Environmental Assessment and Adaptations

Environmental modifications are one area of fall reduction and prevention that a facility has the most control over. Common causes of falls are slips on a wet surface, tripping on obstacles and transferring from soft or moving surfaces. The following chart is a list of environmental fall risks that should be inspected on a regular basis and possible adaptations to improve safety. While comprehensive, this list is not exhaustive. Your facility's environmental safety assessments may include most, all or exceed the listed areas of concern.

The chart is divided into rooms or areas and focuses on the most prevalent environmental risk factors or barriers to independent functional mobility. Adaptations to any environment should be individualized to the specific needs of a resident or residents. In addition to suggestions listed, your team (including resident, direct-care staff, indirect care staff and family) should brainstorm with that concept in mind. Adaptations range from something a simple as non-skid safety strips to large-scale structural changes such as altering a bathroom layout. However, environmental modifications are significantly more cost-effective than the medical care and lost of independence that occurs when a resident is injured due to a fall.

Bathroom	Inspect	Adaptations
	Toilets and sinks: seats, risers and commodes for stability; sinks are secure to wall	Replacing standard height toilets with elevated toilets may reduce need for seat risers and commodes. Black toilet seat for contrast. Non skid strips on edges of the sink can prevent slipping off the edge of the sink. Strips should blend in with the color of the sink.
	Grab bars: secured to wall or toilet, appropriate height and stable	Refer to Occupational Therapy (OT) and or Physical Therapy (PT) regarding recommended height for transfers. Grab bars secured to the wall will provide greater stability than those attached to the toilet or use of commodes.
	Floors: free from clutter and dry Monitor frequently throughout the day for wet floor especially if resident is incontinent.	Non-glare and non-slip surfaces. Non-slip strips in front of toilet and sink blended with floor color to prevent resident from stepping over them. Indoor/ outdoor carpeting absorbs spills and dries quickly.
	Lighting: non glaring and free from burned out bulbs or flickering lights. Light switches are visible and accessible	Night lights assist in finding the bathroom at night. Illuminated light switches or contrast switch are more visible. Motion sensor lighting may be appropriate for confused residents.
	Doors: easy to open and close, door opens in a direction that the resident does not have to walk around it to enter or exit.	Remove bathroom door (if appropriate), accordion or pocket doors (tracks that slide the door open and closed should be only at the top of the door frame if possible in order to eliminate need to step over a raised threshold).
	Layout and safety: entry, sink and toilet, toilet paper and call bell should be easily accessible.	Grab bars should contrast with wall color for visibility. Refer to OT or PT for layout recommendations. A motion sensor alarm (preferably silent) in the doorway would alert staff to a resident entering the bathroom. Cover or remove mirrors to prevent the resident from becoming startled

Bedroom	Inspect	Adaptations
	Beds: mattress are firm for transfers, crank style beds have handle out of the way, wheel locks are in good working order, non hospital bed are the appropriate height for the resident	A person should be able to sit on the edge of the bed with a 90 degree hip angle and their feet planted firmly on the floor. Hi Lo beds are preferable to placing a mattress on the floor to assist in transfers and provide care. Contrasting non-slip strips on the footboard makes it more visible to use for stability or prevent from running into it. Non-skid strips can be placed the length of the bed to keep the resident from slipping or under the bed legs to keep it from sliding. Strips should blend in with the color of the floor
	Floors: free from clutter and dry Monitor frequently throughout the day for wet floor especially if resident is incontinent. If carpeted, inspect for curled edges and excessive wear	Non-glare and non-slip surfaces. Carpeting is slip resistant, decreases noise and cushions in case of a fall. Low cut carpet made of nylon fibers are the easiest to walk on.
	Lighting: non-glaring and free from burned out bulbs or flickering lights. Light switches are visible and accessible	Night lights to assist in finding the bathroom at night. Touch laps can eliminate a resident reaching or fumbling to turn on a light switch. Illuminated light switches or contrast switch plates are more visible. Tinted windows or blinds can reduce glare.
	Furniture and seating: tables are secured and out of the walking path. Chairs and seating is sturdy; check for loose armrests and legs.	Pedestal tables and over bed tables are not recommended and can be a cause of falls. Tables and nightstands should have four legs (no wheels of any kind) and rounded corners. Non-skid pads placed under the legs prevent sliding if the resident uses it for support when transferring. Contrasting edges on a table make them more visible. Chairs should allow a person to sit with 90 degrees of hip flexion and feet planted firmly on the floor. Chairs with armrest are best for transfers; cushions may be used to aid in standing. If using gliders, one that locks for transfers can reduce the risk of fall.
	Layout and safety: placement of furniture allows adequate walking and turning space. Most used items are in reach of the resident. Call bell should be easily accessible.	A distance of 3 feet between pieces of furniture is recommended. Placing dressers and chairs in a corner versus the middle of the wall, maximizes walking space. Grab bars placed in strategic positions will assist in ambulation and transfers. Refer to OT or PT for best placement and height. Remove or cover mirrors.

Hallways and Common Spaces	Inspect	Adaptations
	Floors and pathways: free from clutter and dry. Inspect carpet for curled edges and excessive wear	Low cut carpet made of nylon fibers are the easiest to walk on. Carpeting is slip resistant, decreases noise and cushions in case of a fall. A color contrasting with that of the walls will distinguish the walking path from the wall. Avoid patterns or contrasts within the carpet such as borders. Contrasting borders in front of a doorway can be confusing and a resident may try to step over it. Other surfaces should be non-glare and non-slip surfaces.
	Lighting: non-glaring and free from burned out bulbs or flickering lights.	Fluorescent light is preferable to incandescent. Blue fluorescent light mimics sunlight and is free of shadows. Compact fluorescent lights take time to achieve full brightness and may be beneficial for changes in lighting such as entering a bright bathroom from a darkened room. Halogen lighting produces the least amount of glare.
	Furniture and seating: tables are secured and out of the walking path. Chairs and seating is sturdy; check for loose armrests and legs.	Pedestal tables are not recommended and can be a cause of falls. Tables should have four legs (no wheels of any kind) and rounded corners. Apply safety corners to square tables. Non-skid pads placed under the legs prevent sliding if the resident uses it for support when transferring. Contrasting edges on a table make them more visible. Chairs should allow a person to sit with 90 degrees of hip flexion and feet planted firmly on the floor. Chairs with armrest are best for transfers; cushions may be used to aid in standing. If using gliders, one that locks for transfers can reduce the risk of fall.
	Layout and safety: placement of furniture allows adequate walking and turning space. Grab bars are secured to the wall, and free of sharp corners	A distance of 3 feet between pieces of furniture is recommended. Rest areas are recommended for long hallways and should be spaced 20-30 feet apart. An appealing sitting area decorated with soothing colors, fountains or fireplaces provide a destination and residents who constantly wander may be more inclined to rest. Grab bars along the hall should contrast with wall color for visibility. Round handrails that allow thumb and fingers to meet are the most affective for gripping. Contrasting colors on corners of a wall or doorways may prevent residents from running into the wall or doorframe. Murals on elevator or exit doors discourage residents from leaving the unit.

