Sample tools referenced in the presentation will be provided in print to attendees

2 **OBJECTIVES**

1. Identify key risk factors for geriatric falls
2. Understand how to incorporate evidence based practice into falls prevention, falls response, and falls management across the interdisciplinary team.
3. Understand key individualized care plan interventions and facility wide approaches to managing common fall risk variables.
4. Utilize effective caregiver and patient training tools and develop effective discharge plans for long term fall risk reduction.
5. Understand essential documentation components associated with falls prevention and management.

3 **HOW BIG IS THE PROBLEM?**

- Falls contribute to 40% of nursing home admissions (McElhinney)
- 3 of 4 residents fall each year, & there are 2.6 falls per person per year. (Rubenstein et al.)
- 35% of falls are among non-ambulatory residents (Thapa et al).
- Fall related costs expected to increase to $32.4 billion by 2020
- Falls factor heavily into reduction of functional independence and quality of life

Source: Centers for Disease Control
http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html Retrieved 7/11/16

4 **MOST COMMON CAUSES OF NURSING HOME FALLS**

- 24% weakness and mobility issues
- 16-27% Environmental hazards (wet floors, poor lighting, incorrect bed height, improper wheelchair fit or maintenance
- Medications
- Other: transfer difficulty, poor foot care, poorly fitting shoes, improper use of walking aids

Resource: CDC 2015 retrieved 7/11/16

5 **RISK FACTOR BASED APPROACHES**

6 **F323**

- Fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming force (e.g. pushed)
- If a fall would have occurred if not for staff intervention is considered a fall.
- Fall without injury is still considered a fall
- "Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred"

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

7 ☐ **MAJOR INJURY**

Injury related to a fall: Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.
Injury (Except Major): Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.
Major Injury: Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

8 ☐ **RELATED LONG STAY QUALITY MEASURES**

9 ☐ **FACILITY EXPECTATIONS**

- The resident environment remains as free from accident hazards as is possible
- There is both adequate supervision and assistive devices to prevent accidents
- Transfer and ambulation abilities will not decline unless it is unavoidable
- Transfer and ambulation status will not only be maintained but improved when possible
- Residents have the right to be free from chemical or physical restraints. Restraints have been proven to increase fall risk. Restraints must be systematically analyzed & gradual reductions attempted while treating the medical symptom(s)
- Interventions attempted must be documented and the outcome of the intervention clearly outlined.

10 ☐ **COMMON CITATIONS RELATED TO FALLS**

F323-

- Failing to modify interventions to prevent future falls
- Failing to ensure supervision and assistive devices effective
- Failing to ensure adequate supervision to prevent falls
- Failing to identify and address risks for fall

F282-

- Failing to follow care planned interventions to prevent falls

11 ☐ **QAPI SYSTEMS APPROACH**

Use of a process to consistently:

1. Identify hazards
2. Analyze hazards and risks
3. Implement interventions that address individual risks including the amount of needed supervision
4. Monitor effectiveness of interventions and modify approaches as necessary

12 ☐ **RISK MANAGEMENT**

QAPI IN ACTION

13 **COMMON INDIVIDUAL RISK FACTORS**

1 INTRINSIC

- AGE >80
- Lower extremity weakness
- Poor grip
- Balance deficit
- Gait deficit
- Cognitive impairments
- Depression
- Urinary incontinence
- Visual deficit
- Neurological impairments
- Orthostatic hypotension
- History of falls
- Chronic disorders

2 EXTRINISIC

- Use of assistive device
- Environmental hazards

Rugs, no grab bars, lighting, improper seating

- Foot wear problems
- 4 or more medications

14 **FALL RISK ASSESSMENT**

Complete comprehensive fall risk assessment:

- As soon as possible the day of admission
- Initial MDS, Quarterly, After each fall
- Changes in condition or function, new acute illness, new or increased pain

Apply Person Centered Interventions

- Implement new interventions in response to identified risks
- Review all interventions currently in place and effectiveness

Make changes to those that are no longer effective.

