

Fall Precautions in Assisted Living

Learner Workbook



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INTRODUCTION

Falling is one of the greatest fears of residents in our Communities. As you will learn, the residents' fears are founded in fact. Often a fall begins a downward spiral in the resident's health and functioning.

According to the CDC, Centers for Disease Control and Prevention, more than 90% of hip fractures among adults ages 65 and older are caused by falls. And, about one out of five older adults with a hip fracture dies within a year of their injury. It is our responsibility to do everything we can do to prevent falls.

Statistics

According to the Centers for Disease Prevention and Control (CDC):

- More than one third of adults 65 and older fall each year in the United States.
- Among older adults, most fractures are caused by falls, and falls are the leading causes of injury deaths.
- 20 to 30% of people who fall suffer moderate to severe injuries such as bruises, hip fractures, or head traumas. These injuries can make mobility difficult and limit independent living.
- People 75 and older who fall are four to five times more likely to be admitted to a long-term care facility for a year or longer.
- Men are more likely to die from a fall. However, women are 67% more likely than men to have a nonfatal fall injury.

When an older adult falls, the effects go beyond physical injury. Many residents will develop psychological fears that can limit their mobility.

The good news is that many falls can be prevented. By making some changes, you can help your residents lower their chances of falling.

FALL RISK FACTORS

The causes of falls are known as risk factors. Although no single risk factor causes all falls, the greater the number of risk factors to which an individual is exposed, the greater the probability of a fall. And, we know that a fall among elderly adults threatens the person's independence.

Many of the risk factors for a fall are preventable. We are going to divide the discussion on these risk factors into two general categories:

- First, we will discuss the resident risk factors. These are risk factors that increase an individual's risk of falling, such as poor balance.
- Second, we will discuss environmental risk factors. These risk factors exist in a person's environment that may pose a hazard for a resident, such as a throw rug.

Resident Risk Factors

Our residents have many risk factors that increase the likelihood that they may fall. Four general risk factors are age, history of falling, cognitive problems, and the use of ambulatory aids. As residents age a host of other factors often occur, such as eyesight problems, increased number of medications, etc. Persons who have fallen before frequently have some condition that puts them at a higher risk to fall again. Residents with cognitive problems such as confusion, anxiety, etc. are also more likely to fall. Also residents who are dependent upon mobility devices, such as a walker, are more likely to experience a fall.

Our residents may have many risk factors that increase the likelihood of a fall. For example some specific resident risk factors include:

- Effects of medication
- Eyesight problems
- Hip, leg and foot disorders and injuries
- Disease and illness

RESIDENT FALL RISK FACTORS: EFFECTS OF MEDICATIONS

Medications are a significant risk factor in falls. Drug effects and reactions can affect cognition and balance, thus contributing to falls. According to the CDC, any resident who is taking 4 or more medications or taking any psychoactive medications have an increased risk of falling.

With multiple medications, there is an increased chance of side effects, interactions between different medicines, and problems taking them correctly. Four out of five people aged over 75 years take at least one medicine; 36 per cent of this age group take four medicines or more.

The most common drugs associated with fall risk include those that act on the central nervous system, such as sedatives, antidepressants, tranquilizers, and benzodiazepines. Other medications associated with fall risk are heart medications, high blood pressure medications, diuretics, sleeping pills, and anti-seizure medications.

Individuals receiving three or more psychoactive drugs are particularly at risk of falling. Sedatives, antidepressants, and anti-psychotic drugs can contribute to falls by reducing mental alertness, worsening balance and gait, and cause drops in systolic blood pressure while standing.

The physical effects of aging, such as arthritis and failing eyesight and memory, can also cause issues in taking medicines the way the doctor intended.

When initiating a new medication, the resident should be observed closely for any changes in their gait, alertness, or balance. The resident's physician should be notified of any changes.

RESIDENT FALL RISK FACTORS: EYESIGHT PROBLEMS

Reduced vision leads to an increase in falls. Vision problems occur due to a wide variety of reasons and afflict residents of all ages. Age related eyesight changes include a decline in visual acuity, glare intolerance, altered depth perception, near vision problems, decreased night vision, and/or a decreased night vision, and/or a decline in peripheral vision.

