

OUR PROGRAM BEGINS AT 12:30



PURPOSE



We champion shared learning across the clinical and executive leaders of Minnesota’s assisted living and skilled care settings.

Through supportive dialogue grounded in the ECHO principle of “all teach, all learn,” our virtual community of interdisciplinary leaders shares promising practices to improve operational outcomes and quality of life as we age.



WELCOME February 24, 2026



THE CHECK-IN



FALL PREVENTION



ALL TEACH.

ALL LEARN.



THE CHECK-IN

What is one fall prevention action that works for you right now?



WELCOME

*A discussion about
evidence-based strategies
and implementation in your
aging services settings*



FEBRUARY 24, 2026
**WHAT MAKES FOR AN EFFECTIVE
AND SUSTAINABLE FALL
PREVENTION PROGRAM?**

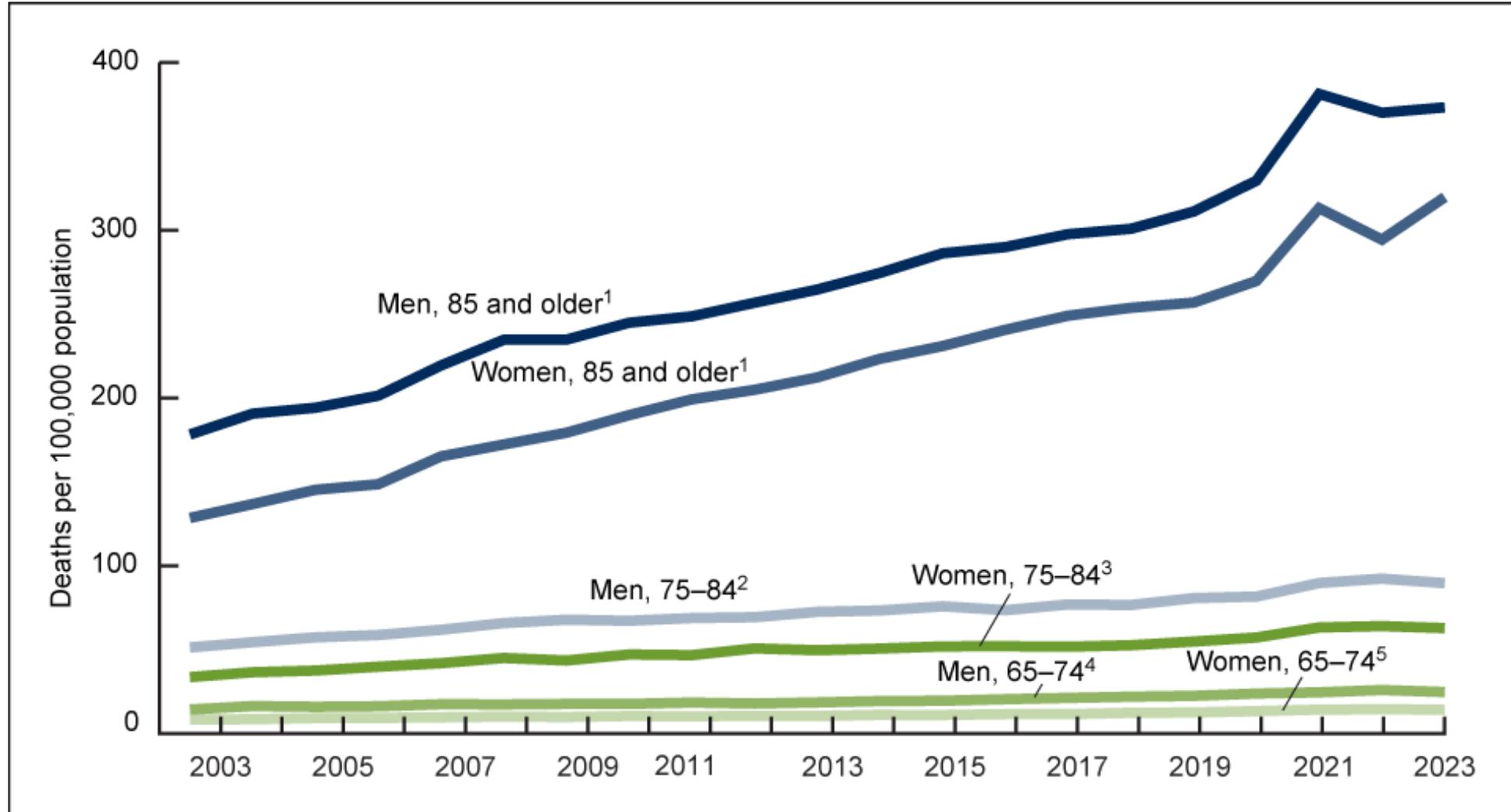
FEATURING



SIOBHAN MCMAHON
UNIVERSITY OF MINNESOTA



Figure 3. Rate of unintentional fall deaths for adults age 65 and older, by year, sex, and age group: United States, 2003–2023



¹Significant increasing trend from 2003 to 2023, $p < 0.05$.

²Significant increasing trend from 2003 to 2008 and from 2018 to 2023 at varying rates of change, $p < 0.05$.

³Significant increasing trend from 2003 to 2012, $p < 0.05$.

⁴Significant increasing trend from 2014 to 2023, $p < 0.05$.

⁵Significant increasing trend from 2003 to 2007 and from 2017 to 2021 at varying rates of change, $p < 0.05$.

NOTE: Unintentional fall deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes W00–W19.

SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Incidence of Falls in Long-Term Care

Higher rates than in community-dwelling older adults:

- Approximately 1.7 falls per resident annually
 - 58% of nursing home residents experience at least one fall per year
 - 40% experience recurrent falls
 - 24% of these result in hospitalization



HHS Office of Inspector General: Sept 2025 Report

Up to 43% of Falls with Major Injury and Hospitalization were *not* reported based on 1 year review period. Reporting gaps more common among homes that were:

- For-profit
- Non-rural
- Served younger residents
- Had lowest fall rates on Care Compare



Higher fall rates were noted among:

- Women, balance problems, psychotropics
- Home with more older residents
- Homes with more short stay residents
- Homes with lower overall star ratings
- Homes with less RN staffing time
- Homes that are for profit

Fall Definitions

Centers for Medicare and Medicaid Services:

An unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

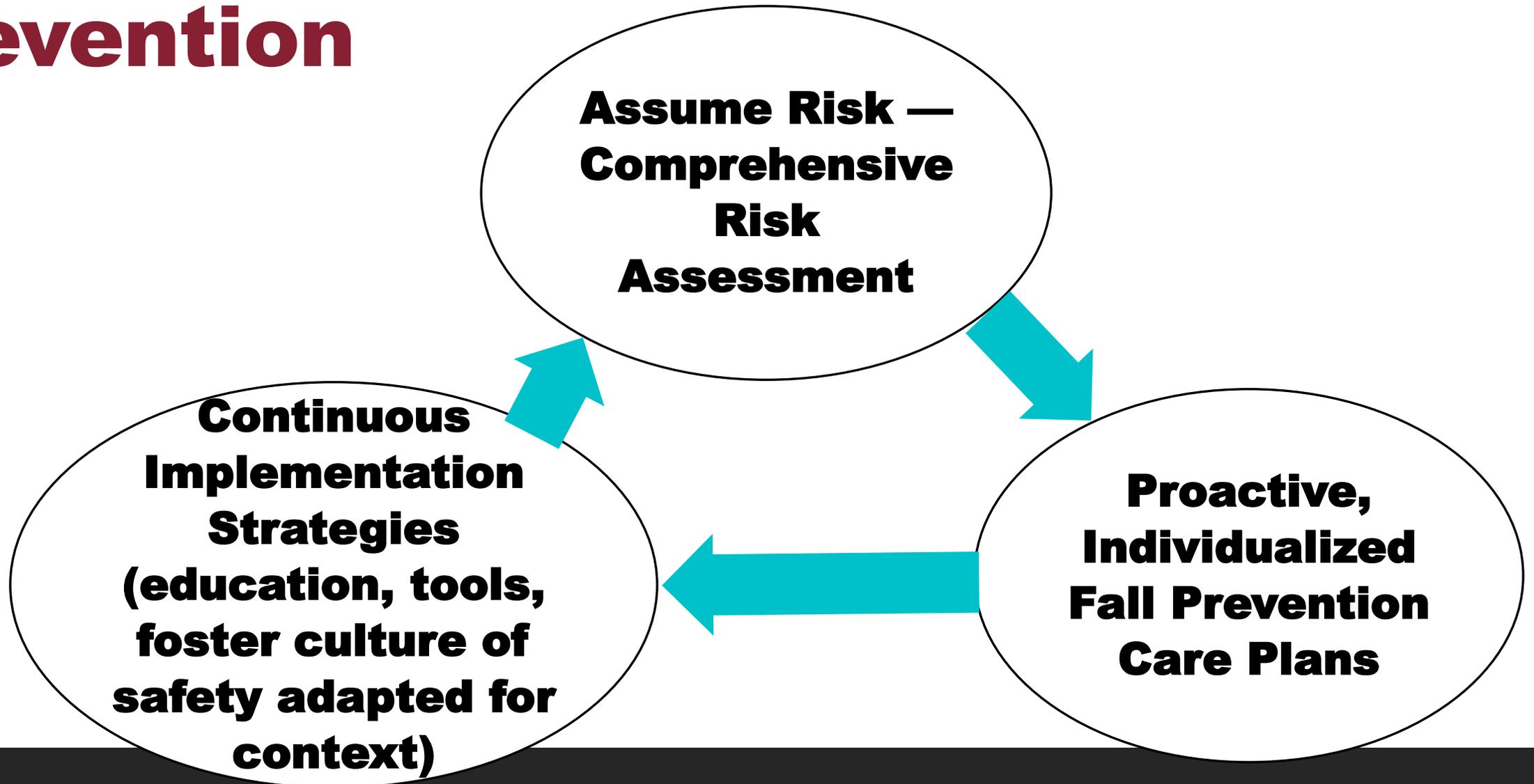
- Intercepted fall: *If a resident would have fallen but was caught by a staff member or grabbed a handrail to "catch" themselves, it is **still a fall**.*
- **Therapy Exception:** An anticipated loss of balance during a **supervised therapeutic intervention** (like balance training in PT) is not considered a fall—*unless* the resident actually hits the floor or a lower surface despite the therapist's assistance
- **External Force (New Update):** As of October 2025, CMS updated the definition to include events caused by an "**overwhelming external force.**" Previously, if a resident was pushed by another resident, it might have been coded as an accident/altercation. Now, it is officially coded as a fall.

Fall Injury Definitions

- **No Injury** No signs of injury; no complaints of pain; no change in behavior.
- **Injury (Except Major)** Skin tears, abrasions, lacerations, superficial bruises, hematomas, or sprains. Includes any fall where the resident complains of pain.
- **Major Injury** Includes **but it not limited to traumatic** bone fractures, joint dislocations, internal organ injuries, **all head injuries** (with or without altered consciousness, concussions/subdural hematomas), or spinal cord injuries, but not pathological fractures.

