## Assessing Falls and Their Causes

### Level III

**Purpose**
The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.

**Preparation**
1. Review the resident’s care plan to assess for any special needs of the resident.
2. Identify the resident’s current medications and active medical conditions.
3. Assemble the equipment and supplies as needed.

**General Guidelines**
1. Falls are a leading cause of morbidity and mortality among the elderly in nursing homes.
2. Approximately 50 percent of residents fall annually and 10 percent of these falls result in serious injury.
3. Fear of falling may limit an individual’s participation in activities.
4. Falling may be related to underlying clinical conditions and functional decline, medication side effects, and/or environmental risk factors.
5. Residents must be assessed in a timely manner for potential causes of falls.
6. Relevant environmental issues should be addressed promptly.

**Equipment and Supplies**
The following equipment and supplies will be necessary when performing this procedure.

1. Equipment to assess vital signs, such as stethoscope; sphygmomanometer or electronic blood pressure device; and oral or rectal thermometer;
2. Tools to assess resident’s level of consciousness and neurological status, if necessary;
3. First Aid Kit, if necessary;
4. Resident’s medical chart; and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

**Steps in the Procedure**
1. **After a Fall:**
   a. If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities.
   b. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid.
   c. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.
   d. Nursing staff will notify the resident’s Attending Physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax or by phone the next office day).
   e. Nursing staff will observe for delayed complications of a fall for approximately seventy-two (72) hours after an observed or suspected fall, and will document findings in the medical record.

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**Steps in the Procedure (continued)**

f. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings.

g. An incident report must be completed for resident falls. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services no later than 24 hours after the fall occurs.

2. **Identifying Causes of a Fall or Fall Risk:**
   a. Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc.
   b. Staff will evaluate chains of events or circumstances preceding a recent fall, including:
      1. Time of day of the fall;
      2. Time of the last meal;
      3. What the resident was doing;
      4. Whether the resident was standing, walking, reaching, or transferring from one position to another;
      5. Whether the resident was among other persons or alone;
      6. Whether the resident was trying to get to the toilet;
      7. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or
      8. Whether there is a pattern of falls for this resident.
   c. The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found.
   d. The Nursing Supervisor/Charge Nurse or Director of Nursing Services should consult with the Attending Physician or Medical Director to confirm specific causes from among multiple possibilities.
   e. As indicated, the Attending Physician will examine the resident or may initiate testing to try to identify causes. If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g., workup already done, finding a cause would not change the approach, etc.).
   f. When possible, the Attending Physician or nursing staff will document the basis for identifying specific factors as the cause.
   g. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a transient ischemic attack or an adverse drug reaction (ADR), or if the resident continues to fall despite attempted interventions, the nursing staff will discuss the situation with the Attending Physician or Medical Director.
   h. If causes of a fall cannot be readily identified and if the fall is accompanied by other signs and symptoms (e.g., confusion or lethargy), the staff and physician will consider a possible underlying acute medical cause.

3. **Performing a Post-Fall Evaluation:**
   a. After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results of this effort.
   b. If the individual has no difficulty or unsteadiness, no further evaluation is needed at that time.
   c. If the individual has difficulty or is unsteady in performing this test, additional evaluation may be initiated as warranted.

4. **Identifying Complications of Falls:**
   a. Staff, with the Attending Physician’s input, will define the complications of a fall such as bruising, fracture, or increased fear of walking.
   b. Additionally, the staff and physician will identify significant potential complications of falling for each resident at risk for falling; (e.g., fracture in someone with osteoporosis or bleeding in someone receiving anticoagulation).
**Documentation**

When a resident falls, the following information should be recorded in the resident’s medical record:

1. The condition in which the resident was found (e.g., “resident found lying on the floor between bed and chair”).
2. Assessment data, including vital signs and any obvious injuries.
3. Interventions, first aid, or treatment administered.
4. Notification of the physician and family, as indicated.
5. Completion of a falls risk assessment.
6. Appropriate interventions taken to prevent future falls.
7. The signature and title of the person recording the data.
8. All falls will be tracked at least monthly on tracking/trending reports.

**Reporting**

1. Notify the following individuals when a resident falls:
   a. The resident’s family;
   b. The Attending Physician (timing of notification may vary, depending on whether injury was involved);
   c. The Director of Nursing Services; and
   d. The Nursing Supervisor on duty.
2. Report other information in accordance with facility policy and professional standards of practice.

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**References**

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<tr>
<th>MDS (RAPs)</th>
<th>G; J4; O4b; O4c; P4c; (RAP #2); (RAP #5); (RAP #11); (RAP #17); (RAP #18)</th>
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<tbody>
<tr>
<td>Survey Tag Numbers</td>
<td>F252; F323</td>
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<tr>
<td>Related Documents</td>
<td>Report of Incident/Accident (Resident Safety – Appendix B)</td>
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<tr>
<td>Risk of Exposure</td>
<td>Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals</td>
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**Procedure Revised**

Date: **3-28-2016**

By: __________________________

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