# Index

## SECTION I  MODULE OVERVIEW

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>5</td>
</tr>
<tr>
<td>Resource Description</td>
<td>6</td>
</tr>
<tr>
<td>Purpose, Goals, and Objectives</td>
<td>9</td>
</tr>
<tr>
<td>Intended Audience(s)</td>
<td>10</td>
</tr>
<tr>
<td>Prerequisites</td>
<td>10</td>
</tr>
<tr>
<td>Instructor Qualifications and Responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>Required Resources</td>
<td>10</td>
</tr>
</tbody>
</table>

## SECTION II  HOW TO USE THE MODULE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures for Implementation</td>
<td>12</td>
</tr>
<tr>
<td>Glossary of Terms</td>
<td>13</td>
</tr>
<tr>
<td>Instruments and Supporting Materials</td>
<td>13</td>
</tr>
<tr>
<td>Case Studies and/or discussion scenarios/questions</td>
<td>13</td>
</tr>
<tr>
<td>Extension Activities (optional)</td>
<td>14</td>
</tr>
<tr>
<td>Relationship to Other Materials</td>
<td>14</td>
</tr>
<tr>
<td>Lessons Learned (optional)</td>
<td>14</td>
</tr>
<tr>
<td>Competencies to be Attained and Methods of Assessment</td>
<td>14</td>
</tr>
<tr>
<td>Evaluation</td>
<td>15</td>
</tr>
<tr>
<td>List of References</td>
<td>15</td>
</tr>
</tbody>
</table>
APPENDICES

Peer Feedback Form (Appendix I)

Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs) Sheet (Appendix II)

Pre-Training Assessment Questionnaire (Appendix III)

Post-Training Assessment Questionnaire (Appendix IV)

Curriculum Evaluation by Nursing Home Instructor/Trainer (Appendix V)

Educational Handout (Appendix VI)
SECTION I

MODULE OVERVIEW
Background

Why are fall prevention and fall reporting important?
As many as 75% of nursing home residents fall each year. Fall incidents among older adult nursing home residents clearly impact overall health and can result in serious injuries and death. The need for “falls” training was established through a formal needs assessment process, discussions with experts, and testing of the materials. This falls curriculum is the result of the collaboration of the Teaching Nursing Home (TNH) program, AHCA, and a broad array of public and private industry and academic partners throughout Florida.

This Guide was developed for use by Nursing Home training coordinators, risk managers, and / or directors of nursing who may be responsible for in-service training of staff, quality improvement, and addressing quality monitor issues.

BACKGROUND AND RATIONALE

The National Center for Injury Prevention and Control identifies assessment after a fall as required to identify and address risk factors in preventing falls in nursing homes. Yet, based on our interviews with nurses and discussions with experts, there appears to be much confusion about what constitutes a fall and hence when to conduct assessment critical to tailoring an effective fall prevention strategy.

Most nursing staff in the three nursing homes we have studied are unaware of any precise “fall” definition that should be used, but instead spoke in the following terms: A “fall” is …
- a sudden drop from an upright position
- a sudden loss of an upright position
- dropping to a lower or less erect position; "she fell back in her chair," "he fell to his knees"
- any drop (free and rapid descent under the force of gravity)

To date, much of the fall prevention activities implemented in nursing homes utilize a “resident fall” as the trigger for resident assessment and subsequent planning of tailored fall prevention activities. For example, in the Clinical Practice Guideline, developed by the American Medical Directors Association and the American Health Care Association, the first question clinicians are asked to answer is whether or not the resident has had a recent fall, the strongest predictor of future falls (see p. 2 of AMDA’s 1998 Falls and Fall Risk clinical guideline). The evidence-based practice protocol, Fall Prevention for Older Adults (Lyon, 2004) also uses a “fall history” as the starting point for a fall prevention algorithm for nurses.

There are extensive knowledge and attitudinal barriers to falls recognition and reporting. Specifically, some examples of common barriers to fall reporting are:
- “I didn’t know that was considered a fall.”
- “I caught the resident so that’s not a fall.”
- “Low staffing is the reason for many falls.”
- Sixty-two percent of nurses believe falls are a normal part of aging.
Forty-six percent of nurses believe falls are unavoidable in the elderly. Fear of legal liability affects nurses’ approach to falls prevention (Department of Veterans Affairs, 2002, p. 21).

