QUINTE HEALTHCARE CORPORATION

Patient – Fall Prevention and Post-Fall Management

Title: Patient – Fall Prevention and Post-Fall Management		**Policy No:**	3.18.8
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Approved By:	Nursing Practice Committee Interprofessional Practice Committee		

1. POLICY STATEMENT

This policy and procedure outlines the expectation that all admitted patients at Quinte Healthcare Corporation (QHC) will be assessed for potential risk of falling. The risk of falls is elevated in the hospital setting as the hospital environment is different than the home environment. The inherent risk for falls is increased in the hospital setting due to the new environment, physiologic factors such as illness, medication use, toileting needs and equipment. Strategies to reduce patients' risk of falling are considered for all patients, and dependent on the risk assessment scoring, additional interventions and care planning are revised to meet the patients' needs.

The purpose of this policy and procedure is to enhance patient safety and minimize risk through the prevention of falls and through appropriate interventions should a patient fall occur. Patients who do experience a fall at QHC will be assessed and provided with care and interventions following evidence based practice. Standard Fall precautions are the minimum standard of care for falls prevention. These practices are outlined in the following procedure.

The Falls Prevention and Management Program have the following goals:

1. To reduce the incidence and severity of falls
2. To identify patients for potential risk of falling
3. To raise awareness that falls are predictable and many injuries are preventable
4. To educate all staff in falls prevention and management
5. To promote and support best practice falls prevention strategies
6. To develop standardized tools, forms and reports for falls management
7. To educate patients and families in fall prevention strategies
8. To evaluate trends and causes of falls as part of a continuous improvement process

2. DEFINITIONS

Fall

A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury (Registered Nurses Association of Ontario, 2011).

This would include:

- Unwitnessed falls where the patient is unable to explain the events and there is evidence to support that a fall has occurred; and
- Near falls, where the patient is eased to the ground or floor or other lower level by staff or family members (Nova Scotia Health, 2006. Falls Assessment Framework)

Fall Injury

A fall injury is defined as an injury that results from a fall, which may or may not require treatment. The injury can be temporary or permanent and vary in the severity of harm.

Patient falls can be classified 4 ways:

1. *Anticipated Physiological Falls* – falls that are related to the patient's diagnosis, characteristics or medications that may predict their likelihood of falling. These are the falls that can be identified with the use of the falls assessment tool.

2. *Unanticipated Physiological Falls* – No obvious risk factors identified on assessment; fall may be related to conditions that were not anticipated, such as syncope or medication reaction.

3. *Accidental Falls* – These falls are often due to environmental factors. This type of fall is prevented through environmental strategies that should be in place for all patients and staff.

4. *Developmental Falls* – Falls that are due to the child's growth and development; usually occur as children are learning to walk, run and pivot.

3. FALLS RISK ASSESSMENT TOOLS

The following fall risk assessment tools are approved for use at QHC

1. Morse Fall Risk Assessment Tool
2. Paediatric Screening Fall Risk Assessment Tool
3. Obstetrical Fall Risk Assessment Tool

4. PROCEDURE

A. Falls Risk Assessment

1. The Morse Fall Risk Assessment (or other population appropriate tool) will be completed on all admitted patients (except newborns) as part of the Nursing Admission.

2. All patients will be assessed for fall risk on admission, on transfer from one patient care unit to another, after a fall or near miss (almost a fall), and when there has been a change in patient condition (Appendix A - MORSE Fall Risk Assessment Tool).

3. All paediatric patients will be assessed for fall risk on admission, after a fall or near fall, and with any change in patient condition or medications (Appendix B - Paediatric Falls Assessment Screening Tool).

4. All obstetrical patients will be assessed for fall risk on admission to the unit, transfer from L & D post-delivery, prior to first ambulation, daily, PRN and after a fall (Appendix C - Obstetrical Falls Risk Assessment Tool).

5. A score will be calculated indicating category of risk for the patient. The score and category of risk will be populated on the Admin Data Screen as a result of completing the fall risk assessment tool.

6. Categories of risk are standard risk (score 0-24), moderate risk (score 25-50) and high risk (score is 51 or greater) OR low risk (score <5) or high risk (score ≥ 5) for paediatric and obstetrical patients.

