

Falls Policy Overview

The following is a suggested falls prevention policy. It is not required to be implemented. There are several areas that need to be covered in a falls prevention policy:

- I. Definitions of a Fall, Type of Falls, Severity of Injury
- II. Fall Risk Assessment for Inpatients
- III. Fall Risk Assessment for Outpatients
- IV. *Environmental Rounds*
- V. Responsibilities of Staff
- VI. Intervention Strategies
- VII. Post Fall Procedures/Management

I. Definitions

Fall: Loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair; excluding falls resulting from violent blows or other purposeful actions.

Types of Fall.

Accidental Falls: Falls associated with extrinsic environmental risk factors or hazards: spills on the floor, clutter, tubing / cords on the floor, etc., or errors in judgment, such as not paying attention

Anticipated Physiological Falls: Falls associated with known fall risks, such as those indicated on the Morse Fall Scale or other screening scales, that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur to the patients' existing physiological status, history of falls, and decreased mobility upon assessment.

Unanticipated Physiological Falls: Falls associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale: syncope; extreme hypoglycemia; stroke; heart attack; seizure.

*From Morse J. (1997). *Preventing patient falls*. CA: Sage.

Injury Severity:

An injurious fall is any fall in which physical injury occurs, regardless of severity.

The VHA defines a major injury related to a fall as:

Any fall that sustains a fracture and/or trauma requiring emergency treatment; head trauma which includes patient's head striking a surface or object and may include or result in any of the following: subdural hematoma, concussion, TBI or behavioral changes. * The major injury definition includes **Death**—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).

National Database of Nursing Quality Indicators® (NDNQI®) (2011) fall injury levels are defined as:

None—patient had no injuries (no signs or symptoms) resulting from the fall; if an x-ray, CT scan or other post fall evaluation results in a finding of no injury

Minor—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion

Moderate—resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain

Major—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of a fall

Death—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

(National Database of Nursing Quality Indicators® (NDNQI®) Guidelines for Data Collection and Submission on Quarterly Indicators. Available at: ndnqi@kumc.edu)

II. Fall Risk Screening using the Morse Fall Scale (Morse, 1997) for Inpatients

Patients should be screened for their fall risk using the guidance (FACT):

- Following a fall (F)
- On admission to the facility (A)
- Following any change of status (C)
- On any transfer from one unit to another within the facility or discharge (T)

A. Morse Fall Scale, Screening tool

This is one of the most widely used fall risk screening tools available. It is a *reliable* and *valid* measure of fall risk. (Oliver, et al., 2010)

Morse Fall Risk Assessment

Risk Factor	Scale	Score
History of Falls	Yes	25
History of Falls	No	0
Secondary Diagnosis	Yes	15
Secondary Diagnosis	No	0
Ambulatory Aid	Furniture	30
Ambulatory Aid	Crutches / Cane / Walker	15
Ambulatory Aid	None/ Bed Rest/ Wheelchair/ Nurse	0
IV / Heparin Lock	Yes	20
IV / Heparin Lock	No	0
Gait / Transferring	Impaired	20
Gait / Transferring	Weak	10
Gait / Transferring	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
Mental Status	Oriented to Own Ability	0

To obtain the Morse Fall Score add the score from each category

Morse Fall Score*

High Risk	45 and higher
Moderate Risk	25 - 44
Low Risk	0 - 24

* Based on most common scores used in VA

The scores enable the nurses to determine a patient's fall risk level for anticipated physiological falls. Based on the category of fall risk (low, moderate or high), the nurse selects universal fall precautions. For each positive variable on the Morse Fall Scale, the nurse and appropriate interdisciplinary team members must complete assessment, followed by differential diagnosis of fall risk factors. The differential fall risk factors are the basis for clinical interventions to mitigate or eliminate the fall risk factor if modifiable. Thus, the patient's fall prevention plan of care should include a combination of universal fall precautions, but is individualized by interventions specific to fall risk factors.

The main advantages of this comprehensive, multifactorial assessment are:

- 1. Determination of modifiable and non-modifiable fall risk factors*
- 2. Requires interdisciplinary involvement in fall risk factor analysis*
- 3. Focuses interventions on specific risk factors rather than general risk score.*
- 4. Does not rely on a score as a basis for patient care management*

III. Fall Risk Assessment for Outpatients

Outpatient fall risk assessments can be done on two levels. The primary care provider can do an initial screening of fall risk factors, gait and balance, then refer patients that are at risk to either physical therapy or kinesiotherapy to perform a more in-depth balance and functional assessment, as long as the provider has ruled out causes of the fall that are unrelated to gait/balance/strength (e.g., syncope, brady/tachyarrhythmia, seizure). The occupational therapist evaluates fall risks associated with activities of daily living. For patients 65 years and older, primary care providers should conduct multifactorial fall risk assessment according to the American and British Geriatric Societies (2010). The United States Preventative Services Task Force provides different guidance that fall risk assessment should be on a case by case basis (Moyer, 2012)

