Fall Prevention Strategy – Adult Inpatient and Outpatient			
Signing Authority:	Chief Nursing Executive		
Approval Date:	14-08-2019	Effective Date:	16-10-2019

SCOPE:

This policy and procedure applies to all staff that care for adult patients at the Royal Victoria Regional Health Centre (RVH) and that are involved in the prevention, screening/assessment, and interventions related to falls.

POLICY STATEMENT:

It is the policy of RVH to promote a safe environment for all patients utilizing a Fall Prevention Strategy. It is expected that all staff shall adhere to the principles outlined in this policy.

Inpatient Adult:

1. Universal fall prevention interventions shall be implemented for all adult inpatients (refer to Appendix II).
2. All staff providing direct patient care shall complete annual Fall Prevention Strategy education, including regular updates, as required.
3. Each patient shall be assessed for risk of falls:
   a. at time of admission; and
   b. after a fall or a near fall; and
   c. when transferred from another unit;
   d. whenever there is a significant change in the patient's condition; and
   e. weekly on Friday.
4. Completion of the electronic nursing admission assessment process shall result in an automatic calculation of a falls risk score. If the patient is found to have a history of falls or a falls risk score of four or more, or if the assessing clinician deems the patient to be at risk for falls, a Falls Prevention Strategy shall be implemented.
5. The results of the falls risk assessment shall be communicated to the health care team, the patient and the family/substitute decision maker (SDM) and documented in the patient health care record.
6. An individualized plan of care shall be developed to reduce the risk of falls. Assessment shall include consideration of causes of falls and interventions to address these causes (refer to Appendix III).
7. Each department shall ensure that all equipment used is safe and secure.
8. All patient falls and near falls shall be reported using the Safety Learning System (SLS).
9. A copy of the falls education brochure shall be provided to patients and/or the family/ SDM who are identified as being at risk for falls.

Outpatient Adult:

1. All outpatients, including patients in the Emergency Department (ED) and at both the in-centre and off-site Dialysis Clinic, shall be screened for their fall risk at time of registration and for each clinic visit.
2. Patients who are identified at risk for falls shall be visually identified by use of an orange armband and the falling leaf sticker on paperwork (if clinic utilizes paper documentation) to alert all staff of the patient's fall risk status.
3. Universal fall prevention interventions shall be implemented for all adult outpatients (refer to Appendix V)
4. The receiving healthcare provider shall be responsible to further assess the patient in order to develop an individualized plan of care, as appropriate.
5. Each department shall ensure that all equipment used is safe and secure.
6. All outpatient falls and near falls shall be reported using SLS.
7. A copy of the falls education brochure shall be provided to patients and/or the family/SDM that are identified as being at risk for falls.

RVH In-Centre and Off-Site Dialysis:

1. Universal fall prevention interventions for adult outpatients (refer to Appendix V) shall be implemented and documented, as applicable.
2. Patients who are identified at risk for falls shall be identified by the falling leaf sticker on their picture located in patient chart and on the Kardex.

DEFINITIONS:

Adult: A patient who is 18 years of age or older.

Degrees of Injury:

None Apparent: No injury sustained as a result of the fall.

Slight/No Treatment: The fall resulted in minor injury which did not require treatment.

Slight/Minor Treatment: The fall resulted in abrasion, reddening of the skin, a bump, a bruise or other apparently minor damage to tissue. The treatment required was non-invasive (e.g. topical ointment, dressing or ice pack).

Moderate: The fall resulted in temporary impairment and clinical intervention (e.g. sutures, first and second degree burns). Falls which have the potential for serious outcomes that require monitoring/intervention.

Serious: The fall resulted in a fracture, hemorrhage, aspiration, loss of consciousness, transfer to critical care area, increased length of stay, or death.

Fall: An event that results in the patient coming to rest, unintentionally, on the ground or floor or other lower level whether or not it results in injury.

Near fall: A sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles, or trips but is able to regain control prior to falling. It is also considered a near fall when the patient is eased to the floor by staff or family members

Repeat falls: Two or more falls within the previous six months.

Timed Up and Go (TUG) Test: A test that observes the time it takes a person to rise from an arm chair, walk three metres, turn, walk back, and sit down again.

Unwitnessed fall: When the patient is unable to explain the events and there is evidence to support that a fall has occurred.