This TNH deliverable provides a DVD-based curriculum (also downloadable via the GeriU Web site) that enables learners to recognize and report falls and participate in fall prevention quality improvement initiatives. While a standardized methodology for the identification of a “fall” event and an understanding of the need for an accurate fall history (including the nature and circumstances surrounding a fall) are the critical first steps toward prevention, few fall prevention programs have focused on these issues. Rather, the focus has been more on the multiple risk factors of falls, mechanics of falls, and care plan individualization. Relatively few studies have taken a broadly inclusive approach to nursing staff education on falls recognition and reporting as the foundation for improving falls prevention (Chang et al., 2004). TNH’s DVD-based curriculum follows that relatively uncommon strategy; the curriculum’s key instructional foci are:

- Accurate recognition of a fall in a nursing home resident
- Knowledge about the prevalence, consequences, and causes of falls in nursing homes
- Rationale for and understanding the process of falls reporting
- Barriers to fall incident reporting, including nursing staff concerns about liability (and blame) following a resident fall

### Resource Description

Anecdotal evidence together with the new data we will present indicates that nursing home staff are not recognizing falls properly (according to CMS and state standards for nursing homes). This failure to identify what constitutes “a fall” hinders fall and related injury prevention in nursing home residents. Accordingly, the TNH consortium designed and developed a DVD-based curriculum to address the proper recognition of falls and the rationale and general approach for falls reporting. In preparation for this curriculum development, we identified knowledge gaps and underlying preconceptions. We conducted preliminary evaluation to demonstrate that this DVD-based curriculum can help prepare and motivate nursing staff for appropriate recognition and reporting of falls. The TNH curriculum provides knowledge basic to an understanding of why falls occur and how they can be prevented.

In most nursing homes a fall can be reported by a resident, visitor, family member, or any witness to the event. This curriculum was designed to serve as an introduction and refresher to falls prevention for certified nursing assistants (CNAs) and licensed practical nurses (LPNs). Clearly, the nursing staff plays a critical role in identifying residents at risk for serious falls and injuries. Yet, no one discipline or person is fully responsible for the prevention of falls in a nursing home. **TNH’s new curriculum prepares all nursing staff working in nursing homes to better recognize and report falls, witnessed or suspected. Improved falls reporting and assessment should soon improve care and reduce injurious falls.**

### Educational Approach

This DVD-based curriculum was developed by a group consisting of geriatricians, nurse educators, nurses, e-learning experts, and risk managers. Professional actors and specialized
graphic artists were employed for the DVD production; all of the participants are actors. All of the DVD scenes have been created to illuminate fall reporting issues and common causes of falls.

Outline of Module Content

This module on Prevention of Falls and Serious Injuries in Long-Term Care is created in segments that follow the outline below:

Introduction
Falls in general
How serious is the Problem?
What are the complications of falls?
What is a fall?
Examples of a fall
Why do falls occur?
Causes of falls
Barriers to fall prevention
The MDS & RAP connection
Epilogue
Credits

Fall prevention requires a combination of medical treatment, rehabilitation, and environmental modification. Interventions include:

- **Assessment after a fall to identify and address risk factors and treat underlying medical conditions (Rubenstein, 1990)**
- Physical conditioning and/or rehabilitation using prescribed exercises to improve strength and endurance; physical therapy; gait training; and walking programs (Rubenstein, 1994; Province, 1995)
- Environmental assessments and modifications to improve mobility and safety such as installing grab bars, adding raised toilet seats, lowering bed heights, and installing handrails in the hallways (Ray, 1997)
- Review of prescribed medications to assess their potential risks and benefits and minimize use (Cooper, 1994, 1997)
- Providing patients with hip pads that can effectively prevent most hip fractures if a fall occurs (Kannus, 2000).
• Technological devices such as alarm systems that are activated when patients try to get out of bed or move unassisted (Rubenstein, 1994)

http://www.cdc.gov/ncipc/factsheets/nursing.htm

Primary Findings from Pilot Evaluation

Utility Outcomes for Nursing Staff

Utility outcome 1: Nurses participating in the educational program experienced increased knowledge about falls.

