



FALL PREVENTION PROGRAM RESOURCE MANUAL

OFFERED BY:

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DISCLAIMER

The information, suggestions, and guidelines provided in this Fall Prevention Program Resource Manual are intended to serve as a resource to assist providers in developing their own fall prevention program.

The information included in this resource manual is not all-inclusive. This is not legal advice and should not be construed as such. Additional information may be required to meet federal, state, and/or local laws.

When developing and/or reviewing policy and procedures, it is expected that each provider incorporate "best practices" as directed by the Pennsylvania Office of Developmental Programs.



INTRODUCTION

Falls are the second leading cause of accidental death in the United States, and the leading cause of death due to injury for individuals age 73 and over (National Safety Council, 2007). 75% of falls occur in older adults (Newton, 1999). The United States Public Health Service estimates that 2/3 of deaths due to falls can be prevented.

Although little information is available concerning the relationship of falls and the population with intellectual/developmental disabilities (I/DD), it is known that falls are responsible for a large number of serious injuries. Individuals with I/DD often have multiple factors that place them at risk for falls. These may include impaired cognition, impaired mobility as a result of gait and balance disturbances, visual impairment, seizures, adaptive and maladaptive behaviors, and the use of antipsychotic medications.

There are wide-ranging consequences of falls. Physical health, emotional health, mental health, quality of life, and financial well-being can all be affected. Fractures, traumatic brain injury, prolonged hospitalization, and even death can occur. Mobility and independence can be affected, leading to a diminished quality of life. In many instances, fallopobia (fear of falling) develops, and places the person at risk of falling again. Extensive medical costs can be incurred due to hospitalization, rehabilitation, and possibly long term care placement. All of this can lead to anxiety and depression. Caregivers and family may incur injuries as a result of trying to keep the person from falling, or in trying to get them up after a fall.

Preventing and reducing falls poses a significant challenge to all providers of care for individuals with I/DD. With the advent and availability of fall prevention strategies, providers of care are being held legally accountable. Falls are a serious risk management issue that can be addressed through a fall prevention program. This type of program is a multifaceted approach to the prevention and reduction of falls. It involves everyone at all levels of an organization. Fall prevention must be considered in strategic planning and resource allocation. The benefits of having a fall prevention program in place are tremendous and include:

- Creates a teamwork culture
- Allows focus on prevention strategies
- Reduces number of falls
- Reduces number of serious injuries associated with falls
- Preserves and improves quality of life
- Reduces healthcare costs
- Provides information on falls related to individuals with I/DD
- Can prove a valuable asset if litigation occurs



- Creates a culture of change, not a culture of blame

This resource manual was developed to assist providers of care for individuals with I/DD in the development of an individualized fall prevention program geared toward the specific population they support. It will guide providers through the steps needed to create a fall prevention program, and provides tools and resources that can be utilized in implementation of the program.



SECTION A



STEPS IN DEVELOPMENT OF A FALL PREVENTION PROGRAM

1. Designate a team
2. Develop policy
3. Identify individuals at risk
4. Create a safe environment
5. Develop method of reporting
6. Develop post fall protocol of care
7. Develop prevention strategies
8. Education
9. Program evaluation



DESIGNATE A TEAM



The first step in implementing a fall prevention program is designating a team. This team will be responsible for development, implementation, oversight, and evaluation of the program. Implementing a fall prevention program is best accomplished using an interdisciplinary team approach. The interdisciplinary team approach is beneficial for numerous reasons, including:

- Success is more likely if a team is utilized when implementing a complex plan.
- Different perspectives to the entire process are gained when a team from all areas of an organization is utilized.
- Teams empower individuals at all levels of an organization, resulting in a “buy-in” to the process.

Senior management should designate someone to be the coordinator of the program. This person should be knowledgeable in fall prevention and have ample time to devote to the program. The coordinator, along with senior management, should then choose other members to serve on the team. Members of the team and the number of persons comprising the team will differ depending on the size of an organization. A person from each level and/or department of an organization should be included. Potential persons to consider when choosing a team are:

- Clinical staff
 - Medical director
 - Nursing staff
 - Pharmacist
 - Therapists



- Non-clinical staff
 - Senior management
 - Middle management
 - Direct care staff
 - Risk manager
 - Quality management staff
 - Facilities staff
 - Maintenance
 - Janitorial

Each member of the team should have individual responsibilities that are clearly defined in the fall program policy.

After the team is designated, the coordinator should set a meeting date to orient other team members to the fall prevention plan process. At this meeting the team should decide how to proceed with program development, the coordinator should assign individual responsibilities, and additional meeting dates should be set.



DEVELOP POLICY



The first responsibility the team should address is development of the fall prevention program policy. This policy will provide the framework for the fall prevention program and will serve as a resource for all staff. During the fall prevention program development phase the policy will be an ever-changing document. The team should start with an outline for the policy and make additions as the program is developed.

Following is a list of areas that should be included in a fall prevention program policy. An organization may decide to eliminate some areas or add areas to this list to tailor the policy to their needs.

- Statement of purpose: This statement should describe why the policy is being implemented and what it is supposed to accomplish.
- Definition of a fall, near fall, and an unwitnessed fall: There is no universally accepted definition of a fall, and many definitions are available. The organization must decide what is appropriate to their specific situation. Refer to Appendix A for a list of definitions that can be utilized in developing an organization's fall definition.
- Delegation of authority and responsibility: This section should delegate authority to one person to oversee the team. It should spell out the specific responsibilities of each team member, department, or staff person involved.
- Procedures
 - Fall risk assessment
 - Individual
 - Assessment tool to utilize
 - When/how often it will be performed
 - Who will perform
 - Where it will be stored



- Environment
 - Assessment tool/s to utilize
 - When/how often it/they will be performed
 - Who will perform
 - Where it will be stored
- Method of informing staff of high risk individuals
- Intervention strategies
 - Individual
 - General
- Reporting
 - How to report
 - Verbal: Who to notify
 - Written: What form to utilize
 - What incidents to report
 - Time frame for reporting
 - Who receives report
 - Where report will be stored
- Post fall protocol
 - Who will perform assessment
 - What reporting form to utilize
 - What risk assessment and action plan form to utilize
 - Time frame for completion
 - Follow-up
 - Who receives report
 - Where report will be stored
- Program evaluation
 - General evaluation of program
 - Incident evaluation
 - Methods to utilize
 - What incidents to evaluate
 - Time frame for evaluation
 - How information will be shared and with whom
- Education
 - Who to include
 - What to include
 - How often to educate
 - Documentation method
 - Where records will be stored

The policy should be reviewed at least annually, with improvements made as necessary throughout the year.