PROCEDURE:

Inpatient Adult:

1. Assessment
    a. Complete the electronic nursing admission assessment, which includes the initial falls risk assessment, within 24 hours of when the admission orders were written.
    b. If the patient has a history of falls or a falls risk score of four or more, or if the assessing clinician deems the patient to be at risk for falls, the Fall Protocol and an individualized care plan shall be initiated. Refer to Appendix I for a list of risk factors, Appendix IV for a list of drugs commonly associated with increased risk of falls and Appendix III for a list of individualized interventions to consider for patients.
    c. If there is a significant change in the patient's condition, review the list of risk factors and reassess the patient's risk of falls.
    d. The falls risk assessment shall be completed upon transfer to another unit.
    e. Reassess each inpatient's risk for fall every Friday utilizing the electronic falls Assessment/Precautions screen.
2. Fall Prevention Strategy
    a. Develop an individualized plan of care to prevent falls for patients determined to be at risk. Interventions to consider are listed in Appendix IV.
    b. Ongoing documentation of progress shall be documented in MEDITECH Patient Care System (PCS) Falls Intervention screen with further narrative documentation as needed in the interprofessional progress notes.
    c. Identify the patient as being at risk of falls by:
        i. placing orange wrist band on patient's wrist; and

ii. placing falling leaf sticker on spine of patient chart and Kardex; and
iii. placing falling leaf logo/interventions above the patient's bed.

d. Involve interprofessional team members as appropriate to assist with mobility aids, medication assessments, etc.
e. Communicate the patient's risk of falling with the patient/family and SDM as well as with staff.
f. Communicate the patient's fall risk status at each shift change during bedside shift report.
g. When a patient is being transported from one department to another, the patient's fall risk status shall be communicated to the receiving department as part of the Transfer of Accountability.
h. Provide the patient/family/SDM with the education brochure on falls.
i. Evaluate the effectiveness of the plan of care and alter individualized care plan, as necessary, every 24 hours.
j. Utilize restraints only when all alternatives have failed and other criteria are met as per RVH Policy and Procedure: Least Restraint.
k. Plans for discharge shall include the interprofessional team members to ensure that appropriate community supports are in place so that the patient can safely return home.

3. If a fall occurs:
    a. Keep the patient comfortable but do not move the patient until the patient is assessed for injuries. Document symptoms such as pain score, swelling, discolouration, bruising in the patient record.
    b. Refer to Appendix VI: Post-Fall Checklist as a guide for actions to be carried out following a patient fall. Document using Post-Fall Checklist intervention within MEDITECH or using the Post-Fall Checklist form #RVH-2371 and place in patient's chart.
    c. If the patient struck their head, do not move patient initially. Call for assistance, as required, if head or neck pain is reported. Complete a head to toe assessment including a neurological assessment and Glasgow Coma Scale.
    d. Check vital signs including temperature, pulse, respirations, oxygen saturation, blood pressure, orthostatic pulse and blood pressure – lying, sitting, and standing (if not clinically contraindicated).
    e. If there is evidence or a suspicion of injury, contact the most responsible provider (MRP) immediately and communicate all assessments**.**
    f. Provide immediate treatment to patient, as appropriate.
    g. Speak to the patient and/or witness(es) to find out what happened.
    h. Ensure the area in which the patient fell has been inspected for further immediate dangers.
    i. Remove immediate dangers contributing to the fall to decrease chance of recurrence.

j. Classify the fall as witnessed or unwitnessed for SLS.
k. For both witnessed and unwitnessed falls, notify the MRP immediately if the patient is on anticoagulant therapy.
l. Monitor the patient closely for 24 hours assessing for neurological, behavioural, or functional changes. If changes occur, notify the MRP immediately.
m. Consult MRP and/or pharmacist to complete a medication review, as applicable.
n. A patient fall or near fall is a patient safety incident. Report incident as per RVH Incident Reporting policy and procedure. Every fall or near fall, regardless of degree of injury, requires an incident report. To report the incident refer to RVH Policy and Procedures: Patient Safety Incident Reporting and Investigation and Disclosure of Harm.
o. Initiate Fall Protocol. If the patient was already on Fall Protocol, re-evaluate the individualized care plan and revise, as needed.
p. Document the fall in the interdisciplinary progress notes/PCS electronic notes.
q. Documentation shall include:
    i. date and time of fall
    ii. location of fall
    iii. description of the fall (patient's perception shall be included, if possible)
    iv. patient assessment, injuries (if any) and treatment provided
    v. vital signs
    vi. notification of MRP and SDM/family (if appropriate)
q. Members of the care team shall participate in a post-fall huddle on the day of the fall to review the incident and to help identify cause(s) and possible changes to the plan of care (refer to Appendix VI).