Initial Screening for Fall Risk

1. *Send the patient a Fall History Questionnaire and review at the appointment*

- a. If patient does not have a fall history questionnaire, then go over the questionnaire with them during the clinic visit (be sure to annotate this in the notes section of the appointment)
- b. If several medications and supplements are listed, have a pharmacist review the medications and supplements for any drug interactions or side effects which could increase the likelihood of falls.

2. *Perform the 8 ft. Up & Go test¹*

- a. Place a chair against the wall or another sturdy object. Set up 8 feet away for the patient to walk around. Tell the patient to get up and walk as quickly as they can around the object and sit back down.
- b. If the patient takes longer than 8.5 seconds they should be considered high risk and be referred to PT/OT for further evaluation.

Note: Allow the patient to practice one time.

3. For patients 65 years old and older, determine if the patient has experienced more

than one fall in the last year or an injurious fall. If yes, follow the [American Geriatric and British Geriatric Society Guidelines](#) for multifactorial fall risk assessment and interventions.

IV. Environmental Checklist and Rounds (Attachments 1 and 2)

The facility management, nursing and biotech staff should perform environmental rounds. An environmental rounds checklist (Attachment 1) serve as a consistent format for this environmental safety check.

Interdisciplinary environmental rounds (Attachment 2) are documented so that corrective actions are identified and should be monitored through resolution.

A. Facility management staff confirm:

1. Hallways and patient areas are well lit
2. Hallways and patient areas are uncluttered and free of spills

3. Locked doors are kept locked when unattended
4. Handrails are secure, non-skid and unobstructed
5. Tables and chairs are sturdy
6. Chairs are at proper height with arm rests
7. Beds are height adjustable to raise the bed at the proper height for patient standing and lowering, transfers
8. Bathrooms have raised toilets
9. Bi-lateral wall mounted grab bars for toilet mobility are installed behind toilets
10. Furniture with sharp edges are padded

B. Biotech staff confirm:

1. All assistive devices are working properly by inspecting them on a regular basis
2. Devices to secure cords off floors are operational
3. Proper lighting, motion-sensor lighting works.
4. Non-skid flooring or padded flooring in bathrooms
5. Call lights are easily accessible while in bed, chair, bathroom

C. Nursing Staff confirm:

1. Locked doors are kept locked when unattended
2. Patient rooms are set up in a way that minimizes the risk of falling and severity of injury (see Room Set-up in Intervention section)

D. Everyone confirms:

1. Unsafe situations are dealt with immediately either by dealing with the situation or notifying the appropriate staff and ensuring that they arrive and correct the situation.

V. Responsibilities of Staff

In this section, the responsibilities of the following staff are delineated:

A. Medical Center Director

B. Associate Chief Nursing Service/Chief Nurse Executive

C. Nurse Managers

D. Admissions Nurses

- E. Staff and Contract Nurses Including RNs, LPNs and NAs**
- F. Physicians, Physician Assistants and APNs**
- G. Pharmacists**
- H. Physical and Occupational Therapists**
- I. Audiologists and Optometrists**
- J. Biomedical Technologists**
- K. Interdisciplinary Falls Team**
- L. Facility Management Staff**
- M. Education Service**

A. Medical Center Director

The Medical Center Director is responsible for ensuring that falls and fall-related injury prevention is:

1. A high priority at the facility
2. Promoted across the facility through direct care, administrative and logistical staff
3. Adequately funded to provide a safe environment for patients and staff

B. Associate Chief Nursing Service/Chief Nurse Executive:

The Associate Chief Nursing Service/Chief Nurse Executive/Designee is responsible for:

1. Implement fall prevention programs that treat fall risk factors, not count them.
 2. Establishing population-based fall and injury prevention programs at patient//unit/and service levels.
 3. Deploying evidence-based standards of practice when possible
 4. Emphasizing importance of clinical expertise in determining and managing fall and injury risks
 5. Assures interdisciplinary involvement in all levels of fall and injury prevention programs.
3. Overseeing the policy, implementation, and evaluation of fall and injury *prevention program within the VAMC*

C. Nurse Managers

The Nurse Managers are responsible for:

1. Making fall and fall-related injury prevention a standard of care

2. Implements fall and injury prevention specific to specialty patients' risk factors, for example
 - a. Telemetry Unit: Identification of postural hypotension in cardiosurgical patients
 - b. Orthopedic Unit: Identification of patients with known diagnosis of osteoporosis or hip fracture
3. Enforcing the responsibilities of the staff nurses to comply with interventions
4. Oversee post fall huddle processes for patients who sustain falls during their care
5. Involve interdisciplinary staff in fall and injury prevention program and quality improvement
3. Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with facility equipment experts (Attachment X; Equipment Safety Checklist)
4. Ensuring that all nursing staff receive education about the falls and injury prevention program at the facility and understand the importance of complying with the interventions

D. Admissions Nurses

The admissions nurses are responsible to:

1. Complete the fall-risk screening and assessment on admission
2. Notify the unit of any patients admitted due to a fall; fall in the ER; have history of recent falls (in the last 3 months), anticoagulation, fracture risk of history, head injury.
3. Follow any procedure for patients admitted due to a fall or have fall injury history, such as a specific color armband, ensuring the bed assigned is close to the nursing station, ensuring there is a medical alert in the EMR or signage at the bedside, etc.

E. Staff and Contract Nurses Including RNs, LPNs and NAs

Staff Nurses including RNs, LPNs and NAs are responsible for:

1. Ensuring compliance of fall and fall-related injury interventions
2. Completing fall-risk screening on transfers, following a change in status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use

3. Ensuring that rooms with vulnerable patients are assessed and corrected if necessary for slip and trip hazards

RNs are responsible to:

1. Assess factors that make patients more or less at risk for falling.
2. Develop an individualized fall and injury prevention plan of care.
3. Collaborate with interdisciplinary team members for implementation and evaluation of the individualized plan of care.
4. Communicate patient's fall and injury history, risk factors, treatment plan during hand off processes.
5. Implement patient education based on health literacy to assure patient engagement as partner in care, along with family / caregiver as appropriate
6. Assure a safe environment for the patient to protect from injury should a fall occur.
7. Participate in post fall huddle should a patient fall.
8. Participate in quality improvement to evaluate patient safety and quality of care.

F. Physicians, Physician Assistants and APNs

Physicians, physician assistants and APNs are responsible for:

1. Identifying and implementing medical interventions to reduce fall and fall-related injury risk
2. Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls
3. Ensuring all patients are screened for risk factors for osteoporosis and tested if necessary
4. Screening patients for fall-risk using the patient's self-report and the Timed Up & Go test (Outpatient Areas)
5. Referring patients, who were recently admitted to the hospital due to a fall, to a pharmacist to review the medication and to physical or occupational therapy to conduct a more thorough assessment of fall risk (Outpatient Areas)

G. Pharmacists

Pharmacists are responsible for:

1. Reviewing medications and supplements to ensure that the risk of falls is reduced

2. Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls
3. Asking outpatients to list their medications and supplements again and verify the medications and supplements with the list provided by the physician and against the patient record

H. Physical and Occupational Therapists

Physical and occupational therapists are responsible to:

1. Conduct patient assessments of rehabilitation needs and falls risks.
2. Evaluate patient mobility and safety in the patient's environment to ensure safe transfers, mobility, and activities of daily living.
3. Develop, implement and evaluate an intervention program for patients to reduce their fall-risk and injury risk.
4. Contribute to interdisciplinary care planning.
5. Participate in clinical education of staff and program evaluation at the unit-service level.
6. Conduct clinical cross-training with nursing staff for mobility and training.
7. Examine and enhance tools and products at the unit for fall and injury prevention (rolling seated walkers, w/c brake extenders, non-skid seating, etc.)

I. Audiologists and Optometrists

Audiologists and optometrists are responsible for performing annual assessments on patient's vision and hearing to reduce the risk of falls.

J. Biomedical Technologists

Biomedical technologists are responsible for ensuring that:

1. Fall prevention technology, such as bed and chair alarms, wandering sensors are checked regularly and equipped with devices to prevent falls
2. Devices to secure cords off floors are operational
3. Proper lighting, motion-sensor lighting works.
4. Call lights are easily accessible while in bed, chair, bathroom.

K. Interdisciplinary Falls Team

The interdisciplinary falls team is responsible for:

1. Collecting data to ensure that fall and fall-related injury prevention strategies are effective
2. Conducting case-by-case reviews for all falls to ensure that medications are reviewed and prevention measures are recommended
3. Providing assistance to interdisciplinary treatment teams when requested to recommend prevention strategies for a patient
4. Participating in the Quarterly Falls Aggregate Review

L. Facility Management Staff

The facility management staff are responsible for:

Ensuring a safe environment of care by conducting environmental assessments (Attachment A.)