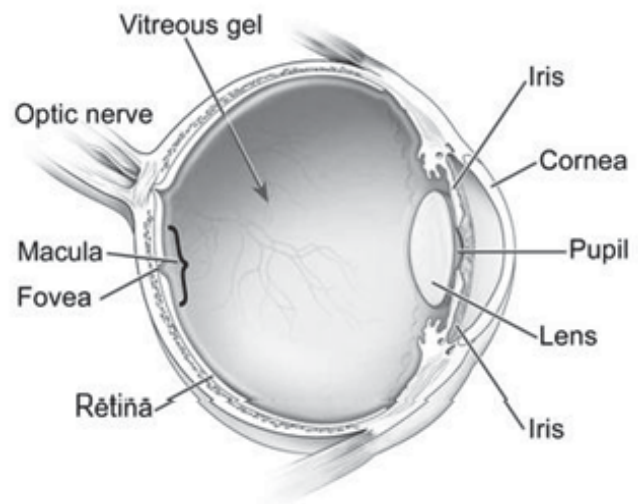
It also takes longer for eyes in the elderly to adjust to changes in light and dark, such as walking indoors after being in the garden.

Disease such as glaucoma, cataracts, macular degeneration, diabetes and blindness can greatly increase instances of falls. These diseases can affect many parts of the eye, including the:

Lens: The lens adjusts the eye's focus, letting us see things clearly both up close and far away.

Retina: The retina is the light-sensitive layer of tissue at the back of the inner eye. It acts like the film in a camera. The retina then converts the light images into electric signals and sends them via the optic nerve to the brain.

Macula: The macula is an oval-shaped spot new the center of the retina. It is responsible for precise, central vision.



Glaucoma

Glaucoma is a disease in which the optic nerve located in the back of the eye is damaged, which leads to progressive, irreversible loss of vision. It is often, but not always, associated with increased pressure of the fluid in the eye. Glaucoma affects 1 in 200 people aged fifty and younger, and 1 in 10 over the age of eighty.

Eye drops prescribed for treatment of glaucoma work to prevent pressure inside the eye from rising and causing damage to the optic nerve. Ensure your resident instills the drops exactly as prescribed by the optometrist, as an increase in intraocular eye pressure is intraocular eye pressure is painful and will blur eyesight which can contribute to falls.

Glaucoma

(Image courtesy National Eye Institute, National Institutes of Health)

Normal Vision



Same scene as viewed
by a person with glaucoma



Cataract

A cataract is a clouding of the eye's natural lens, which lies behind the iris and the pupil. The clouding varies in degree from slight to complete opacity that obstructs the passage of light. The resident's vision clouding caused by cataracts places your resident at a high risk for falls and injury.

Cataract

(Image courtesy National Eye Institute, National Institutes of Health)

Normal Vision



Same scene as viewed
by a person with cataract



When symptoms begin to appear, your resident may be able to improve his or her vision for a while using new glasses, strong bifocals, magnifying lenses, direct lighting or other visual aids. If these measures do not help, surgery is the only effective treatment. Surgery involves removing the cloudy lens and replacing it with an artificial lens.

Age-Related Macular Degeneration

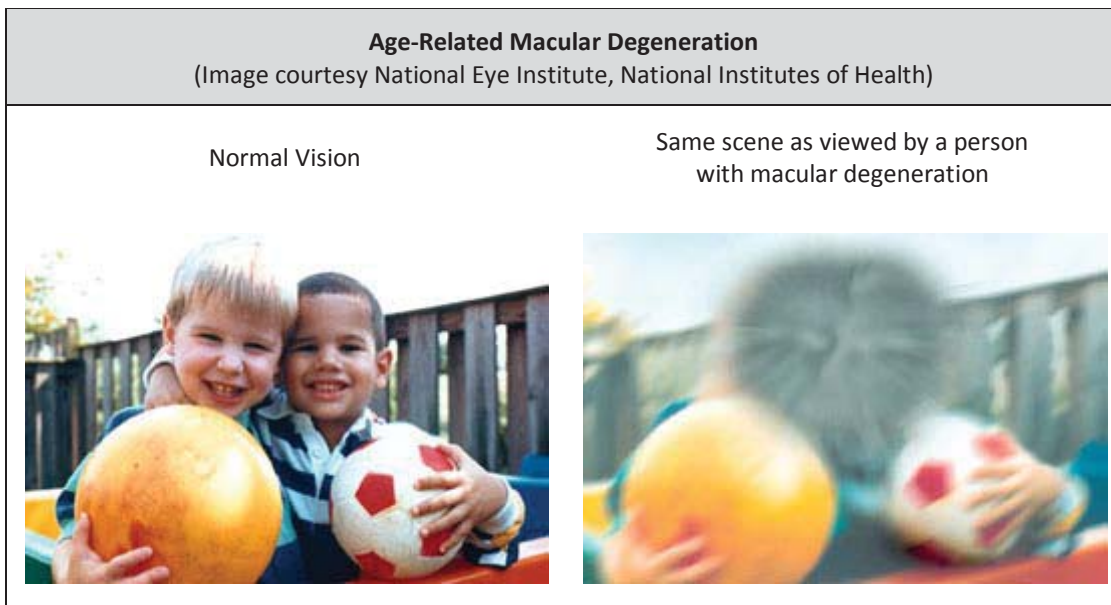
Macular degeneration or age-related macular degeneration (AMD) is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys the sharp, central vision. Central vision is needed to see objects clearly and to do tasks such as reading and walking.