Outpatient Adult:

1. Screening at time of registration:
    a. Upon registration, all adult outpatients shall be screened for their fall risk using the following questions:
        i. Have you fallen (related to such conditions as weakness, impaired mobility, or confusion) in the last six months or since we saw you last?
        ii. Do you have any difficulty with your walking or balance today?
    b. Patients who answer yes to one or both questions shall be considered as being at risk for falls.
    c. It is the responsibility of the receiving healthcare provider to further assess the patient as required.
    d. The procedural outpatient population who receive moderate sedation or anesthesia shall be considered to be at an increased risk for falls. Outpatient cancer patients who receive therapies that cause weakness, nausea, anemia, etc. shall be considered to be at an increased risk for falls that may be transient (due to the procedure) or pre-existing (due to risks that patients have at baseline). All of

these patients shall be observed for signs of unsteady gait or immediate risk for falls, i.e. dizziness, difficulties in standing up, etc.

2. Fall Prevention Strategy:
   a. Patients who are considered to be at risk for falls shall be identified by use of an orange armband and/or the falling leaf sticker on paperwork (if applicable) to visually alert hospital staff, volunteers, students and clinicians to the patient's fall risk status.
   b. Patients who are identified as being at risk for falls, who are not accompanied by a friend or family member, shall be met by a staff member or accompanied to the treatment area by a volunteer, as required.
   c. Outpatient clinics shall utilize a standard set of falls prevention interventions as part of the standard of care (refer to Appendix V). This care shall be tailored to the specific needs of their patient population based on clinical judgment.
   e. Fall Prevention interventions implemented to reduce the risk of falls shall be documented on the unit specific documentation tool.
   f. Staff shall discuss with patients and their families:
      i. their risk of falls and;
      ii. accompaniment by a friend or family member to future appointments and;.
      iii. use of appropriate gait aids and
      iv. education brochure on falls.

3. If a fall occurs:
   a. Follow the steps outlined in Procedure, Inpatient Adult, step 3 with the following exceptions;
      i. Immediately contact the MRP or the Emergency Department.

RVH In-Centre and Off-Site Dialysis:

1. Assessment at each clinic visit:
   a. Patients who are identified at risk for falls shall be identified by the falling leaf sticker on their picture located in patient chart and on the Kardex.
2. If the patient answers "Yes" to the question "Have you fallen since we saw you last?" then the nurse shall ask the following question:
   a. Have you fallen in the last 24 hours?
3. If the patient answers "Yes" to the question "Have you fallen in the last 24 hours?" the nurse shall assess the degree of injury and adjust the heparin dose as ordered by the physician.
4. If a fall occurs:
   a. Follow Procedure, Inpatient, Adult, step 3.

Simcoe Muskoka Regional Cancer Program (SMRCP) Outpatient Clinics:

1. Upon registration for a visit associated with a provider appointment the patient shall be screened at registration for fall risk using the following questions:

a. Have you fallen in the last six months or since we saw you last?
b. Do you have any difficulty with your walking or balance today?

