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| **Huron Perth Healthcare Alliance** |
| **1. Clinical Policies and Procedures** | Original Issue Date:  | October 31, 1986 |
| **Falls Prevention Program** | Review/Effective Date:  | March 14, 2016 |
| **Approved By: VP Quality and Clinical Services** | Next Review Date:  | March 14, 2018 |

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| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
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| **Purpose:** The Huron Perth Healthcare Alliance is committed to providing quality patient care and a safe clinical environment. Falls are one of the most common adverse events in Canadian healthcare. They cause a significant burden to patients related to injury, debility, decreased quality of life and increased risk of mortality. They also contribute to an increased length of stay in hospital which negatively impacts patient access and flow. Falls are the cause of most hip fractures among seniors, and 20% die within a year of the fracture. All employees (clinical and non-clinical), physicians, volunteers and students are expected to exercise vigilance to identify patients and visitors who appear to be at risk of falling at any point of contact within the facility. The purpose of the HPHA Falls Prevention Program is to: * Plan patient care with consideration to an individual's need for dignity, independence and freedom
* Identify patients who are at risk for falls
* Reduce the potential for falls and/or injury
* Reduce the number of actual falls and injury
* Mitigate risk through early identification of falls risk and ensuring timely implementation of the appropriate interventions.
* Integrate patients and family members into the falls prevention strategy

**Definition:** A fall is any event which results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury. **Standard:** All inpatients (except newborns and non-ambulatory infants) and outpatients, including but not limited to the chemo unit, dialysis unit and day surgery, will have an assessment of their risk for falls: * On admission (includes admitted patients in ER)
* Following any change in status or orders that increases or improves the patient's complexity
* Upon any change in psychosocial assessment indicating cognitive decline
* Upon transfer from one patient care unit to another within the Alliance
* Following a fall (repeat the Morse Falls Risk Assessment if the previous score was low to moderate risk)

**Procedure (In-Patients):** 1. The [Morse Fall Risk Assessment](https://intranet.hpha.ca/myalliance/doc.aspx?id=4660) will be completed on all admitted patients (except newborns and non-ambulatory infants) as part of the Nursing Admission Assessment in the Safety section. 2. The Confusion Assessment Method ([CAM](https://intranet.hpha.ca/myalliance/doc.aspx?id=4661) ) will be completed as well on all admitted adult patients as part of the Nursing Admission Assessment. Patients who have a CAM score indicating delirium will have high-risk falls management strategies implemented.3. Patients found to be at low risk (Morse Score 0-24) or moderate risk (Morse Score 25-44) will be managed through the Universal Falls Management Strategies. 4. Patients who are found to be at high risk (Morse Score = or greater than 45) will have High Risk Falls Management Strategies implemented. This intervention screen will be reviewed and updated each shift. 5. Patients with an ALC (LTC), Rehab or CCC designation will have the Morse Fall Risk Assessment repeated every 7 days during their hospital stay and the high risk interventions will be updated as necessary. 6. Patients found to be a High Risk for falls will be automatically noted on the nurses' assignment sheet generated through Meditech. 7. The patient and family are to be educated on the importance of following their individualized falls prevention strategies, including: * Wearing a yellow Fall Risk bracelet during their hospital stay.
* Posting of the [HPHA Falls Risk sign](https://intranet.hpha.ca/myalliance/doc.aspx?id=4662) at their bedside and on any mobility aids such as walkers and wheelchairs.
* Consideration of referral to Physiotherapy and/or Occupational Therapy for further screening.

8. With movement within the hospital (e.g. OR, DI), sending staff will notify receiving staff that the patient has been assessed to be at high risk for falls. 9. Any change in Fall Risk status must be communicated at the change of shift nursing report as part of Transfer of Accountability (TOA). 10. In the event of a fall while an inpatient, the Nurse will: * Complete an immediate head-to-toe assessment, vital signs check and implement ongoing monitoring as needed (Glasgow Coma Scale as indicated)
* Notify the Most Responsible Physician (MRP)
* Notify the Team Leader for the unit on which the fall occurred
* Notify the family/Substitute Decision Maker (SDM)
* Repeat the Morse Fall Scale
* Repeat CAM if an acute change in mental status and/or behaviour is noted
* Update the PI screen
* Document the fall in Meditech Patient Care notes
* Document the occurrence in the Occurrence Management Program (RL 6); refer to the [Safety Incident Reporting Policy](https://intranet.hpha.ca/myalliance/Default.aspx?cid=9142&lang=1)
* The team will review the care/treatment plan, document necessary modifications and assess the environment to eliminate/reduce further falls-related risk factors. If fall is related to equipment failure, the equipment will be tagged, taken out of use and a work order will be completed