The Daily Environmental Safety Watch below may be posted as a reminder or changed to a checklist for daily documentation.

Daily Environmental Safety Watch

Bedrooms are clutter free

Hallways and common areas are clear

Floors are dry-checked frequently

Lights are working

Furniture is safe and stable

Take Action

Move any obstacles in pathways

Report anything that needs to be repaired

Interdisciplinary Falls Management Team

Falls Management Team

A Fall Management Team should consist of the following members:

- DON/ADON
- Unit manager
- Nurses
- CNAs
- Therapies
- Activities
- Social Work
- Administration
- Housekeeping and Maintenance
- Dietician
- Anyone who can add information including resident and family

The purpose of the team is to

- Evaluate new admissions fall risk and determine educational needs related to falls
- Regularly review approaches of residents at high risk
- Evaluate residents who have had new falls (root cause analysis)
- Evaluate and revise approaches for residents whose interventions are not working

The team must have a coordinator who schedules meetings, keeps the team on track, delegates follow up and documents results of meetings.

Falls team meetings should occur daily to discuss effectiveness of interventions for residents at high risk and evaluate any new incidents. A fall may be prevented by changing or fine-tuning approaches that may have questionable effectiveness.

Prior to meetings:

- new incident reports are reviewed
- nurses' notes compared with the incident report
- interviews with staff conducted and
- current interventions evaluated.

Documentation and information that must be present during the meeting consists of the incident report

- post fall review
- resident chart
- care plan and
- fall tracking tool.

Holding the meeting at or near the location where the fall occurred is beneficial when reviewing the incident report and follow up for any additional information. Other members who are not directly involved with the resident may have objectivity when reviewing the site and circumstances. The incident report, nurse's notes and post fall review are reviewed and compared to determine root cause. All current interventions, including changes made immediately following the fall, must be discussed and evaluated for effectiveness. A fall tracking tool is reviewed for trends relating to time, place or similar circumstances of all falls for the resident. Taking into account the resident's profile including social history, all risk factors and current functional status, the team works together to brainstorm new approaches and interventions.

The discussion is documented in the medical record and the resident's care plan is updated. Complete documentation includes:
disciplines present
the rational for using or not using a particular approach and
what education has been provided to resident, staff or family.

Effectiveness of the new approaches is evaluated and documented at a follow up meeting. Evaluation of effectiveness for fall interventions is an on-going process and included in every resident review.

If an approach is for therapies to evaluate to re-evaluate, their documentation should include:

assessment of current functional status
contributing factors to fall (other than dementia i.e.; decline in ambulation related to...),
assessment of possible root cause
educational needs of resident, staff, family
education given and
recommendations for intervention(s).

Interdisciplinary Care Plan Team and Care Plan Guidelines

Interdisciplinary Care Plan Team

The Care Plan Team is made up of all staff that has contact with the resident.

Unit manager
Nurses
CNAs
Therapies
Activities
Social Work
Dietician
Resident and family
Housekeeping and Maintenance
Administration
DON/ADON

Administration and the DON/ADON may be less involved in the everyday care planning process. Their input or approval for interventions such as environmental modifications will be required. Therefore it is important for administrators to be involved in the process, especially for the high risk resident.

Initial Care Plan

Ideally, a plan of care for new admissions should begin *before* they are admitted. Fall history must be part of the screening process and communicated to the admitting nursing unit. Once the initial assessment determines fall risk, interventions must be put into place. Fall risk and interventions must be communicated to all unit staff on the *day of admission*. Some facilities choose to identify those at risk for falls with a discreet symbol on the out side of the medical chart or the resident's door.

Interventions should be evaluated on a daily basis while the resident "settles in" and the staff gets to know them. A resident's social history should be shared with staff and regularly reviewed. Family and staff communication is very valuable during this period. Information related to the resident's daily routine could smooth the transition into your facility and assist in developing a plan of care. If usual routines can be duplicated, confusion and frustration could be lessened, especially for people with moderate to severe dementia, and for staff. Details about a resident's background enable staff to anticipate wants and needs, engage in conversation or an activity that is familiar to the resident and accommodate resident's preferences. Interaction between staff and resident is a very effective fall prevention strategy.

A questionnaire may be use full for gathering details that offer insight resident's routines. The questions are organized in to specific topics. Answers may be place directly in the chart for easy reference.

Guidelines for Fall Prevention Approaches and Documentation in Resident's plan of care.

Document fall risk in the care plan
Make goals realistic. An unrealistic goal would be "Resident will not fall". An example of a more realistic outcome is: "fall risk and injury will be minimized through individualized interventions and evaluation of effectiveness".

List risk factors for falls and individualize approaches using backgrounds (medical and social) and daily routine information. Even if the person does not have a history of falls or a low risk, there should be interventions in place to prevent "a first fall". Conditions checked in the fall risk tool should have an approach related to fall prevention. Do not list approaches that are not realistic if you cannot meet the expectation. If you know you cannot provide 1:1 supervision round the clock, do not use the approach.

Example:

Risk factors are gait instability, ambulates with a device, incontinence, and COPD.

Care plan approaches as they relate to fall risk
Gait instability-PT and OT evaluations for balance and ADL performance.
Provide level of assistance for functional mobility and ADLs as documented by Therapy

Ambulates with device-Resident will be observed throughout the day for appropriate use of walker
Walker condition will be inspected daily. Contact Physical Therapy for replacement or repairs

Incontinence-Resident will be toileted every____hrs or more as per resident need. (Information from resident's daily routine and medical assessment would be helpful in establishing a toileting schedule)
An incontinence garment/pad is used and checked at least every 2 hours.

COPD-rest areas will be available every _____ft. (refer to PT eval for distance resident is able to walk without getting short of breath)
Resident will be encouraged to take frequent rests and be directed to the nearest rest area

Communicate the care plan to all staff, including indirect care staff. They can observe and report if the resident is not using the walker appropriately and they can encourage them to take a rest. Provide details of the approach and rational to the care team. Stress the importance of consistency. Communicate fall prevention approaches to family for additional consistency.