M. Education Service

The education service is responsible for:

1. Developing an education program about falls for all staff
2. Developing competencies for nursing staff about the falls prevention program
3. Develop a patient / caregiver education program for fall and injury prevention; healthy bones; anticoagulation and falls

VI. Interventions

For information on Fall Prevention and Management Practices, Interventions, Fall Prevention Standards

(Refer to AHRQ Toolkit and [Preventing Harm from Injuries from Falls and Immobility](#) as well as other resources in the NCPS fall toolkit.)

[Preventing Harm from Injuries from Falls and Immobility](#) A publication from the Health Research & Educational Trust. <http://www.hret-hiin.org/Resources/falls/18/falls-with-injury-change-package.pdf>

Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHS290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.

Available: <http://www.ahrq.gov/legacy/research/ltc/fallpxtoolkit/index.html>

Additional References:

Morse, J. (1997). Preventing Patient Falls. Thousand Oaks: CA: Sage Publications.

Moyer, V.A. (2012). Prevention of Falls in Community-Dwelling Older Adults: U.S. Preventive Services Task Force Recommendation Statement *Annals of Internal Medicine*. 157(3): 1-8.

Oliver, D., Healey, F., & Haines, T. (2010). Preventing falls and fall-related injuries in hospitals. *Clinics in Geriatric Medicine*, 26, 645–92.

VII. Post Fall Procedures/Management (Attachment 3)

There are two key elements of the post fall procedures/management:

A. Initial post-fall assessment

B. Documentation and follow-up

A. Initial Post Fall Assessment; use of the VANOD Post Fall Note is recommended

First priority is to assess the patient for any obvious injuries and find out what happened. Examples of the information needed is:

1. Date/time of fall
2. Patient's description of fall (if possible)
 - a. What was patient trying to accomplish at the time of the fall?
 - b. Where was the patient at the time of the fall (patient room, bathroom, common room, hallway etc.)?
3. Family/guardian and provider notification
4. Vital signs (temperature, pulse, respiration, blood pressure, orthostatic pulse and blood pressure — lying, sitting and standing)
5. Current medications (were all medications given, was a medication given twice?)
6. Patient assessment
 - a. Presence of Injury and reassessment for delayed injury identification
 - b. Immediate / root cause of fall
 - c. Comorbid conditions (e.g., Orthostasis, dementia, heart disease, neuropathy, etc.)

d. Intrinsic fall risk factors (e.g. incontinence, impaired vision, gait/balance disorders, weakness)

e. Extrinsic fall risk factors (e.g. medications, clothing / shoes, proper and accessible mobility aid, eye glasses on)

7. Environmental factors:

a. Bed in high or low position?

b. Bed wheels locked?

c. Wheelchair locked?

d. Floor wet?

e. Lighting appropriate?

f. Call light within reach?

g. Bedside table within reach?

h. Area clear of clutter and other items?

i. Toilet environment? (too low, no safety rails, slip hazards)

8. Was treatment intervention plan being followed? If not, why not?

9. Were the falls team and other nurses on the unit notified?

B. Documentation and Follow-up

Following the post-fall assessment and any immediate measure to protect the patient:

1. An incident report should be completed

2. A detailed progress note should be entered into the patient's record including the results of the post-fall assessment using the VANOD post fall note

3. Refer the patient for further evaluation by physician to ensure other serious injuries have not occurred

4. Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate

5. Communicate to all shifts that the patient has fallen and is at risk for recurrent falls

For information on Fall Prevention and Management Practices. Interventions, Fall Prevention Standards (Refer to AHRQ Toolkit)

Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHSA290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.

Available: <http://www.ahrq.gov/legacy/research/ltc/fallpxtoolkit/index.html>

Additional References:

Morse, J. (1997). Preventing Patient Falls. Thousand Oaks: CA: Sage Publications.

Moyer, V.A. (2012). Prevention of Falls in Community-Dwelling Older Adults: U.S. Preventive Services Task Force Recommendation Statement *Annals of Internal Medicine*. 157(3): 1-8.