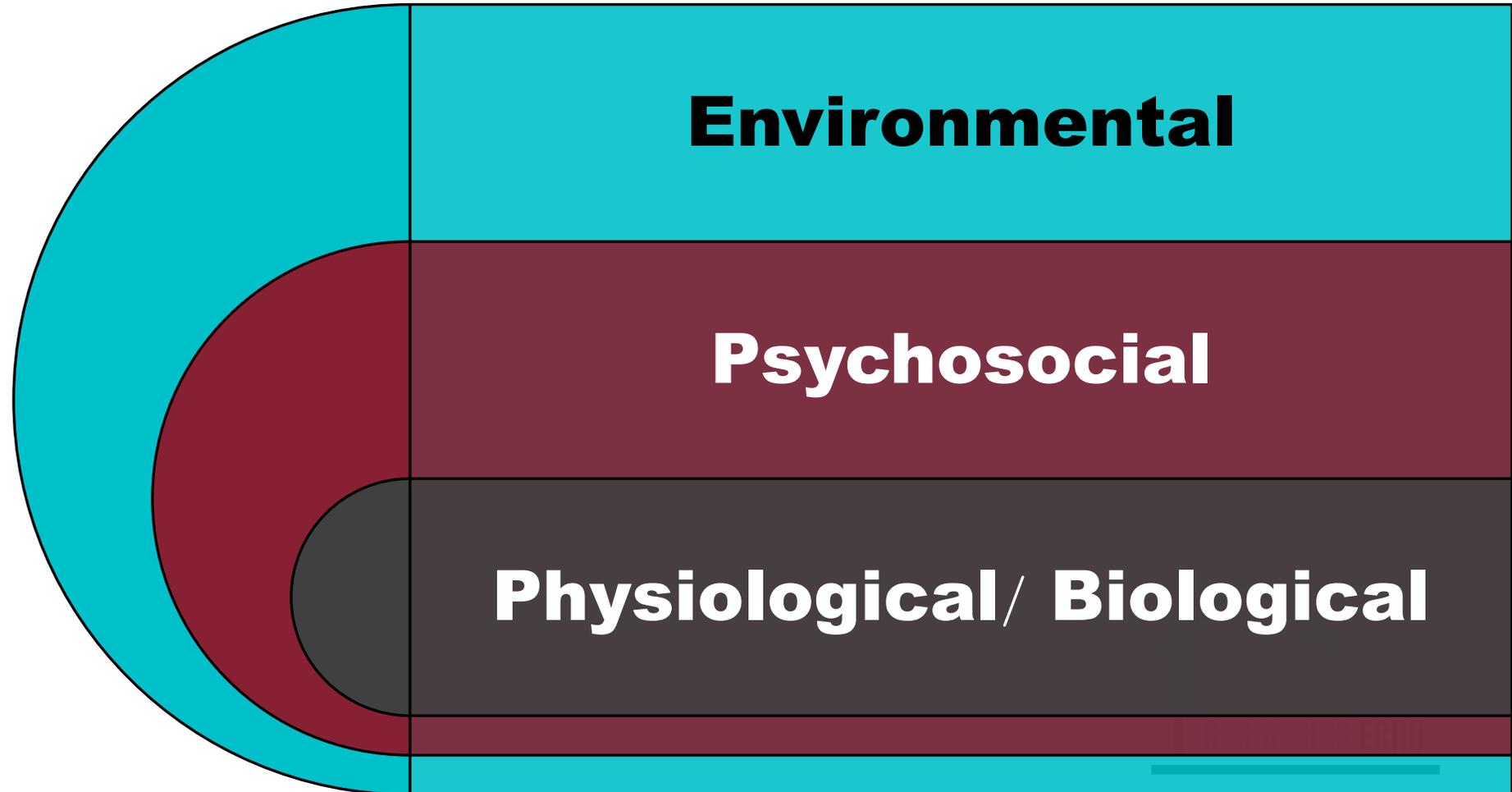


Three Essential Components to Prevention



Assume Risk

Conduct Comprehensive Assessments



Assessment:

Biological/ Physiological

- **Balance Problems/ Mobility Limitations**
- **Psychotropic medications/Fall Risk Inducing Medications**
- **Orthostatic Hypotension**
- **Chronic Conditions**
 - **Cognitive Impairment**
 - **Sensory Impairment**
- **Foot Problems and Inadequate footwear**

Assessment: Psychosocial

- **Fear of falls**
- **Social Isolation**
- **Rushing**
- **Not asking for help**
- **Reluctance or forgetting to use assistive devices
(walking, sensory)**



Assessment: Environmental

- **Cluttered walkways**
- **Cluttered furniture arrangements**
- **Poor lighting**
- **Hazards on floor surfaces: spills, rugs, uneven surfaces**
- **Insufficient or unstable grab bars, handrails in bathrooms, hallways, bedrooms**