Modify interventions immediately if they are not effective. A new approach or modification of the current approaches must occur immediately after a fall. The post fall tool included in this program is designed to assist with determining the cause of the fall and has space to document immediate care plan changes.

Care plan must match all other assessments and documentation. Review all assessments in order to find any discrepancies between disciplines or any additional fall risk. CNA resident information sheets must match the care plan and be updated at the same time as the care plan. If a potentially new fall risk is noted by any discipline, the care plan must be updated.

Fall risk and prevention approaches must be reviewed regularly. Residents who are low to moderate risk can be reviewed as per your facility's care plan schedule. High risk residents should be reviewed daily by the Fall Management Team for changes in functional or medical status or behavior.

At each care plan review the following: How thorough is the documentation? Are the approaches being carried out consistently? Is re-evaluation for effectiveness timely?

A comprehensive list of fall prevention care plan approaches can be found later in this section.

Example care plan approaches as they relate to falls by risk category.

These are only suggestions and should be modified to the individual. Some of the approaches may be used for other conditions. They are only listed once.

Cognitive Status

1. Provide rest areas, encourage rest by offering a snack or drink every 2 hours or engaging in a conversation/activity.
2. Ensure safe walking path free of obstacles.
3. Provide staff and family education related to disease and it's progression.
4. Consistently carry out recommendations for completion of ADLs (list task segmentation recommendations on CNA sheets).
5. Do not attempt to re-orient or argue with resident.
6. Engage in (specific activity) when restless.
7. Talk to resident at eye level in a calm voice.
8. Sensor lights in bed and bathrooms.
9. Do not move things in room.
10. Keep daily routine consistent.
11. Use or post a written schedule.
12. Ensure wheelchair brakes are locked.
13. Anticipate needs. Resident will indicate needs by _____ (restlessness, fidgeting, etc)

Cardiovascular and Pulmonary

1. Monitor for unstable gait.
2. Provide _____ assistance for ambulation and transfers as per PT recommendations. (list specific methodology)
3. Monitor BP and communicate low pressures to CNAs.
4. Assist resident to sit up slowly from bed; instruct resident to stand still for a moment before attempting to ambulate.
5. Monitor for sweating or clammy skin.
6. Encourage use of walker for energy conservation.
7. Encourage frequent rests.

Neuromuscular

1. Toilet every ___ hrs.
2. Specific to Parkinson's or pain: Monitor and provide increased assistance at the end of medication cycle (time).
3. Pain medication every _____ hrs.

Orthopedic

1. Allow extra time for resident to stand. Do not rush. (DJD, contractures, low back pain)
2. Use prosthetic as recommended by PT (list specific methodology).

Visual/perception

1. Provide high contrast colors to furniture, bathroom, pathways etc.
2. Ensure proper lighting (some conditions may require brighter light while others require dim to prevent shadows) .
3. Bring resident glasses if not wearing them.
4. Use bright case to call attention to glasses

Pain

1. Evaluate depression for physical cause
2. Provide antidepressant (some have analgesic effects).
3. Asses for pain when restless or anxious. Give pain meds as needed
4. Reposition for comfort.
5. OT or PT consult for positioning devices.
6. Ambulate resident if sitting for long period of time.

Physical Functioning

1. Ensure assistive device is in working order.
2. Report repair needs immediately

Medications

1. Med reduction review
2. Increase supervision when new med is given
3. Monitor gait if resident is on antihistamines, hypnotics, narcotic, etc.
4. Increase toileting when given laxatives or diuretics.
5. Monitor BP before ambulation if resident is taking Antihypertensives.

Communication

1. List specific ways resident is known to communicate on CNA sheets.
2. Use communication board (pictures or words), interpreter if needed. Resident may revert to previous language.

Environment

1. Ensure alarm is in working order. Check batteries frequently.
2. Review for restraint reduction
3. Monitor O2 tubing.
4. Use portable O2 tanks (may be put in walker basket or worn).
5. Ensure walking paths are clear in room
6. Organize room with shelving secured to wall.
7. Ask family to take unused items home.
8. Use non-skid socks if unable to wear shoes.
9. Increase assistance if wearing inappropriate shoes.
10. Monitor soles and replace worn shoes.
11. Replace or secure unstable furniture. (list specific methodology)

Fall Prevention Policies

It is necessary for every facility to have fall prevention policies, Quality Assurance Measures (QA) and Continuous Quality Improvement programs in place for several reasons. CMS Quality Measures (QM) is most likely the first reason that comes to mind. QM reports reflect the quality of care provided your facility. CMS posts results to their website as a consumer resource to compare facilities. QA and CQI programs will also lead to greater family satisfaction.

Policies

Fall Prevention Policies ensure consistency throughout the facility. Policies should include procedures for evaluation of risk, review of falls, follow up required, time frames for reassessments and instituting interventions.

Examples of Fall Prevention Policies

Directive and Procedure

Subject: Falls Prevention and Intervention

Directive: All residents will receive appropriate preventative measures and intervention to reduce risk for fall or injury.

Procedure:

1. Prior to admission or re-admission, residents will be designated as a falls risk by Admissions or nursing based on known information from the referral source.

2. All new admissions/re-admissions will be evaluated by Nursing for falls risk. Fall prevention interventions will be communicated to staff and put into place within the first shift after admission.

3. New Admissions/re-admissions at risk and or high risk for falls will be reviewed by the Interdisciplinary Falls Management Team by the next day for the appropriateness of:

a. Initial safety interventions
b. Safety education for resident and staff
c. Reduction of medications
d. Environmental modification

4. Residents at high risk for falls will be reviewed daily by the Interdisciplinary Falls Management Team daily. **At risk** residents will be reviewed at regularly scheduled care plan meetings to determine any modifications that could be made to reduce risk factors. Additionally, resident will be assessed upon referral and/or if change in condition occurs.

5. Physical Therapy will assess for need for assistive device in addition to comprehensive functional evaluation within 24hrs of admission/re-admission.

6. All residents will be monitored by therapy no less than annually for any changes in functional status that may increase risk of fall. Additionally, resident will be assessed upon referral and/or if change in condition occurs.

7. If a fall occurs, the Post Fall Tool will be completed and new fall prevention approaches will immediately be added to the care plan.

8. The Interdisciplinary Falls Management Team will meet the next to review incident. Assessment and recommendations will be entered in the resident's medical record.

Directive and Procedure

Subject: **Gait Belts**

Directive: Gait belts will be used by direct care staff to assist in transferring and ambulating designated residents to insure safety of residents and staff members.