Utility outcome 2: Nurses participating in the educational program improved their ability to recognize (accurately identify) “a fall” event.

Utility outcome 3: Most participants think that the training will result in an increase in the number of falls reported.

Usability Outcomes for Nursing Staff
It was clear to all of the administrators and trainers (for all 3 training sites) that nursing staff participating in the program were very satisfied and that falls reporting would improve (see above).

Usability outcome 1: Nursing staff participating in the program were very satisfied and falls reporting improved (also, see utility outcome 3 above).

Usability outcome 2: Participants considered the level of content appropriate.
Purpose, Goals, and Objectives

Purpose

In most nursing homes a fall can be reported by a resident, visitor, family member, or any witness to the event. This curriculum was designed to serve as an introduction and refresher to falls prevention for certified nursing assistants (CNAs) and licensed practical nurses (LPNs). Clearly, the nursing staff plays a critical role in identifying residents at risk for serious falls and injuries. Yet, no one discipline or person is fully responsible for the prevention of falls in a nursing home. *TNH’s new curriculum prepares all nursing staff working in nursing homes to better recognize and report falls, witnessed or suspected. Improved falls reporting and assessment should soon improve care and reduce injurious falls.*

Goals

The goals of this DVD-based educational program are to increase staff awareness of what a “fall” is, why a fall occurs, and the critical importance of falls reporting for preventing repeat falls in the nursing home.

Educational Objectives

➢ Learners will recognize falls in nursing homes and understand their importance; specifically, they will be able to:
- State a standard definition of a fall in nursing homes,
- Discuss fall rates and prevalence in nursing homes,
- Describe fall complications.
➢ Learners will know the primary causes of falls; specifically they will be able to list at least 3 primary/major risk factors/causes for falls.
➢ Given a resident scenario, learners will recognize accurately (according to a standard definition) whether or not that scenario constitutes a “fall.”
➢ Given a resident who falls, learners will be able to describe how reliable fall incident reporting could prevent falls and related injuries.
➢ Learners will know that falls are to be recorded in the MDS and be able to explain how recording falls in the MDS can trigger resident assessment, thereby improving resident care.
Intended Audience(s)

Educational Approach and Target Audience

While this curriculum was designed to serve as an introduction to falls prevention for CNAs and LPNs, it can apply to any nursing home staff. This curriculum can orient new nursing staff and update existing staff (a refresher); no one discipline is fully responsible for the reporting and prevention of resident falls in the nursing home.

Prerequisites

There are no prerequisites for this learning module.

Instructor Qualifications and Responsibilities

Instructor qualifications include small-group facilitation skills, experience in teaching with video, including DVDs, and experience with administration of assessment and evaluation tools. The instructor/facilitator is expected to review all materials and be comfortable with the content prior to facilitating the group learning process.

Instructors are reminded that students should not view assessments prior to the instructional session. Learners should not view answers to assessment questions until all learners have completed the assessment of learning.

A Learner’s Manual is available for the learners. The instructor must be familiar with the content and able to refer to it during the session.

Additional learner assessment instruments as well as evaluation materials are available on the website: http://ltc.geriu.org. Simply login to the PICs site and access other materials.

Required Resources

Resources necessary to implement this module training within your facility include:

- TV monitor
- DVD player

The Prevention of Falls and Serious Injuries in Long Term Care training on the included DVD is also available on the TNH website GeriU, at www.GeriU.org\pics.
SECTION II

HOW TO USE THE MODULE
Procedures for Implementation

Preparation
1. Before implementing the training, instructors should watch the DVD to identify content that requires more explanation or modification for their learners. The content is based on current MDS reporting guidelines (see Appendix), but any modification related to a specific facility should be presented to prevent learner confusion regarding “fall” definition.
2. Before implementing this training, the instructor (i.e., clinical educator, supervisor, risk manager) should review the facility’s internal policies and procedures for fall incident reporting.
3. Be prepared during the training session to discuss local barriers to fall reporting, methods to improve reporting procedures, liability concerns, recent fall events, and the definition of a “fall.”
4. Prior to viewing the DVD and taking part in the discussion and other relevant materials, each learner should complete the pre-test Assessment Questionnaire.