15 **FALL RISK ASSESSMENT**

1 Fall History
Social Needs/Motivation for Moving
Mental/Cognitive Status
Ambulation/Gait Ability
Standing/Transfer Ability
Bowel/Bladder Continence

2 Wandering Behavior
Adaptive Equipment
Footwear
Bed/Chair Positioning

Vision
Change in Condition
Medications
Diagnoses

16 ☐ **DETERMINING SUPERVISION LEVEL**

Obligated to provide adequate supervision to prevent accidents
Type and frequency of supervision individualized based on resident's assessed needs and identified hazards

- May vary from resident to resident and from time to time for the same resident

Types of supervision may include:

- Resident Safety Rounds
- Sitter Program
- Eyes and Ears Program

17 ☐ **REDUCING RISK OF FALLS RELATED TO MEDICATIONS**

Conduct medication regimen reviews:

- Admission/re-admissions
- After each fall occurrence
- Change in conditions
- Quarterly

Eliminate medications if there is no active indication to use them.
Reduce doses of necessary medications to the lowest effective dose.
Avoid prescribing medications for an older person where the risk from side effects outweighs the benefit
Implement process to monitor new medications effects for first 2 weeks after new medication ordered

18 ☐ **MEDICATIONS THAT INCREASE FALL RISK**

1 ☐
- Antidepressants
- Neuroleptics and antipsychotics
- Benzodiazepines
- Sedatives and hypnotics
- Antihypertensive agents
- Nonsteroidal anti-inflammatory drugs

2 ☐
- Diuretics
- Beta Blockers
- Narcotics
- Anti-Parkinson's Agents
- Medication with anticholinergic effects
- Use of multiple medications

19 ☐ **WHERE ARE RESIDENT'S HEADED WHEN THEY FALL?**

20 ☐ **HOW CAN WE IMPROVE BED TRANSFER SAFETY?**

21 ☐ **A NEW WAY OF THINKING ABOUT….**

1 BED HEIGHT

2 Resident sits on edge of bed with feet flat on floor; hips slightly higher than knees
Mark wall with tape to indicate top of mattress or top of headboard
Bed height is checked and maintained by all staff every time in room

3 FLOOR MATS

4 Mat creates uneven floor surface
Mat doesn't go full length of bed
Confusing to dementia residents
Efficacy unproven
Trip hazard

22 ☐ **HOW CAN WE IMPROVE ACCESS TO THE TOILET AND BATHROOM SAFETY?**

23 ☐ **TOILETING PLANS**

Interventions individualized based on resident assessment & nature of incontinence
May include scheduled toileting or prompted voiding based on individualized voiding pattern

Consider…

- Getting help
- Finding bathroom
- Managing clothing/briefs
- Mobility under stress
- User friendly bathroom based on individual issues

24 ☐ **BATHROOM**

1 PHOTO ON BATHROOM DOOR

2 CONTRAST TOILET FROM WALL/FLOOR

25 ☐ **WHAT'S ON YOUR NIGHTSTAND?**

Life history & preferences
What matters most
Usual routines
Significant relationships
History
Interests
Pass-times
Comforts
Aversions

26 **MANAGING THE FALL EVENT**

QAPI PRINCIPLES: SYSTEMIC APPROACHES

27 **AFTER THE FALL:**
CHECK, CALL, CARE

1. Immediately go to the resident, stay with the resident
2. If you are not a nurse, call for a nurse
3. Encourage resident not to move. Ask "Are you ok?"
4. Ask: " What were you doing just before you fell?"
5. Start getting answers to 10 questions
6. Assist in getting the fall huddle started once the resident is stabilized
7. Stay for the fall huddle

Source: Empira 2015

28 **10 QUESTIONS**

1 1. Are you ok?
2. What were you trying to do?
3. Ask or determine: What was different this time?
4. Check position of res.
   - Near a bed, toilet, chair?
   - How far away?
   - On their back, front, side?
   - Position of arms/legs?
5. What was surrounding area like?
   - Noisy, busy, cluttered?
   - If in bathroom, toilet contents?
   - Poor lighting/visibility?
   - Position of furniture, equipmt, bed height.

26. What was floor like?
   - Wet, urine, uneven, shiny?
   - Carpet or tile?
7. What was res. apparel?
   - Shoes, socks, slippers, barefoot?
   - Poorly fitting clothes?
8. Using an assistive device?
   - Walker, cane, w/c, other
9. Glasses or hearing aids on?
10. Who was in area when they fell?