Refer to the guidelines for a fall prevention program policy in Appendix B.



IDENTIFY INDIVIDUALS AT RISK



A critical component of any fall prevention program is identification of individuals who are at risk of falling. Falls are multifactorial. Individuals who fall typically have more than one risk factor. Risk factors may be intrinsic (physiologic) or extrinsic (environmental) and must be examined on an individual basis. What results in a fall for one individual may not result in a fall for another individual. Refer to Appendix C for a list of risk factors.

Performance of fall risk assessments will allow for identification of individuals at risk for falling and their individual risk factors. Individual risk factors can then be examined more closely and prevention strategies put into place. An organization must decide who will be assessed, designate when assessments will be performed, decide on who will perform the assessments, and determine where the assessments will be stored. Most will state that all individuals will have an initial assessment completed on admission. These initial assessments often identify information not immediately apparent that may place the person at risk of falling. Ongoing assessments are needed to identify changes that may occur over time. Other times that may be designated for assessment may include upon transfer, whenever there is a change in status, whenever medication changes occur, after a fall, after hospitalization, or at regular intervals. Care must be taken not to “label” a person, but to focus on specific preventive strategies. It is preferable to have someone with a clinical background complete the assessment. If a clinical person is not available, then someone with sound judgment should be assigned the task. Completed assessments may be stored in the individual’s record or at some other designated place, but should be available for comparison when follow-up assessments are completed.

It is crucial for an organization to decide on one assessment tool that will be utilized. When the fall prevention program team is designated, one of the first tasks it will have is examining fall risk assessment tools and deciding which one will be utilized. These tools are the foundation of every fall prevention program.



There are numerous tools available; unfortunately most are not specific to individuals with I/DD. The most widely used is the Morse Fall Risk Scale. It is a valid and reliable tool but is not designed for long term care, and almost all individuals will be identified as high risk. Another tool is the Hendrich Fall Risk Assessment. This tool is not as researched as the Morse Scale and almost all individuals will fall into a high risk category. Both tools can be accessed at http://www4.va.gov/ncps/SafetyTopics/fallstoolkit/notebook/05_FallsPolicy.doc. Although these tools have been developed for hospital settings, they may be utilized as resources when developing an organization's own assessment tool. Assessment tools can be developed by an organization and tailored to meet specific needs. One such tool is available in Appendix D. The team must keep in mind that whatever assessment tools are chosen, they must be easy to use for the designated staff. If they are too cumbersome they will likely not get completed.

When individuals are identified as high risk for falls an organization must designate a system of communication to staff apprising them of this risk. One method is through visual cues, such as using a specific sticker on the person's record or doorway. The Veteran's Administration uses a "falling star" sticker to designate a person at risk of falls. Another method could be through posting of a notice of those at risk in the staff area. The team should brainstorm for ideas and choose one appropriate for their organization.



CREATE A SAFE ENVIRONMENT



A safe environment doesn't just happen. Proper maintenance of the environment is critical to the success of a fall prevention program. Environmental risk factors for falls need to be identified through initial and on-going observation and inspection. This is best accomplished through the use of an environmental checklist and an equipment safety checklist. These checklists will provide staff with guides to assess the environment and equipment for potential to cause falls. Standardized checklists should be adopted. Numerous generic checklists are available on the internet, or an organization can develop one specific to their needs. Refer to Appendix E for an example of an environmental safety checklist and to Appendix F for an example of an equipment safety checklist. A time interval for completing these checklists should be established. Some organizations may choose to have them completed weekly and some monthly. An environmental inspection can be approached room by room or by elements such as lighting, flooring, clutter, etc. Inside and outside inspections should be included. A specific individual should be designated to complete these checklists, with facilities maintenance staff being preferable. Depending on the size of the organization, there may be more than one person designated. When a risk factor is identified it should require corrective action be taken, and a specific person should be designated to perform that corrective action. Although there are specific individuals completing these checklists, it must be stressed to all staff that creating a safe environment is everyone's responsibility. If a risk factor is identified at any time, it should be reported to the proper person with follow-up to ensure that corrective action has been taken. A fall hazard report form can be utilized for this purpose. Refer to Appendix G for an example of a fall hazard report form. There should be a designated place for storage of these checklists, fall hazard reports, and corrective actions that have been taken.



DEVELOP METHOD OF REPORTING



Within a fall prevention program there must be a method of reporting. A decision should be made on what events will be reported. Most organizations will report all falls, near falls, and identified hazards within the organization. Verbal and written reporting should be addressed. Staff should have clear direction of whom to verbally notify and the timeframe within which this notification should occur. Standardized forms, specific to the organization, should be developed. These should include a fall hazard report form and a fall/near fall report form. These will allow for identification and correction of hazards, evaluation of individual falls, and the collection of data that will be used for evaluation of the program. Each form should include sufficient detail about the hazard or event to allow for comprehensive analysis.

A fall hazard report should include:

- Name of person reporting hazard
- Date of report
- What hazard is being reported
- Location of hazard
- Immediate corrective action taken
- Measures taken to correct hazard
- Follow-up
 - Date completed
 - What action taken
 - Who completed

A fall/near fall report form should include:

- Name of person reporting event
- Witnesses to event
- Date of the report
- Name of person involved
- Location of event
- Date/time of event
- Who and when notified



- Narrative description of event to include level of consciousness, injuries, description of what person was doing when event occurred, actions taken
- Contributory factors
 - Mobility
 - Cognitive and functional
 - Environmental
 - Assistive devices
- Follow-up by organization supervisor/nurse

Refer to Appendix G for an example of a fall hazard report and Appendix H for an example of a fall/near fall report form.

