Improving Patient Safety in Long-Term Care Facilities:

Falls Prevention and Management

Supplemental Material to Accompany the Webinar

The first three Webinars in the series **Improving Patient Safety in Long-Term Care Facilities: Introduction to the Webinar Series, Detecting Change in a Resident's Condition, and Communicating Change in a Resident's Condition** are available on demand for CE and have no registration fee. The courses can be accessed at: http://ce.ahrq.gov/nurses/

The Instructor Guide can be found at: http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcinstructor.html.

A PDF version of the Instructor Guide can be downloaded and printed by clicking on the download button at the top of the page.

The Instructor Guide comprises all three modules, including suggested slides, pretests, and posttests to gauge the student's knowledge level before and after training. Separate Student Workbooks are available for each module.

Ordering Information
Printed copies of the Instructor Guide and student modules can be ordered separately or as a set from the AHRQ Publications Clearinghouse.

To request copies of the printed materials, send an e-mail to the AHRQ Publications Clearinghouse at AHRQPubs@ahrq.hhs.gov or call 1-800-358-9295. Be sure to specify the AHRQ Publication number when ordering.

Instructor Materials
The 96-page Instructor Guide can be ordered separately or as a complete set that includes one copy of the Instructor Guide and one copy each of the Student Workbooks for Modules 1, 2, and 3.

Single copies are free; charges may apply for additional quantities and for shipping to addresses outside the United States. There are no copyright issues with this material. You may print additional copies from the Web site if you want to avoid the charges associated with ordering multiple copies.

- **Instructor Guide**, 96 pp. (AHRQ publication no. 12-0001-1) (describes how to use the materials in the Student Workbooks as a teaching session, including suggested slides, pretests, and posttests to gauge the student's knowledge level before and after training).
- **Instructor Set** (AHRQ Publication no. 12-0001) (includes one instructor guide and one copy each of the three Student Workbooks).

Student Materials
Separate Student Workbooks are available for each module. The workbooks can also be ordered separately or as a Student Workbook set. Copies of the Student Workbooks are also included in the Instructor Set.

There is no charge for single copies; charges may apply for additional quantities and for shipping to addresses outside the United States.

- **Module 1. Detecting Change in a Resident's Condition: Student Workbook**, 20 pp (AHRQ Publication No. 12-0001-2). Available to download at: http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule1.html

- **Module 2. Communicating Change in a Resident's Condition: Student Workbook**, 19 pp (AHRQ Publication No. 12-0001-3). Available to download at: http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule2.html

- **Module 3. Falls Prevention and Management: Student Workbook**, 19 pp (AHRQ Publication No. 12-0001-4). Available to download at: http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule3.html

- **Student Workbook Set** (includes one copy each of the Student Workbooks for the three-module set) (AHRQ Publication No. 12-0001-5).

Additional Resources:

The following Website provides helpful resources related to the PDSA cycle described in the Webinar: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

U.S. Department of Health and Human Services
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Improving Patient Safety in Long-Term Care Facilities: Falls Prevention and Management

Marian Edmiston, DEd, MSN, RN-BC

Recorded Version

- AHRQ
  - http://ce.ahrq.gov/nurses/
- National Gerontological Nursing Association
  - http://www.ngna.org/
- National Association of Directors of Nursing Administration in Long-Term Care
  - https://www.nadona.org/

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Disclosures

- This Webinar has been funded and developed by the Agency for Healthcare Research and Quality (AHRQ); there has been no outside commercial support.
- Presenter(s)/staff have no conflicts of interest or relevant financial relationships to disclose.

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Requirements for Successful Completion, CE

- Be present for the entire Webinar.
- Complete an online evaluation.
- Pass the posttest with a grade of 80% or higher.
- Complete and submit the evaluation/ posttest within 30 days of the Webinar.

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Designation Statements

The following Continuing Education (CE) credits will be available to participants of the live Webinar.

- The American Association of Nurse Practitioners (AANP) designates this education activity for a maximum of 1 contact hour.
- The Arizona Nurses Association (AzNA) designates this education activity for a maximum of 1 contact hour.
- The Commission for Case Manager Certification (CCMC) designates this continuing education activity for a maximum of 1 clock hour.

