



Complete Summary

GUIDELINE TITLE

Fall management guideline.

BIBLIOGRAPHIC SOURCE(S)

Best Practice Committee of the Health Care Association of New Jersey. Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2006 Sep. 32 p. [41 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Health Care Association of New Jersey (HCANJ). Fall management guidelines. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2005 Feb. 25 p.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Falls

GUIDELINE CATEGORY

Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Physical Medicine and Rehabilitation
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Occupational Therapists
Pharmacists
Physical Therapists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To limit and/or prevent the occurrence of falls within the parameters that can be controlled through structured program interventions
- To minimize the severity of injuries sustained by an elderly individual resulting from a fall
- To provide the professional staff with standards of practice that will enable them to perform effectively
- To educate the resident, family, and staff
- To limit the liability and financial risk to the facility

TARGET POPULATION

Elderly residents of long-term care facilities, including skilled nursing facilities, subacute care, and assisted living facilities

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment/Evaluation

1. Clinical assessment completed by registered nurse
2. Rehabilitation assessment completed by physical therapist (PT) or occupational therapist (OT)
3. Continence protocol, including toilet schedule and bladder training, as indicated
4. Mental status assessment, including assessment of recall and judgment and completion of a mini-mental status assessment
5. Pharmacological assessment completed by pharmacy consultant or physician
6. Environmental assessment (considers physical room layout, equipment, and lighting)
7. Analysis/assessment of level of risk based on collective assessments and professional judgment

8. Development of dynamic treatment plan based on fall assessment results

Post-Fall Evaluation

1. Use of Fall Management Investigation or Post Fall Assessment Tool
2. Physical assessment
3. Determination of contributing factors including environmental factors
4. Reporting mechanism/facility tracking:
 - Facility fall summary/analysis
 - Timely modifications to the treatment plan
 - Family/resident conferences
 - Physical adaptations to room, wheelchair, and/or walking devices
 - Collective review of resident falls throughout the facility

Education/Awareness: Falls Program In-Service

1. Review documentation expectations with staff members upon orientation, semiannually, and after falls as they occur
2. Provision of instructions to resident and information concerning safety awareness on admission, at care plan meetings, quarterly, and after a fall has occurred,
 - Instruction on proper use of call bells, walking devices, wheelchairs, and other assistive devices
3. Description of reasonable expectations from the facility and instruction on how the family can assist upon admission of the resident, as needed, and upon discharge of resident
4. Notification of the Department of Health and Senior Services (DHSS) staff about the facility's Fall Program and its level of implementation

Quality Improvement

1. Collection of falls data, including near miss data, using post-fall tool and falls summary report
 - Interdisciplinary analysis of information
 - Review and revision of policies and procedures, as appropriate
2. Completion of Facility Falls Data summary document
 - Analysis of information
 - Revision of policies and procedures, as appropriate, including retraining of staff

MAJOR OUTCOMES CONSIDERED

- Risk for falling
- Number of falls (with or without injury)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strives to develop guidelines that are consistent with these principles:

- Relative simplicity
- Ease of implementation
- Evidence-based criteria
- Inclusion of suggested, appropriate forms
- Applicable to various long term care settings
- Consistent with statutory and regulatory requirements
- Utilization of Minimum Data Set (MDS) (resident assessment instrument [RAI]) terminology, definitions and data collection

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Program Outline

Each facility/provider is encouraged to use this comprehensive guideline to outline and further define its program-specific fall management policy and procedures.

I. Key Elements to a Fall Management Program

- A. Assessments
- B. Dynamic treatment plan
 - 1. Role of the Interdisciplinary Team or Resident Review Team
 - 2. Use of devices: restraints, protectors, alternatives to restraints
- C. Re-assessments, implementation and evaluation of treatment plan
- D. Education/awareness

II. Detailed Elements

- A. Assessments
 - 1. Clinical assessment
 - a. Assessment form - recommend rating scale
 - b. Completed by registered nurse
 - c. Time of completion
 - Admission fall risk assessment completed within 24 to 48 hours of admission
 - If indicated, comprehensive fall risk assessment within 14 to 21 days after admission
 - d. Frequency of reassessment
 - Upon a fall
 - Significant change likely to increase fall prediction factors
 - Quarterly for skilled nursing facilities and nursing facilities
 - Semi-annually for assisted living facilities
 - 2. Rehabilitation assessment

- a. Completed by physical therapist (PT) or occupational therapist (OT)
 - b. Form: (e.g., Tinetti Gait and Balance Tool or Berg Balance Scale)
 - c. Transfer evaluation
 - d. Evaluate for vestibular imbalance
 - e. Time of completion (recommend 24 to 48 hours after referral)
 - f. Frequency of re-evaluation
- 3. Continenence protocol
 - a. Toilet schedule
 - b. Bladder training, as indicated
- 4. Mental status assessment
 - a. Recall
 - b. Judgment (safety awareness)
 - c. Complete mini-mental status assessment
- 5. Pharmacological assessment
 - a. Completed by pharmacy consultant or physician
 - b. Review of medication profile as needed
 - c. Evaluate risk for osteoporosis and recommend treatment as necessary
 - d. Evaluate need for Vitamin D and/or calcium supplements
- 6. Environment Assessment
 - a. Physical room lay out
 - b. Equipment and assistive devices
 - c. Lighting
 - d. Other
- 7. Analysis/Assess Level of Risk Assessment
 - a. Identify level of risk based on collective assessments and professional judgment
- B. Dynamic treatment plan
 - 1. Specific interventions based on results of fall assessment and resident preferences. The interdisciplinary team members must address:
 - a. Resident, staff, and family teaching
 - b. Room modifications
 - c. Resident's daily routines
 - d. Mental status/behaviors
 - e. Physical limitations
 - Activities of daily living (ADL) skills
 - Continenence
 - f. Pain
 - g. Medication use
 - h. Consistent and proper uses of assistive or protective devices based on assessments