Tools to Guide Comprehensive Assessments



Hendrich II FALL RISK MODEL®

RISK FACTOR	RISK POINTS	SCORE
Confusion/Disorientation/Impulsivity	4	
Symptomatic Depression	2	
Altered Elimination	1	
Dizziness/Vertigo	1	
Gender (Born male and/or self-identify as male.)	1	
Any Administered Antiepileptics (Anticonvulsants)	2	
Any Administered Benzodiazepines	1	
Get-Up-and-Go Test: "Rising From a Chair"	0	
Ability to rise in a single movement - no loss of balance with steps	1	
Pushes up, successful in one attempt	3	
Multiple attempts, but successful	4	
Unable to rise without assistance during test		
TOTAL SCORE:		

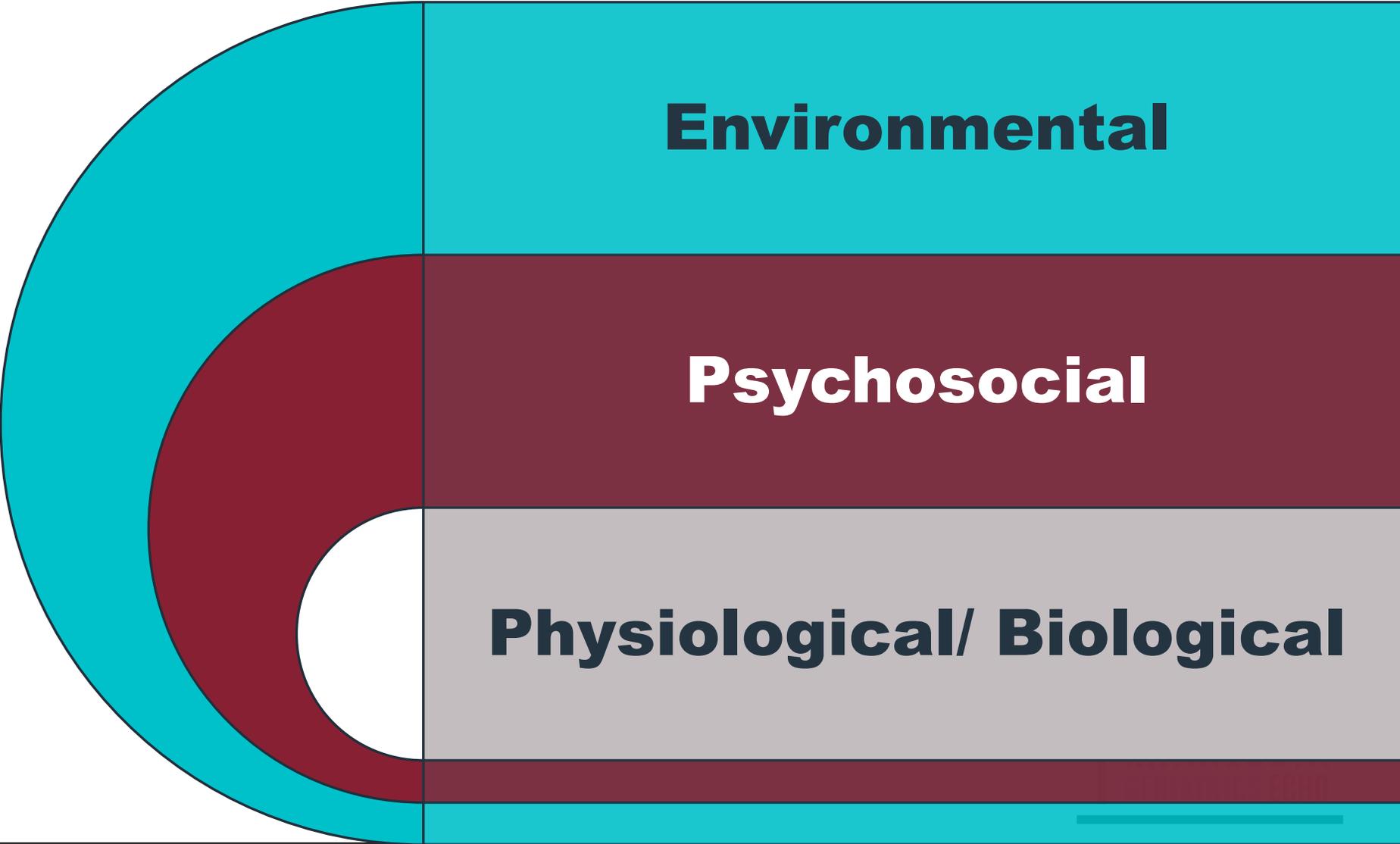
NOTE: If unable to assess, monitor for change in activity level, assess other risk factors, document both on patient chart with date and time.