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Accreditation Statements

- This program was planned in accordance with American Association of Nurse Practitioners (AANP) CE Standards and Policies and AANP Commercial Support Standards.
- This program has been approved by the Commission for Case Manager Certification to provide CE credit to Certified Case Managers (CCMs).
- This continuing nursing education activity was approved by AzNA, an accredited approver by the American Nurses Credentialing Center (ANCC) Commission on Accreditation.
- Accreditation refers to recognition of continuing nursing education only and does not imply AANP, AzNA, or ANCC Commission on Accreditation approval or endorsement of any commercial products discussed or displayed in conjunction with this educational activity.

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Introduction

Margie Shofer, BSN, MBA

Communications Specialist
AHRQ

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Agency for Healthcare Research and Quality (AHRQ)

Mission

AHRQ's mission is to produce evidence to make health care safer, higher-quality, more accessible, equitable, and affordable, and work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

For more information:
www.ahrq.gov

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Scope of Webinar

Module 3

- **Falls Prevention: The role of the team in preventing falls**
- **Falls Management: The role of the team in responding to a fall**

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Improving Patient Safety in Long-Term Care Facilities:

Module 3:
Falls Prevention and Management

Marian Edmiston, DEd, MSN, RN-BC

Learning Purpose

The goal of this Webinar is to provide nurse administrators and nurse educators guidance on training using the materials covered in AHRQ's Improving Patient Safety in Long-Term Care Facilities Instructor Guide.

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Webinar Objectives

At the end of this presentation, participants will be able to:

1. Utilize effective engagement strategies to present an audience-appropriate training program for nursing assistants, licensed nurses, and other staff.
2. Utilize the AHRQ Patient Care training resources to train staff in how to prevent and manage falls.
3. Present relevant case studies as examples of how best to prevent and manage falls and fall-related injuries.

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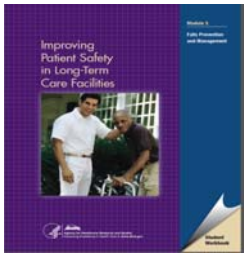
Module 3: Falls Prevention and Management

Available Teaching Materials

- Online Materials
  - Instructor Guide
  - Student Workbook
- Additional Materials Today
  - Student Slide Deck



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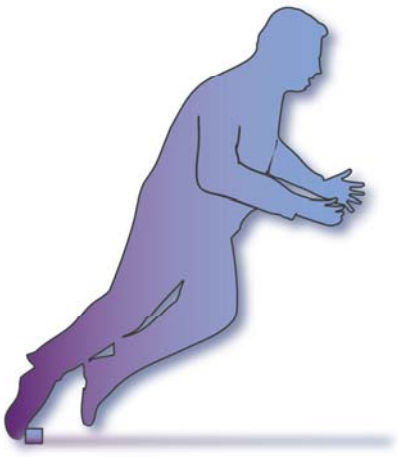
Introduction

Preventing Falls
and
Fall-Related Injuries



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What Staff Need to Know

- Facts about falls in LTC facilities
- Definition of a fall
- Risk factors for a fall
- How to assess and decrease the risk of falling
  - HEAR ME
- Elements of a falls prevention and management team
- Benefits of quality improvement initiatives

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Definition of a Fall

CMS-RAI

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). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground……

Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident)…"

AHRQ's Instructor Guide

Unintentional change in position, coming to rest on the ground or the next lower surface that does not result from being pushed down or collapsing from a sudden medical condition.

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Facts About Falls in LTC Facilities

- Preventing falls is a serious challenge.
- Three of every four residents fall each year.
- Most facilities have >100 falls per year.
- There are several interventions that help reduce the number of falls.
- Staff must have adequate training to acquire the knowledge and skills necessary to prevent and manage falls.

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Preventing Falls

- Effective Interventions
  - Educating staff members about risk factors and prevention strategies.
  - Making environmental changes designed to prevent falls.
  - Reviewing medicines to see which have side effects that might cause falls.
  - Assessing patients after a fall to prevent future falls.