Procedure:

1. Residents requiring assistance to transfer and/or ambulate, will be assessed by Physical Therapy or Nursing for potential use of a gait belt during ambulation and/or transfers.

2. Documentation of use of gait belt will be included in the care plan and CNA assignment. Gait belt use is generally indicated if resident requires greater than supervision assistance.

3. Assure the resident is wearing appropriate footwear. Observe for shortness of breath, decreased strength, fatigue, balance or evidence of pain during ambulation or transfers.

4. Prior to transfer or ambulation, secure the gait belt around the resident at waist level (umbilicus) and snugly adjust belt to allow staff members' hand to firmly hold belt.

5. The gait belt is firmly grasped by staff member and used to assist resident to transfer or ambulate according to technique indicated in plan of care and CNA assignment sheet, (example: sit to stand transfers w/assist of 1). If procedure appears to place resident or staff at risk, consult nurse and/or get additional help.

6. Remove gait belt from resident following transfer or ambulation activity.

Contraindications/Precautions:

- Recent rib fracture
- Recent surgery in area of belt
- Tubes/drainage in area of belt (G tube, colostomy)
- Hiatal Hernia
- Back surgery
- Severe Cardiac or Respiratory disease
- Severe osteoporosis of spine

Quality Assurance Measures and Continuous Quality Improvement

The MDS is the source of information for the QM reports. Indicators calculate fall rate and injury rate. Data used for QA measures can be generated in a number of ways. Most computer documentation programs available are able calculate fall risk for each resident, fall/injury rate of the facility and other valuable information. *EQUIP for Quality*, a service you can subscribe to, will calculate Risk Percentile Scores for individual residents, nursing units or for the entire facility. *IPRO* is another service provider that tracks falls based on the fall data entered by the facility. Data is analyzed and generates reports in percentages and graphs. Trending whom falls, where they fall the most and what time can lead to examination of staffing patterns and the environment.

However, information extracted from these reports is limited to who is predicted to fall, who falls, rate of falls, etc. Documentation review is also required to ensure thoroughness and may lead to greater confidence during the survey process.

The following are samples of a tracking tool, a documentation monitor and Quality Assurance reports.

Monthly Incident Report

Data for (month/year)

Total # of incidents _____
Total # of residents involved _____
Total # of employees involved _____
Total # of visitors/family involved _____

Breakdown per shift 1st _____ per unit Unit 1 _____
2nd _____ Unit 2 _____
3rd _____ Unit 3 _____
Unit 4 _____

Location
Resident room _____ Activity Room _____
Resident bathroom __ Lounge _____
Hallway _____ Dining room _____
Outside facility _____ Other _____

Type of injury:
None apparent _____ Hematoma _____
Skin tear _____ Swelling _____
Bruise _____ Fracture _____
Abrasion _____ Burn _____
Laceration _____ Other _____

Requiring ER visit _____
Requiring Hospitalization _____

Physician Notification: Yes, by standing order _____
By telephone _____
By fax _____
In person _____
No _____ Reason_____

Prevention:
Resident education _____ Staff education _____
Family education _____ Medical intervention _____
Environmental changes _____ Clothing modification _____
Therapy referral _____ Other _____

Facility: Date: Reviewer							
Indicators		X= Satisfactory 0= not met					Comments
Date:							
Environment is as free of accident hazards as possible							
Resident receives adequate supervision, assistance and devices to prevent accidents							
Residents risk for falls are identified and plan of care is in place							
Specific approaches to prevent falls are documented							
Post fall assessments are completed to help determine root cause of falls							
Residents are participating in exercise							

Adapted from Oak Brook Heathcare Centre Ltd, Oakbrook, I

Quality Assurance Monitoring Criteria Summary

	Date: Initails:	Date: Initials:	Date: Initials:
Total no. of incidents/accidents			
No. of falls			
No. of incidents requiring diagnostic intervention in the facility			
No. of incidents requiring emergency treatment or hospital admission			
Lacerations or suture			
Fracture			
Observation and follow up complete			
No. of residents with repeated falls during the month			
No. of residents who have fallen within the last 90 days			
Comments			

Adapted from Oak Brook Healthcare Centre Ltd, Oakbrook, IL

Continuous Improvement Monitoring Form

Design (Plan)

Scope of Care/Service: Incidence of Accidents, Falls and New Fractures
Important Aspect of Care/Service (Objective): Residents will achieve/maintain their optimal level of safety throughout stay
Rationale for Monitoring (Priorities): 1 High Risk __ High Volume 2 Problem Prone

Consistent with mission, vision and strategic plans? Explain: Promotes independence and meaningful living.

Measure (DO)

Indicator	Goal	Threshold	% Achieved
1. Documentation in accident and incident report is complete			
2. Care plan modified and dated with new approach to address accident			
3. Interdisciplinary falls Prevention Team met within 24 hrs of incident			
4. Follow up documentation is complete			
5. Physical Therapy received referral for assessment			
6. Physical Therapy documentation is complete			
7. Occupational Therapy received referral for positioning for incidences involving fall from w/c			
8. Occupational Therapy documentation is complete			

Name _____ ID No. _____ Date _____

Fall Risk Tool

Risk Category	Condition	Risk Factor
Cognitive Status	Wanders	
	Alzheimer's diagnosis	
	Dementia diagnosis	
	Intermittent confusion	
	Disoriented x3	
Cardiovascular and Pulmonary	Syncope	
	Hypotension-Orthostatic or due to medication	
	Cardiac dysrhythmias	
	Dizziness	
	Neuropathy	
	PVD	
	COPD/respiratory	
Neuromuscular	Parkinson's	
	CVA	
	Multiple Sclerosis	
	Seizures	
	Recent weight loss	
	Bowel incontinence	
	Bladder incontinence	
	Unsteady static balance	
	Unsteady gait	
	Pain-daily, moderate or severe	
Orthopedic	Loss of Limbs	
	DJD/Arthritis	
	Osteoporosis	
	History of fractures	
	Any contractures	
	Low back pain	
Vision / Perception	Cataracts	
	Macular degeneration	
	Glaucoma	
	Legally blind	
	Sees halos, rings, lights or curtain over eyes	
	Needs glasses but does not wear	

Risk Category	Condition	Risk Factor
Possible Indications of Pain		
	Depression	
	Restlessness	
	Apathy	
	Anxiety	
Physical Functioning		
	Ambulates with device or uses furniture as support	
	Needs assistance for:	
	Ambulation	
	Transfers	
	Bed Mobility	
	Anxiety	
Medications	Anesthetics	
	Antihistamines	
	Antihypertensive	
	Laxitives	
	Diuretics	
	Hypnotics	
	Narcotics	
	Psychotropic	
	Sedatives	
	Medication change in last 5 days	
Communications		
	Impaired speech	
	Impaired hearing	
	Language barrier	
Environment	Alarm or use of restraint	
	Uses O2 continuously	
	Room is a double	
	Room is cluttered	
	Unable to wear or prefers inappropriate shoes	
	Furniture is unstable	

Any history of falls in the last 12 months- Automatic High Risk

Risk Level Score by Sum of Risk Factors

Score 1 point for one or more risk factors in each category

0-3 Lower Risk

1-6 Moderate Risk

6-10 High Risk

Daytime Routine Questionnaire

The following example was based on the information contained the MDS. The questionnaire format provides greater detail. It may be modified to best suit you facility's needs. Both 1st and 2nd person versions may be found later in this section.

