LONG TERM CARE
COMMUNITY COALITION
Advancing Quality, Dignity & Justice

FALL AND ACCIDENT PREVENTION IN NURSING HOMES

FACT SHEET

Each year, more than half of nursing home residents experience a fall, while one in three residents will experience multiple falls.[1] These incidents can lead to serious harm, including functional decline, injury, reduced quality of life, and death. Approximately three million older adults visit the emergency room after a fall every year, and over 800,000 are hospitalized from injuries related to a fall, such as head trauma or hip fracture.[2]

This fact sheet explains why falls are common in nursing homes, how falls can be prevented, and federal regulations on falls and accidents.

Note: Italicized text is directly from the Code of Federal Regulations (CFR) or federal guidance and other text is paraphrased from these or other resources (see footnotes). Federal standards are applicable to all residents in licensed U.S. nursing homes, including short-term, long-term, private pay, Medicaid, Medicare, or privately insured.

COMMON CAUSES OF NURSING HOME FALLS:[3]

- ✓ Equipment in hallways, which accounts for about one in five nursing home falls
- ✓ Hazards, such as poor lighting, wet floors, and wheelchair issues
    - Research has indicated that upgraded lighting with higher intensity during the day and lower intensity at night can reduce falls by 43%[4]
- ✓ Muscle weakness and gait instability, which account for one in four nursing home falls
- ✓ Using psychotropic drugs, including anti-anxiety and antipsychotic medications
- ✓ Medication side effects
- ✓ Underlying chronic conditions, such as heart failure, neurologic disorders, or joint disorders
- ✓ Giving medications that interact poorly with underlying medical conditions

COMMON PROTOCOLS FOR PREVENTING NURSING HOME FALLS:[5]

Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls.

- ✓ Use evidence-based fall risk screening tools to identify fall risk

[1] Agency for Healthcare Research and Quality, https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man1.html.
[2] Centers for Disease Control and Prevention, https://www.cdc.gov/falls/facts.html.
[3] Centers for Medicare & Medicaid Services, https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf.
[4] Journal of the American Medical Directors Association, https://pubmed.ncbi.nlm.nih.gov/35850166/.
[5] HMP Global Learning Network, https://www.hmpgloballearningnetwork.com/site/altc/articles/strategies-reducing-falls-long-term-care.

- ✓ Implement a comprehensive fall reduction program to prevent future falls
- ✓ Closely observe those with high fall risk
- ✓ Address fall risk factors such as environment and staffing
- ✓ Provide assistive devices such as walkers and wheelchairs
- ✓ Review medications that cause dizziness
- ✓ Thoroughly investigate after a fall to identify the cause and assess for injury
- ✓ Provide proper footwear with correct sizing and non-slip grip
- ✓ Conduct annual vision check-ups
- ✓ Promote regular exercise to build strength and improve gait
    - **Note:** the benefit of bed alarms has not been proven, and according to a study of hospitalized patients, these alarms should not be used for fall prevention as they only notify that a fall has already occurred.[6]

After the fall: An eight-step response program

Source: Agency for Healthcare Research and Quality

1. Evaluate and monitor resident for 72 hours after the fall
2. Investigate fall circumstances
3. Record circumstances, resident outcome, and staff response
4. Alert primary care provider
5. Implement immediate intervention within first 24 hours
6. Complete falls assessment
7. Develop plan of care
8. Monitor staff compliance and resident response

Note: *Falls generally do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraints, including, but not limited to, bed rails and position change alarms, will prevent or reduce falls. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices, are not considered safe, appropriate health care restraint interventions for use by a nursing home.*

Accidents

42 C.F.R. § 483.25(d)

Nursing homes are responsible for ensuring the safest environment possible for residents in a manner that helps promote quality of life and respects the residents' rights to privacy, dignity, and self-determination. *An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents.*

Facilities must ensure that—

1) *The resident environment remains as free of accident hazards as is possible; and*
2) *Each resident receives adequate supervision and assistance devices to prevent accidents.*

Get the Facts. Visit **nursinghome411.org/facts** for more free fact sheets to inform your advocacy for better resident care and quality of life.

[6] Shorr, R.I., Chandler, M., Mion, L.C., Waters, T.M., Liu, M., Daniels, M.J., Kessler, L.A., and Miller, S.T. (2012). Effects of an intervention to increase bed alarm use to prevent falls in hospitalized patients. Annals of Internal Medicine 157(10), 698.