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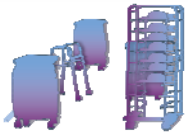
Educating Staff About Risk Factors And Prevention Strategies For Falls

- Resident-centered

- Environmental
  - Facility-based



  - Organizational

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Patient-Centered Risk Factors

- Previous falls
- Fear of falling
- Diminished strength
- Gait / balance impairments
- Vision impairment
- Alzheimer's disease / dementia
- Medications

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Focus on: Medications

Any drug that causes the following increases the risk of falling.

- ✓ Drowsiness
- ✓ Dizziness
- ✓ Hypotension
- ✓ Parkinsonian effects
- ✓ Ataxia/gait disturbance
- ✓ Vision disturbance

Drugs known to increase the risk of falls:

➢Sedatives	➢Diuretics
➢Hypnotics	➢Antihypertensive drugs
➢Antidepressants	➢Vasodilators
➢Benzodiazepines	

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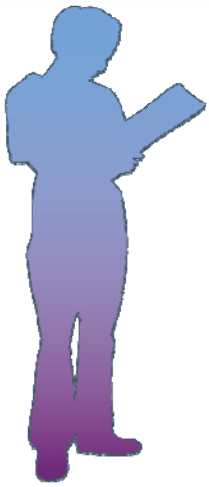
Case #1: Mrs. Lawson



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Case #1: Mrs. Lawson

Mrs. Lawson:

87-year-old female recently admitted.

Alzheimer's disease for 4 years; was cared for by her husband and daughter.

Hypertension, type 2 diabetes, osteoarthritis and depression.

Fallen repeatedly over the last 2 years at home.

Prescribed medications include: Lopressor HCL 25 mg and Lasix 40 mg daily for hypertension,
Namenda 10 mg daily for moderate to severe Alzheimer's, Amaryl 1 mg daily for her diabetes, and Celexa 20 mg daily for depression.

Milk of magnesia 30 ml and Ativan 0.5 mg may be given PRN for constipation and increased anxiety respectively.

Acetaminophen 325 mg can be administered every 6 hours as needed for pain.

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Case #1: Mrs. Lawson

On the 2nd day after admission, Mrs. Lawson was extremely restless and anxious during the afternoon.

Ativan 0.5 mg for anxiety at 4 PM. Ate her evening meal and the staff later assisted her in preparing for sleep. She appeared less agitated and was asleep by 9 PM.

At 1 AM, Mrs. Lawson was found sitting on the floor next to her bed.

She was crying out for her husband.

She was assessed for injuries related to the apparent fall and was found to have none. An incident report was filed and her physician and family were notified.
She was placed back in her bed.
The nurse administered Ativan 0.5 mg and her NA remained in the room until Mrs. Lawson fell asleep.
She slept through the night.

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Case #1: Discussion

- Ask the following questions:
  - Given Mrs. Lawson's history, diagnoses, and medications, what is her risk for experiencing a fall?
  - What steps can staff take to reduce the risk and incidence of falls for Mrs. Lawson?
- Important to note:
  - The patient's history of falls and the medications she receives put her at increased risk for falling.
  - Review the patient's current medications.
  - Assess BP frequently.

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Medication Management and Reduction Programs

- Unless prescribed, avoid administering meds at meal times.
- Determine a time during the day to give once-daily medications.
- Reduce TID meds to BID whenever possible.
- Adjust the timing of BID meds to times that work best for the individual resident's schedule.
- Discontinue unnecessary medications.
- Reduce the number of PRN medications.
- Discontinue waking residents for medication whenever possible.