The Team Leader on the unit will conduct an extensive review of the falls incident, including a review of all documentation to determine if all appropriate interventions were in place. Upon identification of any non-compliance with the HPHA Falls Prevention Protocol, they will follow-up with appropriate staff at the earliest opportunity, to reinforce the importance of adhering to the protocol. 11. [The Falls Prevention Brochure](https://intranet.hpha.ca/myalliance/doc.aspx?id=5415) will be provided to patients identified to be at moderate or high risk for falling at the time of admission to any inpatient unit. The brochure will also be supplied to all outpatient clinics, including but not limited to the Ortho Clinic, Surgical Pre-Admit Clinics, the Dialysis Unit, the Chemotherapy Unit, Mental Health Clinics and the ER for their use according to patient needs. During the patient's stay at the hospital, if the risk status changes from low-risk to moderate or high-risk, the brochure will be provided to the patient/family. **Procedure (Outpatients):** 1. For outpatients, Universal Falls Management Strategies will be applied as appropriate to the setting. The Outpatient Fall Risk Screen is a visual check of the patient when moving (transferring/walking) by the most responsible health care professional. If the healthcare professional detects a falls risk concern, the following 4 questions are to be asked: 1. Have you had a fall in the past 3 months? 2. Do you need help to move around safely? 3. Do you feel dizzy or lightheaded? 4. Do you have any foot conditions that affect your balance and/or ability to walk?Outpatients who answer positively to any of the above questions are found to be at high risk and will have individualized High Risk Falls Management Strategies to reduce patient risk during visit/procedure (example: inform patient/family of concern with fall risk - provide Falls Prevention Brochure; Yellow Fall Risk bracelet if being seen by more than one practitioner/department, offer wheelchair for transportation). A referral to the Community Care Access Centre (CCAC) may be recommended.Universal Falls Management Strategies * Assign bed that enables exiting toward stronger side.
* Approach patients with weakness from unaffected side. (Consider other strategies for management of patients who have suffered a stroke and have neglect)
* Transfer patients with weakness towards stronger side.
* Assess balance and coordination before assisting with transfer and mobility activities.
* Consider referral to other services: Internal Medicine, Psychiatry, Social Work, Physiotherapy, Occupational Therapy, pharmacy, dietitian and CCAC.
* Assess bowel and bladder self-management and elimination patterns. Establish a toileting routine when there are issues with frequency, urgency and/or incontinence, and for patients on diuretics.
* Instruct patient on use of grab bars in bathroom.
* Ensure availability of glasses, hearing aids and other communication devices in close proximity to patient.
* Assess potential for or existence of orthostatic hypotension/syncope and implement the appropriate compensatory strategies.
* Assess for medications and/or secondary diagnoses that may impair balance, mobility and/or cognition, and implement the appropriate compensatory strategies.
* Provide patient with the pamphlet “[Medications and the Risk of Falling"](https://intranet.hpha.ca/myalliance/doc.aspx?id=4663)”.
* Consider consulting Pharmacist if patient on multiple [high-risk medications](https://intranet.hpha.ca/myalliance/doc.aspx?id=4664).
* Discuss medication times/dosages, side effects etc.
* Assess mental status (confusion, delirium, disorientation, dementia).
* Assess for nutrition risk and request assessment from a Registered Dietitian for nutrition intervention if patient is at [high nutrition risk](https://intranet.hpha.ca/myalliance/doc.aspx?id=4665).
* Assess for appropriate footwear, and provide non-slip socks if indicated.
* Clear environment of all tripping hazards.
* Wipe-up any spills immediately.
* Educate and engage patient and family in aspects of falls prevention strategies while in hospital.
* Instruct all patients in the use of assistive devices (crutches, walker, reacher, etc) prior to providing the equipment.
* Ensure mobility aids are readily available to the patient.
* Lock movable equipment before transferring patient and when not in use.
* Continue ambulation care plans (as per Physiotherapy) at all times, including weekends and statutory holidays.
* Observe the patient and their environment through routine safety checks, including hourly rounding. Consider referral to CCAC if home-based needs are evident

**High Risk Falls Management Strategies** In addition to the Universal Falls Management Strategies: * Use bed and/or chair alarms
* Use low bed and leave in the lowest position when appropriate (e.g. patients of shorter stature, patients identified as being at risk for safe transfers, patients with memory loss who forget to ring the call bell for assistance).
* Ensure alarms at exits are activated where available as necessary.
* Place yellow Fall Risk bracelet on patient.
* Post Falls Risk sign at bedside and on wheelchairs and walkers.
* Add “High Risk for Falls” to PI screen.
* Update PI screen for all implemented falls prevention interventions.
* Assess for use of side rails or other potential restraint devices (as per HPHA Least Restraints Policy).
* Evaluate and treat for pain
* Consider use of low pressure call bells
* Engage the patient and their family and volunteers to increase time spent with patient

**Quality Assurance:**1. Completion of annual e-learning module plus quiz by all staff. 2. Inclusion of Falls Prevention Program in orientation of all new staff. 3. Leaders will ensure staff complete e-learning module. 4. Monthly audits by Unit Team Leader to ensure compliance with falls prevention policy interventions**References:** 1) “Reducing Falls and Injuries from Falls – Getting Started Kit”, Safer Healthcare Now: www.saferhealthcarenow.ca (accessed May 14, 2014) 2) Morse JM. Preventing Patient Falls: Establishing a Falls Prevention Program (2nd Edition), Springer Publishing Company, New York, New York, 2009 Copyright © 2016 Huron Perth Healthcare Alliance - HPHA -Terms Privacy Policy  |