AMD causes cells in the macula (a part of the retina) to die, so central vision loss may occur. With loss of central vision comes an increase in the risk for falls and increased risk of injury.

In some cases, AMD advances so slowly that people notice little change in their vision. In others, the disease progresses faster and may lead to a loss of vision in both eyes.

The symptoms of age-related macular degeneration include:

- The need for increasingly bright light when reading or doing close work
- Increasing difficulty adapting to low light levels, such as when entering a dimly lit room
- Increasing blurriness of printed words
- A decrease in the intensity of brightness of colors
- Difficulty recognizing faces
- Gradual increase in the haziness of overall vision
- Blurred or blind spot in the center of the visual field combined with a profound drop in the sharpness (acuity) of central vision



Diabetic Retinopathy

Diabetes can cause vision disturbances which place the resident at a risk for falls. All people with diabetes – both type 1 and type 2 – are at risk of diabetic retinopathy. Retinopathy refers to non-inflammatory damages to the retina of the eye, in most cases, due to problems with blood supply. Retinopathy leads to decreased vision and eventually blindness.

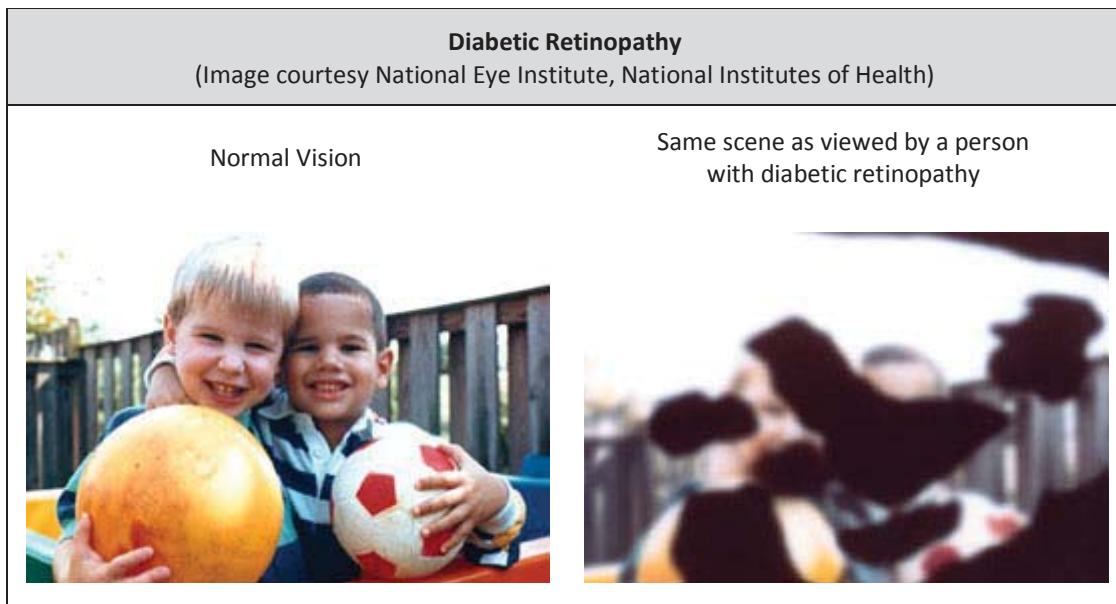
Diabetic retinopathy is the leading cause of blindness in those with diabetes. Between 40 to 45 percent of Americans diagnosed with diabetes have some stage of diabetic retinopathy. The longer someone has diabetes, the more likely he or she will get diabetic retinopathy.

Poor blood sugar control in diabetic patients makes small blood vessels in the eye (capillaries) become fragile and leak onto the macula (part of the retina), which is responsible for precise vision. As the disease progresses, some of the damaged blood vessels are closed off and block the blood supply to parts of the retina.

During the later stages of retinopathy, new capillaries grow in the eye to supply blood to the areas that are damaged. These new capillaries are very fragile. Bleeding from these new capillaries can severely reduce vision capacity and cause blindness.

Symptoms of diabetic retinopathy include:

- Blurred vision and gradual vision loss
- Floaters (particles that float in the eye)
- Shadows or missing areas of vision
- Difficulty seeing at nighttime



Good control of blood sugar levels through medications and/or lifestyle changes prevents the onset and slows down the progression of diabetic retinopathy. However, diabetics also have a higher risk of other eye problems we discussed previously including cataracts and glaucoma.