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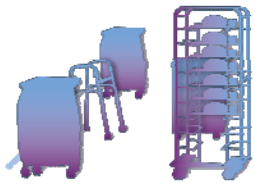
Facility-Based Risk Factors

- Overcrowded rooms
- Obstacles
- Design issues
- Equipment misuse or malfunction



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Organizational Risk Factors

- Inadequate staffing
- Poor communication
- Inadequate staff training
- Inadequate QI policy for falls prevention
- Use of restraints

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Falls Assessment

Instruments

- Hendrich II Fall Risk Model
- Comprehensive Falls Risk Screening Instrument
- Falls Assessment portion of the Falls Management Program
- Vanderbilt Fall Prevention Program for Long-Term Care
- Timed Up and Go Test

Common Assessment Elements

- History of falls
- Cognition
- Impulsivity
- Vision
- Attached equipment
- Ambulation
- Continence
- High-risk medications
- Assistive devices
- Familiarity with environment

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HEAR ME

Hazards — notice and eliminate environmental hazards

Education — educate residents about safety

Anticipate — anticipate the needs of residents

Round — round frequently to learn residents' needs

Materials — ensure materials and equipment are in working order

Exercises — assist residents with exercise and ambulation

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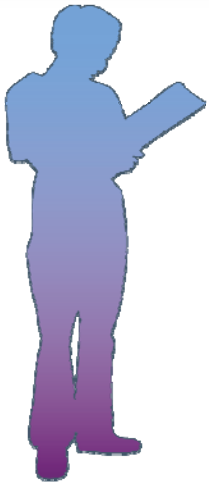
Case #2: Mr. Phillips



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Case #2
Mr. Phillips

Mr. Phillips:

- 84 years old
- Mild dementia, orthostatic hypotension
- Wife has recently died
- Depressed, sleeps poorly
- Has cut himself shaving
- Fallen 4 times in 6 weeks

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Case #2
Mr. Phillips

- *Antidepressant, sedative daily*
- *Antihypertensive twice daily*
- *Uses wheelchair now*
- *Often misplaces eyeglasses*
- *Falls typically occur at night*

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Case #2: Discussion

- Ask the following questions:
  - What patient-related factors make Mr. Phillips prone to falling?
  - What environmental factors may have been at play?
- Important to note:
  - The HEAR ME acronym could be used to highlight necessary changes to the patient's environment.
  - Assistive devices should be checked.
  - Eyeglasses should be checked and kept close.
  - Nighttime staffing should be reviewed.

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Falls Management

1. Responding to a fall
2. Limiting future falls

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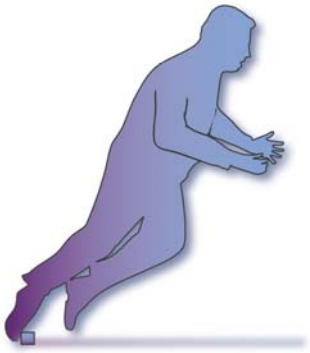
Responding to a Fall

1. Observe and evaluate
2. Investigate and document
3. Implement individualized care plan
4. Develop falls management program



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Limiting Future Falls

Patient Interventions

- Keep frequently needed items close
- Remove hazards
- Add safety equipment
- Provide additional aid
- Provide a balance exercise program
- Evaluate assistive devices
- Develop a care plan

Center-Wide Interventions

- Medication management and reduction program
- Falls management team
- Falls surveillance
- Multidisciplinary assessments
- Assessment of staffing needs
- Falls prevention and management training for staff and residents

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Falls Management Team

- Interdisciplinary group
- Meet regularly
- Analyze risk factors for falls
- Identify intervention(s)
- Perform systemic evaluation
- Monitor and document results

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Role Of The Care Team In Falls Prevention and Management

- Licensed nurses have assessment skills and knowledge about medications that are essential to preventing and managing falls.
- NAs and other front-line staff spend more time with residents, which gives them insight on how to prevent falls in the context of residents' daily activities.

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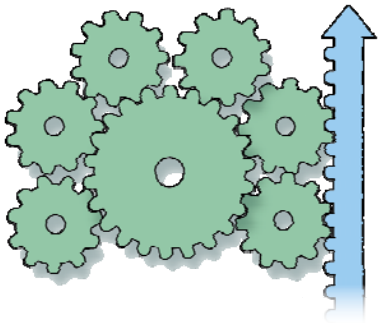
Teamwork

- Communication
- Report possible risks across the care team
- Work together to improve the risk(s)
- Take action as a team



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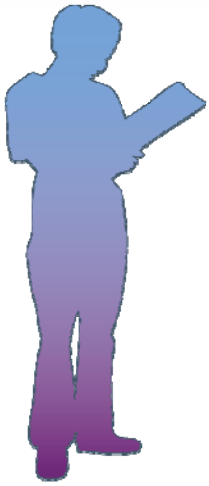
Case #3: Mrs. Pelham



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Case #3
Mrs. Pelham

Mrs. Pelham:

- Admitted from hospital, June 6
- Primary diagnosis of PD
- Multiple risk factors for falls
- Requires assistance walking
- Now using wheelchair
- Angry at loss of independence

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Case #2
Mrs. Pelham

Mrs. Pelham

July 2, attempted to rise from wheelchair.

