

FALLS PREVENTION PERFORMANCE IMPROVEMENT PROJECT
BRAINSTORMED CAUSES OF RESIDENT FALLS
AUGUST 29, 2006

RESIDENT PHYSICAL CHARACTERISTICS	RESIDENT BEHAVIORS	STAFF	ASSESSMENT	ENVIRONMENT	OTHER
Unsteady gait	Life changes: psychosocial, i.e., death in family	Unavailability of staff	Lack of fall tracking by: resident, location, time, day of week, unit, fall history, specific staff involved, shift, type of staff, if fall was observed/not observed, injury, notification of family, notification of physician, and notification of state	Wheelchair pedal use: when used residents trip over them while attempting to get up	Lack of resident exercise
Loss of limb (amputation, neuropathy)	Lack of safety awareness	Carelessness of staff			Staff injury causes a fall
Dehydration	Desire to maintain independence	Staff's failure to wait on care equipment availability		Lack of wheelchair pedal use: when staff pushing resident in wheelchair and feet touch down causing the resident to flip out of wheelchair	Lack of family education
Medication changes	Loss of independence/control	"Not my resident" attitude			Unrealistic expectations - family
Use of medications causing diarrhea	Boredom	Staff being slow to answer call lights	Lack of ability to sort data to see trends readily		Unrealistic expectations - resident
Use of medications causing sedation	Attention seeking	Staff not answering call lights		Interventions in use cause a fall: mats	Family in denial
Use of medications causing dizziness	New admission – psychosocial adjustment period	Staff not recognizing when a resident needs a rest period	Tracking information not easily accessible to unit staff	Resident use of powder that gets on the floor	Lack of physician co-operation
Use of medications causing confusion	Depression	Staff not adjusting to a resident's schedule	Failing to assess the need for adaptive equipment	Lack of brake extensions	Lack of management commitment to fall prevention
Use of medications causing increased urination	Dementia	Too many staff off the unit at one time	Lack of referrals by staff for therapies	Lack of front and back anti-tip bars	Well meaning volunteers or family that attempt to help the resident
Use of medications causing hypotension (postural)	Sun-Downing	Staff's non-compliance with interventions	Resident risks not identified	Bed not wide enough	Inappropriate footwear
			Inaccurate assessments	Chair height not appropriate for resident	

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Inappropriate use of medications	Lazy resident: does not want to participate in therapy	Staff's lack of follow through with plan of care	Resident identified as being at risk; however, pertinent interventions are not put into place	Bed height not appropriate for resident	General use of assistive devices increasing risk for falls: walkers, canes
Medication times	Resident to resident altercations	Staff unclear as to the specifics of the plan of care	History of previous falls and causes not available	Toilet height not appropriate for resident	Interrupted sleep cycle
Orthostatic Hypotension	Other residents interfering with interventions	Lack of staff following through with the toileting program	Lack of information about what interventions have been used in the past for the resident.	Use of alarms scaring residents and causing them to fall	Lack of access to interventions for staff (locked up)
Incontinence	Residents running into other residents	Lack of communication of the plan of care to staff	PRN pain medications not used appropriately: i.e., not given to prevent pain, may need to be changed to routine, not given in advance of therapies or painful activities	Malfunction of alarms	Uncooperative family members not adhering to safety measures that are in place
Dementia	Residents toileting other residents	Heavy patient load		Alarms not turned on	
Cognitive impairment	Resident non-compliance with interventions	Staff not meeting the needs of a resident: toileting, pain		Loose rugs	Lack of activities after 8 p.m.
Diagnoses: i.e., Cardiovascular Arthritis	Resident does not want to bother staff	Unfamiliar staff		Slippery floors	Lack of activities on weekends
Acute illness	Residents knocking other residents over with their electric wheelchairs	Staff's failure to lock beds		Inappropriate lighting	
Fatigue	Resident's impatience to wait on staff assistance	Assistive devices malfunctioning		Inappropriate layout of the room to meet resident's needs	Improper fitting clothing
Weakness d/t: anemia, infections, pneumonia, thyroid				Clutter in room	Tripping over bedspreads
Acute events: UTI, pneumonia, lab values, dehydration				Clutter and equipment in halls	

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Seizures TIA's – small strokes Tardive Dyskenesia Parkinson's Disease Multiple Sclerosis Huntington's Chorea Visual deficits Muscle weakness Age > 80 years		Assistive Devices unavailable due to finances Assistive devices not in reach Inappropriate use of assistive devices by the resident Glasses dirty Glasses not on Hearing aides not in Hearing aides full of wax Resident has hearing problem and no hearing aides Lack of staff education regarding appropriate use of assistive devices	Lack of identification of need for a toileting program Lack of identification of need to change the toileting program Lack of bone density status in order to determine risk of fracture or need for use of preventative equipment Lack of assessment for appropriate use of merry walkers for residents Generalized interventions used; however, not individualized to meet the resident's needs Inappropriate use of side rails Lack of assessment for appropriate bed type	Tripping over tubing Toileting equipment in walking pathway Tripping over equipment Unfamiliar environment Use of wax on the floors Lift chairs (from home) and resident's inexperience or ability to use safely Use of special mattresses causing residents to slide off and fall Cushions on chair causing residents to slide off Wet floors	

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		<p>Lack of education of ancillary staff, i.e., housekeeping, maintenance</p> <p>Poor orientation and training of all staff</p> <p>Ancillary staff removing care equipment and not informing staff, i.e., PT, OT, etc.</p> <p>Failure to take all interventions to new room or unit i.e., non-skid strips on floors</p> <p>Staff using improper lifting techniques</p> <p>Staff minimizing the importance of therapy when talking with the resident or doing too much for the resident</p>	<p>Inappropriate use of restraints</p> <p>Lack of assessment for impaired ADL's</p> <p>Lack of assessment for gait problems</p> <p>Lack of assessment for medication side effects that could lead to increased falls</p>	<p>Changes in surfaces</p> <p>Uneven surfaces – indoors</p> <p>Uneven surfaces – outdoors</p>	

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		<p>Front line staff not communicating with management after a fall: failure to inform, lack of information about the scene of a fall, possible causes, what the resident was attempting to do, what staff did to intervene to prevent a repeat fall from the same cause</p> <p>Lack of communication from falls committee to the front line staff</p> <p>Lack of follow-through of all interventions in all settings</p> <p>No monitoring system in place to review that interventions are in place as per the plan of care</p>			

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		<p>Medications used to decrease need for supervision</p> <p>Staff rushing the resident during care such as dressing, ambulating</p> <p>Staff not placing wet floors signs when needed</p>			