2. Patients who answer yes to one or both questions shall be considered as being at risk for falls.
3. Patients who are considered to be at risk for falls shall be identified by use of the orange armband and the falls icon indicator is activated in the Cancer Program electronic medical record (ARIA™).
4. The receiving nurse shall be responsible to further assess the patient in order to develop an individualized plan of care, as appropriate.
5. Upon identification of the patient at risk for falls the nurse shall complete the fall risk assessment and intervention questionnaire in ARIA™.
6. Patients shall be divided into low risk and high risk depending on the assessment score. A score risk of four or higher shall be considered a high risk patient and the appropriate interventions and referral shall occur.
7. Interventions/Strategies to reduce Risks for Low Risk Fall
   Education:
   a. Communication to patient/family/SDM re fall risk education regarding general fall interventions as per Appendix V.
8. Interventions/ Strategies to Reduce Risks for High Risk of Fall
   a. Education:
      i. Communication to patient/family/SDM re: fall risk education regarding general fall interventions as per Appendix V.
      ii. Provide “Falling Hurts. Let’s Prevent Falls” brochure to patient and family members.
   b. Medication Review:
      i. SMRCP’s Pharmacy personnel shall conduct medication reviews to assess patient’s medication such as dosage, side effects, and interactions with food or other medications. For patients who require interventions, Pharmacy shall notify the primary health provider and oncologist to reduce medication-related fall risk factors.
      ii. Since the effect of medications is variable and patient specific, it is difficult to attribute a risk value to any specific medication or combination of medications. Medication is more likely to be implicated in a fall if they have been recently initiated or increased in dosage. In addition, taking more than 4-5 medications irrespective of type can increase one’s risk of falling. There are some medications that have higher association with falls. Appendix IV lists medications that contribute to falls in elderly patients through potential adverse effects. This list is not exhaustive; hence, other medications may contribute to falls and the listed adverse drug effects.

   c. Referral:

i. Referral to the North Simcoe Muskoka Integrated Regional Falls Program (IFRP): For patients age 55 and over and who are assessed and deemed a high risk for falls, the nurse shall refer the patients to North Simcoe Muskoka IFRP, with the patient's consent, by completing referral form and faxing the form to RVH IFRP nurse. This shall be a one-time referral only.

CROSS REFERENCES:

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Safer Health Care Now (2015). *Reducing Falls and Injuries from Falls Getting Started Kit.* Retrieved from http://rnao.ca/sites/rnao-ca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf

Appendix I: Universal Interventions Required for All Adult Inpatients to Prevent Falls

Patient/Safety:

- Orient patient to unit environment.
- Encourage non-skid footwear be used (discuss with family).
- Provide opportunity for regular physical activity as indicated for patient.
- Ensure all rails up when transporting patients.
- Do not leave at risk patients unattended in diagnostic or treatment area.

Communication:

- Ensure frequent contact with patients to offer assistance.
- Respond to call bells as soon as possible.

Environment:

- Provide adequate lighting during the day and night.
- Ensure all electrical cords/tubing tucked out of the way.
- Ensure bedside table, bed, chairs are locked and the bed is at the lowest height.
- Place patients in a suitable location on the unit (e.g. close to nursing station, avoid isolation when medically appropriate).
- Keep floors non slippery and clean up spills immediately.
- Ensure pathway to bathrooms and hallways are free of obstacles.

Equipment:

- Ensure call bell is within easy reach, the patient has been shown how to use it and it is in working condition.
- Ensure toileting facilities are within reasonable distance from the patient. Assist with frequent toileting, if warranted.
- Ensure walking aids, hearing aids, glasses, drinks, books, etc. are within easy reach.

Appendix II: Individualized Interventions for Adult Inpatients at Risk to Prevent Falls

Patient/Safety:

- Assess for orthostatic hypotension.
- Consult MRP regarding medical concerns that may be contributing to falls (e.g. orthostatic hypotension, dizziness, etc.).
- Medication review with MRP/Pharmacist.
- Check hearing and vision.
- Referral to other health care professionals as appropriate (e.g. Pharmacist, Occupational Therapist, Physiotherapist, Dietitian).
- Place near nursing station.
- Check patient at a minimum of every hour.
- Encourage patient to change position slowly, sit at edge of bed a few minutes before getting up and ask for assistance.
- Assess functional level.
- Instruct patient not to get out of bed without assistance.
- Encourage independence, assist patient with ADL's, as required.
- Ensure adequate nutrition and hydration.
- Frequently re-orientate the patient and reinforce use of call bell.
- Toilet routinely and appropriate clothing for easy toileting.
- Supervision while in bathroom.
- Adequate pain management
- Structured exercise program.
- Diversional activities (i.e. pets, music, TV, puzzles, crafts, cards, snacks, activity apron, etc.).