A TOTAL SCORE OF 5 OR GREATER = HIGH RISK

Hendrich II Fall Risk Model Morse Fall Scale



Proactive, Individualized Fall Prevention Care Plans



Possible Fall Prevention Actions: Biological/ Physiological

- **Balance problems?** *Refer to physical therapy and/or physical activity program*
- **Fall Risk Inducing Medications?** *Regular medication reviews in collaboration with pharmacist for optimization, reduce FRIDS*
- **Optimize Management of Chronic Conditions**
- **Cognitive impairment?** *Provide cognitive assistance to match deficits*
- **Sensory impairments?** *Encourage regular eye and ear exams and encourage relevant compensatory strategies*
- **Foot problems?** *Manage Foot Problems and Pain*
- *Encourage adequate footwear*

Possible Fall Prevention Actions: Psychosocial

- Fear of falls, Isolation, decreased balance?
 - ***Physical Activity Programs for those who can mobilize independently with or without walking aid***
 - Progressive (some standing strength & dynamic balance)
 - Tailored to individual, supervised
 - Light or moderate intensity - 80 minutes per week
 - **One Example: Otago**
- Tendency to not ask for help; cognitive or sensory impairment?
 - ***Meet all person's needs before leaving their space/ location***
 - ***Hourly Rounds***
 - Address 4 Ps (pain, placement, personal needs (potty), positioning)

Possible Fall Prevention Actions: Environmental

- **Tendency for clutter or spills?**
 - Regular environmental rounds
 - Prioritize prompt removal potential hazards

Universal environmental considerations

- **Good lighting**
- **Ensure therapeutic environment in private and public spaces that support well-being and mobility**
- **Walking paths/ gardens**