There should be a designated person who receives the forms and a designated place for storage of the documents. Copies of the reports should be sent to the falls prevention program team for review.



DEVELOP POST FALL PROTOCOL FOR CARE



Development of a post fall protocol for care is critical to the success of any fall prevention program. The protocol should include assessing and addressing immediate and long term care needs of the person, as well as actions to ensure the reduction of risk for future falls. Additionally it should include a retrospective look at the person's record to see if a fall risk assessment was performed, and if so, if the identified risks were addressed at that time.

Assessing and addressing immediate needs should occur as soon as a fall is witnessed or discovered. This should be performed by staff that is either with or finds the person. If injuries are sustained, specific actions to take should be clearly defined.

The fall should be documented on the approved fall report form. A designated method for notifying all staff of the fall and increased risk of fall should be specified. A post fall risk assessment and action plan form should be completed to identify contributing factors and address corrective actions. Refer to Appendix I for an example of a post fall risk assessment and action plan form. A copy of this form should be provided to each person responsible for a part of the action plan and a copy sent to the falls prevention program team for review. Someone should be designated to follow-up within a specified timeframe to ensure compliance with the action plan. A designated place for storage of the post fall assessment and action plan form should be determined.



DEVELOP PREVENTION STRATEGIES



Completing a fall risk assessment on individuals and performing an environmental assessment is just the beginning of a fall prevention program. Once risks are identified, it will be possible to consider each factor individually and identify strategies aimed at prevention to address those risks. It is helpful if a list of preventive strategies has been developed and incorporated into the fall prevention program. This will save time and effort by eliminating the need to come up with strategies each time a risk is identified. Staff will know what interventions are available to them, and it will assist in developing support plans based on specific needs of individuals.

One method of developing prevention strategies is to take each identified risk factor for an organization and have the team brainstorm ways to minimize that risk. As new risk factors are identified, they should be addressed in the same manner and added to the list. Refer to Appendix J for a list of prevention strategies.

Additionally, the prevention strategy list can be used for individual risk factors identified through a fall risk assessment. Additional strategies may be added to the list as they are identified.

This prevention strategy list should be used in a proactive manner. When a risk assessment is performed, individual or environmental, identified risks should be addressed immediately. Not all strategies will be appropriate to an identified risk, but rather, strategies should be chosen from the list that are appropriate to the given individual or situation. Strategies for individuals should then be utilized to make changes to the person's Individual Support Plan.

EDUCATION



Education is essential to the success of a fall prevention program. Designation should be made on who will be trained, when/how often training will occur, and what will be included in training sessions. These are questions the fall prevention program team must consider.

Educational sessions should include staff at all levels, individuals, and families. Each session should be individually designed to meet the differing needs of each group.

At a minimum, all staff should be trained upon hire and annually thereafter. Knowledge of the program and its components will empower staff to become active participants in fall prevention. Everyone must understand why it is important to support the fall prevention program. Training sessions should be designed to meet the needs of an organization. This resource manual can be used as a resource for an education program. Following is a list of suggested topics to consider as part of staff training:

- Purpose of fall prevention program
- Members of the fall prevention program team
- Fall prevention program policy review
- Definitions of fall, near fall, and unwitnessed fall
- Expectations of each level of staff
- Report forms review
 - Fall/near fall report
 - Post fall risk assessment and action plan
- Common risk factors
- Fall risk assessment form
- Method of staff notification of individual at risk
- Environmental safety checklist
 - Fall hazard report form
- Equipment safety checklist
- Prevention strategies
 - How to incorporate into individual support plan
- Program evaluation



Effectively trained staff will increase the awareness of individuals at risk of falling, assist in identifying individual and environmental risk factors, and increase the likelihood of preventive strategies being implemented before a fall occurs.

Providing education on the fall prevention program to individuals and families can be a contributing factor to the program's success. Knowledge that a fall prevention program is in place will convey an organization's attitude of safety and caring for the individuals supported. Individual preventive strategies and environmental preventive strategies may be better accepted when individuals and families understand the reasons behind them. Information should be provided upon admission and reviewed on a regular basis thereafter. The information can be provided either verbally and/or in written format. An organization may choose to develop a brochure with information related to the fall prevention program. However the information is presented, it should be designed to meet the needs of the organization. Suggested educational information to include for families and individuals follows:

- Purpose of the fall prevention program
- Members of the fall prevention program team
- Fall risk assessments
 - Individual
 - Environmental
 - How to report an identified risk
- Steps taken after a fall occurs
- Evaluation process after a fall occurs
- Preventive strategies for the individual
- How the fall prevention program is evaluated

All education provided to staff, individuals, and families should be documented and stored in a designated place.

PROGRAM EVALUATION



Comparing fall data between organizations is difficult and unreliable. This stems from lack of consistent fall definitions, reporting methods, and resident populations. The most reliable method of measuring success of a fall prevention program is for an organization to analyze its own quality indicators over time.

Initially, consider performing an organizational self assessment. The Veterans Administration has an Injurious Fall Prevention Organizational Self Assessment. The assessment is geared toward VA hospitals, but can be adapted for use by any organization. This assessment can be accessed on the following website: <http://www.visn8.va.gov/PatientSafetyCenter/fallsteam/FallAssessmentTool.doc>.

An organization must determine how often it will analyze fall data. It may be monthly, quarterly, and/or annually. Measuring the success of a fall prevention program typically involves four steps:

STEP 1 is determining what data will be reviewed. This may include all falls, near falls, falls with injury, and severity of injury. Other data that an organization may want to examine includes who fell, when did the fall occur, where did the fall occur, and why did the fall occur.