Daytime NA able to intercept and help her back to the chair.

LPN notes weight loss of 12 lbs since admission.

BP in low-normal range for 1 week.

Same near-fall on PM shift.

Supervisor schedules meeting with the falls prevention team.

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Case #3: Findings and Management

Findings:

- Mouth sore resulted in difficulty eating.
- Weight loss, weakness, low blood pressure.
- Compounded PD stiffness.
- Emotional upset due to lack of independence.

Management:

- Treatment for canker sore.
- Dietary supplementation.
- Schedule a neurologic consultation.
- Reassess hypertensive medications.
- Schedule physical therapy.

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Case #3: Discussion

- Ask the following questions:
  - What role did the Nursing Assistant play in 'solving' this case?
  - How might a breakdown in team communication have changed the outcome?

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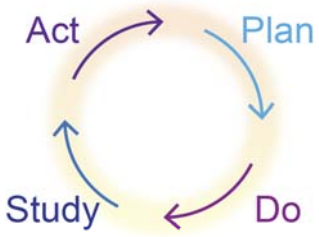
Quality Improvement

- Plan: Identify a problem and design a change to address it.
- Do: Implement a small change.
- Study: Measure and analyze the effects of the change.
- Act: Take action based on the results of analysis, such as trying another change.



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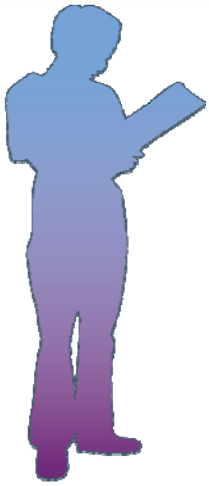
Case #4: Increased Incidence of Falls



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Case #4: Increased Incidence of Falls
The Problem

- Falls have increased by 21% in past year
- Team assembled to investigate
  - NAs
  - Licensed staff
  - Social worker
  - Occupational therapist

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Case #4: Increased Incidence of Falls What the Team Learned

- The facts:
  - Falls typically occur Thursday-Saturday
  - Between 9 AM and 2 PM
  - More falls occur in women than men
- The cause:
  - Floors deep cleaned Thurs-Sat after breakfast
  - Hairdresser onsite Thurs-Sat, 9 AM to 2 PM
  - Hair salon in basement

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Your QI Initiative

- Consider:
  - Which staff members to appoint to an investigative team?
  - What interventions could be introduced at your facility?
  - How will you measure the success of your intervention?

Remember PDSA

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Key Points

- Multiple risk factors
- Falls risk assessment
- Risk assessment after a fall
- Fall prevention requires active engagement
- Teamwork necessary to prevent falls
- Go beyond incident report to develop a revised care plan after fall

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Questions?

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Remember!

- This is the final Webinar in this four-part series.
- Recording of previous Webinars available for CE at:
  - http://ce.ahrq.gov/nurses/
- Technical assistance call on September 24, 2014, 1:00 PM – 2:00 PM (ET).

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Wrap-Up

- To obtain credit:
  - Complete an online evaluation. Login to your CME University account: http://ahrq.cmeuniversity.com/course/disclaimer/110285
  - Pass the posttest with a grade of 80% or higher.
  - Complete and submit the evaluation/posttest within 30 days of the Webinar.

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Wrap-Up (cont.)

Request for volunteers for follow-up.