Day time routine and general demeanor	Please answer the following questions, to the best of your knowledge, about (resident's name) routines in order to assist us in providing care.
Did they live on their own or with someone? What was their relationship? (spouse, son/daughter, etc)	
Did they go out frequently, attend a social group or adult day program or did they prefer to stay home?	
How did they interact with family and visitors? Are they generally social or private?	
How to they respond to noise and distractions?	
How do they communicate wants and needs? Do they behave in a particular way if they are hungry, tired, sick etc.	
How would we know if they had pain?	
Do they remember to take their own medications?	

Eating	
Is their appetite good or poor?	
Did they eat 3 meals a day or several throughout the day?	
Did they eat meals at a regular time? If known, please provide preferred times to eat.	
Are they social during meals or prefer to eat privately?	
What are some favorite foods and foods they dislike?	
What do they prefer to drink?	

Sleep habits	
Did they get up in the early or late?	
Did they go to bed early or stay up late?	
Did they nap? Morning evening or both?	
Are they a sound or light sleeper?	
Did they get up to go to the bathroom during the night? What size bed did they sleep in?	
Were they used to sleeping next to a spouse?	
What side of the bed did they sleep on?	

Toileting	
Are they incontinent? Bladder, bowel or both?	
How is incontinence managed? Frequent toileting, protective pads or garments?	
Did they urinate frequently or several hours apart? Did they have a regular time of day to move their bowels?	

Past roles	
What was their job?	
Did they work during the day, evening or overnight shift?	
What kind of leisure activities did they participate in (golf, bowling)?	
Do they have a hobby?	
Where did they live prior to admission; a house or apartment?	
Where was it located?	

Name: _____

ID #: _____

Date: **Time of fall or time found on floor:**

POST FALL TOOL

SECTION 1 Complete immediately after a fall

Fall in Bedroom	YES	NO
Was the fall observed?		
Was the call bell in reach?		
Was the call bell functioning?***		
Was an alarm present?		
Was the alarm functioning?		
Were needed items within reach? (Ex: water, TV remote, tissues, phone etc.)		
Any paper or dropped item on the floor?		
Was a reacher available?*		
Was bed in lowest position?		
Floor wet?		
Shoes/appropriate footwear worn?		
Glasses on?		
Any clutter or furniture out of place?		
Assistive device within reach?		
Device used and properly functioning?**		
Time last toileted:		
Time of last snack or drink:		

Brief description of WHY this person fell:

Fall in Bathroom	YES	NO
Was the fall observed?		
Was the call bell in reach?		
Was the call bell functioning?***		
Assistive device used and properly functioning?**		
Was the floor wet?		
Was the resident incontinent?		
Time last toileted:		
Was the light on?		
Was the fall backward onto the toilet?**		
Was a raised toilet seat or higher toilet available?*		
Was a grab bar available?		
Was the area cluttered?		

Brief description of WHY this person fell:

Fall in places other than bedroom or bathroom	YES	NO
Was the fall observed?		
Was an alarm present?		
Was the alarm functioning?		
Was an assistive device used appropriately?		
Was the device working properly?		
Was the path blocked by object or person?		
Floor wet?		
Shoes/appropriate footwear worn?		
Glasses on?		
Time last toileted:		
Time of last snack or drink:		

Brief description of WHY this person fell:

Signature_____Date_____

Immediate Care Plan Approach(es):

SECTION 2 Complete within 24 hrs after a fall

	YES	NO
New or exacerbated medical condition?		
Orthostatic hypotension?		
Dizziness or vertigo?		
Any indications of pain?		
Pain meds ordered/given?		
Medical conditions that increase risk of falls?		

List:

New or change in medication?		
Meds taken that can cause falls?		

List:

Any change in physical functioning?		
Any change in vision?		
Any signs of depression?		
Any changes in cognition?		

Date of any previous falls:

Brief description of WHY **(root cause)** this person fell:

Additional Care Plan Approach(es):

	DATE
* Referred to Occupational Therapy	
**Referred to Physical Therapy	
***Referred to Maintenance	

Signature_____Date_____

Program Evaluation

Preventing Falls: A Team Approach in Dementia Care

Please take a few minutes to let us know what you think about the training DVD you have viewed. In addition to rating content in the program, we hope you'll give us suggestions or comments that might help us improve it in the future.

At the end of this form you have the option of giving us your name and contact information in case we'd like to follow up with you regarding your comments. This is optional, so you can choose not to give us this information if you prefer.

Section(s) reviewed: **Introduction**
Understanding Alzheimer's and Related Dementia
Introduction to Strategies for Reducing Falls
Risk Assessment
Fall Risk Assessment for Therapists
Problem Solving to Reduce Risk
Case Studies

Date: _____

Circle the number that reflects your opinion.	*Not Applicable*	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
Content						
1. The subject of this program is relevant and useful to my job. Comment:	0	1	2	3	4	5
2. I will be able to apply what I've learned to my job. Comment:	0	1	2	3	4	5
3. The content was well organized and easy to follow. Comment:	0	1	2	3	4	5
4. What topics were the *most* useful to you?						
5. What topics were the *least* useful to you?						

	Presentation	*Not Applicable*	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
6.	The overall presentation was good. Comment:	0	1	2	3	4	5
7.	the examples and demonstrations used in the program were helpful. Comment:	0	1	2	3	4	5
	Overall						
8.	The program met my expectations. Comment:	0	1	2	3	4	5
9.	I would recommend this program to other staff at my facility. Comment:	0	1	2	3	4	5
10.	Are there any topics that should be added to this program?						
11.	Any other comments about this program?						

Optional

Name: _____ Department _____

Job title: _____ Unit _____ Shift _____

Fall Prevention Case Studies

Listed below are suggestions related to the case studies. Your answers and recommendations may be different.