STEP 2 involves the determination of what type of measurement to perform. The basic types of measurement include outcome, process, and balancing. Outcome measurements measure goals. They determine if a desired outcome such as a decrease in the number of falls or a decrease in the number of falls with major injury has occurred. A fall rate/injury rate calculation can be used to show the level of falls or major injuries in an organization. It may also be used to show that an intervention was effective in reducing the number of falls or major injuries. A fall rate is a formula used to measure risk for falls. It indicates how many falls can be expected per every 1000 bed days of care (BDOC). The formula is: $\text{Number of falls/BDOC} \times 1000 = \text{fall rate}$. If an organization supported 30 individuals for 30 days and there were 5 falls within those 30 days then the calculation would be: $5/900 \times 1000 = 5.5$ or for every 1000 BDOC the

organization can expect 5.5 falls. An injury rate is a formula used to measure risk for injury with falls. It indicates how many injuries can be expected for each 100 falls. The formula is: $\text{Number of injuries/number of falls} \times 100 = \text{injury rate}$. If an organization had 10 falls and 4 injuries as a result of the falls then the calculation would be: $4/10 \times 100 = 40$ or for every 100 falls the organization can expect 40 injuries. Process measurements determine if implemented processes, such as a fall risk assessment, environmental checklist, or staff education have been successful. Balancing measurements watch data on areas that might be affected by implementations for improvement made in another area. Examples of this might include how restraint usage is affected by fall prevention strategies or how resident rights are affected by fall prevention strategies.

STEP 3 is collecting baseline data to be used for comparison. This data will originate prior to program or preventive strategy implementation and is used to determine if change has occurred after implementation of interventions.

STEP 4 is collection of data after the program or preventive strategy implementation and consequent analysis of that data. There are various methods of data analysis that can be utilized. They can be reviewed on the following websites:

- <http://www.premierinc.com/safety/topics/falls> (under measurements & comparisons)
- http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/07_m easuringsuccess.pdf (under # IV Analyzing the Data)
- <http://www.health.vic.gov.au/qualitycouncil/downloads/falls/tools.pdf> (under #11 - Falls Incident Data Management Framework Excel File)

The fall prevention program itself should be reviewed by the interdisciplinary fall prevention team annually and updated as needed throughout the year.

Data should be shared with staff to assist them in understanding the types of falls and the contributing factors to falls. As with any program evaluation, be careful not to ignore the successes. Share the data that shows success with all members of the staff, and provide them with credit for the part they have played in the fall prevention program. This will empower them to continue to work toward identifying risk factors and implementing prevention strategies.



SECTION B



APPENDICES

- A. Fall Definitions
- B. Fall Prevention Program Policy (Guidelines)
- C. Risk Factors
- D. Falls Risk Assessment
- E. Environmental Safety Checklist
- F. Equipment Safety Checklist
- G. Fall Hazard Report Form
- H. Fall/Near Fall Report
- I. Post Fall Risk Assessment and Action Plan
- J. Prevention Strategies



APPENDIX A

FALL DEFINITIONS

Fall:

1. Loss of upright position that results in landing on the floor, ground or an object or furniture or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair (United States Department of Veterans Affairs).
2. An event which results in a person coming to rest non-purposely to the ground or other lower level and is not the result of the following: Sustaining a violent blow, loss of consciousness; sudden onset of paralysis, as in stroke; or an epileptic seizure (Kellogg International Working Group).
3. A sudden, uncontrolled, unintentional downward displacement of the body to the ground or other object excluding falls resulting from violent blows or other purposeful actions (United States Department of Veteran Affairs).
4. Any untoward event in which the patient comes to rest unintentionally on the floor (Central Florida Kidney Center).
5. Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of syncope or overwhelming force (APS Healthcare SWPA HCQU).
6. To leave an erect position suddenly and involuntarily (Merriam-Webster Online Dictionary).

Near fall:

1. Sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling (United States Department of Veterans Affairs).
2. Loss of balance that does not result in a fall (Agency for Healthcare Research and Quality).
3. A slip (sliding of the support leg), trip (impact of the swinging leg with an external object) or loss of balance where the person starts to fall but is able to stop or prevent the fall to the ground or other lower surface (Arnold & Faulkner).

Un-witnessed fall:

1. Occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she got there (United States Department of Veterans Affairs).



APPENDIX B

FALL PREVENTION PROGRAM POLICY (GUIDELINES)

TITLE: FALL PREVENTION PROGRAM POLICY (Guidelines)

PURPOSE: Statement of intent. Consider: To delegate responsibility and establish procedures to assess fall risk, implement fall reduction strategies, outline documentation procedures, and evaluate effectiveness.

DEFINITIONS: Develop organization specific definitions.

Fall:

Near fall:

Unwitnessed fall:

DELEGATION OF TEAM AND RESPONSIBILITIES:

- Fall prevention team will consist of:
 - Use titles rather than names, as individuals may change
 - Designate one person to oversee the team
- Responsibilities of (one bullet for each title)
 - Consider what each person can contribute to the team
 - Example: Responsibilities for agency nurse
 - Assess fall risk of each individual upon admission and annually
 - Complete incident report following fall
 - Supervise ancillary personnel in providing safe care

PROCEDURES:

- Fall risk assessment
 - Individual assessment
 - Designate the assessment tool to be utilized
 - Designate who will be screened
 - Specify when/how often the assessment will be completed
 - Name who will complete the assessment
 - Specify where these assessments will be stored
 - Specify how high risk individuals will be addressed (i.e. an depth clinical assessment)
 - Specify system for communication to staff of high risk status
 - Environmental assessment
 - Designate the assessment tool/s that will be utilized
 - Specify when/how often the assessment will be completed
 - Name who will complete the assessment
 - Specify where assessments will be stored



- Intervention strategies
 - List specific strategies that will be utilized to reduce fall risk
- Reporting
 - Designate who is to be notified when a fall occurs
 - Designate what form to use for reporting a fall, near fall, unwitnessed fall, fall hazard
 - Specify what types of incidents should be reported
 - Specify a time frame for reporting
- Post fall protocol of care
 - Designate who will perform an assessment
 - Designate what form to use for reporting
 - Designate what form to use for risk assessment and action plan
 - Specify a time frame for completion
- Program evaluation
 - Specify what methods will be utilized for evaluation
 - Specify what incidents will be evaluated
 - Specify time periods for evaluation
- Education
 - Designate who will be included in education regarding fall prevention
 - Specify what will be included in the education program
 - Specify when education on fall prevention will be provided

Date Issued:			
Review/Revision Date:			
Signature/Initials:			
NOTE: The information included in this manual is not all-inclusive. Additional information may be required to meet federal, state, and/or local regulations. See full Disclaimer Page i.			