7. Standard fall precautions will be implemented for ALL patients. Standard fall precautions include call bell within reach at all times, bed in lowest position, orientation to surroundings, clutter-free room, recommend proper footwear, ensuring personal items and telephone are within patient's reach and ensuring brakes/locks are in place on movable furniture/aids (Appendix D - Falls Prevention and Management Standard Falls Precautions).

8. Review, implement and document most appropriate interventions that apply for the category of risk identified for the patient. Incorporate and document individualized falls prevention strategies and interventions in the patient's plan of care.

9. Place Fall Prevention sign above patient's bed and entrance point to patient room for patients identified at moderate or high fall risk (Appendix F - Fall Prevention Poster and Appendix G - Paediatric Fall Prevention Poster).

10. Apply a yellow (pre-printed) Fall Risk bracelet to the wrist of patients identified in the category of moderate or high fall risk.

11. For patients identified at moderate and high risk a bed exit alarm or chair alarm or non-skid socks when used can be an effective method in the prevention or reduction of falls (where available).

12. Provide the patient/family with the QHC Falls Prevention Patient/Family Handout (Appendix K - order #040321). Paediatric patients should receive the Paediatric Patient/Family Education Falls Prevention Handout (Appendix J). Discuss fall assessment and review interventions with the patient/family.

13. Use appropriate transfer techniques to move a patient and minimize risk of staff injury.

14. Communicate patient's risk status during shift report and document in all fall screens.

15. Fall prevention interventions must be reassessed and documented every shift using the Falls Prevention intervention screen.

16. When a patient is moved within the hospital for diagnostics or procedures (example: OR, DI) the sending staff will notify the receiving staff that the patient has been assessed to be at risk for falling.

B. Post Fall Assessment and Protocol *(Appendix E - Post Fall Interventions)*

1. After a fall has occurred, the nurse will ensure that the patient is in a safe place and any items of immediate danger have been removed from the environment.

2. The nurse will complete an initial assessment of the patient and assist the patient to his/her bed or a safe environment, as appropriate.

3. The nurse will document his/her findings and assessment using the Post Fall Assessment screen on the patient chart. The nurse will notify the most responsible physician (MRP) or his/her delegate immediately if the patient condition warrants. If there is no change in the patient's condition the nurse will notify the most responsible physician or his/her delegate in a timely manner (ideally within 12 hours of the patient fall). Note: Special Considerations include the following (but are not limited to):

- If the patient was on a cardiac monitor review alarms prior to and during the event and continue cardiac monitoring at the previous level until otherwise ordered by the MRP or his/her delegate
- **If the patient has been taking IV, Subcutaneous or Oral anticoagulants within 48 hours prior to the fall, the MRP or his/her delegate must be called immediately and asked if specific investigations may be indicated such as: INR/PTT, CBC within 8 hours of, and 16 hours post event, CT of head, temporary discontinuation or reduction of anticoagulant dosage**
- **The MRP will be notified immediately when the patient is a neonate or paediatric**

4. Professional responsibilities require appropriate notification to the MRP or delegate of any significant changes in the patient's condition. At the time of notification, the most appropriate registered staff will gather all relevant information from the care team members and utilize the SBAR (Situation/Background/Assessment/ Recommendations) tool to provide the MRP/delegate with concise, adequate detail inclusive of actions already taken to assist the physician in making the best decision for the care of the patient. Documentation of these notifications needs to be clear and objective.

5. If the patient has struck their head OR the fall was unwitnessed, vital signs and a neurological assessment (including Glasgow Coma Scale and pupils) will be completed and documented at the time of the fall within the Post Fall Assessment screen, and as follows:

- Every fifteen minutes for the first hour post fall
- Every thirty minutes for the next two hours
- Every four hours for the remainder of the 24 hour period

6. If the patient fall was witnessed, and there is no head injury, and the patient is not at increased risk of bleeding, vital signs and a neurological assessment will be completed and documented at the time of the fall within the Post Fall Assessment screen, and as follows:

- Every hour for four hours, then
- Every four hours x 2, then
- As previously ordered

7. Neurological assessment findings that vary from pre-fall assessment should be reported promptly to the MRP or his/her delegate.