29 ☐ **FALL HUDDLE**

Performed immediately once resident stabilized
Charge nurse has all staff working in the area of the fall meet together to start root cause analysis
Review 10 questions
Ask staff:
- "who has seen or has had contact with resident in the last few hours?"
- How did they appear? Behave?

Plan for 7-10 minutes
Initiate the Fall Scene Investigation Report

30 ☐ **FALL SCENE INVESTIGATION** Analyze the fall scene for clues Document answers to the 10 questions Why was the resident moving?
What were contributing factors?
How far away from the transfer surface?
Re-enact the fall during the huddle if necessary
Determine the root cause
How can you prevent this fall in the future?

31 ☐ **SEE SAMPLE FALL SCENE INVESTIGATION TOOL**

32 ☐ **ROOT CAUSE ANALYSIS- STEPS**

1. Gather clues about what happened
2. Determine why it happened- what conditions allowed the problem to exist
3. Implement corrective actions

33 ☐ **ROOT CAUSE ANALYSIS- AREAS TO INVESTIGATE**

34 ☐ **ROOT CAUSE ANALYSIS – POST FALL**

35 ☐ **ROOT CAUSE ANALYSIS- INTERNAL CAUSE EVALUATION**

- Ask residents what they were doing or trying to do just before the fall
- Where did the fall occur?
  - At bedside
    - Orthostatic BP
  - 5 feet away
    - Balance/Gait
  - > 15 feet
    - Strength/Endurance
  - In bathroom or at commode

- Check contents of toilet
- Is there urine on floor?

36 ☐ **IMMEDIATE INTERVENTIONS**

Should address the root cause and resident contributing risk factors

37 ☐ **SEE INTERVENTION DISCUSSION GUIDE-Huddle Practice Case Study Slides**

☐ **CARE PLAN SUCCESS**

44 ☐ **PERSON CENTERED CARE PLANS: INTERVENTIONS THAT ADDRESS RISKS**

1 MOST COMMON REASONS:

2 Restorative/Exercise

Bed height, visual contrast, obstacles on path to bathroom

Footwear review

AD placement & use

- Noise reduction & sleep vitality
- Reduce alarm use

3 CARE PLAN INTERVENTIONS:

4 Mobility/weakness

Environmental hazards

Medications

Other: Footwear, use of AD

45 ☐ **ROOT CAUSE ANALYSIS- INTERVENTIONS/SOLUTIONS**

- What will you do to prevent this problem from happening again?
- Do the interventions / solutions match the causes of the problem?
- How will it be implemented? Who will be responsible for what?
- How will the solutions impact or affect other operations / people in your facility?
- What are risks to implementing the solutions?
- Move from weak to strong interventions.

46 ☐ **FALLS TEAM MEETING**

Interdisciplinary

- Include nurse & nurse aides from fall site

Bring all relevant information

- Fall Scene Investigation report
- MAR
- Medical Record
- Fall Huddle Findings

Agenda

- Review of all new falls
- Status of residents from previous falls
- Systems and operational changes needed

47 ☐ **DOCUMENTATION**

- Fall history
- Analysis of the current situation & trends
- Measurements of resident specific fall risk factors with formal assessment(s)
- What interventions put in place to reduce the risk of another (similar) fall
- The outcome of each of your interventions
- The skilled teaching and training you are providing
- The objective gains you achieved as a result of your interventions
- How you are promoting long term maintenance of achievements

48 ☐ **FALLS DATA**

- Assess fall rates & prevention practices on routine basis
- Examine trends in fall data
  - Causes
  - Times
  - Staff
  - Locations
  - How is rate changing?
- Regularly monitor care processes related to falls
  - Fall risk assessment process
  - Care plan implementation compliance

49 ☐ **DATA MONITORING**

IPRO- Quality Improvement Organization for New York
http://qio.ipro.org/nursing-homes-hac/clinical-topics-tools-resources/restraint-clinical-tools-resources

- Monthly Falls Tracking Form/Version 5.3
- Falls Statistical Trending Form/Version 5

50 ☐ **FALL RISK VARIABLE REVIEW**

KEY CONSIDERATIONS FOR LTC FALLS PREVENTION AND MANAGEMENT

51 ☐ **SLEEP DEPRIVATION**

Empira Project found that reducing noise and reducing uninterrupted sleep helped to reduce falls.