APPENDIX C

RISK FACTORS

Demographics

- Over age 65
- History of falls

Medical Related Factors

- **Neurologic**
 - Seizure disorder
 - Parkinson's disease
 - Trans-ischemic attack (TIA)
 - Cerebral vascular accident (CVA)
 - Cognitive impairment
 - Dementia
 - Alzheimer's disease
 - Confusion
 - Disorientation
 - Peripheral neuropathy
 - Dizziness
 - Vertigo
- **Eye**
 - Cataracts
 - Diabetic retinopathy
 - Glaucoma
 - Macular degeneration
 - Decreased depth perception
 - Decreased contrast sensitivity
 - Increased sensitivity to glare
 - Decreased peripheral vision
 - Decreased night vision
 - Decreased visual acuity
 - Multifocal lenses
 - Outdated prescription lenses
 - New prescription lenses
- **Ear**
 - Hearing impairment
 - Inner ear infections
 - Meniere's Disease



- **Musculoskeletal**
 - Cerebral palsy
 - Multiple sclerosis
 - Muscular dystrophy
 - Rheumatoid arthritis
 - Osteoarthritis
 - Osteoporosis
 - Gait/balance problems
 - Scissoring gait
 - Walking on toes
 - Shuffling
 - Hip drop
 - Inability for leg to clear the floor
 - Muscular weakness
 - Deconditioning

- **Cardiovascular**
 - Arrhythmias
 - Orthostatic hypotension
 - Valve problems

- **Gastrointestinal**
 - Bowel incontinence

- **Urinary**
 - Urinary tract infections
 - Urine incontinence
 - Urinary urgency
 - Difficulty starting flow of urine

- **Metabolic**
 - Fluid/electrolyte imbalance
 - Dehydration
 - Diabetes Mellitus

- **Foot related**
 - Corns
 - Bunions
 - Overgrown nails
 - Ingrown nails
 - Thin heel pad
 - Dry, cracked skin
 - Decreased sensation
 - Ulcers



- **Emotional**
 - Depression
 - Fallophobia

Medications

- Polypharmacy: Four or more
- Side effects such as dizziness, drowsiness, or low blood pressure
- Types
 - Antianxiety
 - Antiarrhythmic
 - Anticholinergic
 - Antidepressant
 - Antiepileptic
 - Antihypertensive
 - Antiparkinson
 - Antipsychotic
 - Benzodiazepines
 - Diuretics
 - Hypnotics
 - Laxatives
 - Narcotic analgesics
 - Sedatives
 - Vasodilators

Assistive Devices

- Improper use
- Improper fit
- Faulty mechanics

Clothing

- Items too long: Skirts, dresses, pants, sleeves

Footwear

- Badly worn shoes
- Ill-fitting shoes
- High heels
- Flip-flops
- Backless shoes/slippers
- Thick soles
- Slick soles
- Crepe soles

Restraints



Environmental

- **Outside**
 - Lack of handrails on steps
 - Uneven sidewalks/terrain
 - Snow, ice on walkways
 - Clutter/debris/leaves on walkway
 - Gravel walkways

- **Inside**
 - Inadequate lighting
 - Lack of handrails in hallways/on stairways
 - Pets
 - Loose cords/wires
 - Monochromatic color scheme
 - Clutter
 - Raised doorsills
 - Low furniture: Sofa, chair
 - Wheels on furniture: Chairs, beds
 - Flooring
 - Shiny floors
 - Loose carpet
 - Thick pile carpet
 - Throw rugs
 - Linoleum/tile in ill-repair
 - Bathroom
 - Wet floor
 - Lack of grab bars
 - Low toilet seat
 - Kitchen
 - Wet floor
 - Item stored out of reach



APPENDIX D

FALLS RISK ASSESSMENT

Risk Factor		Risk Factor	
Age: Is the individual > 65	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence/frequent toileting/nocturia	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of fall/near fall: Has the individual had 2 or more falls in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feet/footwear: Does the individual have corns, bunions, etc.? Does the individual wear improper footwear?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Medications: Is the individual taking 4 or more medications? Does the individual take any of the following types of medication? <input type="checkbox"/> Psychotropic <input type="checkbox"/> Antidepressant <input type="checkbox"/> Antiepileptic <input type="checkbox"/> Antihypertensive <input type="checkbox"/> Antiparkinson <input type="checkbox"/> Narcotic analgesic <input type="checkbox"/> Sedative/Hypnotic <input type="checkbox"/> Diuretic <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Vasodilator	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic conditions: Does the individual have any of the following conditions that affect their balance and mobility? <input type="checkbox"/> Respiratory <input type="checkbox"/> Cardiac <input type="checkbox"/> Neurologic (Seizure disorder, stroke, cerebral palsy, Parkinson's, etc) <input type="checkbox"/> Vestibular disorder (Meniere's Disease, inner ear infection, etc.) <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Balance/Gait problems: Does the individual have difficulty with ambulation? Does the individual use an assistive device?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental status: Does the individual have any of the following: <input type="checkbox"/> Dementia <input type="checkbox"/> Confusion <input type="checkbox"/> Disorientation <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Fallophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensory loss: Vision Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Home modification required	<input type="checkbox"/> Yes <input type="checkbox"/> No



APPENDIX E

ENVIRONMENTAL SAFETY CHECKLIST

Location: _____ Date: _____

Person Completing: _____

	YES	NO	N/A
OUTSIDE AREAS			
Are walkways even, free of cracks or buckling?			
Are walkways free of overhanging branches and clear of shrubs or bushes?			
Are walkways free of clutter, debris, or leaves?			
Is there adequate room to maneuver walking aids on walkways?			
Are steps in good repair?			
Do steps have non-slip edges?			
Are step edges clearly defined?			
Are handrails present and in good repair on both sides of steps?			
Are ramps in place and in good repair if needed?			
Is there adequate outside lighting in walkway area?			
Is outdoor furniture sturdy and in good repair?			
Can a person enter and exit a vehicle on a level surface?			
KITCHEN			
Is adequate lighting present?			
Is there adequate space to maneuver walking aids?			
Are commonly used items stored so reaching/stretching is not needed?			
Is the floor free of clutter?			
Is the floor free of loose wires or cords?			
If carpet is present is it low pile and firmly secured?			
If throw rugs are present are they firmly secured?			
If flooring is hard surface is it a matte finish rather than shiny?			
Are non-skid cleaning/waxing products used on hard surface flooring?			
If flooring is hard surface, is it level and in good repair?			
Are door handles secure?			