RESIDENT FALL RISK FACTORS: HIP, LEG, AND FOOT DISORDERS AND INJURIES

Hip, leg and foot disorders and injuries include:

- Arthritis
- Osteoporosis
- Loss of a limb or a toe
- Weakness or paralysis from a stroke or trauma
- Lack of muscle tone, strength, and flexibility

Arthritis

Arthritis is inflammation of one or more joints, which results in pain, swelling, stiffness, and limited movement. Arthritis can occur in men and women of all ages. About 1 out of every 7 people in America has arthritis of some kind.

Types of Arthritis

There are more than 100 different types of arthritis. Some of the more common types include:

Osteoarthritis. This is the most common type of arthritis. It occurs when the cartilage covering the end of the bones gradually wears away, the bones begin to rub against each other, and the resulting friction leads to pain and swelling. Osteoarthritis can occur in any joint, but most often affects the hands and weight-bearing joints such as the knee, hip and facet joints (in the spine).

Rheumatoid arthritis. Rheumatoid arthritis is a long-term disease that most commonly involves the hands, wrists, and knees. With rheumatoid arthritis, the immune system – the body's defense system against disease – mistakenly attacks itself and causes the joint lining to swell. The inflammation then spreads to the surrounding tissues, and can eventually damage cartilage and bone. In more severe cases, rheumatoid arthritis can affect other areas of the body, such as the skin, eyes, lungs, and nerves.

Gout. Gout is a painful condition that occurs when the body cannot eliminate a natural substance called uric acid. The excess uric acid forms needle-like crystals in the joints that cause swelling and severe pain. Gout most often affects the big toe, knee, and wrist joints.

With arthritis of the hands or fingers, gripping a cane or other walking device becomes more difficult. Should that grip fail, a fall is more likely. Let us look at an example:

Your resident, Mary, has arthritis of the hands and uses a single point cane for safety and mobility. Mary walks from the bathroom to the living room, catching her cane on the carpet as she transitions. She drops the cane, as she cannot grip it tightly, stumbles and falls to the floor. This fall may have been prevented had she been using a different mobility aid she was able to hold onto with both of her hands, such as a walker.

Remember, arthritis can occur in the lower limbs as well. It is common in ankles, knees and hips causing pain, stiffness, swelling and weakness. A resident with lower extremity arthritis is prone to stumbles and falls.

Residents with diabetes and impaired circulation are at a higher risk of losing a limb or toe. Obviously, the loss of a digit or a lower extremity amputation affects the balance of mobility and raises the risk of falls.

Pain medications given to arthritis sufferers, also pose a fall risk, especially if the medication has side effects that cause cognition and balance deficits.

Osteoporosis

The word “osteoporosis” means “porous bone.” It is caused by more bone cells being reabsorbed than being deposited. This imbalance results in a progressive loss of bone density and a thinning of bone tissue. Osteoporotic bones are more porous and therefore more vulnerable to fracture.

Osteoporosis is often called “silent” because bone loss occurs without symptoms. People may not know that they have osteoporosis until a sudden strain, bump, or fall causes a bone to break.

Osteoporosis is a chief cause of fractures in older adults, especially among women. Professionals debate whether brittle bones break after a fall or break first which causes the fall. In either event, a decrease in bone density contributes to falls and injuries.

Osteoporosis can strike at any age, but it most common among older people, especially older women. Of the 10 million Americans with osteoporosis, 80 percent are women. One out of every 2 women and 1 out of every 4 men will have an osteoporosis-related fracture in their lifetime.

Osteoporosis is caused by hormonal changes, a decreased in physical activity, and calcium and vitamin D deficiency. Regular exercise and vitamin and mineral supplements can reduce and even reverse loss of bone density. Several medications are approved by the Food and Drug Administration for the treatment of osteoporosis.

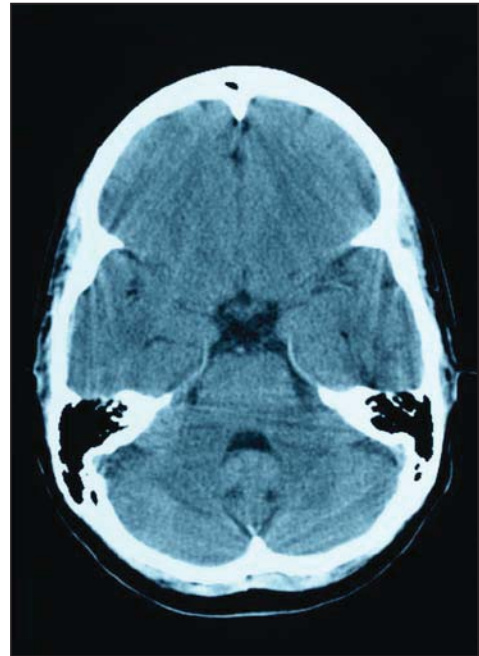
Weakness or Paralysis from Stroke or Trauma

A stroke, sometimes called a cerebrovascular accident (CVA), happens when blood flow to a part of the brain is interrupted. This can be due to ischemia (lack of blood flow) caused by blockage or a hemorrhage (leakage of blood). The symptoms of stroke depend on what part of the brain is damaged.