52 ☐ **RESTORATIVE SLEEP VITALITY EMPIRA PROGRAM GOALS**

- Undisturbed sleep at night
- Fully engaged, awake during the day (reduce day time naps to no more than one 40 min nap)
- Program managed by administrator (not nursing)
- Calcium rich (milk, yogurt, cottage cheese, figs, apricots, whole wheat bread/cereal) & Magnesium rich foods (whole grain cereal, nuts, black beans, spinach) contribute to better sleep
- Small bedtime snack and reduced fluid intake later in the day and after evening meal

- Reduced noise levels (electronic sounds, staff conversations, paging, interior noises e.g. toilet flush, door closing, heater, towel dispenser) and elimination of alarms. Consider silent pill crusher, tvs off when not watched, wireless headphones
- 30 minutes of sunlight daily, white/blue spectrum light during day, amber/red spectrum light at night
- Do not awaken sleeping resident at night to administer meds & non-specific med times (e.g. upon rising and prior to bed at night"). Long acting pain meds.
- Reduce disturbance to toilet/reposition at night based on medical condition

53 **ALARM USE FACTS**

- Do not prevent falls from happening
  - Alert staff that the resident has moved
  - Alert staff that a resident has fallen
- Have same potential negative effects as restraints
- No evidence to support alarms usefulness in preventing falls and injuries

54 **EVIDENCE BASED CARE: ALARMS**

1 ALARMS

2 Alarms hinder movement & alarms contribute to confusion, agitation, behaviors, depression, incontinence, skin breakdown & falls; Alarms annul our attention & cause reactionary vs. anticipatory nursing

3 MOVEMENT: 4 Miconception: When a resident moves they fall down so prevent movement to prevent falls

55 **ALARM REDUCTION- STEPS**

- Family Education on admission, at care conferences, provide a brochure, discuss root cause analysis
- Staff Education on root cause analysis, alarm reduction rationale
- Consider beginning the process on a specific unit or shift & for a specific resident population
- Begin rounding on residents that have fallen
- Do not place alarms on new admissions
- Do not place alarms on any resident that does not currently have one
- Eliminate alarm if resident has not fallen in 30 days
- Eliminate alarm if it appears to scare, agitate, or confuse resident
- If resident has a fall with alarm on, discontinue use of the alarm

56 **ROUNDING FOR NEEDS**

- To anticipate care needs instead of waiting until asked for something and then reacting
  - Goal: To meet care needs before they arise
- Check on residents every 1-2 hours and assess the 5Ps:
  - Pain – What is pain level?
  - Potty – Do they need to use the restroom?
  - Position – How comfortable is the resident?
  - Proximity – Is everything they need within reach?
  - Personal needs – Is there anything else they need?

57 **IMPACT OF ROUNDING FOR NEEDS**

- 52% reduction in falls
- 37% reduction in use of call lights
- 14% decline in skin breakdown & pressure injuries
- 12% increase in satisfaction ratings
- Reduced noise levels on units
- Increased job satisfaction & productivity

58 **FOSTER SAFE MOVEMENT**

59 **MOTOR CONTROL**

60 **PHYSICAL PERFORMANCE RISK VARIABLES**

- Vision
- Vestibular impairments
- Posture
- Balance
- Positioning

62 **INTERVENTION STRATEGIES**

1 ENVIRONMENTAL MODIFICATIONS

2 Lighting

- Reduce glare
- Task lighting
- Ease transitions
- Night to day light

Contrast

Tactile cues

Organization (meal tray, closet, toiletries)

3 COMPENSATIONS

4 Visual motor exercises

Viewing strategies based on condition

Books on tape/large print/writing guides

Self care routines

Mobility safety & injury prevention

Caregiver Training

63

64 **VESTIBULAR SYSTEM**

65 **VESTIBULAR SYMPTOMS**

1

- Complaints of dizziness
- Loss of balance
- Vertigo
- Nystagmus

- Nausea with movement that is impacted by head position or turning

2 Assessment should focus on gathering info on:
- provoking factors
- history of head, neck, vision, ear problems
- proprioceptive functioning