BATHROOM	YES	NO	N/A
Is adequate lighting present?			
Is a nightlight present?			
Is the door handle secure?			
Is the floor free of clutter?			
Is the floor free of loose wires or cords?			
If carpet is present is it low pile and firmly secured?			
If throw rugs are present are they firmly secured?			
If flooring is hard surface is it a matte finish rather than shiny?			
Are non-skid cleaning/waxing products used on hard surface flooring?			
If flooring is hard surface, is it level and in good repair?			
Are grab bars present, secure, and properly positioned at the toilet, tub, and/or shower?			
Is the toilet seat well-fitted and secure?			
Is the toilet seat at a height to allow for easy transfer?			
If needed, is a raised toilet seat available?			
Is there a step free shower base?			
Is there a non-slip surface or mat in the tub/shower?			
Are the tub/shower doors made from shatterproof glass?			
Are the soap/shampoo holders within easy reach to prevent bending or stretching to reach them?			
Is there room for a seat near and in the shower?			
BEDROOM			
Is the floor free of clutter?			
Is the floor free of loose wires or cords?			
If carpet is present is it low pile and firmly secured?			
If throw rugs are present are they firmly secured?			
If flooring is hard surface is it a matte finish rather than shiny?			
Are non-skid cleaning/waxing products used on hard surface flooring?			
If flooring is hard surface, is it level and in good repair?			
Is the door handle secure?			
Is adequate lighting present?			
Is a nightlight present?			
Is there a bedside stand on which to place personal items without stretching within reach of the bed?			
Is the furniture arranged to allow for ample room to maneuver walking aids?			
If the bed has wheels, are they in locked position?			
Is there room to store an assistive device next to the bed so that it can be reached without stretching?			



BEDROOM, CONT.	YES	NO	N/A
Does the bed height allow the person to sit on the edge of the bed with their feet on the floor and legs at a 90° angle?			
Is the mattress firm enough to provide support when the person is moving in/out of bed?			
Is the bedspread clear of the floor?			
LIVING AREA			
Is adequate lighting present?			
Is the floor free of clutter?			
Is the floor free of loose wires or cords?			
If carpet is present is it low pile and firmly secured?			
If throw rugs are present are they firmly secured?			
If flooring is hard surface is it a matte finish rather than shiny?			
Are non-skid cleaning/waxing products used on hard surface flooring?			
If flooring is hard surface, is it level and in good repair?			
Is the door handle secure?			
Is the furniture arranged to allow for ample room to maneuver walking aids?			
Does the furniture height allow the person to sit on the edge with their feet on the floor and legs at a 90° angle?			
Are chair legs straight and not angled out from the seat?			
Do chairs have sturdy armrests that can be used for support when sitting or getting out of the chair?			
HALLWAYS/STAIRS			
Is adequate lighting present?			
Is a nightlight present?			
Are there light switches at the top and bottom of stairs?			
Is the floor free of clutter?			
Is the floor free of loose wires or cords?			
If carpet is present is it low pile and firmly secured?			
If throw rugs are present are they firmly secured?			
If flooring is hard surface is it a matte finish rather than shiny?			
Are non-skid cleaning/waxing products used on hard surface flooring?			
If flooring is hard surface, is it level and in good repair?			
Is there adequate room to maneuver a walking aid?			
Are there handrails on both sides in a contrasting color?			
Are the handrails properly secured and at a proper height?			
Are step edges clearly defined?			
Do the step edges have non-slip edging?			



All "no" responses require follow-up action.

"NO" RESPONSE	FOLLOW-UP ACTION



APPENDIX F

EQUIPMENT SAFETY CHECKLIST

Name: _____ Date: _____

Person Completing: _____

BEDS	YES	NO	N/A
If there are wheels, do the brakes secure the bed firmly in place?			
Are the brakes engaged?			
Is the bed approved for the weight of the person?			
WHEELCHAIRS			
Do the brakes secure the chair when applied?			
Does the armrest detach easily for transfers?			
Do the leg rests adjust easily?			
Do the foot rests fold easily to allow for standing?			
Are anti-tip devices installed?			
ELECTRIC WHEELCHAIRS			
Is speed set at the lowest setting?			
Does the horn work properly?			
Wiring is intact and not exposed?			
WALKERS			
Are the rubber tips in good condition?			
Do the wheels, if present, roll freely?			
Is the unit stable?			
Is the unit at the proper height for the person?			
CANES			
Are the rubber tips in good condition?			
Is the unit stable?			
Is the unit at the proper height for the person?			
SHOWER SEATS/STOOLS/COMMUNE CHAIRS			
Are the rubber tips in good condition?			
Is the unit stable?			
Is the unit at the proper height for the person?			
LIFTS			
Is the unit stable and in good working order?			
Have staff been instructed on use of the lift?			



All "no" responses require follow-up action.

"NO" RESPONSE	FOLLOW-UP ACTION



APPENDIX G

FALL HAZARD REPORT
SECTION A: To be completed by person identifying hazard
Name: _____ Date: _____
Location of hazard: _____
Type of hazard (describe in detail):
Describe immediate corrective action taken:
Measures taken to correct hazard: Name of person notified: _____ Date: _____
SECTION B: To be completed by person correcting hazard
Name: _____ Date: _____
Actions taken to correct hazard:
Signature and title: _____ Date: _____



APPENDIX H

FALL/NEAR FALL REPORT

SECTION A: To be completed by staff involved in event

Employee name: _____
 Witnesses: _____
 Date of Report: _____

Individual Name: _____
 Date and time of event: _____
 Location of event: _____

Name of staff notified: _____
 Date and time above staff notified: _____

Family/guardian notified: _____
 Date and time notified: _____

Description of event: Include if witnessed or unwitnessed, level of consciousness, injuries, what person was doing when event occurred, actions taken. Be specific and include details.