Mr. M., an elderly gentleman with dementia, repeatedly gets on the elevator to leave the unit. Because he is wearing a "Roam Alert" bracelet the elevator does not leave the unit but makes a loud dinging noise. The noise and the fact the elevator will not move causes frustration for the resident. He is found on the floor near the elevator at 3:45pm.

What factors contributed to this resident's behavior and fall?

Since the Mr. M regular behavior is to wander elevator doors create a challenge.
The time of day is significant because it is around the time of a shift change. The elevator doors will be opening and closing with people coming and going and there may be less staff available. The fact that the elevator does not move and makes a loud dinging noise contributes to this Mr. M's frustration and agitation.

List some approaches to prevent this fall from reoccurring. List approaches that relate to resident behavior, staff interventions and environmental changes.

Mr. M may be encouraged to participate in an activity such as exercise prior to or during the shift change.
A person may be assigned to engage Mr. M at this time. The person can be an indirect care staff person or family as well as any direct care staff member. Staff could be asked to use the stairs whenever possible at that time of day.
The elevators could be "camouflaged" with wallpaper or painting to distract from the fact that it is an elevator. The alert bracelet could be adjusted so that it does not allow the door to open and signals staff with a silent alarm.

Mrs. J. was taken to the bathroom at 2PM. It is now 2:10PM and Mrs. J has attempted to get out of her chair at least 5 times. Staff redirects Mrs. J. to sit down. The next time Mrs. J. stands, she falls.

What could be the reason Mrs. J. was attempting to get up?

She could have to go to the bathroom again.
She could be uncomfortable or in pain.
She could be bothered by noise or others in the area.
She could be thirsty or hungry.
She may just want to go for a walk.

What else could have been done besides redirecting Mrs. J. to sit down?

Attempt any of the above to determine what Mrs. J. needed.

List a care plan approach or approaches that should be used with Mrs. J. to prevent a fall.

The risk factor may be decreased ability to communicate needs and wants. Care plan approaches should include the best way to determine what Mrs. J. needs based on past interactions with her. For example, when Mrs. J. becomes restless, she should be offered a drink (snack, walk etc).

Allison is a CNA who has been having a particularly rough morning. Mr. C has been assigned to her for the past 4 days and has needed a great deal more assistance than usual. The resident has also been more resistive to care, crying and yelling throughout the day. Allison is stressed because all the other residents on her assignment are complaining they are not getting enough help. Today, Mrs. K fell while Allison was helping Resident M.

How could Mrs. K's fall been prevented?

Teamwork among all staff on the unit to ensure safety and meet resident's needs is one of the leading fall prevention approaches. CNAs should be encouraged to assist each other if other residents have more care needs than others. Indirect care staff can be utilized to reassure residents while they are waiting for assistance.

The facility may also consider evaluating routines and schedules to allow for flexibility in mealtimes so all residents do not have to be ready at the same time.
Of course, Mrs. K's fall should be reviewed as per facility procedures.

What could Allison do to decrease her stress?

CNA's should feel comfortable asking for assistance and team members should be encouraged to offer assistance freely. A change of resident assignments may also be necessary to prevent burnout. Another CNA may have a different rapport with the same resident and have less difficulty providing care.

How should the changes in Mr. M be addressed?

A medical assessment may be required to determine cause of decline or change of condition. Certain medical conditions such as UTIs can cause confusion and changes in behavior. Review of medications, oxygen level, and other medical reasons could be the cause of a behavior change. Even cold medications can have an negative effect on some people.

Mr. D is a new admission. He was living alone and was hospitalized due to dehydration. His only medical history is high blood pressure and takes medication. His family states he was "starting to get a little confused" and needed more supervision. They are unsure if he has had any falls. His immediate family lived out of town but friends stopped by on occasion. They could only fill out part of the Daily Routine Questionnaire:
He has lived in the area for all of his life.
His wife was deceased 4 years ago.
He rarely went out and has always been a private person.
He was a sports writer for a local newspaper.
He liked to read, played golf on occasion and has a large collection of baseball cards.

What are some risk factors for falls?

Confusion, dehydration and HTN may be some considerations for falls.
Mr. D may also be at risk for falls due to a change of environment. He has been use to quite and may be even more disoriented or confused due to the noise levels in long term care facilities.

List initial care plan approaches for fall prevention related to the risk factors.

Monitor for low blood pressure. Keep in a quiet but supervised area until PT and OT evaluation is complete and recommendations made. Activate bed alarm whenever in bed.

List some ways to help Mr. D transition to living in the facility.

Provide sports magazines, newspapers and activities of choice to engage Mr. D.
Maintain privacy as much as possible. Talk with Mr. D and, if possible, his friends to obtain further information about his daily routine and preferences.

Mr. P is in the mid to late stages of Alzheimer's disease and has lived on a locked special care unit for 2 years due to wandering from the facility. He is generally content to independently wander the unit with a walker but has been experiencing a number of falls. The Falls Management Team met to review his falls.

What pieces of documentation should be present at the review?
incident report
post fall review
resident chart
care plan and
fall tracking tool

From the review of documentation, it is found that Mr. P has fallen 3 times between 2 and 4 pm in the common area. He needs reminders to use his walker and has a cold.

What are some possible reasons for Mr. P's falls?

He may get restless in the afternoon. His walker may not have been near him or somewhere else. He may have had an antihistamine if he has a cold.

List some care plan approaches to prevent further falls.

Increase supervision or engage in activities between 2 and 4. Review antihistamine and it's effects. If he receives one every 4–6 hours, it's effects may be the highest at that time of day and re-scheduling may help. He could be switched to a 24 hr antihistamine. Even "non drowsy" cold medicines may have different effects on certain people. PT evaluation for changes in gait and strength or change in assistive device.

---

1. _____ True or False: All residents with Alzheimer's or dementia live on a specialized unit.

2. _____ Alzheimer's disease causes _____to stop working.
   a. neurons
   b. the brain
   c. neutrons

3. _____ True or False: A person with dementia can forget how to get into bed.

4. _____ You might suspect a resident has some mild Alzheimer's disease if:
   a. they become incontinent
   b. they begin to forget your name
   c. they can tell you what they had for dinner last night

5. _____ True or False: A person with mild dementia is not at risk for falls.

6. _____ Actions a person with advanced Alzheimer's disease may be:
   a. talking in their first language (example; if the resident grew up speaking Italian)
   b. looking for their (deceased) mother or father
   c. dressing to go out for an appointment every day.
   d. all of the above.