Communication:

- Communicate patient's "AT RISK" status during bedside shift report and with other disciplines
- Include patient/family/SDM in development of individualized safety plan, considering age and patient cognition when planning care – collaborate with family/SDM to maintain patient's independent functioning.
- Request family/caregiver assistance in supervising patient.
- Language interpretation aids as necessary
- Inform and educate patient/family regarding plan of care to prevent falls
- Provide patient/family with education brochure on falls

Equipment:

- Commode/urinal at bedside, raised toilet seat in bathroom
- Ensure appropriate use of assistive devices
- Utilize bed/chair alarm
- Hip protectors
- Floor mats
- Wedge cushion
- Mechanical lift
- Limited use of bed rails and restraints
- Patient watch (shall be last resort)

Appendix III: Universal Interventions Required for All Adult Outpatients to Prevent Falls

Environment:

- Utilize safety devices on procedure/exam tables, such as safety straps, when needed.
- All areas of the clinic are kept clear of clutter and trip hazards.
- Uneven/slippery floors are reported.
- Broken equipment is reported and removed from care areas.
- Use chairs with handrails, and assist patient to use safely.
- Use stools with stoppers instead of wheels.
- Ensure proper use of transfer aids such as the pivot stand aid or lifts when required.
- Direct high risk patients to washrooms equipped with grab bars and remain available to enter and assist if necessary (otherwise assist with bedpan/urinal).
- Place bed, chair, and stretcher or procedure/exam table at lowest or most appropriate height (ideally so that patient's feet can touch the floor).
- Use step stools with handles when needed and available, and assist to use safely.
- Effective lighting shall be used when required (e.g. nightlights, bathroom lights).
- Keep floors clean and dry.

Physical Status:

- Assess patient prior to ambulation for those that appear at high risk for falls (i.e. have difficulty going from sit to stand, use a mobility aid, have vision impairment, appear to have an unsteady gait).
- Encourage patient to bring and use personal mobility aids.
- Utilize wheelchairs where needed or upon client's request.
- Remain close and give support, as needed, to the patient while getting on/off the procedure/exam table.
- Where needed, accompany/assist patient to the room using appropriate method of transportation.
- All patients who require a weight shall be weighed with assistance and/or supervision.
- Minimize client need to travel to different care areas as much as possible.
- Ensure patient is accompanied by staff member, volunteer or family member/caregive on discharge/conclusion of visit using appropriate mode of transportation.
- Ensure patients are escorted home with appropriate accompaniment post sedation/anesthetic.
- Encourage use of properly fitting clothing and footwear (non-slip).

Cognition:

- All outpatient areas shall have adequate signage.
- Orientate patient to surroundings, where appropriate.

Communication:

- Make education brochure on falls available to all patients.
- Communicate falls risk status to team members.

Medications:

Review medication list, when appropriate, for drugs which may predispose patient for falls.

a. Previous fall in last six months (strongest predictor of risk of future falls)
b. Age greater than 65 years
c. Cognitive impairment (confusion, dementia, delirium)
d. Impaired mobility (gait and/or balance)
e. Generalized weakness
f. Greater than five medications or high risk medications (see Appendix IV)
g. Significant visual impairment/hearing impairment
h. Serious illness/multiple illnesses
i. Incontinence (bladder or bowel)

Appendix V: Medication Class, Impacts and Examples

Class of Medication	Impact of Medication	*Examples*
HIGH RISK		
Sedatives, Hypnotics, Anxiolytics	These medications tend to cause an altered or diminished level of consciousness impairing cognition and causing confusion	Benzodiazepines (Diazepam, Oxazepam, Lorazepam, Chloral Hydrate, Zopiclone)
Antidepressants	Increase risk of a fall by causing the individual to feel restlessness, drowsiness, sedation, blurred vision	Tricyclic antidepressants (amitriptyline, nortriptyline), SSRI (citalopram, fluoxetine, sertraline), SNRI (venlafaxine, mirtazipine)
Psychotropics/ Neuroleptics	Neuroleptics tend to cause individuals to experience agitation, cognitive impairment, dizziness, gait or balance abnormalities, sedation and visual disturbances (e.g., hallucinations)	Neuroleptics (haloperidol, risperidone, olanzapine, quetiapine, chlorpromazine, perphenazine)
MODERATE RISK		
Cardiac Medications	Medications that affect or alter blood pressure can increase the individual's risk to experience a fall Can be expressed as syncope	Vasodilators: hydralazine, minoxodil, nitroglycerin Diuretics: hydrochlorthiazide, lasix, spironolactone Calcium Channel Blockers: amlodipine, diltiazem, nifedipine, verapamil Beta Blockers: metoprolol, carvedilol, atenolol Alpha Blockers: terazosin Ace-Inhibitors: captopril, enalapril, fosinopril, ramipril Antiarrhythmics: amiodarone, digoxin