Number of Participants
5. Although designed with a synchronous small-group (5-10 learners) approach in mind, this curriculum can be administered asynchronously to one or more learners with follow-up discussion and assessment in individual or group format.

Providing the Training
6. This training should take about 45 minutes. Be sure all of the participants can see and hear the DVD clearly.
7. Continuous viewing of the DVD takes about 20 minutes, but it is strongly suggested that extra time be allocated to discuss local issues regarding fall reporting and procedure.
8. Each learner should be provided a copy of the Educational Handout (available as a PDF file on the DVD and on http://ltc.geriu.org), as well as the Learner Guide, also available on the website.

Implementation at Your Facility
9. Consider implementing this curriculum in conjunction with education of residents, families, nursing home staff, and physicians in order to prevent any confusion about fall reporting.
10. To assist in this educational outreach, see the section "What Is a Fall?" in the Educational Handout.
11. The important message to convey to staff, residents, families, and physicians is that identifying and reporting noninjurious fall incidents will prevent future falls and serious injuries, the primary purpose of fall reporting.
12. In many facilities this educational program may actually increase the number of falls reported by the staff; however, the number of injurious falls should not increase, but rather decrease.

After the learner has completed the module, he/she should complete the post-test Assessment Questionnaire, provided in the appendix, and available online at: http://ltc.geriu.org.

Glossary of Terms

**Definition of a “Fall”:** “Fall” refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (e.g., a resident pushes another resident). To facilitate learning, definition in the DVD was condensed to: **A fall is unintentionally coming to rest on a lower level but not as a result of an overwhelming external force.**

Instruments and Supporting Materials

This Guide includes the following Instruments and Supporting Materials:

- Peer Feedback Form (Appendix 1)
- Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs) Sheet (Appendix II)
- Pre-Training Assessment Questionnaire (Appendix III)
- Post-Training Assessment Questionnaire (Appendix IV)
- Curriculum Evaluation by Nursing Home Instructor/Trainer (Appendix V)
- Educational Handout (Appendix VI)

Case Studies and/or discussion scenarios/questions

There are no supplemental case studies or scenarios, other than those included in the Guides.
Extension Activities (optional)

There are no extension activities identified to complement this content at the present time.

Relationship to Other Materials

This module is designed as a stand alone learning module. The learner does not need to complete other learning modules prior to or following this, specifically. However, GeriU\'pics website: http://ltc.geriu.org, contains several modules and learning activities that are complementary. Both the facilitator and learner may choose to explore any or all of these learning pieces as well. Related items available through http://ltc.geriu.org include:

- E-Learning Tutorials: Performance-Oriented Mobility Assessment (POMA)
- Interactive Lectures: Balance and Gait Module
- Interactive Lectures: Approach to the Older Person who has Fallen

Lessons Learned (optional)

It is incumbent upon the Facilitator to be familiar with the facility internal policy regarding the content area before implementing the training. If there are conflicts between this content and internal written policy, be prepared to address the particulars with the learner(s).

Competencies to be Attained and Methods of Assessment

APPENDIX III and IV at the end of this Guide include the Pre- and Post- Training Assessment Questionnaires for use with the Prevention of Falls module. The Assessment Questionnaire is designed to ascertain the learner baseline level of knowledge verses the comprehensive knowledge post-training. The Assessment Questionnaires are designed to tie to the stated Educational Objectives for the module, as shown below:

- Learners will recognize falls in nursing homes and understand their importance; specifically, they will be able to:
  - State a standard definition of a fall in nursing homes,
  - Discuss fall rates and prevalence in nursing homes,
  - Describe fall complications.
- Learners will know the primary causes of falls; specifically they will be able to list at least 3 primary/major risk factors/causes for falls.
Given a resident scenario, learners will recognize accurately (according to a standard definition) whether or not that scenario constitutes a “fall.”

Given a resident who falls, learners will be able to describe how reliable fall incident reporting could prevent falls and related injuries.