7. _____ How could you respond to the situations above?
   a. remind them that they don't have anywhere to go.
   b. ask them to tell you about their parents, appointment or job
   c. ignore them

      (b) Re-orienting them or ignoring them can lead to agitation for the resident. Talking in a low voice and asking questions may assist in calming and redirecting the resident.

8. _____ How could you respond to a resident who always says they have to use the bathroom.
   a. take them to the bathroom
   b. take them for a walk
   c. offer them a drink or a snack
   d. sit a talk with them for a moment
   e. all of the above

9. How does understanding dementia help to prevent falls?

_____

_____

_____

_____

1. True or False: All residents with Alzheimer's or dementia live on a specialized unit.
   False. 60% of all nursing home residents have mild to moderate dementia and may live anywhere in a facility. Not all facilities have specialized units. It is important for all staff members to have an understanding of dementias to better meet the needs of residents and decrease their frustration.

2. Alzheimer's disease causes _____ to stop working.
   a. neurons
   b. the brain
   c. neutrons
   (a) Neurons die due to Alzheimer's disease. This interrupts the communication between nerve cells and affected parts of the brain will waste away.

3. True or False: A person with dementia can forget how to get into bed.
   True. Due to the disruption in normal thought processes that control motor planning, a person may loose the ability to perform common tasks.

4. You might suspect a resident has some mild Alzheimer's disease if:
   a. they become incontinent
   b. they begin to forget your name
   c. they can tell you what they had for dinner last night
   (c) Short term memory loss is one of the first visible signs of Alzheimer's. Incontinence may occur in later stages. If a resident suddenly becomes incontinent, it may be from a medical problem and should be brought to the attention of their doctor

5. True or False: A person with mild dementia is not at risk for falls.
   False. Memory loss and confusion may increase a person's anxiety level and could lead to poor judgment around obstacles. They may try to move too fast and lose their balance.

6. Actions a person with advanced Alzheimer's disease may be:
   a. talking in their first language (example; if the resident grew up speaking Italian)
   b. looking for their (deceased) mother or father
   c. dressing to go out for an appointment every day.
   d. all of the above.
   (d) Any of the actions described could be related to advanced Alzheimer's. Long term memories stay intact the longest, so it would not be unusual for a person to be literally living in the past.

7. How could you respond to the situations above?
   a. remind them that they don't have anywhere to go.
   b. ask them to tell you about their parents, appointment or job
   c. ignore them
   (b) Re-orienting them or ignoring them can lead to agitation for the resident. Talking in a low voice and asking questions may assist in calming and redirecting the resident.

8. How could you respond to a resident who always says they have to use the bathroom.
   a. take them to the bathroom
   b. take them for a walk
   c. offer them a drink or a snack
   d. sit a talk with them for a moment
   e. all of the above

   (e) First take them to the bathroom. Then if they go or even if they didn't, any of the activities could be used to engage a resident to distract them from asking to use the bathroom.

9. How does understanding dementia help to prevent falls?

_____

_____

_____

Suggestions: Increase awareness for signs of decline
Decrease frustration or anxiety for the resident with a calm reassuring approach
Improve ability of staff to understand resident's actions and anticipate needs

1. _____ True or False. Fall prevention approaches should be individualized to the resident.

2. _____ True or False. If you start a new approach for fall prevention you don't have to worry about it unless the resident falls again.

3. List the team members who should be involved in the "brainstorming" session to develop fall intervention approaches.

   _____
   _____
   _____

4. Asking "why" an accident occurred at least 5 times is called _____ _____ _____

5. _____ When are residents with dementia more likely to fall?
   a. As soon as they get out of bed.
   b. When they are using the bathroom.
   c. During change of shift

6. List at least 6 activities you can use to engage residents at the time they are most likely to fall.

   _____
   _____
   _____

7. List 4 environmental changes that can help reduce the risk of falls.

   _____
   _____
   _____

8. List 2 of your ideas for a fall prevention approach that involves using all staff and families.

   _____
   _____
   _____

9. If you are assisting a resident with dementia who has difficulty with dressing or brushing their teeth you should:
   a. do it for them
   b. allow them to take their time and give specific instructions when needed.
   c. use 2 people to get it done faster.

10. Mr. M., an elderly gentleman with dementia, repeatedly gets on the elevator to leave the unit. Because he is wearing a “Roam Alert” bracelet the elevator does not leave the unit but makes a loud dinging noise. The noise and the fact the elevator will not move causes frustration for the resident.

What factors could contribute to a possible fall for this resident?

a. seeing the elevator open.
b. the time of day.
c. no staff member being present.
d. all the above.

11. The nurse is able to get the resident off the elevator and brings the resident into the Living Room and turns on the Tai Chi DVD. While sitting facing the resident the nurse guides the resident’s arms through the Tai chi movements. The resident falls asleep.

_____

_____

12. Mrs.W. was taken to the bathroom at 2PM. It is now 2:10PM and Mrs.W. has attempted to get out of her chair at least 5 times. Staff redirects Mrs. W. to sit down. The next time Mrs. W. stands, she falls. What would have been a better response by staff:

a. find out if Mrs. W. need to go to the bathroom again.
b. put a movie on for Mrs.W.
c. take Mrs. W. to her room and put her to bed.
d. give Mrs. W. something to eat.

1. _____True or False. Fall prevention approaches should be individualized to the resident.
   True. Each of a resident's risk factors should have an approach specific to the resident. Example: If a resident has fallen when getting out of bed, approaches may be to wear non skid socks or leave shoes on when napping.

2. _____True or False. If you start a new approach for fall prevention you don't have to worry about it unless the resident falls again.
   False. New (and all) fall prevention approaches should be reviewed daily for effectiveness.

3. List the team members who should be involved in the "brainstorming" session to develop fall intervention approaches.
   Nursing (RN, LPN and CNAs), PT, OT, Recreation, Social Work, housekeeping, food service, family and anyone else who has regular contact with the resident.

4. Asking "why" an accident occurred at least 5 times is called **root cause analysis**

5. _____When are residents with dementia more likely to fall?
   (c.) During change of shift if there is less supervision and less to engage the residents. Statistics show most falls occur between 3 and 7pm.

6. List at least 6 activities you can use to engage residents at the time they are most likely to fall.
   Suggestions: memory boxes, music or singing, movies, balls, moving to quiet areas, exercise (CAREx), hand massages, walking, reading with the resident, talk about families.

