GRAND RIVER HOSPITAL
your health, your hospital

Let's prevent falls!

Ensure your safety with a few tips:

- Wear gripper sock or non-slip footwear
- Wear your glasses and hearing aids
- Use your walker or cane to move about safely – do not use the furniture, IV poles, tray table or a wheelchair to help you walk
- Tell your nurse if you:
  - Have recently fallen at home
  - Are afraid of falling
  - Need to go to the bathroom frequently

Call, don't fall…

- Do not attempt to get out of bed alone if you feel:
  - Weak
  - Dizzy
  - Unsteady on your feet

It is OK to ask for help!

GRH FALLS AUDIT TOOL

STATEGY IMPLEMENTATION

CRITERIA	AUDIT ACTIVITY	YES =1	NO =0	N/A Comments
Has patient been assessed for fall risk?	Has patient had a MORSE falls scale completed?			
Is this patient a high risk for falls?	As documented from MORSE fall scale.			
Pt is wearing a purple arm band.	Examine patient's wrist for presence of purple arm band			
Call bell is within reach.	Examine bed-space and determine if call-bell can be accessed safely and independently by patient.			
Bed is in lowest position.	Examine bed space. Bed should be at a level so the patient can sit and touch the floor with their feet, with legs at 90 degrees			
Bed rails are being used appropriately (Max: two up at head only) .	Determine if bed rails should be up or down for this patient and observe if they are positioned accordingly			
Bed area is free of clutter.	Examine bed-space. There should be adequate access for the patient with required gait aids.			
Patient has been reviewed by a physiotherapist.	Determine whether physiotherapy assessment is required for this patient and review integrated notes for evidence of this assessment (HED)			
Patient's table and belongings are within reach.	Observe bed-space to determine whether the patient can safely and independently access their table and belongings (May include phone, water, glasses, etc)			
Slip socks or appropriate footwear is available.	Determine if patient has slip socks on or available/and or proper footwear (non-slip, low heel, secure fit)			
Appropriate sensory aids are	Determine what sensory aids are required and observe if patient			

available.	has available and accessible.			
Orthostatic vitals have been completed (lying and standing)	Determine if the patient had had orthostatic vitals (lying and standing) BP with pulse documented in chart.			
Ensure toileting routine or continence aids have been provided.	Toileting routine is documented on care plan (e.g. take to toilet every 3 hours) or toileting devices have been provided (such as commode at bedside, raised toilet seat, urinal, etc)			
Mobility aid is within reach	Determine whether a mobility aid is required for this patient and is it within reach?			
Is there a high risk fall sign over the bed.	Is there a falls sign placed at the head of patient's bed?			
Is a bed alarm being used?	If appropriate for patient (pt is unpredictable to ring call bell for assistance) it is incorporated on care plan.			
Are hip protectors being used?	If appropriate for patient (thin, frail elderly with high fall risk) it is incorporated on care plan.			
Is patient on vitamin D?	If appropriate for patient (high fall risk, not on bisphosphanate and not a renal patient)			
Has medication review been done for high risk drugs (benzodiazepines) that contribute to falls?	Is patient currently on: Valium…Diazapine Ativan…..Lorazapam Serax ……Oxazapam			
ARE ALL APPROPRIATE FALLS PREVENTION STRATEGIES IN PLACE? ***If one or more questions regarding strategy implementation have been answered NO appropriate strategies are deemed not in place.**				

GRAND RIVER HOSPITAL
Advancing Exceptional Care

Fall Assessment and Prevention Care Plan

Addressograph

Number of falls in the past 6 months: ____ High risk interventions in place: ☐ No ☐ Yes		
	Risk factors Check (✓) only where applicable	**Possible interventions** Check (✓) only those initiated
Neurological/ Behavioural	☐ Impaired judgment; dementia; delirium; disoriented, confused, agitated ☐ Somnolence, lethargy ☐ Responsive behaviours (BPSD)	☐ Medication review (Physician or Pharmacist) ✓ Assess patient every hour and prn ☐ Move close to nursing station ☐ Move to private room ✓ Keep bed at lowest position and lock wheels ☐ Use bed alarm ☐ Use chair alarm ☐ Hip protectors ✓ Head rails only ☐ Place bed against wall if space permits ☐ Posey mat on floor next to bed ☐ Encourage family to stay with patient ☐ Discuss possibility of sitters with family ☐ Consult with Geriatrics ✓ Consult with OT ✓ Consult with PT ☐ Refer to HELP (Hospital Elder Life Program) ☐ Consult with Rec Therapy
Cardiovascular	☐ Dizziness, syncope, orthostatic hypotension	✓ Monitor for postural hypotension ☐ Teach patient/family to: use armrests/edge of bed for support when rising ☐ Medication review (Physician or Pharmacist)
Urinary and gastro-intestinal	☐ Urinary/fecal incontinence or urinary frequency	☐ Assess for underlying cause if new onset ☐ Place commode/urinal at bedside ✓ Assess patient every hour and prn ☐ Implement toileting schedule Review need for Foley catheter (see policy CLN-C-35) ✓ Light on in bathroom at night
Mobility	☐ Difficulty with gait, balance, transfers, or reduced muscle strength ☐ Use of assistive device (cane/walker/wheelchair)	☐ Assist with ambulation (assist x ____) ☐ Assist with transfer (assist x_____ or lift_____) ✓ Mobility/transfer status noted on whiteboard ☐ Hip protectors ✓ Consultation with PT ✓ Consultation with OT

	Risk factors Check (✓) only where applicable	**Possible interventions** Check (✓) only those initiated
Mobility cont'd		✓ Receiving rehabilitation therapy ☐ Put patient on walking list ✓ Review of assisted devices by therapy staff ✓ Place mobility aid within patient's reach ✓ Gripper socks or other non-slip footwear on at all times
Medications	☐ Narcotics, sedatives, anti-psychotics, anti-hypertensives, diuretics, anti-depressants, anti-emetics ☐ Polypharmacy (> 5medications)	☐ Medication review (Physician or Pharmacist) ☐ Explore non-pharmacological treatment of sleep problems (i.e. music therapy, relaxation, avoid sleeping during the day) ☐ Supervise ambulation until return to baseline ☐ Assess motor and sensory function until return to baseline
Perceptual difficulties	☐ Decreased vision ☐ Decreased hearing ☐ Language barrier	✓ Place glasses within patient's reach ✓ Verify that patient is wearing hearing aid; speak slowly, face patient ☐ Use pocket talker ☐ Use translator or family members as translator
Use of restraints	☐ Patients who are physically restrained	☐ Refer to Least Restraint Policy: CLN-R-20
Pain	☐ Presence of pain affecting mobility	☐ Ensure optimal pain relief
Fear of falling	☐ Patients has fear of falling	☐ Provide reassurance, encourage mobilization with assistance ☐ Work with family members to provide support to patient ☐ Implement structured exercise program, put patient on walking list ✓ Receiving rehabilitation therapy

Comments:

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Completed by: _____ Date: _____