Learners will know that falls are to be recorded in the MDS and be able to explain how recording falls in the MDS can trigger resident assessment, thereby improving resident care.

This Questionnaire is to be administered to learners prior to watching the DVD and participating in the facilitator-led blended learning activities.) Learners can provide responses for both the pre and post-test Questionnaires online by accessing: http://ltc.geriu.org, login, select the PICs logo, and then selecting the “Prevention of Falls” module and this Questionnaire. If the learner chooses to complete the Questionnaire in paper and pencil format, please mail the completed Questionnaire to:

PICs Training
Stein Gerontologic Institute
Miami Jewish Home
5200 NW 2nd Ave.
Miami, FL  33137

Evaluation

Your feedback is essential! Our goal is to provide an educational product that helps simplify staff education. We need to hear from you to learn if we are accomplishing our goal and how we can improve the product and the process. We greatly appreciate any and all suggestions. After you have reviewed/implemented this educational program, please take a few minutes to complete a feedback questionnaire. A copy of the questionnaire is attached and is on the DVD as a PDF file, as well as provided in the Appendix of this Guide. You may also visit http://ltc.geriu.org to fill out the questionnaire online.

The Evaluation tools that are provide in the Appendix of this Guide include the following:

Peer Feedback Form  (Appendix I)

Curriculum Evaluation by Nursing Home Instructors/Trainers  (Appendix V)

List of References

American Medical Directors Association (AMDA). Falls and fall risk. Columbia (MD): American Medical Directors Association (AMDA); 16 pp, 1998


Lyons SS. *Fall Prevention for Older Adults*. Iowa City: University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 2004


APPENDIX I

Peer Feedback Form

Feedback from You. Your feedback is essential! Our goal was to provide an educational product that helps simplify staff education. We need to hear from you to learn if we are accomplishing our goal and how we can improve the product and the process. We greatly appreciate any and all suggestions. After you have reviewed/implemented this educational program, please take a few minutes to complete a feedback questionnaire. A copy of the questionnaire is attached and is on the DVD as a PDF file. You may also visit www.geriu.org/pics to fill out the questionnaire online.

Feedback Questionnaire
“Prevention of Falls and Serious Injuries in Long-Term Care” DVD

Please complete this questionnaire and fax it to (305) 762-1472 or mail it to:
TNH Program Administrator
Stein Gerontological Institute
5200 NE 2nd Ave
Miami, FL 33137

Alternatively, you may visit http://ltc.geriu.org and fill out the questionnaire online.

1. Did you implement this training?
   ○ Yes   ○ No

2. Your overall reaction to the training material?
   ○ Excellent
   ○ Good
   ○ Fair
   ○ Inadequate
   ○ Bad

3. Who would benefit from the content?
   (Check all that apply.)
   ○ RN
   ○ LPN
   ○ CNA
   ○ Housekeeping
   ○ Other ____________________
4. Did the *Facilitator’s Guide* add to the value of the DVD?
   - Yes
   - Somewhat
   - No
   Comments ___________________________________________________________
   ____________________________________________________________________

5. Do you have any reservations about staff reaction or other concerns about the materials provided?  
   - Yes  
   - No
   If yes, please specify: _________________________________________________

6. Please indicate your recommendation(s). (Check all that apply.)
   - I would recommend using the material as part of self-directed individual learning.
   - I would **not** recommend using the material as part of self-directed individual learning.
   - I would recommend using the material as part of group learning.
   - I would **not** recommend using the material as part of group learning.
   - Other recommendations (please specify):
     ____________________________________________________________________
     ____________________________________________________________________

   ____________________________________________________________________
   ____________________________________________________________________
APPENDIX II

Minimum Data Set (MDS) and RAPs

The definitions outlined below are provided as a quick reference. **Before implementing this educational program, we suggest that you review your facility’s current policy and procedures for fall reporting and compare them to the MDS Item J Falls definition.** Recent research has demonstrated that the MDS process appears to underreport falls (Westmoreland-Hill EE, Gruber-Baldini AL. *Journal of the American Geriatrics Society* 53: 268-273, 2005).