Appendix V: Medication Class, Impacts and Examples

Class of Medication	Impact of Medication	*Examples*
Alpha-blockers (for Benign prostatic hyperplasia)	Medication may cause vasodilation, lowering blood pressure and causing confusion.	Alpha Blockers (e.g., tamsulosin)
Anticholinergics	Cause altered balance, motor coordination impairment, impaired reflexes, impaired cognition, visual disturbances	Benztropine, oxybutynin, atropine, hyoscine
Anti-histamines/Anti-nauseants	Affect balance, impair coordination, can cause sedation, and have anticholinergic properties	Antihistamines: meclizine, hydroxyzine, diphenhydramine (benadryl), chlorpheniramine Anti-nauseants: dimenhydrinate (gravol), prochlorperazine, metoclopramide
Anticonvulsants	Tendency to decrease level of consciousness or cause disequilibrium (problems with balance)	gabapentin, valproic acid, phenytoin, carbamazepine
Muscle Relaxants	Affect balance, motor coordination, reflexes, may impair cognition by causing sedation	Baclofen, Cyclobenzaprine, Methocarbamol, orphenadrine, tizanadine
Parkinson treatments	Can lower blood pressure and cause confusion	Levodopa, pramipexole, ropinirole
RISK IN SOME CLIENTS		
Opioids, Narcotic Analgesics	Primarily cause change in level of consciousness leading to confusion, sedation and potential visual hallucinations	Codeine, morphine, hydromorphone, fentanyl, oxycodone
Non-steroidal anti-inflammatory agents (NSAIDs)	Can cause sedation, confusion	Naproxen, ibuprofen

Appendix V: Medication Class, Impacts and Examples

Class of Medication	Impact of Medication	*Examples*
Stimulants	Primarily cause change in level of consciousness leading to confusion, and potential visual hallucinations	Methylphenidate, Ephedra
Insulin and oral hypoglycemics	Duration of action can vary from individual to individual due to different sources of exogenous insulin or oral medication Too little or too much insulin can cause a hyperglycemic or hypoglycemic reaction which can result in confusion, possibly orthostatic hypotension, dizziness and change in mental status	
Over the Counter (OTC), Natural or Herbal Products and Alcohol	Over the counter products may contain anticholinergic agents or may have a sedating or stimulating effect	Cough and cold preparations Anti-allergy medication Decongestants Herbal products (e.g., valerian, kava, gotu kola, ginseng, St. John's Wort, ephedra) Alcoholic beverages
Ophthalmic medications	Medications can affect pupil dilation and night vision, sensitivity to light and glare, and blurring.	timolol/latanoprost/ pilocarpine eye drops, natural tears or lubricants

Safer Health Care Now (April, 2015). *Reducing Falls and Injuries from Falls Getting Started Kit.*