The signs of a stroke may include weakness, numbness, blurred vision, confusion, and slurred speech. Prompt treatment of stroke may minimize brain damage and improve the chances of survival and subsequent disability.

The prognosis following a stroke is related to the severity of the stroke and how much of the brain has been damaged. Some patients return to a near-normal condition with minimal awkwardness or speech defects.

Many stroke patients are left with permanent problems such as weakness on one side of the body, difficulty or the inability to speak, or incontinence of the bowel and/or bladder. A significant number of persons die from a stroke.



Brain injury during a stroke leaves survivors prone to nerve and muscle imbalances. About 40 percent of survivors have serious falls within a year of their stroke. Residents with mild weakness on one side display poor arm and leg swing, which becomes more obvious during periods of rapid walking. With severe weakness, the knee of the affected leg moves in a wide swinging pattern to help with ground clearance. Even so, the weakened foot tends to drag and place the resident at risk for tripping and falling.

Lack of Muscle Tone, Strength, and Flexibility

Any cause at any age that creates a lack of muscle tone, lack of strength, and lack of flexibility will increase the risk of falls and severity of injury due to falls. Unfortunately, decreased strength from loss of muscle tissue, poor muscle tone, and loss of bone mass and flexibility are normal aging changes. As an individual ages, he/she is at greater risk of falls unless diligent attention is paid to regularly performing weight bearing exercises that include strength building and flexibility movements.

Physical changes in older people tend to create a stooped posture, with head and neck slightly bent forward and hips and knees flexed. This change not only alters the body's balance, but may result in more instability when attempting to stop a fall in progress.

Changes in gait occur with normal aging and may contribute to falls. Women develop a narrow walking and standing base, and walk with a pelvic waddle. Older men tend to adopt a wide-standing walking base with a small stepped gait. Both sexes decrease walking speed and spend more time in the support phase of gait.

RESIDENT FALL RISK FACTORS: DISEASE AND ILLNESS

A wide variety of diseases can contribute to falls. For example, any disease that creates weakness, loss of balance, or loss of flexibility can contribute to a fall. In addition, many medications that are prescribed to treat these conditions can contribute to a fall.

Let's look at a few common examples:

- Any condition or medication that may cause a person to feel dizzy or light headed. This can be due to a number of causes such as blood pressure medication, flu, or respiratory illness, urinary tract infection, effects of a new medication, over medication, lack of hydration, and alcohol use.
- Pulmonary disease, tremor, seizure disorder, heart or vascular disease, and many other diseases can also contribute to a fall. Chronic disease may increase the risk of falls through direct effects of the disease and indirect effects, such as reduced physical activity, muscle weakness, and poor balance.
- Cognitive disorders are also a contributing factor. Confusion, anxiety, depression, the use of tranquilizers and antidepressants, and the interaction of multiple medications are all associated with an increased risk of falling.
- Incontinence, especially urge incontinence, can lead to a fall. A resident who suddenly feels the need to toilet may try to get up quickly and rush to the bathroom.
- Hearing difficulties can also be a fall risk if a resident cannot hear instructions from caregivers that are for the safety of the resident, such as to remain sitting until the caregiver adjusts the resident's mobility device.
- Any change of condition seen in a resident should prompt a physical evaluation. A change of condition may indicate a disease or condition that can very quickly increase the fall risk change of condition should be conducted as soon as possible to minimize the risk of a fall.

ENVIRONMENTAL RISK FACTORS

Environmental factors account for up to one-half of all falls among elders. The risk of environmental hazards contributing to falls is greatest in those individuals with poor ambulation and transfer abilities. The design of the environment needs to consider the residents' capabilities. For example:

- Individuals with poor gait are at greater risk of balance loss and falls when walking on waxed or slippery floors than those individuals with normal gait.
- Individuals with poor transfer capabilities are at greater fall risk when getting up from low-seated chairs than individuals with normal transfer capabilities.

A resident who is new to your Community is at greater risk for fall due to being in an unfamiliar environment. Be certain to provide a good orientation to light switches and other details. Also, residents who utilize equipment such as oxygen concentrators can fall while attempting to move the equipment. Remind them to ask for staff assistance before attempting to move the equipment on their own.

