☐
Environmental Considerations		
Are new residents thoroughly oriented to the senior care facility?	☐	☐
Are new residents taught how to properly use the nurse call system and techniques for safe movement around the facility?	☐	☐
Are residents' fall risks considered when determining their room locations (e.g., higher risk residents are located closer to nursing stations)?	☐	☐
Is the facility, including common areas and living spaces, assessed daily or weekly for potential fall hazards (e.g., clutter, cords, poorly designed furniture, carpeting hazards, inadequate lighting, wet floors, bed hazards, etc.)?	☐	☐
Is an equipment management protocol in place, and are staff trained on how to remove an unsafe piece of equipment from use and report safety issues?	☐	☐
Is equipment routinely inspected and repaired in a timely manner?	☐	☐

	Yes	No
Environmental Considerations (continued)		
Are protective equipment, supplies, and risk-prevention techniques available (e.g., safety rails, grab bars, hip protectors, individualized wheelchair seating, alarms/sensors, and safe footwear)? Are they appropriately used based on each individual's fall risks?	☐	☐
Incident Response Considerations		
Are staff monitored for compliance with the facility's fall risk program's policies and procedures, including fall risk assessments and care plans?	☐	☐
When a resident falls, is a thorough investigation and evaluation of potential risks completed immediately?	☐	☐
When a resident falls, is an incident report also completed immediately?	☐	☐
Are both intrinsic and extrinsic factors considered when evaluating the cause of a fall? (Examples of intrinsic factors include muscle weakness, behavioral issues, chronic conditions, and medication side effects. Examples of extrinsic factors include environmental hazards, equipment failures, and unsafe personal items.)	☐	☐
Following a fall, are key areas of risk identified and assessed for potential improvement (e.g., toileting, bed safety, medical conditions, and pain management)?	☐	☐
Following a fall, is the resident's individualized care plan reviewed and modified? Is the resident reassessed for fall risk?	☐	☐
Do individualized care plans include multidisciplinary input (e.g., input from a primary care provider, pharmacist, physical therapist, occupational therapist, etc.) as well as input from direct care staff?	☐	☐
Is the fall disclosed to the resident's family, including the circumstances (as known), treatment plans, and future prevention strategies?	☐	☐
Documentation Considerations		
Are residents' fall histories documented in their health records?	☐	☐

	Yes	No
Documentation Considerations (continued)		
When a fall occurs, is the incident recorded in the resident's health record, including the circumstances, staff response, treatment provided, and facts about the incident?	☐	☐
Is the process of disclosing the fall to the resident's family documented properly?	☐	☐
Are residents' individualized care plans documented in their health records and updated appropriately when modifications occur?	☐	☐
Are orders and consult reports from primary care and specialty providers reviewed and included in residents' health records?	☐	☐
Training and Education Considerations		
Do employees receive training on fall prevention and fall management during orientation and as part of ongoing staff education?	☐	☐
Do employees receive education about what steps to take if they see a patient falling?	☐	☐
Are residents and family members provided with ample, easy-to-understand information about reducing the risk of falls?	☐	☐

Resources

For more information about fall prevention, see MedPro's *Risk Resources: Falls and Fall Risk in Older Adults*.

Endnotes

[1] Agency for Healthcare Research and Quality. (2017). *The falls management program: A quality improvement initiative for nursing facilities*. Retrieved from www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/fallspxman1.html

[2] MedPro Group. (2022, January). Senior care: A coded case analysis. Retrieved from www.medpro.com/documents/10502/5086245/Senior+Care_Claims+Data+Analysis_2022_MedPro+Group.pdf

[3] Agency for Healthcare Research and Quality, *The falls management program;* Agency for Healthcare Research and Quality. (2018). *AHRQ's safety program for nursing homes: On-time falls prevention.* Retrieved from www.ahrq.gov/patient-safety/settings/long-term-care/resource/ontime/fallspx/index.html; Willy, B., & Osterberg, C. M. (2014). Strategies for

reducing falls in long-term care. *Annals of Long-Term Care, 22*(1). Retrieved from www.hmpgloballearningnetwork.com/site/altc/articles/strategies-reducing-falls-long-term-care; Institute for Healthcare Improvement. (n.d.). Patient fall prevention and management protocol with toileting program. Retrieved from www.ihi.org/resources/Pages/Tools/PatientFallPreventionManagementProtocolwithToiletingProgramVAMCBayPines.aspx; Gray-Miceli, D. L., & Capezuti, E. (n.d.) A nursing guide to the prevention and management of falls in geriatric patients in long-term care settings. Medscape. Retrieved from www.medscape.org/viewarticle/504373; Chu, R. Z. (2017, March). Preventing in-patient falls. *Nursing, 47*(3), 24-30. doi: 10.1097/01.NURSE.0000512872.83762.69; Health Research & Educational Trust. (2016, October). *Preventing patient falls: A systematic approach from the Joint Commission Center for Transforming Healthcare project.* Retrieved from www.hpoe.org/Reports-HPOE/2016/preventing-patient-falls.pdf; The Joint Commission. (2015, September 28). Preventing falls and fall-related injuries in health care facilities. *Sentinel Event Alert, 55.* Retrieved from www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_55_falls_4_26_16.pdf