Appendix VI: Post-Fall Checklist

Post-Fall Checklist	NAME: _____ DOB: _____ (DD/MM/YYYY) HRN: _____

Date of fall: _____

Time of fall: _____

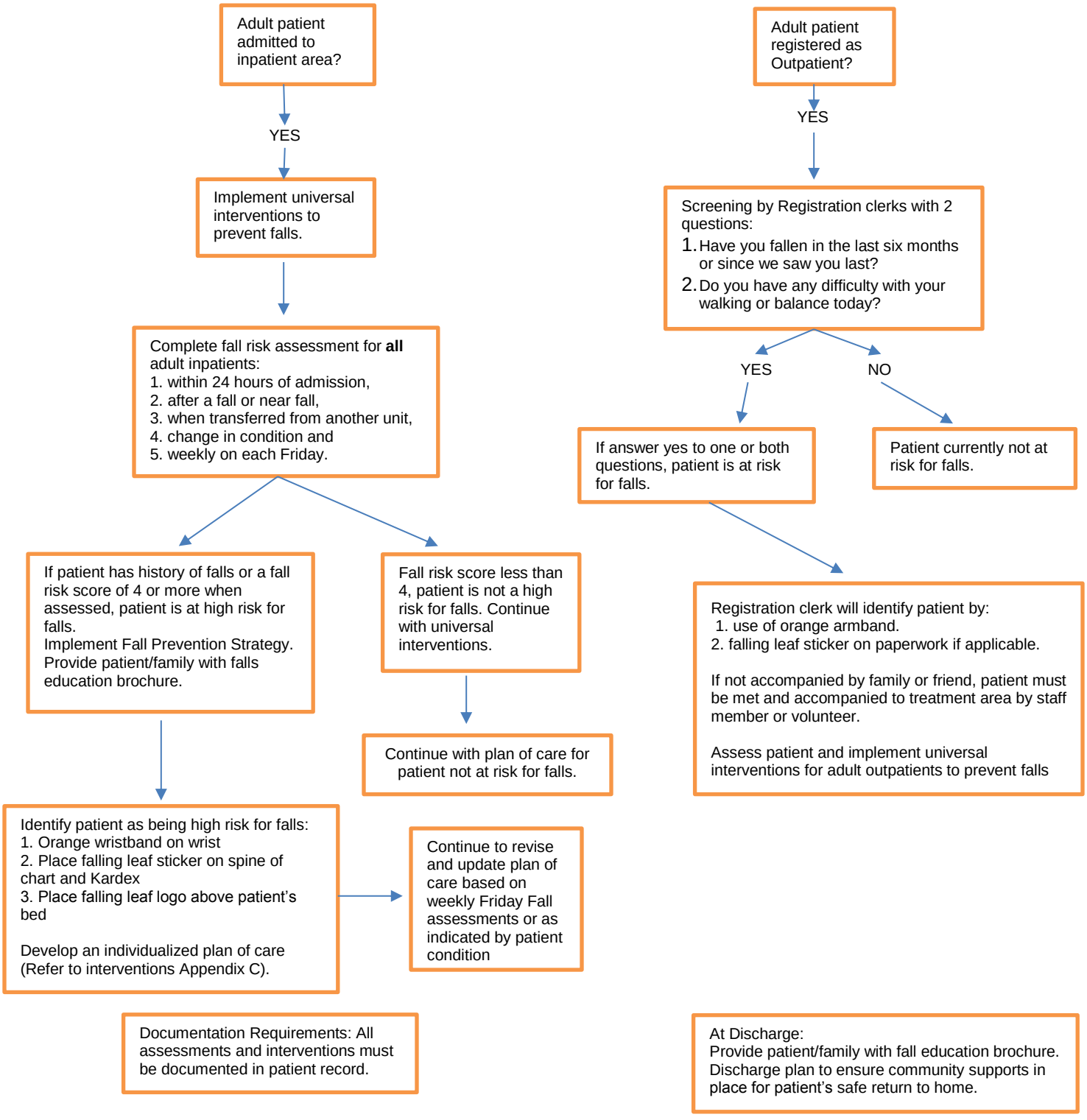
Was fall ☐ witnessed ☐ unwitnessed

Yes/No/NA	Action
	1. Keep patient comfortable – do not move initially.
	2. Call for assistance.
	3. Check Vital Signs
	4. Complete head to toe assessment.
	5. Did patient hit head or complain of head/neck pain?
	6. If yes to #5, include neurological assessment and Glasgow Coma Scale.
	7. Notify MRP and communicate all assessments.
	8. Identify if patient is on anticoagulant therapy. If yes, contact MRP immediately.
	9. New orders received?
	10. Continue to monitor as per MRP orders.
	11. Report incident using Safety Learning System.
	12. Outpatients: Notify MRP or Emergency Department if any injuries noted.
	13. Inpatients: Initiate Fall Protocol. If patient already on Fall Protocol, reassess and revise plan of care.
	14. Documentation of fall completed.
	15. Post fall huddle held on day of the fall.
	Other:

Print Name	Signature	Employee Number	Date
_____	_____	_____	_____

*Do Not Print

Appendix VII: Falls Risk Assessment and Prevention Algorithm



Appendix VIII: Post Fall Assessment and Management Algorithm