Always refer to the most recent CMS manual in developing your institution’s policy in MDS fall reporting. In developing this program we attempted to adhere to the MDS Item J Falls definition. MDS requires reporting of a fall “past 30 days” and “past 31-180 days.”

**Minimum Data Set (MDS)** *(Definition from MDS version 2.0. Item-by-Item Self Study Guide and Quick Reference, p. vii)*

A core set of screening of clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.


The Resident Assessment Protocols (RAPs) are problem-oriented frameworks for additional assessment; these are “triggered” by specific MDS entries and identified conditions (e.g., falls).

**Included in MDS Item J Falls** *(from CMS’s RAI Version 2.0 Manual, Rev Dec 2002, p. 3–146 and 147) are:*

An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.

a) The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.

b) When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there and to put into place an intervention to prevent reoccurrence. Unless there is evidence suggesting otherwise, the conclusion is that a fall has occurred.

c) The distance to the next lower surface (in this case, the floor) is not a factor in determining whether or not a fall occurred. The incident of a resident rolling off a bed or mattress that is close to the floor is considered a fall.

The point of accurately recording occurrences of falls is to identify and communicate resident problems/potential problems, so that staff will **assess carefully and implement interventions** to **prevent** falls and injuries from falls. Although the case of a resident rolling off a mattress close to the floor is still recorded as a fall, it is possible that staff had assessed and intervened before this instance and had concluded that placing a bed close to the floor to avoid injuries from falls is the intervention that best suits this particular resident. The key point is that injuries, not necessarily falls, will always be reduced by reporting and addressing a “fall.”
APPENDIX III  Pre- Training Assessment Questionnaire

This Questionnaire is to be administered to learners prior to watching the DVD and participating in the facilitator-led blended learning activities. Learners can provide responses for both the pre and post-test Questionnaires online by accessing: http://ltc.geriu.org and then selecting the “Prevention of Falls” module and this Questionnaire. If the learner chooses to complete the Questionnaire in paper and pencil format, please mail the completed Questionnaire to:

PICs Training
Stein Gerontologic Institute
Miami Jewish Home
5200 NW 2nd Ave.
Miami, FL  33137

Pre-Training Assessment Questionnaire

The purpose of this questionnaire is to learn how to reduce falls at your facility. Your answers will identify ways to improve the quality of care provided for your residents.

Facility: __________________________ First, Middle, Last Initial: ____________________

The above information is necessary so that we can compare pre and post-intervention responses and provide feedback to your facility.

YOUR BACKGROUND

1. Which shift do you work?
   - [ ] Day
   - [ ] Evening
   - [ ] Night

2. At what professional level do you work at this facility?
   - [ ] CNA (certified nursing assistant)
   - [ ] LPN (licensed practical nurse)
   - [ ] RN (registered nurse)
   - [ ] RN supervisor
   - [ ] Other (please identify):

3. How many years have you been working in this facility?
YOUR EXPERIENCE WITH FALLS

I’m going to read you some statements about falls.
For each one, please tell me how much you agree or disagree with it by giving me a number from 1 to 4, where 1 means “strongly agree” and 4 means “strongly disagree.”

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree = 1</th>
<th>Agree = 2</th>
<th>Disagree = 3</th>
<th>Strongly Disagree = 4</th>
<th>Don’t Know</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Falls are a common problem.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Falls are a normal part of aging.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Falls can be reduced.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Falls among the elderly are unavoidable.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Only falls with serious injuries need to be reported.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Falls have multiple causes.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10. One reason we fill out fall incident reports is to comply with regulations.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11. One reason we fill out fall incident reports is to improve patient care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

12. Based on your experience, what percentage of nursing home residents fall each year?

13. How long ago was the last time you filled out a falls incident report?

14. Based on your experience and knowledge of falls occurring in the nursing home, please indicate how much you agree or disagree with each statement.
Give me a number from 1 to 4, where 1 means “strongly agree” and 4 means “strongly disagree.”

<table>
<thead>
<tr>
<th>Response</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. I know the definition of a fall.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>16. I know how common falls are in nursing homes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>17. I know the different types of causes for falls.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>18. I believe that the number of falls in nursing homes can be reduced.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>19. I know the consequences of falls in residents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

I’m going to read you some descriptions of residents experiencing some problems.