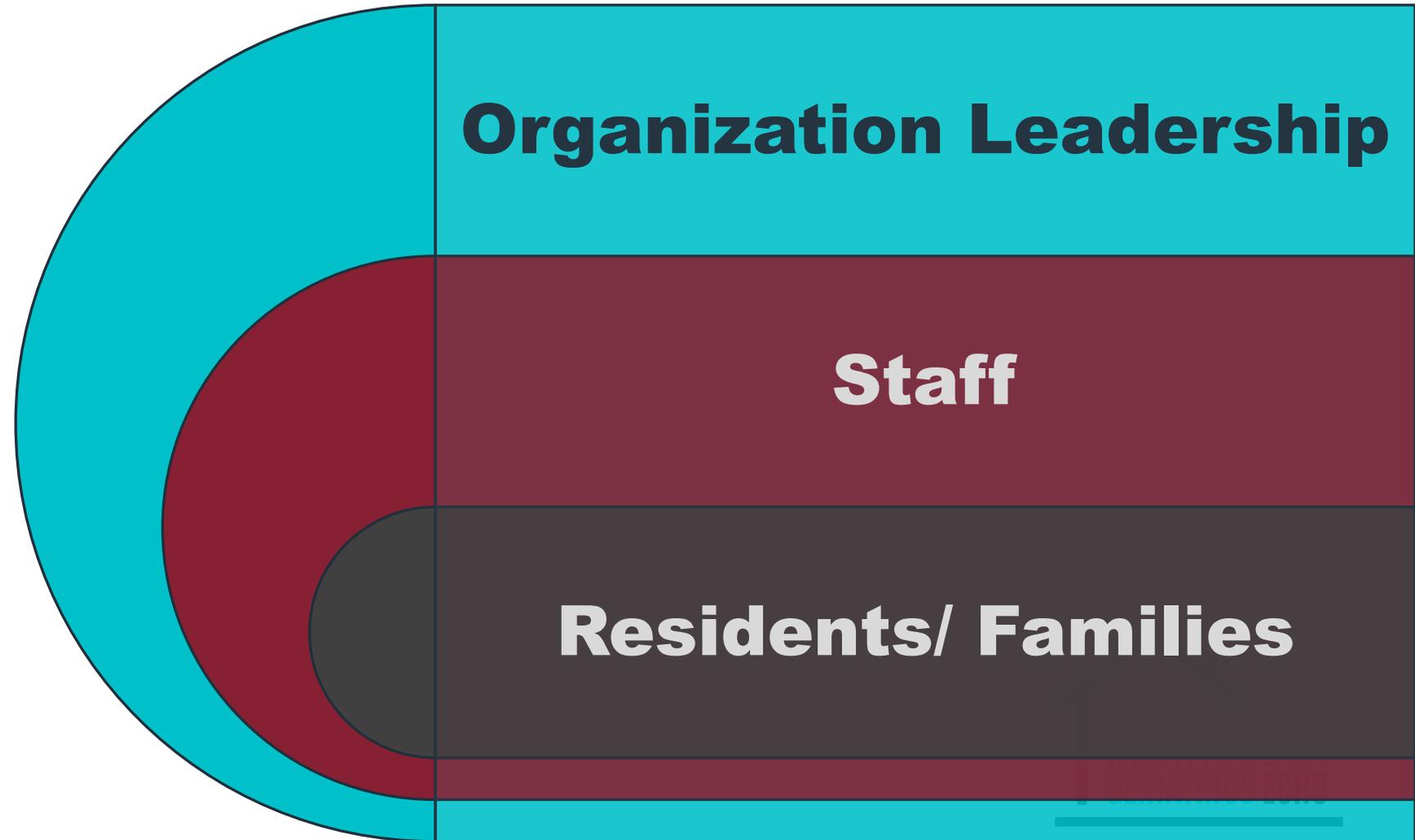
Post Fall Management is Key to Optimizing Fall Prevention Care Plan

- Physical assessment
- Fall details documented
- Comprehensive fall risk assessment updated
- Family and Provider notified
- Fall prevention plan updated/revised with care team, provider, resident, family
- Team communications of changes in risk and plan



Continuous Implementation Strategies

Adapted to Context



Continuous Implementation Strategies Adapted to Context

Education and training

- Include staff in all roles
- One study found student-led programs were effective

Promote interdisciplinary collaboration including all staff and provider roles

- Developing, implementing, evaluating individualized plans

Engage residents, families, staff

- Developing, implementing, evaluating Individualized plans
- Culture of safety
- SWOT analysis of current state of fall prevention policies

Leadership support

- Fall prevention champion?
- Fall prevention committee
- Regular timely measurement and feedback related to fall prevention

Case Study: Ella

A 92-year-old woman who prefers to be called Ella and lives in a long-term care community, has had several falls. She enjoys music, light exercise with assistance, and walking inside and outside. She likes to stay active and takes short walks about every hour. Between walks, she prefers to sit with her legs raised to ease her back pain. She wears comfortable tennis shoes that she "loves."

Her walking is unsteady and legs are sometimes weak. She usually needs some help getting out of a chair. She uses a walker most of the time but sometimes forgets. She has high blood pressure, back pain, moderate dementia, and depression. She takes fall risk inducing medications for blood pressure, depression, and dementia symptoms. She sometimes forgets or does not ask for help when getting up from her chair or bed. Her last two falls happened when she tried to get out of bed alone, and her legs became weak. She was not injured.

Based on your experience and fall prevention protocols in your community:

- ***What are some additional details about fall risk you would like to assess?***
- ***Describe at least one specific fall prevention action you and your team might recommend?***
- ***Describe a strategy you and your team use to implement effective and sustained fall prevention practices for folks like Ella and her neighbors in your community.***

ALL TEACH. ALL LEARN.



- What themes emerged in your small group?
- What questions do you have for the group?
- What lessons do you have to share on this topic?



NEXT SESSION: March 10, 2026
12:30-1:30

What improves quality of life for residents on dialysis?

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