2. Updated information consistently communicated to the staff, resident and family
 - a. Staff
 - General classification system identifying resident's potential to fall
 - Summary of assessments/changes in plan of care
 - Verbal and written reports
 - b. Residents
 - One-to-one education and review
 - c. Families
 - Care conferences

C. Evaluation

1. Post fall evaluation
 - a. Fall Management Investigation or Post Fall Assessment Tool
 - Physical assessment
 - Contributing factors to fall
2. Reporting mechanism/tracking of falls within the facility
 - a. Facility Fall Summary/Analysis
 - b. Action of the interdisciplinary team
 - Timely modifications to the treatment plan
 - Family/resident conferences
 - Physical adaptation to room, wheelchair, and/or walking devices
 - c. Collective review, identification, and analysis of trends in resident falls throughout the facility (see "Quality Improvement," below)
3. Facility protocol may include falls management review and analysis by the safety committee, falls committee, interdisciplinary care (IDC) plan committee, quality improvement committee, or other established interdisciplinary group

D. Education/Awareness

1. Falls Program In-Service
 - a. Staff members
 - Intervals for review of Fall Management Program:
 - i. Upon orientation
 - ii. Semiannual
 - iii. Post fall evaluation as necessary
 - Contents of review:
 - i. Policies and procedures
 - ii. Documentation standards
 - b. Resident
 - Intervals for review of Fall/Safety Information:
 - i. Admission
 - ii. Care plan meetings
 - iii. Quarterly resident population education on falls management
 - iv. After a fall
 - Contents of review:

- i. Instructions and information concerning safety awareness
 - ii. Proper use of call bells, walking devices, wheelchairs, and other assistive devices
 - c. Family
 - Intervals for review of Fall/Safety Information:
 - i. Upon admission of the resident
 - ii. Address with family as resident presents need to discuss
 - iii. Upon discharge of resident
 - Contents of review:
 - i. Reasonable expectations from the facility
 - ii. How they can assist
 - d. Department of Health and Senior Services (DHSS)
 - Inform the DHSS staff about the facility's Fall Program and what is the level of implementation
- E. Quality Improvement
- 1. Collect falls data (including near miss data)
 - a. Post fall tool
 - b. Falls summary report
 - Conduct interdisciplinary analysis of information to gain helpful knowledge
 - Review and revise policies and procedures as appropriate
 - i. Retrain staff on new policies and procedures
 - 2. Complete Facility Falls Data summary document
 - a. Analyze information
 - b. Revise policies and procedures as appropriate
 - Retrain staff on new policies and procedures

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Prevention of falls, reduced injury, and ultimately improved quality of life of residents
- Limited liability and financial risk to the facility

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use by your organization, it should be reviewed by counsel knowledgeable concerning federal and state health care laws and rules and regulations. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.
- This Best Practice Guideline is offered to nursing facilities, assisted living facilities, residential health care facilities, adult day health services providers, and professionals for informational and educational purposes only.
- The Health Care Association of New Jersey, executors, administrators, successors, and members hereby disclaim any and all liability for damage of whatever kind resulting from the use, negligent or otherwise, of all Best Practice Guidelines.
- The Best Practice Guidelines usually assume that recovery/rehabilitation is the treatment or care plan goal. Sometimes, other goals may be appropriate. For example, for patients receiving palliative care, promotion of comfort (pain control) and dignity may take precedence over other guideline objectives. Guidelines may need modification to best address each facility, patient and family's expectations and preferences.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Recognizing the importance of implementation of appropriate guidelines, the Best Practice Committee of the Health Care Association of New Jersey plans to offer education and training. Guidelines will be made available at www.hcanj.org. In addition, a selection of Fall Risk Assessment and Investigation Forms, Balance Assessment instruments, and Quality Improvement Forms are provided in the original guideline document. Intended users may choose the tools that are appropriate for their respective utilization.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Sep (revised 2006 Sep)

GUIDELINE DEVELOPER(S)

Health Care Association of New Jersey - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Health Care Association of New Jersey

GUIDELINE COMMITTEE

Best Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Health Care Association of New Jersey Web site](#).

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

AVAILABILITY OF COMPANION DOCUMENTS

The following implementation tools are available in the original guideline document:

- Fall risk predictive factors assessment form
- Falls management: optional initial plan of care
- Falls management investigation—post fall tool
- Falls management—post fall assessment tool
- Tinetti balance and gait assessment tools
- Berg balance measure
- Quality improvement forms

Electronic copies: Available in Portable Document Format (PDF) from the [Health Care Association of New Jersey Web site](#).

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 18, 2005. The information was verified by the guideline developer on July 20, 2005. This NGC summary was updated by ECRI on September 20, 2006. The updated information was verified by the guideline developer on September 25, 2006.

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