If you have any questions or problems, please contact us at:

educationservices@hayesinc.com
Phone: 267-498-7926

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Improving Patient Safety in Long-Term Care Facilities: Falls Prevention and Management
Live Webinar: August 13, 2014

Questions & Answers

1. **Q: Considering that most attendees list communication problems as the primary cause of falls, could you expand on strategies for improving communication around falls?**

   A: It is interesting that a large number of attendees of this Webinar listed communication problems as a cause for falls within their facilities. This validates the importance of addressing communication issues in depth. We devoted two Webinars in this patient safety series to addressing communication challenges, and offered interventions and solutions to this clearly universal issue. Two important aspects of effective communication within long-term care settings are the appropriate detection of changes in a resident and the subsequent appropriate reporting and documentation of those changes to direct interventions that will address the change/problem. To provide the most comprehensive answer to this question, we recommend that you access the previous Webinars in this series, which are available on the AHRQ Web site at: http://ce.ahrq.gov/nurses/.

2. **Q: Do you measure the success of your interventions by the decrease in falls or using the Plan/Do/Study/Act (PDSA) process?**

   A: The PDSA is a Quality Improvement (QI) process that provides a template for change within an organization. It helps the QI team to create a plan (P) that addresses a need and then to implement (D) an intervention for that need. The team then analyzes (S) the effects of the intervention to determine whether it should be incorporated (A) as a standard in your facility. A decrease in the number of falls both per resident and for the organization is an appropriate metric to determine the success of a falls prevention/management intervention. The PDSA process is a vehicle to bring about change.

3. **Q: Any help with a team who cannot develop any more new interventions on a resident who has fallen 10 times this year?**

   A: Frequent falls are a frustrating problem for caregivers and a serious safety concern for the individual resident and his or her family. Appropriate steps include:
   - Appropriate documentation and reporting of the incidents.
   - A thorough assessment/investigation into the cause of the falls.
   - The introduction of strategies to reduce the number of falls, including:
     - A review, by a falls prevention team, of the resident's history of falls, medications, underlying disorders, and possible cognitive changes as described in this Webinar.
     - The falls prevention team should include those caregivers that know the resident best, and representatives from physical and occupational therapy, as well as social services, who can really concentrate efforts in developing a plan to minimize the number of falls.

   Perhaps this individual case could be the target of a QI project that would explore the root cause of this situation. The QI team could take time outside of the busy daily schedule in the nursing unit to explore all aspects of the resident's situation, including the physical, emotional, psychological, and social influences that may have an impact on the number of falls for this person.

Improving Patient Safety in Long-Term Care Facilities: Falls Prevention and Management Live Webinar: August 13, 2014

4. **Q: How long will the modules be available to review?**
   Q: Will the slides be posted on the AHRQ Web site?
   A: The August 13 Webinar was recorded and will be converted into an enduring learning activity available for continuing education (CE) for a 2-year period. The recording will be available on August 27, 2014, at http://ce.ahrq.gov/nurses/. Supplemental materials, including a set of PowerPoint slides for use in training the module to staff, as well as a handout containing information on how to order and download the AHRQ materials, were provided as part of the live Webinar and will also be available with release of the recording.

5. **Q: Is there any consideration for adopting the NDNQI falls definitions used by hospitals?**
   A: The ANA – NDNQI (National Database for Nursing Quality Indicators) provides an inclusive definition for falls as: an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury. All types of falls are included, whether they result from physiological or environmental reasons (*Patient Safety and Quality: An Evidence-based Handbook for Nurses, 2008)*. Long-term care facilities providing skilled services must adhere to the CMS (Centers for Medicare & Medicaid Services) definition as follows: a fall is 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)… Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident)." The definition also describes an intercepted fall as a fall that "occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this intercepted fall is still considered a fall."

   These definitions are similar in intent and both define the process of the physical fall, acknowledging that falls can occur as a result of patient-related, environmental, or organizational factors.

6. **Q: Just wondering how many callers are on this call today? If from the Long-Term Care (LTC) or acute care facilities?**
   A: There were 177 people in attendance at the live Webinar, and we believe there were others who chose to attend in groups. We do not know how many of the attendees were from LTC versus acute care facilities, but our belief is that the majority of attendees were likely from a LTC facility.