For each one, please let me know if what happened A— is a fall, B— is NOT a fall, or C— you are not sure.

<table>
<thead>
<tr>
<th>Description</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. A resident tries to get up from his chair. He is not strong enough and inadvertently sits back down.</td>
<td>Is a Fall</td>
<td>Not a Fall</td>
<td>Not Sure</td>
</tr>
<tr>
<td>21. You walk behind a resident. He loses his balance and starts to fall backward. You catch him before anything happens. The resident regains his balance, thanks you, and walks away.</td>
<td>Is a Fall</td>
<td>Not a Fall</td>
<td>Not Sure</td>
</tr>
<tr>
<td>22. You find a resident sitting on the floor. You ask him how he ended up on the floor. He is unable to remember how. He is fine and has no injuries.</td>
<td>Is a Fall</td>
<td>Not a Fall</td>
<td>Not Sure</td>
</tr>
<tr>
<td>23. A resident is sitting in a chair. He slides slowly from the chair to the ground.</td>
<td>Is a Fall</td>
<td>Not a Fall</td>
<td>Not Sure</td>
</tr>
<tr>
<td>24. A resident is walking in a hallway. She loses her balance and hits the wall. She is able to regain her balance.</td>
<td>Is a Fall</td>
<td>Not a Fall</td>
<td>Not Sure</td>
</tr>
</tbody>
</table>
APPENDIX IV  Post-Training Assessment Questionnaire

Post-Training Assessment Questionnaire

Facility: _____________________  First Name, Last Initial: ___________________

YOUR EXPERIENCE WITH FALLS

For each statement below, please indicate how much you agree or disagree with it by marking one of the numbers from 1 to 4, where 1 means “strongly agree” and 4 means “strongly disagree.”

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Falls have multiple causes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Falls are a common problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Falls are a normal part of aging.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Falls among the elderly are unavoidable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

5. Please list the three most common causes of falls:
   a. ____________________________________________________________
   b. ____________________________________________________________
   c. ____________________________________________________________
Based on your experience and knowledge of falls occurring in the nursing home, please indicate how much you agree or disagree with each statement. Mark one of the numbers from 1 to 4, where 1 means “strongly agree” and 4 means “strongly disagree.”

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>I know the definition of a fall.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I know how common falls are in nursing homes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I know the different types of causes for falls.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I believe that the number of falls in a nursing home can be reduced.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I know the consequences of falls in residents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>I can recognize when a fall incident report is required.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Below are some descriptions of residents experiencing some problems. For each one, please indicate if what happened to the resident is a fall, is not a fall, or if you are not sure.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Is a Fall</th>
<th>Not a Fall</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>A resident tries to get up from his chair. He is not strong enough and inadvertently sits back down.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>You walk behind a resident. He loses his balance and starts to fall backward. You catch him before anything happens. The resident regains his balance, thanks you, and walks away.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>You find a resident sitting on the floor. You ask him how he ended up on the floor. He is unable to remember how. He is fine and has no injuries.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>A resident is sitting in a chair. He slides slowly from the chair to the ground.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>A resident is walking in a hallway. She loses her balance and hits the wall. She is able to regain her balance.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued on the next page......
17. How appropriate was the level of the content?

<table>
<thead>
<tr>
<th></th>
<th>Much Too Advanced</th>
<th>Too Advanced</th>
<th>At the Right Level</th>
<th>Too Basic</th>
<th>Much Too Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

18. How effective or ineffective was the DVD at helping you learn more about the recognition and prevention of falls in long-term care?

<table>
<thead>
<tr>
<th></th>
<th>Very Effective</th>
<th>Effective</th>
<th>Neither Effective nor Ineffective</th>
<th>Ineffective</th>
<th>Very Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

19. How was your overall experience with the training?

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Inadequate</th>
<th>Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

20. Please write any additional comments you have about the training.

Questionnaire in paper and pencil format, please mail the completed Questionnaire to:
PICs Training
Stein Gerontologic Institute
Miami Jewish Home
5200 NW 2nd Ave.
Miami, FL 33137

Alternately, you may access the website, [http://ltc.geriu.org](http://ltc.geriu.org), login and complete the questionnaire online.
APPENDIX V  Curriculum Evaluation by Nursing Home Instructors/Trainers

Instructor Survey

Prevention of Falls and Serious Injuries in Long-term Care

Please tell us what you think of this training material. Your feedback will help us improve the training materials we develop.