Contributory Factors: Check all that apply	
Mobility: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulate with assistance <input type="checkbox"/> Ambulate with assistive device <input type="checkbox"/> Altered gait/balance	
Assistive Devices: <input type="checkbox"/> Assistive device not appropriate <input type="checkbox"/> Assistive device in ill-repair <input type="checkbox"/> Assistive device not within reach <input type="checkbox"/> Assistive device not correctly/safely used <input type="checkbox"/> No documentation of education in proper use	
Cognition: <input type="checkbox"/> Alert and oriented <input type="checkbox"/> Disoriented/confused <input type="checkbox"/> Lethargic	
Environment (provide description): <input type="checkbox"/> Floor wet <input type="checkbox"/> Inadequate lighting <input type="checkbox"/> Cluttered area <input type="checkbox"/> Footwear <input type="checkbox"/> Floor covering <input type="checkbox"/> Other (describe)	
Signature and title:	Date:
SECTION B: To be completed by supervisor/nurse	
Date of last fall risk assessment:	
Additional contributory factors indentified:	
Corrective/preventive measures taken to reduce risk of reoccurrence:	
Signature and title:	Date:



APPENDIX I

POST FALL RISK ASSESSMENT AND ACTION PLAN

IDENTIFIED RISK			ACTION PLAN
Fall History			Fall History
Has the individual had a fall within the past year?	NO	YES	If no, no further action necessary. If yes, review all falls looking for common factors.
Has the individual had a fall risk assessment completed within the last 6 months?	NO	YES	If no, complete a fall risk assessment. If yes, review assessment for risks.
If a fall risk assessment was completed within the last 6 months, was a risk identified?	NO	YES	If no, no further action necessary. If yes, determine if support plan was updated.
If a risk was identified, was an action plan developed and carried out?	NO	YES	If no, update support plan and follow-up with action plan. If yes, no further action necessary
Mobility			Mobility
Does the individual ambulate independently?	NO	YES	If no or yes, reassess ambulation.
Does the individual ambulate with assistance?	NO	YES	If no or yes, reassess ambulation.
Does the individual use an assistive device to ambulate?	NO	YES	If no or yes, reassess need for assistive device.
If an assistive device is used, has the individual been instructed on proper use?	NO	YES	If no, provide instruction on proper use of device. If yes, no further action necessary.
If an assistive device is used, is it in good repair?	NO	YES	If no, have repairs on device completed. If yes, no further action necessary.
Individualal Hygiene			Individualal Hygiene
Is the individual continent of bowel and bladder?	NO	YES	If no, reassess elimination patterns and develop support plan. If yes, no further action necessary.



Was the fall related to toileting needs?	NO	YES	If no, no further action necessary. If yes, reassess toileting needs and bathroom accessibility.
Was the fall related to an assistive device (shower chair, commode frame, etc.)?	NO	YES	If no, no further action necessary. If yes, assess use of device.
Has the individual been instructed in the proper use of the device?	NO	YES	If no, provide instruction on proper use of device. If yes, no further action necessary.
Is the device in good repair?	NO	YES	If no, have repairs on device completed. If yes, no further action necessary.
Medications			Medications
Does the individual take more than 4 medications or any of the following: Antipsychotic, Antianxiety, Antidepressant, Sedative/Hypnotic, Antiepileptic, Antihistamine, Narcotic, Cardiovascular	NO	YES	If no, no further action necessary. If yes, request medication review.
Medical Conditions			Medical Conditions
Does the individual have any medical conditions that may have contributed to a fall?	NO	YES	If no, no further action necessary. If yes, request medical evaluation of condition.
Sensory			Sensory
Does the individual have impaired vision?	NO	YES	If no, no further action necessary. If yes, request visual evaluation.
Does the individual have impaired hearing?	NO	YES	If no, no further action necessary. If yes, request hearing evaluation.
Environment			Environment
Are there any environmental factors that may have contributed to the fall? List factors.	NO	YES	If no, no further action necessary. If yes, correct identified risks.

APPENDIX J

PREVENTION STRATEGIES

RISK: INDIVIDUAL/ENVIRONMENTAL	PREVENTION STRATEGY
History of falls/near falls	<ul style="list-style-type: none"> • Review previous falls for trends: Time of day, location of fall, activity at time of fall, time in relation to medication administration • Ensure a “Fall Risk” identifier is in place
Age over 65 years	<ul style="list-style-type: none"> • Discuss adjustment in schedule to allow for more time with transferring or ambulating
Fallophobia	<ul style="list-style-type: none"> • Discuss possible reasons • Rule out medical or mobility issues • Provide extra support • Refer for behavioral assessment
Mental Status	<ul style="list-style-type: none"> • Reassure frequently • Decrease noise in area • Decrease traffic in area • Provide divisional activities • Utilize relaxation tapes/music

<p>Medications/Polypharmacy</p>	<ul style="list-style-type: none"> • Have comprehensive medication review performed • Monitor for side effects that affect balance and sensorium • Provide extra assistance if balance and sensorium are affected • Advise to change positions slowly • Education for staff on medication side effects • Place a “Falls Risk Identifier” on front of MAR
<p>Balance/Gait/Muscular weakness issues</p>	<ul style="list-style-type: none"> • Refer to physical therapy for assessment • Institute approved exercise program • Institute activity program: Enjoyable and individualized • Have comprehensive medication review performed • Ensure mobility aids are appropriate, in good repair, and within reach • Monitor closely when ambulating • Provide extra assistance when ambulating • Wear sturdy, non-skid footwear • Change from sitting to standing position slowly • Instruct staff on proper ambulation assistance and transfer techniques • Provide transfer instruction to individual before transfer • Lock all wheel locks on assistive devices when stationary • Transfer toward stronger side