66 **IMPACT OF POSTURE ON FALL RISK**

Balance is achieved by making adjustments to maintain center of gravity (COG) over base of support (BOS); • The feet, when standing • The buttocks, when sitting
During walking or transfers, the COG extends beyond BOS
Visual, vestibular, & proprioceptive centers detect imbalance & signal protective response

67 **OSTEOPOROSIS**

Osteoporosis increases risk of abnormal posture and more fractures when falls do occur

68 **OSTEOPOROSIS INTERVENTIONS**

1 DIETARY/PHARMACOLOGY
2 Calcium 1200 mg per day (700 mg from diet, 500 mg supplement)
Vitamin D for institutionalized due to lack of sunlight
Antiresorptives (bone retaining)
Anabolics (bone forming)

3 EXERCISE
4 Weight bearing and resistance training
Avoid forward flexion of spine or twisting, jerking movements
Teach joint protection

69 **OBJECTIVE MEASUREMENT & DOCUMENTATION: REEDCO TOOL**

70 **FOOT/ANKLE ASSESSMENT**

Appearance
Areas of pressure
Deformities
Sensation
ROM
Hygiene/self care performance
Foot wear
Presence of infection
Edema

71 **TREATMENT STRATEGIES**

1 Training
Train for self care of feet
Train for self sensory test & skin protection
Compensatory strategies

Train re: foot wear
- 2-3 pairs of shoes
- Proper fit

2 Treatment
Modalities
Positioning
Pressure relief
Maximize functional ROM
Edema management

72 **ASSESSMENT TOOLS FOR BALANCE**

A formal test of balance establishes a baseline and subsequent improvements/fall risk reduction following your skilled intervention.
Recommended tests:
- Tinetti
- BERG

73 **WHEELCHAIR SEATING**

Both feet on floor (or footrests)
with knees flexed at 90 degrees.
Kick space below the seat to
allow one foot to slide underneath
(consider the biomechanics of rising.)
Avoid too soft cushions that hinder rising and make weight shifting difficult . Best type of cushion is relatively flat and firm with some resilience
Watch for slinging upholstery

74 **CHOOSING A WHEELCHAIR BASE FRAME**

75 **BASE OF SUPPORT**

Firm base of support at seat and feet is key to stability
Note hammocking seat upholstery resulting in :
• Internal femoral rotation; • Adduction; • Pelvic obliquity; • Poor weight distribution

76 **POSTERIOR PELVIC TILT**

Excessive posterior pelvic tilt results in excessive spinal flexion or postural kyphosis

77 **DEMENTIA AS A FALL RISK FACTOR**

1 DEMENTIA RISK
2 Residents with dementia fall nearly twice as often
Van Doorn et. al

3 CONTRIBUTING FACTORS
4 Impaired judgment
Motor response
Gait deficits

Visual spatial perception
Decreased ability to recognize and avoid hazards

78 **ALLEN COGNITIVE LEVEL (ACL)**
ABILITIES ARE ANALYZED BASED ON:

- What residents pay attention to
- Motor control expectations
- Communication ability

79 **ACL - DEVELOPMENTAL AGE**

80

81 **WHEN IS "LEARNING" EXPECTED?**

1 BENEFITS FROM INSTRUCTIONS
2 Level 6 (Normal Cognition)
Can learn through the use of language & written materials . Can plan ahead.
Level 5 (Mild cognitive impairment)
New models for new motor skills are formed
3 EARLY STAGE BENEFITS FROM DEMONSTRATION
4 Level 4 (Early)
Out of the ordinary is recognized with striking sensory cues (usually visual).
New models of performing tasks are imitated for situation specific tasks.

82 **LOWER LEVEL DEMENTIA TRAINING**

1 Level 3
Drilling practice under constant supervision to develop new habits using standardized, routine steps
2 Level 1 and 2
Learning is not a treatment objective. Teach caregivers. Set up environment & daily activity structure .

83 **INTERVENTIONS ARE NOT ONE SIZE FITS ALL…**
3.6 recalls information for how long?