- Potential signs of increasing intracranial pressure after a head injury include:
  - Decreased respirations
  - Slowing bounding pulse
  - Widening pulse pressure
  - Increased restlessness/excitability following a period of calm
  - Decreasing level of consciousness
  - Unrelenting headache which increase in intensity
  - Vomiting – especially projectile
  - Abnormal pupil size and /or changes in pupil reaction
  - Leakage of clear fluid from nose or ear (cerebrospinal fluid)

8. Assess for any musculoskeletal and/or integumentary changes.

9. If patient is diabetic, consider hypoglycemia.

10. Notify the team leader/unit manager or designate immediately of a fall.

11. The nurse will continue to monitor patient for changes in baseline assessment and behaviour accordingly or as ordered by the MRP or his/her delegate.

12. Conduct a Post-fall huddle.

13. Complete a new Fall Risk Assessment.

14. Ensure the patient's family is informed and discuss any contributing factors leading to the fall. The nurse and/or physician will inform patient's family or substitute decision maker of significant clinical injury which requires further investigations or treatment as a result of the fall.

15. **For all neonatal or paediatric patient falls the child's parent(s), guardian or substitute decision maker must be notified immediately (within 30 minutes).**

16. The nurse will document all actions, assessments and communication as per QHC documentation policy (use foci note "FALLS" for all documentation regarding the event) including details of the fall and outcome.

17. Complete an event report using the QHC Cares event reporting system.

C. Post Fall Huddle

A post fall huddle is a conversation that occurs as soon as possible following a fall or near miss fall.

Purpose: to identify conditions that led to the fall or near miss fall. It allows for feedback and brainstorming from all staff, patient and family to decrease the potential of a recurrent fall.

1. All available staff attend Post Fall Huddle (can include manager, clinical staff, allied health, pharmacy, HSR, PSW, physician, team leader, in-charge, patient and family).

2. A Post Fall Huddle should take place as soon as possible after fall at bedside or site of fall.

3. A Post Fall huddle will include immediate assessment of conditions that led to fall and any new interventions necessary to prevent recurrence of fall.

4. The Post Fall Huddle should include completion of QHC Cares Event report and a new Falls Risk assessment.

5. If family is not available at the time of the fall, ensure they are informed about factors leading to fall.

APPENDICES AND REFERENCES

Appendices

Appendix A - Morse Fall Risk Assessment Tool
Appendix B - Paediatric Falls Risk Assessment Screening Tool
Appendix C - Obstetrical Falls Risk Assessment Screening Tool
Appendix D - Falls Prevention and Management Standards Falls Precaution
Appendix E - Post Fall Interventions
Appendix F - Falls Prevention Poster
Appendix G - Paediatric Falls Prevention Poster
Appendix H- Paediatric Falls Intervention Protocol
Appendix I - Morse Falls Risk Assessment Tool Downtime Form
Appendix J - Paediatric Patient Family Falls Prevention Education Information Sheet
Appendix K - Falls Patient and Family Handout

References:

Dunning, K., LeMasters, G., & Bhattacharya, A. (2010). A major public health issue: The high incidence of falls during pregnancy. *Maternal and Child Health Journal,* 14 (5), p. 720-725.

Fran, B., Lane, C., & Hokanson, H. (2009). Designing a post-epidural fall risk assessment score for the obstetric patient. *Journal of Nursing Care Quality,* 24 (1), p. 50-54.

Lockwood, S. & Anderson, K. (2013). Postpartum safety: A patient-centered approach to fall prevention. *Maternal Child Nursing,* 38 (1), p.15-18. Doi:10.1097/NMC.0bO13e31826bae4b

Morse, J. (1997). *Preventing patient falls.* Thousand Islands, CA: Sage Publishing.

North York General Hospital. (2012). *Corporate Falls Prevention Program* (Policy).

Nova Scotia Health (2006). Falls Assessment Framework. Nova Scotia Health Promotion and Protection.

Registered Nurses Association of Ontario (2011). *Prevention of Falls and Fall Injuries in the Older Adult*. (Revised) Toronto, Canada: Registered Nurses Association of Ontario.

Registered Nurses Association of Ontario (2007). *Falls Prevention: Building the Foundations for Patient Safety*. Toronto, Canada: Author.

Southlake Regional Health Centre. (2009). Policy, Clinical Manual. *Falls – Patient with – Follow-up Assessment*. Toronto, Canada: Author.

United States, Department of Veterans Affairs (2007). *The Falls Toolkit Notebook: Falls Policy.* Retrieved on April 15, 2012 from

http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html#resource

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