**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.

**DVD-Based Educational Program**
The goals of this educational program are to increase staff awareness of what a “fall” is, why a fall occurs, and the critical importance of fall reporting (and MDS entry) 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.

**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.

**Educational Approach and Target Audience**
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. **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; no one discipline is fully responsible for the reporting and prevention of resident falls in the nursing home.**
**TIPS FOR TRAINERS**

**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.”

**Number of Participants**
4. 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**
5. This training should take about 45 minutes. Be sure all of the participants can see and hear the DVD clearly.
6. 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.
7. Each learner should be provided a copy of the *Educational Handout* (available as a PDF file on the DVD and on www.GeriU.org).

**Implementation at Your Facility**
8. 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.
9. To assist in this educational outreach, see the section "What Is a Fall?" in the *Educational Handout*. 
10. 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.
11. 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.

**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 to fill out the questionnaire online.
APPENDIX

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.”