

# Key Components of Fall Prevention

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Steps	Actions
<b>Assessing Fall Risk</b>	<ul style="list-style-type: none"><li>• The main purpose of risk assessment is to identify those residents most likely to fall (Table 1). The rationale for a risk assessment is that if residents at high fall risk can be identified, then appropriate strategies can be instituted to reduce risk.</li><li>• Baseline fall risk assessments should be completed upon admission (within 2 hours of admission).</li><li>• Reassessment of fall risk needs to be ongoing; completed whenever residents experience a change of condition or medication, daily/every shift in certain high risk residents (e.g., recent confusion, taking sedatives, recent fall, temporary acute illness, etc.), and immediately post-fall.</li></ul>
<b>Communicating Risk</b>	<ul style="list-style-type: none"><li>• Once a resident's risk of falling has been identified, it's important that their risk status is communicated to everyone involved (e.g., nurses, nursing assistants, occupational and physical therapies, physicians and other relevant staff members).</li><li>• Communication of fall risk can be achieved by means of colored decals (i.e., placed on the resident's chart and/or bedroom), colored wristbands, and daily shift reports.</li></ul>
<b>Multidisciplinary Evaluation</b>	<ul style="list-style-type: none"><li>• Following risk assessment, an attempt should be made to identify the cause(s) of all risk factors identified. Since most residents will have multiple risk factors, multidisciplinary referral and evaluation is necessary.</li><li>• The risk assessment and subsequent multidisciplinary evaluations completed serve as the basis for selection of risk reduction strategies.</li></ul>

<p><b>Care Planning</b></p>	<ul style="list-style-type: none"> <li>• A fall prevention program is only useful if there is also an effective treatment or strategy available to reduce risk.</li> <li>• For those residents "at-risk", strategies (e.g., medical, nursing, rehabilitative and environmental interventions) needed to be targeted towards identified risk factors.</li> <li>• It's important to remember that as risk factors change, strategies may have to change as well.</li> </ul>
<p><b>Post-Fall Assessment</b></p>	<ul style="list-style-type: none"> <li>• All residents who fall should receive a post-fall assessment. The purpose of this assessment is to discover what caused the fall and to prevent another fall from occurring.</li> <li>• Key components of the post fall assessment include: identifying all internal and/or external factors contributing to the fall and identifying the presence of any new or additional risk factors. This information is very helpful in conducting an analysis of the fall (i.e., asking, "What happened?" and "Why did it happen?"), and designing appropriate strategies to prevent further falls.</li> </ul>
<p><b>Monitoring</b></p>	<ul style="list-style-type: none"> <li>• Monitoring or follow-up of the resident's care plan should occur on a regular basis.</li> <li>• The purpose of monitoring is to twofold: first, to evaluate the effectiveness of strategies designed to reduce falls and/or fall risk, and second, to decide what to do next if the strategies are not effective in reducing risk.</li> </ul>

**Table 1**

<b>Fall Risk Factors</b>	
<b>Internal or Health Factors</b>	<p>Recent falls (a history of falls is the best predictor of future falls).</p> <p>Poor vision (cataracts; macular degeneration; glaucoma)</p> <p>Lower extremity dysfunction (arthritis; muscle weakness; impaired sensory function)</p> <p>Unsteady gait/balance (stroke; Parkinson's disease, etc.)</p> <p>Uses cane/walker (ambulation aids are a marker for underlying gait/balance disorders)</p> <p>Elimination problems (excessive night time urination; incontinence)</p> <p>Altered cognition (dementia; depression; agitation)</p> <p>Fear of falling (leads to over-precaution, fear of walking, and consequently, weakness, poor balance, and increased fall risk)</p> <p>Polypharmacy ( 4 or more prescription drugs)</p> <p>Medication side effects (especially drugs that affect central nervous system, such as sedatives and tranquilizers)</p> <p>Mobility impairment (bed, toilet, and chair/wheelchair transfers)</p> <p>Foot deformities (corns, calluses, bunions can destabilize gait)</p>
<b>External or Environmental Factors</b>	<p>Toilets (lack of equipment for support, such as grab bars)</p> <p>Furnishings (inappropriate bed/chair heights )</p> <p>Floors (loose or thick-pile carpeting, sliding rugs, highly polished or wet ground surfaces)</p> <p>Poor lighting (lack of night lights)</p> <p>Footwear (ill-fitting shoes, slippery soles)</p>

	<p>Assistive devices (improper and/or broken cane, walker or wheelchair)</p> <p>Bed rails (rather than preventing falls, bed rails increase risk for injurious falls)</p> <p>Clutter in rooms or hallways.</p>
<p><b>Behavioral Factors</b></p>	<p>Certain resident activities may increase the risk of falls. Examples are:</p> <p>Walking in stocking feet.</p> <p>Rushing to the bathroom (especially at night when not fully awake or when lighting may be inadequate).</p> <p>Failing to use a cane or walker for balance support.</p> <p>Exhibiting unsafe behavior (overestimation of one's abilities to self-transfer and ambulate, poor safety awareness, desire not to "bother" staff for assistance, and resistance to care).</p>
<p><b>Situational Factors</b></p>	<p>New admission/post-fall (many falls occur during the first week after admission and immediately following a fall).</p> <p>Post-meal times (need for toileting).</p> <p>Night-time hours (many falls occur at night; often while traveling to the bathroom and/or transferring from bed).</p> <p>Acute diseases and/or change in condition (e.g., urinary infection, pneumonia, acute dehydration, CVA, TIA, acute medication reaction, sudden hypoglycemia or hyperglycemia, etc.).</p>