7. List 4 environmental changes that can help reduce the risk of falls.
   Suggestions: lighting, gait or unit entryway, decorations/pictures, non-skid surfaces, no overhead paging or simple carpeting

8. List 2 of your ideas for a fall prevention approach that involves using all staff and families.
   Discuss answers

_____ 1. Understanding what causes falls and how to prevent them is important because:
a. It makes my job easier
b. It keeps the resident safe from possible injury
c. It improves family relationships
d. All of the above

_____ 2. True or False
When considering factors that contribute to a fall, balance problems would be categorized as an intrinsic risk factor .

_____ 3. List 3 intrinsic risk factors that are likely to be associated with residents having dementia.
_____
_____
_____

_____ 4. List 4 extrinsic risk factors that may contribute to falls.
_____
_____
_____
_____

_____ 5. True or False.
Organizations risk factors can only be managed by increasing staff.

_____ 6. The most effective strategies for managing falls in long term care facilities involves_____with support from_____.

_____1. Understanding what causes falls and how to prevent them is important because:
(d.) All of the above. Workloads increase if a resident has fallen due to increased supervision needed or care if the resident is injured. Injuries may lead to permanent loss of function or even death. Family become doubtful of the facilities ability to keep their family member safe which leads to a strained relationship.

_____2. True or False
True. Balance problems would be categorized as an intrinsic risk factor because they pertain to the resident's physical functioning.

_____3. List 3 intrinsic risk factors that are likely to be associated with residents having dementia.
disorientation, anxiety, agitation, impaired judgment and decision making, hallucinations, impaired perception and communication skill, failure to remember physical limitations

_____4. List 4 extrinsic risk factors that may contribute to falls.
Poor lighting, wet or shiny floors, obstacles, walkers, restraints, w/c footrests, Inappropriate footwear or clothing

_____5. True or False. Organizational risk factors can only be managed by increasing staff.
F**alse. Improved training, teamwork and support from the entire facility can decrease fall risk. CNAs can work together to supervise a group of residents while one completes other assignments. Indirect care staff can assist with supervision and engage residents in activities during "peak fall periods".**

_____6. The most effective strategies for managing falls in long term care facilities involves **everyone** with support from **family and volunteers.**

Examples - Care Plan Approaches

These are only suggestions and should be modified to the individual. Some of the approaches may be used for other conditions. They are only listed once.

Cognitive Status

1. Provide rest areas, encourage rest by offering a snack or drink every 2 hours or engaging in a conversation/activity.
2. Ensure safe walking path free of obstacles.
3. Provide staff and family education related to disease and it's progression.
4. Consistently carry out recommendations for completion of ADLs (list task segmentation recommendations on CNA sheets).
5. Do not attempt to re-orient or argue with resident.
6. Engage in (specific activity) when restless.
7. Talk to resident at eye level in a calm voice.
8. Sensor lights in bed and bathrooms.
9. Do not move things in room.
10. Keep daily routine consistent.
11. Use or post a written schedule.
12. Ensure wheelchair brakes are locked.
13. Anticipate needs. Resident will indicate needs by _____ (restlessness, fidgeting, etc)

Cardiovascular and Pulmonary

1. Monitor for unstable gait.
2. Provide _____ assistance for ambulation and transfers as per PT recommendations. (list specific methodology)
3. Monitor BP and communicate low pressures to CNAs.
4. Assist resident to sit up slowly from bed; instruct resident to stand still for a moment before attempting to ambulate.
5. Monitor for sweating or clammy skin.
6. Encourage use of walker for energy conservation.
7. Encourage frequent rests.

Neuromuscular

1. Toilet every ___ hrs.
2. Specific to Parkinson's or pain: Monitor and provide increased assistance at the end of medication cycle (time).
3. Pain medication every _____ hrs.

Orthopedic

1. Allow extra time for resident to stand. Do not rush. (DJD, contractures, low back pain)
2. Use prosthetic as recommended by PT (list specific methodology).

Visual/perception

1. Provide high contrast colors to furniture, bathroom, pathways etc.
2. Ensure proper lighting (some conditions may require brighter light while others require dim to prevent shadows) .
3. Bring resident glasses if not wearing them.
4. Use bright case to call attention to glasses

Pain

1. Evaluate depression for physical cause
2. Provide antidepressant (some have analgesic effects).
3. Asses for pain when restless or anxious. Give pain meds as needed
4. Reposition for comfort.
5. OT or PT consult for positioning devices.
6. Ambulate resident if sitting for long period of time.

Physical Functioning

1. Ensure assistive device is in working order.
2. Report repair needs immediately

Medications

1. Med reduction review
2. Increase supervision when new med is given
3. Monitor gait if resident is on antihistamines, hypnotics, narcotic, etc.
4. Increase toileting when given laxatives or diuretics.
5. Monitor BP before ambulation if resident is taking Antihypertensives.

Communication

1. List specific ways resident is known to communicate on CNA sheets.
2. Use communication board (pictures or words), interpreter if needed. Resident may revert to previous language.

Environment

1. Ensure alarm is in working order. Check batteries frequently.
2. Review for restraint reduction
3. Monitor O2 tubing.
4. Use portable O2 tanks (may be put in walker basket or worn).
5. Ensure walking paths are clear in room
6. Organize room with shelving secured to wall.
7. Ask family to take unused items home.
8. Use non-skid socks if unable to wear shoes.
9. Increase assistance if wearing inappropriate shoes.
10. Monitor soles and replace worn shoes.
11. Replace or secure unstable furniture. (list specific methodology)

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Arditi, A., Enhancing the visual environment for older and visually impaired persons, Alzheimer's Care Quarterly 2005: 6 (volume) 4 (issue), 294-299

Perritt M, McCune, E.D., and McCune, S. L., Research Informs Design: Empirical findings suggest recommendations fro carpet pattern and texture, Alzheimer's Care Quarterly 2005: 6 (volume) 4 (issue), 300-305

Resource Websites

Alzheimer's Association; Western New York branch
http://www.alz.org/wny/

Alzheimer's Association; National branch
http://www.alz.org/index.asp

American Medical Directors Association
http://www.amda.com/tools/cpg/falls.cfm

National for Disease Control; Center for Injury Prevention
http://www.cdc.gov/ncipc/duip/preventadultfalls.htm

Fall Prevention Center of Excellence
http://www.stopfalls.org/researchers_educators/re_mm.shtml
Fall Prevention Center by Rein Tideiksaar, Phd
http://www.seekwellness.com/fallprevention/

New York Department of Health Electronic Dementia Guide for Excellence (EDGE) Project
http://www.health.state.ny.us/diseases/conditions/dementia/edge/index.htm

Alzheimer's Care Quarterly
http://www.acqjournal.com/pt/re/acq/home.htm

American Journal of Alzheimer's Disease and Other Dementias® http://aja.sagepub.com/