7. **Q: SBAR Tool is also a good tool for communication between staff.**
   A: The SBAR (Situation, Background, Assessment, Request) tool is an excellent communication tool that was highlighted in the previous Webinar in this series. More than just a reporting tool, the SBAR aims to improve communication between staff, specifically between nursing staff and physicians. It is designed to enhance the evaluation of, and documentation for, residents who have an acute change in condition. Once a change in condition has been identified and it has been determined that a physician needs to be notified, a nurse completes the SBAR. The SBAR can be used as a paper tool; it is also increasingly being used electronically for integration into a patient's electronic medical

record (EMR). Typically, the SBAR becomes part of a patient's medical record and includes a progress note. To find out more about the SBAR tool and other communication tools, including the STOP and WATCH and CUS (Concern, Uncomfortable, Safety) tools, access the previous Webinar in this series at http://ahrq.cmeuniversity.com/course/disclaimer/110249.

8. **Q: September 23 (first day of Fall) is National Falls Prevention Awareness Day; might be good to highlight this and frame education efforts around this national initiative; google National Council on Aging for more info.**
   A: Thank you for this comment. The Falls Prevention Awareness Day Web site can be found at http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention/falls-prevention-awareness.html. This year's theme is Strong Today, Falls Free® Tomorrow, and seeks to raise awareness about how to prevent fall-related injuries among older adults.

9. **Q: how can information technology help and assist with preventing falls? How are folks using their health IT solutions?**
   A: The use of information technology, along with sensor and game technology, is a growing area for research and innovation for falls prevention in the aging population. Electronic risk assessment tools and analysis of individualized patient risk factors are enabling the development of customized interventions to reduce falls. Globally, research products are being developed that utilize technology to assess, monitor, and motivate health care providers and patients to improve mobility and decrease the risk of falls. The following links provide a sampling of some exciting and innovative projects that address the use of technology in falls management:
   - AHRQ Health Care Innovations Exchange available at: http://innovations.ahrq.gov/content.aspx?id=3094
   - AHRQ Patient Safety Network available at: http://psnet.ahrq.gov/resource.aspx?resourceID=19724
   - International Journal of Medical Informatics available at: http://www.ijmijournal.com/article/S1386-5056(14)00058-6/abstract?cc=y?cc=y
   - iStoppFalls project available at: http://www.istoppfalls.eu/cms/front_content.php

10. **Q: What do you think of the recommendation by Empira in their falls training to stop doing fall risk assessments routinely and consider all residents at risk for falls on admission and put interventions in place based on their known risk factors and root cause analyses post falls?**
    A: Empira is a collaborative effort of older adult service providers in Minnesota with a primary activity that is "to research, develop and implement customized clinical pathways and educational programs from the most recent evidence based practices in the field of gerontological research." They have developed educational programs in several clinical areas, including falls prevention. In recommending that all residents in long-term care facilities be considered as "at risk for falls," Empira is helping to expand awareness of patient safety to the entire facility population and to

encourage the trend toward individualized interventions based on the actual needs of the resident. With this philosophy in mind, care providers should be better able to apply safety measures for falls prevention in a customized manner that will result in more appropriate care for each resident based on patient needs.

11. Q: What is your experience with the STEADI program?

A: The STEADI (Stopping Elderly Accidents, Deaths & Injuries) program is a toolkit developed by the CDC for health care providers who treat older adults living independently at home or in assisted living settings. The majority of these materials would also be very useful in nursing and rehabilitation facilities. The STEADI program is a comprehensive assessment, training, and educational resource that is easy to navigate and use. All of the information within the toolkit is offered in PDF format and is easily downloadable and printable for use in primary care treatment settings. There is no cost for the program. The STEADI Falls Risk Checklist document and the Integrating Falls Prevention into Practice document might be of particular interest when implementing a falls prevention and management program. In addition, the case studies provided for staff training pertain to community-based patients, but again, would also be useful in generating discussion about assessing and determining care for residents in facilities. The STEADI toolkit includes the standardized gait and balance assessment tests. The presentation of the documents and the "how-to" videos clips that accompany the documents are great teaching tools for staff. You can access the STEADI program at: http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html.