Falls – Clinical Protocol

Assessment and Recognition

1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.

    a. Staff will ask the resident and the caregiver or family about a history of falling.
    b. The staff and physician should document in the medical record a history of one or more recent falls (for example, within 90 days).
    c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause.

2. In addition, the nurse shall assess and document/report the following:

    a. Vital signs
    b. Recent injury, especially fracture or head injury
    c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.
    d. Change in cognition or level of consciousness
    e. Neurological status
    f. Pain
    g. Frequency and number of falls since last physician visit
    h. Precipitating factors, details on how fall occurred
    i. All current medications, especially those associated with dizziness or lethargy
    j. All active diagnose

3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk.

    a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and blood pressure.

4. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant).

    a. Falls often have medical causes; they are not just a "nursing issue."

5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.

    a. Falls should be categorized as a) those that occur while trying to rise from a sitting or lying to an upright position, b) those that occur while upright and attempting to ambulate, and c) other circumstances such as sliding out of a chair or rolling from a low bed to the floor. They should also be identified as witnessed or unwitnessed events.

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Cause Identification

1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall.

    a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke.
    b. Often, multiple factors in varying degrees contribute to a falling problem.
    c. After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, further evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur.

2. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes.

    a. After more than one fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling.
    b. Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling.

3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk.

Treatment/ Management

1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

    a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing).

2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).

Monitoring and Follow-Up

1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved.

    a. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.

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Monitoring and Follow-Up (continued)

2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.

    a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.
    b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented.

3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved.
4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.
5. As needed, the physician will document the presence of uncorrectable risk factors, including reasons why any additional search for causes is unlikely to be helpful.