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Attachment 1:

Equipment Safety Checklist	
Wheelchairs	
Brakes	Secures chair when applied
Arm Rest	Detaches easily for transfers
Leg Rest	Adjusts easily
Foot Pedals	Fold easily so that patient may stand
Wheels	Are not bent or warped
Anti-tip devices	Installed, placed in proper position
Electric Wheelchairs/Scooters	
Speed	Set at the lowest setting
Horn	Works properly
Electrical	Wires are not exposed
Beds	
Side Rails	Raise and lower easily
Side Rails	Secure when up
Side Rails	Used for mobility purposes only
Wheels	Roll/turn easily, do not stick
Brakes	Secures the bed firmly when applied
Mechanics	Height adjusts easily (if applicable)
Transfer Bars	Sturdy, attached properly
Over-bed Table	Wheels firmly locked
	Positioned on wall-side of bed
IV Poles/Stands	
Pole	Raises/lowers easily
Wheels	Rolls easily and turns freely, do not stick
Stand	Stable, does not tip easily (should be five-point base)
Footstools	
Legs	Rubber skid protectors on all feet
	Steady — does not rock
Top	Non-skid surface
Call Bells/Lights	
Operational	Outside door light
	Sounds at nursing station
	Room number appears on the monitor
	Intercom
	Room panel signals
Call Bells/Lights	
Accessible	Accessible in bathroom

	Within reach while patient is in bed
Walkers/Canes	
Secure	Rubber tips in good condition
	Unit is stable
Commode	
Wheels	Roll/turn easily, do not stick
	Are weighted and not “top heavy” when a patient is sitting on it
Brakes	Secure commode when applied
Geri/Broda Chairs	
Chair	Located on level surface to minimize risk of tipping
Wheels	Roll/turn easily, do not stick
Breaks	Applied when chair is stationary
	Secure chair firmly when applied
Footplate	Removed when chair is placed in a non-tilt or non-reclined position
Footplate	Removed during transfers
Positioning	Chair is positioned in proper amount of tilt to prevent sliding or falling forward
Tray	Secure
Flooring	Dry
	Non-Skid
	Clutter-free
	Free of trip hazards

Multiple examples of environmental checklists also in the AHRQ Falls Toolkit

Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHS290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.

Attachment 2

Environmental Rounds

Area:

Location:

Date:

Reviewer:

	YES	No*	NA
Exit signs exist and are visible			
Are hallways and corridors clear of obstacles			
Furniture and equipment is sturdy and wheels are locked			
Furniture and equipment is suitable for the specific needs of the unit			
Chairs, gerichair, wheelchairs are suitable			
Commode/seat lifts are properly installed (not loose)			
Door handles are secure			
Handrails in halls present, accessible and properly secured to wall			
All lights are working properly and areas are well lit			
Floor is clean and dry			
Floor is clear of personal items			
Flooring is level and free of tripping hazards, such as broken tiles or thresholds that are above the level of the floor			
Call bell/light within reach			
Bed in low position			
Bedside table within reach			
Water within reach			
Light within reach			
Room furniture arranged to allow patient space when walking and grab bars/hand rails are accessible			
Is there a 2-foot-wide path for the patient to walk in or use w/c			
- Door to bed			
- Bed to commode			
- Bed to chair			
- Chair to commode			
Does patient have footwear present			
Patients clothing does not drag on the floor			
Do slippers have non-slip soles			
Are there grab bars next to the toilet			
Is the toilet seat at a height that allows easy transfer			
Is there a night light in the bathroom			
Other			
Other			
Other			
Other			

ANY IMMEDIATE SAFETY ISSUES NOTIFY PROPER SERVICE IMMEDIATELY

Notes:

Attachment 3

Post-Fall Management

Residents / Patients experience a fall with injury are treated based on hospital emergency response protocols.

Residents/Patients Experiencing a Fall with

- No loss of consciousness
- No injuries to exceed minor hematomas and lacerations
- Conduct post fall team huddle to determine immediate/root cause of the fall within 15 minutes of the fall
- Conduct multifactorial assessment of the patient post fall, per hospital policy and guidelines, considering the following practices:

A. No Head Trauma

1. Determine vital signs to include orthostatic blood pressure (sitting/repeat standing blood pressure 1 and 3 minutes; manual cuff) and pulse.
2. If diabetic, check blood glucose
3. Determine circumstances leading to the fall with corrections.
4. Notify the attending physician (or nurse practitioner per hospital, CLC protocol) on as soon as possible.
5. For the 48 hours following the fall:
 - a. Obtain vital signs per hospital policy (usually every 8 hours or every shift)
 - b. Observe for possible injuries not evident at the time of the fall (limb reflex, joint range of motion, weight bearing, etc.)
 - c. Mental status changes

B. Minor Head Trauma

1. Use the same protocol outlined above.
2. Perform neuro-checks according to hospital / facility policy.
3. Alert the attending physician for any changes.

Additional Measures:

- Complete post fall note in the medical record
- Complete the post fall huddle form

- Complete incident report
- Review fall prevention interventions and modify plan of care as indicated
- Communicate to all shifts that patient has fallen, circumstances and results of the fall event, and changes to the plan of care
- Consult Fall Response Team for additional suggestions for changes to plan of care