1. Your overall reaction to the training material?
   ○ Excellent
   ○ Good
   ○ Fair
   ○ Inadequate
   ○ Bad

2. Did you feel the length of the curriculum (i.e., time to implement) was appropriate for the content?
   ○ Yes
   ○ No
   ○ Unsure
   ○ Comments ______________________________

3. Do you plan on implementing this educational training facility wide?
   ○ Yes
   ○ No
   ○ Unsure
   ○ Comments “I will start with RNs and LPNs” “All staff “

4. Who would benefit from the content? (Check all that apply.)
   ○ RN
   ○ LPN
   ○ CNA
   ○ Housekeeping
   ○ Other
5. Did the handout (i.e., *Educational Handout*) add to the value of the DVD?
   ○ Yes
   ○ Somewhat
   ○ No
   ○ Comments

6. Do you have any reservations about staff reaction or other concerns about the materials provided?  ○ Yes  ○ No
   If yes, please specify:

7. Please indicate your recommendation. (Check all that apply.)
   ○ I would recommend using the material as part of self-directed individual learning.
   ○ I would *not* recommend using the material as part of self-directed individual learning.
   ○ I would recommend using the material as part of group learning.
   ○ I would *not* recommend using the material as part of group learning.
   ○ Recommendations
     Please specify):

8. Do you have any other comments about this training material?

9. Have we provided a good quality product? Does the module set reflect experience/competency/quality?  ___ yes ___ no

10. Does it provide a value for education in-service?  ___ yes ___ no

11. Will this product reflect well on you the trainer?  ___ yes ___ no

12. Does the product meet a need?  ___ yes ___ no

Thank you and your nurses for participating in this feasibility study.

Questionnaire in paper and pencil format, please mail the completed Questionnaire to:
   PICs Training
   Stein Gerontologic Institute
   Miami Jewish Home
   5200 NW 2nd Ave.
   Miami, FL  33137

Alternately, you may go to [http://ltc.geriu.org](http://ltc.geriu.org), login and complete the questionnaire online.
Educational Handout

PREVENTION OF FALLS AND SERIOUS INJURIES IN LONG-TERM CARE

For additional information or questions, please contact Marilyn Cheung at (305) 762-1468 MCheung@mjlha.org
FALL FACTS

• MANY FALLS AND RESULTING SERIOUS INJURIES ARE PREVENTABLE

• AN INCIDENT REPORT IS THE FIRST CRITICAL STEP IN THE PREVENTION OF REPEAT FALLS

• FALLS IN NURSING HOMES ARE MUCH MORE COMMON THAN IN THE COMMUNITY
  ○ Each year as many as 3 out of 4 nursing home residents fall, many of whom fall multiple times.
  ○ Each year the typical 100-bed nursing home files 100-200 fall incident reports.

• FALL COMPLICATIONS
  ○ Fracture
  ○ Head injury
  ○ Serious cut requiring suture
  ○ Bruising
  ○ Decline in function

• WHAT IS A FALL?
  A fall is unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force.

• WHAT CAUSES A FALL?
  ○ Poor nutrition  ○ Acute or chronic disease
  ○ Altered mental status  ○ Altered walking and balance
  ○ Poor vision  ○ Foot or shoe problems
  ○ Medication side effects  ○ Environmental hazards

PREVENTION OF FALLS AND SERIOUS INJURIES IN LONG-TERM CARE
WHAT IS A FALL?

"Fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force.

When a staff member prevents a fall, a fall is considered to have occurred.

A fall without injury is still a fall.

The lower level does not have to be the floor.

When a resident is found on the floor without an explanation, a fall is considered to have occurred.

PREVENTION OF FALLS AND SERIOUS INJURIES IN LONG-TERM CARE
WHAT CAUSES A FALL?

PREVENTION OF FALLS AND SERIOUS INJURIES IN LONG-TERM CARE