84 **DEMENTIA LANDMARKS**

85 ☐ Depression and related fatigue may make people feel less secure in physical abilities Regular daily activities are reduced which decreases positive reinforcement from doing these activities

86 ☐ **FEAR OF FALLS**

Assessments:
Falls Efficacy Scale (FES)
Activity Specific Balance Confidence Scale (ABC)

87 ☐ **EFFECTIVE FACILITY SYSTEMS**

WORKING TOGETHER TO REDUCE FALLS

88 ☐ **FALL PREVENTION BASICS**

- Multidisciplinary team approach
- Comprehensive assessment to identify and address risk factors and treat underlying medical conditions.
- Educate staff about fall risk factors and prevention strategies.[1]
- Reviewing prescribed medicines to assess their potential risks and benefits and to minimize use.[17, 18]
- Environmental assessment to make it easier for residents to move around safely.
- Exercise programs to facilitate balance, strength, mobility, and physical functioning among nursing home residents.
- Behavioral strategies

89 ☐ **ENVIRONMENTAL INTERVENTIONS**

1
- Remove hazards below knee and above eye level
- Glow tape line to bathroom
- Lighting: reduce glare, night lights, assess transition from light to dark areas
- Non-skid strips (with careful observation)
- Carpeting vs. tile
- Grab bars in bathroom

2
- Low bed
- Remove pedestal furniture
- Photo of toilet on BR door
- Personalized walker
- Move closer to BR
- Rocking chair
- Bedside commode
- Adjust seat/toilet height
- Many places to sit & rest

90 ☐ **ENVIRONMENTAL LIGHTING REVIEW**

access to switches
night time lighting—watch shadows
transition areas to different flooring surfaces & through doorways. Moderate strong lighting discrepancies from one area to the next (bright hallway into dark resident room)

91 ☐ **HOW CAN WE INCORPORATE MORE MOVEMENT INTO THE DAY?**

92 ☐ **ACTIVITIES & RNP PROGRAMMING**

Sample Exercise Groups:

1. Seated aerobics/ROM
2. Falls prevention for ambulatory residents incorporating some standing & balance exercises

93 ☐ **GET MOVING!**

- Walk/Ride programs, when able can walk, others propel their w/c
- Helping residents to transfer from w/c to regular chairs during meals, activities, etc.
- Assisting residents in walking to the bathroom for toileting, rather than using the w/c to transfer or using bed pan if in bed
- Assisting residents in wheelchairs to be able to stand multiple times per day, with AD, wall railing, etc.
- Walk to Dine programs
- Movement Breaks: Facility wide 5-10 minute breaks during the day (2/3x per day) during which music is played and employees and residents take a "stretch break" led over the speakers, performing simple stretches and active ROM movements.

94 ☐ **GROSS MOTOR INTERVENTIONS**

1 • Resistive training alone has shown little to no evidence of fall reduction.

- To see gains include:
  - Balance retraining = A MUST
  - Core and limb strengthening & flexibility (esp. ankles & hips)
  - Postural stability
  - Coordination, Proprioception, visual compensatory strategies to improve senses for orientation and ability to make anticipatory changes
  - Gait training as appropriate

2 • Ongoing training required– results shown at one month yet gone at one year

- Tailored HEP of strengthening and balance retraining reduced falls and fall-related injuries by 35%

Resource: Shumway-Cook

95 ☐

96 ☐ **FALLS REFERRALS & IDT SYSTEMS**

1 Method of reporting every fall to rehab (with incident report if possible)

Rehab follow up screen and evaluation if skilled intervention would be beneficial

Rehab falls assessment reviewing ALL risk factors and responding with relevant individualized interventions.

2 Rehab participate in falls committee

QA process to follow up on care planned interventions

97 **CASE EXAMPLE**

98 **STAFF TRAINING SUGGESTIONS**

- Basic fall prevention strategies
- Positioning & Restraints
- Dementia management
- Behavior management
- Sensory changes
- Identifying decline/referral process
- Documentation to support falls prevention efforts and rehab
- Effective restorative programs
- 2 minute change of shift inservices (see examples)

99 **RESOURCES**

Empira Project Sue Ann Guildermann, RN, BA, MA

Oregon Patient Safety Commission- Fall Investigation Guide Toolkit: How to Guide. http://oregonpatientsafety.org/healthcare-professionals/nursing-homes/long-term-care-falls-investigation-toolkit/284/

Agency for Healthcare Research & Quality. The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities. http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/index.html Advancing Excellence: Mobility Goal. https://www.nhqualitycampaign.org/goa1Detail.aspx?g=mob#tab4

100 **QUESTIONS OR COMMENTS?**