Common environmental hazards include:

- Elevated bed heights
- Low-seated chairs
- Low-seated toilets lacking sufficient grab bar support
- Poor lighting
- Stairways (especially with lack of hand supports/rails)
- Slippery floor surfaces (wet or polished floors, and rugs)
- Slippery tub/shower ground surfaces/insufficient grab bars
- Bedroom and hallway clutter
- Poorly maintained walking aids (canes and walkers)
- Lack of safety equipment, such as durable medical equipment

When a resident is elderly, frail, unstable, or weak from a recent illness or accident or suffers from a debilitating disease causing impaired balance or vision, the odds of having an accident are greatly increased.

Care providers must be aware that even the slightest irregularity, environmental factors causing unbalanced body posture, or inadequate lighting can cause a fall. For example, loose rugs and bathmats, uneven or loose steps, irregular transitions from room to room, cupboards or shelves that are either too high or too low to reach easily, or dim lighting in rooms and hallways are all serious environmental risk factors for falls.

FALL RISK REDUCTION STRATEGIES

Now that we have reviewed common fall risk factors, you probably have a pretty good idea what can cause falls. In this section we will discuss major fall risk reduction strategies.

Fall Risk Assessment

The first step in a good fall risk reduction program is to conduct a fall risk assessment on each resident. This should be performed by an appropriately trained or licensed health professional (refer to your Community policy).

A good fall prevention assessment should include:

1. A pre-admission assessment that should be conducted before move-in to identify individual fall risk factors.
2. The identification or underlying conditions that may increase a person's fall risk. Be aware of those conditions that need treatment to reduce the person's risk.
3. A medication assessment to determine the number and types of medications that may increase a resident's risk of falling.
4. An assessment after a fall to determine the cause of the fall and take steps to prevent a fall in the future.

Now let us look at some specific fall prevention recommendations that apply to all residents.

GENERAL FALL RISK REDUCTION STRATEGIES

- Always remind the resident to request assistance as needed.
- Ensure that all pathways (hallways, bedroom, bathroom, etc.) are free of obstacles and is properly lighted.
- Provide appropriate chairs with arms that are solid and secure.
- Observe environment for potentially unsafe conditions, such as loose carpeting, uneven walkways, slippery floors, loose grab bars, water on the floor, etc. Immediately notify appropriate department(s) of hazardous conditions.
- Identify residents that are “at risk” for falling and implement specific fall risk reductions strategies for that specific resident. For example, residents who require a 2-person lift, residents who have recently returned from the hospital, residents on new medications, etc.
- Make sure both the resident and the resident’s family members are educated on that resident’s plan of care to prevent falls.
- Consider the resident’s cognition when planning fall prevention strategies.
- Make sure all staff are educated about medical conditions and prescribed medications that affect level of consciousness, gait, and balance.
- Communicate the resident’s “at risk” status and/or changes in condition during shift report and with other medical professionals as appropriate.
- Keep stairs and sturdy hand rails maintained in good repair.
- Remind residents to wear prescribed glasses, and make sure the glasses are clean for best vision.
- Encourage the wearing of sun glasses while in bright sunlight.



- When assisting a resident into a room with a different light level, allow him/her time for their eyes to adjust to the change.
- Have an emergency call system in place, such as call lights, so a resident does not have to get up to get help.
- Minimize glare from outside by applying tint to windows or using blinds during the day.
- Make sure the resident has adequate light to illuminate reading materials.
- Recommend/provide reading materials in large print or books on tape for the sight impaired.
- Do not rearrange the furniture in a vision impaired resident's room.
- Confirm that residents with hearing impairments actually heard instructions, such as to stand a moment before walking.
- Always allow sufficient time after a resident stands up before removing support or having the resident walk. Orthostatic hypotension (also called postural hypotension) is a form of hypotension (low blood pressure) in which a person's blood pressure suddenly falls when the person stands up from sitting or lying down. Orthostatic hypotension can cause a resident to feel dizzy or even faint and cause a fall.
- Make sure staff is trained on fall risk factors and prevention strategies.

FALL RISK REDUCTION: MEDICATIONS

Let us look at some specific medication related recommendations to consider when designing fall prevention strategies.

- Have the resident take a list of all prescription and over-the-counter medications and supplements to all doctor's appointment. It is important for the physician to be aware of any medication interactions that could increase the risk of a fall.
- Do not allow family members or residents to change medication regimen without a doctor's approval and order.
- Always give medications exactly as prescribed.
- When beginning a new medication or an increase in a medication dosage, a resident is likely to experience adverse reaction or side effects making him/her more susceptible to falling. Carefully observe this resident for any changes in their baseline behavior and report any changes to their physician promptly.
- Conduct a regular pharmacy or physician review of medications to identify medications and interactions that can increase fall risk.
- Be aware of any over-the-counter medications that a resident may be taking or brought to a resident by a family member. It is recommended (and required in many states) that a physician's order be obtained for all over-the-counter medications.
- If a resident falls, he/she should be evaluated by a medical professional, including a review of medications. The resident's physician may choose to stop drugs that increase the risk of a fall or adjust dosage to the lowest effective dose.
- If a specific disorder is identified as a risk factor, some targeted interventions may help. For example, physical therapy may reduce risk of falls for patients with Parkinson's disease. If you have a resident with a disorder that is having difficulty, you may wish to consult with the resident's physician to see if he/she thinks a targeted intervention may help prevent a fall.