Mobility issues	<ul style="list-style-type: none"> • Assess need for assistance • Make staffing adjustments to meet need for assistance • Instruct staff on proper ambulation assistance and transfer techniques • Provide transfer instruction to individual before transfer • Transfer toward stronger side • Refer to physical therapy for assessment • Anticipate needs and respond promptly to requests • Assess for appropriate footwear
Assistive devices	<ul style="list-style-type: none"> • Refer to physical therapy for evaluation of proper device • Assess device for proper fit • Assess if device is in good repair • If repairs needed, complete as soon as possible • Instruct individual and staff in proper use • Inspect device on a regular basis • Keep device within reach • Perform home modifications if needed: Widen passageways, etc. • Ensure use of wheel brakes with wheelchairs

Feet/footwear/clothing	<ul style="list-style-type: none"> • Refer to podiatrist • Provide education in proper footwear • Inspect feet daily • Moisturize feet daily • Avoid use of abrasives on feet • Replace ill-fitting, worn footwear • Discourage use of open-backed footwear, flip-flops, thick/crepe soles, slip-ons, heels higher than 1” • Do not wear treaded slippers on carpet • Use long shoehorn • Avoid clothing that drags on the ground • Avoid too long sleeves that can get caught on items
Medical conditions: Acute and chronic	<ul style="list-style-type: none"> • Refer to physician for evaluation • Reassess after acute illness for change in risk level • Have comprehensive medication review performed • Evaluate and treat pain • Evaluate and treat orthostatic hypotension
Continance issues	<ul style="list-style-type: none"> • Monitor for signs of urinary tract infection • Refer to physician if signs of urinary tract infection • Implement bowel/bladder program • Institute regular toileting times • Monitor fluid intake • Review timing and amount of caffeine intake • Toilet more frequently if taking a diuretic • Review timing of diuretics and/or laxatives • Consider medication for reducing urgency • Consider use of clothing without fasteners, or with fasteners that are easy to open

<p>Visual impairment: Known or suspected</p>	<ul style="list-style-type: none"> • Refer to optometrist/ophthalmologist for evaluation • Consider referral to Orientation and Mobility Specialist if severe visual impairment or blind • If glasses are used, ensure they are worn • Ensure glasses are cleaned daily and when needed • Monitor closely after change in glasses prescription • Increase lighting: 75watt or better bulbs or fluorescent lighting • Hang light weight curtains/shades to decrease glare • Don't rearrange furniture • Avoid monochromatic color schemes • Avoid patterned carpet or flooring • Clearly mark edges of steps • Remove or repair uneven walking surfaces • Keep walkways free of clutter • Place bells on pet collars • Encourage to pause when moving from dark to bright light or bright light to dark
<p>Hearing impairment</p>	<ul style="list-style-type: none"> • Refer to audiologist for evaluation • If safety issues are discussed ensure they were heard correctly • If hearing aid is used, ensure that it is worn • Ensure hearing aids are clean and properly functioning

<p>General</p>	<ul style="list-style-type: none"> • Rid area of clutter • Do not move furniture unless absolutely necessary • Arrange furniture for easy movement throughout rooms • Ensure furniture is sturdy • Consider chairs with armrests • Ensure all furniture with wheels is locked • Evaluate height of furniture for ease in getting in/out • Ensure door handles are secure • Place cords and wires out of walking area • Keep chairs pushed in at tables • Keep lounge chairs in down position when not in use • Do not leave doors partially open/closed
<p>Lighting</p>	<ul style="list-style-type: none"> • Ensure lighting is adequate in all areas: Replace lights with 75 watt or greater bulbs or fluorescent lighting • Place nightlights in each room, hallways • Ensure light switches are within reach • Delineate light switches with reflective tape or contrasting color
<p>Flooring</p>	<ul style="list-style-type: none"> • Secure loose carpeting • Replace thick pile carpeting • Replace patterned carpeting with solid color • Avoid throw rugs • Repair broken/loose tiles/linoleum • Remove elevated door sills • Replace shiny flooring with a matte finish • Avoid shiny floors

Hallways/stairs	<ul style="list-style-type: none"> • Place light switch at top and bottom of stairs • Place light switch at both ends of hallways • Handrails on both sides of hallways and stairs • Ensure handrails are at appropriate height and are secure • Delineate top and bottom steps and edges of steps with contrasting color
Kitchen	<ul style="list-style-type: none"> • Clean spills immediately • Store commonly used items at chest level • Keep reacher/grabber within reach • Do not let refrigerator or oven door open
Bedroom	<ul style="list-style-type: none"> • Keep table at bedside within reach from bed • Place light on bedside table • Keep flashlight by each bedside • Keep assistive devices within reach of bed • Ensure bed height is appropriate: Feet should touch floor when sitting and legs should be at 90° • Ensure wheels are locked on bed • Consider low height bed frame • Do not allow bedspread to touch floor • Avoid satin sheets • Replace mattress • Consider concave mattress • Position bed so transfers can be made from stronger side

Bathroom	<ul style="list-style-type: none"> • Assess height of toilet seat for ease in getting up • Consider raised toilet seat • Install transfer bars at toilet • Tighten toilet seat • Install slip resistant strips in shower/tub • Use shower/mat in shower/tub • Install grab bars in shower/tub • Ensure shower grab bars covered with material that provides increased traction when wet • Consider use of a shower/tub chair • Install step free shower base • Install hand-held shower head • Install wall dispensers for soap/shampoo • Replace shower/tub doors with shatterproof glass • Wipe up any water immediately
Pets	<ul style="list-style-type: none"> • Place bell on all pet collars
Outside	<ul style="list-style-type: none"> • Install automatic lighting to illuminate passageways • Install handrails on both sides of all stairs • Repair loose handrails • Repair broken steps • Install non-slip edges on steps • Repair uneven/broken walkways • Remove overhanging/overgrown branches/shrubs • Remove snow, ice, debris from walkways • Replace gravel walkways with solid surface • Widen walkways • Ensure outside furniture is sturdy and in good repair • Create level surface for vehicle transfers



SECTION C



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