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Post Fall Physical Assessments

Nursing home regulations direct providers to "ascertain if there were injuries following a fall and provide treatment as necessary." However, the guidelines don't provide recommendations or best practices for the frequency or duration of follow-up assessments, which leaves providers wondering what the best practice is and what should staff assess for.

Root Cause:

When a fall occurs, providers should do their best to attempt to determine (or assist the tenant/patient depending on the level of care in determining) why the fall occurred or the root cause. This helps drive new fall interventions that can prevent similar falls from possibly occurring. If you're unable to identify a root cause, you may consider implementing new interventions that would reduce the resident's risk for injury. Typically, a post fall investigation into the possible contributing factors is completed once with a follow up to ensure that the implemented intervention is appropriate. For example, following a fall, you determined that Resident #1 stood up unassisted and attempted to walk to the bathroom which led to a fall. During investigation, it was determined that last assisted to the resident in the bathroom three hours prior and the resident was incontinent of urine at the time of the fall. Even if the resident is unable to tell you they needed to go to the bathroom, a reasonable assumption given the circumstances could be that the resident may have been attempting to go to the toilet and appropriate interventions could be assisting the resident to use the bathroom every two hours. During follow up review of the intervention it was determined that the resident still attempted to walk unassisted despite staff compliance with the toileting plan and fall intervention which means that the intervention may not have been appropriate and should be reevaluated to determine if the intervention is still necessary or if something different should be implemented.

Physical Assessments:

Additionally, nurses should assess the resident/patient to determine if an injury is apparent. Neurological assessments may also be indicated and are based on your individual policy. Some providers require that neurological assessments should be completed for all unwitnessed falls, which leaves your nurses sometimes scrambling to complete them without any clear signs of head trauma while others just complete neurological assessments if there is an indication or belief that the resident hit their head. This is nursing home and survey/deficiency specific as it may have been a plan of correction to a previous finding of noncompliance. There isn't anything in guidance that

states neurological assessments after each fall or unwitnessed falls are required. It is the standard of practice that if you have suspicion of a resident hitting their head, you complete neurological assessments.

According to references cited below, a resident should be assessed for physical injuries prior to moving them from the location of the fall because if the resident sustained an injury, moving them may cause further physical injury, such as a cervical or spinal injury. If a significant injury is suspected based on clinical assessment findings, the resident should not be moved, and the nurse should follow the procedures for transferring the resident/patient to a higher level of care for evaluation (such as to an ER). Allow the emergency medical personnel to complete splinting or bracing of potential injury areas prior to moving the resident/patient and then assisting the resident onto a cot for transport.

The nurse assessing the resident/patient following a fall should assess:

- Vital signs include the resident's pulse, blood pressure, respiratory rate, oxygen saturation. Some providers include orthostatic blood pressure and pulses to determine if orthostatic hypotension (when the blood pressure decreases as someone changes elevation) was a contributing factor to the fall. Vital sign abnormalities could indicate a potential injury as well as a possible indication of an underlying infection that could have contributed to the fall.
- Cognition or a change in consciousness as an indication that the resident/patient may have suffered a head injury.
- Muscle strength, sensation, and range of motion which could be indicators of possible injuries including sprains, strains, or fractures.
- Deformities could be an indication of a physical injury such as external rotation of a leg or one leg is longer than the other in a possible hip fracture.
- Skin integrity such as abrasions, skin tears, or bruises.

<u>Frequency:</u>

The resource documents referenced below vary in the recommendations of the frequency of follow-up assessments. Injuries from a fall may not always present immediately upon the incident such as a head injury that may take hours for the residents to display a change in consciousness. It is important for nurses to complete some type of follow-up assessment after the fall to ensure that any possible injuries are identified and treated as soon as possible.

The recommendations include anywhere from every four hours to every shift and for durations extending to 24 – 48 hours post fall. Some providers may extend this out to a 72 hour period, just to be on the safe side. Additionally, follow-up assessments may vary based on any suspected injuries. If a resident has signs that they hit their head during the fall, neurological assessments should be completed more frequently than general physical assessments without signs of head trauma. Whatever your policy is, ensure that your nurses have a clear process of completing the follow-up assessments including where and how they are documented for consistency.

Notification of State Survey Agency:

Some providers are required to notify the state survey agency of specific incidents. Staff should have knowledge of the specific requirements to report to the survey agency along with the method for expedited reporting. Iowa rules are outlined below:

Nursing Homes – 481-50.7(1) requires that accidents causing major injury be reported to the department within 24 hours or the next business day. Major injury is defined as resulting in death, requiring admission to a higher level of care for treatment, other than for observation, or requiring consultation with the attending physician or designee who determines on a major injury determination form that the injury is a major injury. Residents who are independently ambulatory are not included in this requirement, so far as the nursing home did not culpability in the fall.

Assisted Living – 481-67.4(1) Similar to the nursing home, assisted living programs must report accidents that result in major injury with major injury being defined the same as the nursing home rules above.

Policy & Procedure:

Finally, all steps in the fall process must be included in your policy and procedure. This includes pre-fall preparation such as completing a fall risk assessment, identifying preventative interventions to when a fall occurs and what the expectations are of your staff to monitor the individual ongoing for possible injuries or a change in condition. Whether the resident sustains an injury or not, ensure that the resident/patient's responsible party and physician are notified timely of the incident and include findings from the assessment.

References:

Chapter 50 – Health Care Facilities Administration

Chapter 67 – General Provisions for Elder Group Homes, Assisted Living Programs, and Adult Day Services

AAPACN – Post-Fall Assessments

AHRQ – Falls Management Program: A Quality Improvement Initiative for Nursing Facilities – Chapter 1.

Preventing Falls in Hospitals – Tool 3N: Postfall Assessment, Clinical Review

Veteran's Administration – Falls Policy Overview

CMS – Appendix PP for Nursing Homes