FALL RISK REDUCTION: FOOTWEAR

Let us look at some specific recommendations related to footwear that can help prevent falls. We all are aware that residents should wear “sensible shoes.” But, what does that really mean?

- Shoes should have non-skid soles. Residents should not wear shoes with smooth leather or plastic soles, which can be slippery on carpets, wood and tile floors, and wet surfaces.
- On the other side of the spectrum, residents should also not wear shoes with heavy rubber lugs that can catch on carpets, especially when they are worn by people who barely pick up their feet when they walk. Also, the rubber tips on the toes of running shoes can cause a stumble on a carpeted surface.
- For an all-around shoe, consider walking shoes, which provide good traction and support but do not have heavy soles or rubber over the toes.
- Shoes should fasten securely. Velcro closures can make shoes easier to put on and take off. This may help prevent awkward positions while struggling with shoes.
- Avoid slip on shoes such as mules, clogs, slippers, and flip flops can side off or catch on the floor causing a fall.
- Make sure shoes fit well and are not loose.



FALL RISK REDUCTION: EXERCISE

Exercise is key to maintaining balance, muscle tone, and strength. Exercise that is weight bearing, such as walking, can also help keep bones strong.

Tai Chi, chair yoga, walking, dancing, and daily range of motion exercises, with physician approval, are appropriate for maintaining strength and flexibility. Your resident should have a physician's clearance before beginning any exercise program. If your resources are limited, encourage residents to utilize local resources, such as the senior center, for group exercise classes.

If the mobility of a resident is limited, Physical and Occupational Therapy may be able to provide service to a resident in your Community. Physical therapy and exercise programs can be done in the resident's room.

Physical therapists customize exercise programs to improve balance and gait and to correct specific problems contributing to fall risk, such as lower-extremity strength training.

A resident should always consult with his/her physician for exercise recommendations before beginning a new exercise activity. All exercise programs should be supervised by a qualified therapist or trainer experienced in working with elderly people.

A great exercise resource for older adults was published by The National Institute of Aging, which is part of the National Institutes of Health. They offer a free book called "Exercise and Physical Activity: Your Everyday Guide from the National Institute on Aging." This resource is available in print and online at:

<http://www.nia.nih.gov/HealthInformation/Publications/ExerciseGuide>



FALL RISK REDUCTION: GENERAL ENVIRONMENTAL SAFETY

- Remove loose floor rugs.
- Ensure adequate lighting that the resident doesn't have to turn on, especially at night.
- Remove clutter or obstructions from stairwells, hallways, and floor areas where walking occurs.
- Place commonly used items on middle and lowest shelves of kitchen and bathroom.
- Instruct residents to call for assistance to retrieve hard-to-reach items.
- Anchor loose telephone, extension and appliance cords.
- Be aware of the risks associated with bed rails. Full bed rails may be considered restraints, increase the likelihood of death due to bed entrapment, and can cause injury if a resident attempts to climb over the side rails. Half rails, assist rails, or transfer poles may be appropriate to enable mobility in limited circumstances with orders from the resident's physician. Make sure residents are instructed in proper use of devices.
- Adequately place chairs where residents can sit down in hallways or gardens if he/she gets tired.

FALL RISK REDUCTION: BATHROOM

- Install secure grab bars on tub side or shower wall to help with getting in or out of the tub/shower and on wall for extra support around toilet area.
- Never allow the resident to use toilet paper holders, towel racks or wall mounted sinks for supporting one's weight.
- Install non-slip mats in bathroom.
- Provide adequate lighting at all times.
- Provide or encourage purchase of a bathtub or shower seat for those with poor standing balance or general weakness. They are available with or without backs, height adjustments, and heavy-duty models to accommodate greater weight capacities and slip-resistant rubber feet or foldaway portable models.
- Provide a hand held shower head for residents to shower while sitting securely in a shower chair or stool.
- Provide or encourage residents who need it to purchase a bathtub transfer bench seat if the resident or caregiver has difficulty stepping over a bathtub wall or stepping into a standard shower stall. Transfer benches may be non-sliding, slide, and/or swivel. Sliding transfer benches may be free standing; others mount onto the tub wall.
- Have a resident use a raised toilet seat when the standard seat is too low to help those who have difficulty bending, sitting, or getting up and down from a regular toilet.
- Consider the use of a bedside commode placed next to the resident's bed for nocturnal toileting. A bedside commode allows the resident to toilet in close proximity to the bed without having to ambulate to a bathroom.

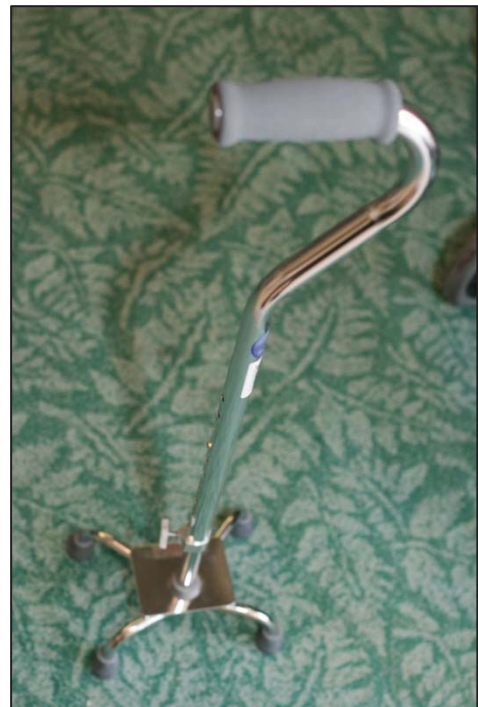
FALL RISK REDUCTION: ASSISTIVE DEVICES

Many residents use a cane, walker, wheelchair, lift chair, or other assistive device. Let's look at some general recommendations to prevent falls that are related to assistive devices:

- Always make sure the resident's assistive device is within easy reach and that the resident uses it as prescribed.
- If a resident's assistive device is moved by a direct care staff (such as outside the dining room) make sure the resident is instructed to wait for his/her device before attempting to stand. Ideally, a resident's assistive device should be within the resident's reach at all times.
- Make sure all assistive devices (walker, cane, wheelchair, mobility scooter, etc.) are properly adjusted and in good condition.

Canes

- All canes should be evaluated by an appropriate medical professional for correct height and usage. Generally, the height of the cane should come to the wrist when the user is standing still and straight. If the height looks incorrect, have the resident talk with his therapist or physician. Care staff should never adjust the height of a cane.
- Make sure the grips and stoppers on the bottom of the cane are not worn or broken.
- Make sure he/she has a good grip of the cane and that the fingers and thumb do not overlap.
- Never allow a resident to use another resident's cane.



Walkers

- Make sure a resident who has been prescribed a walker always uses it. These residents need the additional support to maintain balance or stability while walking.
- Make sure the resident was taught the proper way to use it.
- Never allow a resident to use another resident's walker.
- People who use a walker may need to have their doors and bathroom layout changed to accommodate this equipment. Special attention should be made to the direction that the door opens and transition plates from one room to the next.



- NEVER push a resident while the resident is sitting in a walker. They can easily tip and serious injury may result. If you must transport a resident who does not wish to walk, transfer the resident into a wheelchair.
- Evaluate rooms, doors, and bathrooms to determine if the layout will safely accommodate the use of a walker.

Wheelchairs

- Make sure the wheels of a wheelchair are firmly locked before transferring the resident in or out of a wheelchair.
- Be aware of uneven surfaces, such as thresholds and curbs, where it is necessary to wheel the resident backwards for safety.
- Be careful not to run the chair or resident into obstacles or other people.
- Remain attentive to consistently monitoring a resident's ability to safely navigate a mobility scooter.

- Evaluate the facility's architecture to determine if the layout is safe for the use of mobility scooters.

Chair Aids

- Chair aids include lift chairs or lift cushions.
- Make sure the resident and direct care staff follow the physician's/therapist's recommendations for transferring in and out of the chair aid.

RESPONDING TO A FALL

Despite our best efforts, a resident may fall. If a resident falls, always follow your Community's policy for how to respond when a fall occurs. In general, here are some recommended steps to follow:

1. Do not move a resident who has fallen. Call for help.
2. Inspect the resident for injury, such as does the resident feel any pain, are there any cuts or bruises, did the resident hit his/her head, are there any obvious signs of trauma, etc.
3. Seek medical attention. This may be from an in-house nurse or you may need to call 9-1-1 if you suspect a serious injury. Again, follow your Community's policy.
4. When in doubt, call 9-1-1. It is very difficult to see fractures or head injuries. And, the resident may have experienced a condition that lead to the fall such as a mini-stroke.
5. Once the resident is being safely cared for, contact the resident's family and responsible party to let them know of the fall.
6. Document the fall and the steps that were taken. Follow your Community's policy regarding documentation and reporting procedures.
7. Follow-up with the resident to provide care and to determine any preventative steps that could be implemented.