TITLE:	**Fall Risk Reduction and Post Fall Assessment**		
Manual/Policy #:	Patient Resident Services II-F-1	**Division:**	AGH/ FVM
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1. POLICY STATEMENT:

Fall prevention and fall risk assessment is **everyone's** responsibility. Each patient/resident must be assessed on admission, on a regular schedule, with any change in condition or after a fall for potential risk of falling in order to take a preventative approach. Staff should use the tool specific to their area. Discussions regarding the acceptable level of risk must be based on individual assessment with input from the patient, family and the interdisciplinary team.

The Health Care Provider responding to a fall is expected to attend to the immediate needs of the patient/resident, put universal fall risk interventions in place to prevent/reduce recurrence of the fall and document all facts related to the event on the patient or resident's health record. Notify the attending physician, the patient/resident's emergency contact and the Admin on Call after immediate patient care is complete. In addition, the Health Care Provider is expected to complete an incident report using the PRIMS web-based incident management system. Individualized interventions may also be required.

2. SCOPE:

This policy applies to all Health Care Providers in the prevention and management of falls at Almonte General Hospital (AGH) and Fairview Manor (FVM). The inter-professional team will promote safety for all admitted and day stay patients/residents through on-going risk assessment and implementation of universal fall risk interventions.

3. GUIDING PRINCIPLES:

3.1 Our patients/residents will have an increased quality of life and maintain their mobility with a falls prevention approach to care. Fall risk assessment is important as it provides direction for the multiple interventions which have been shown to reduce a person's risk of falling. Commonly identified fall risk factors for elderly patients in health care settings include confusion, medication use, hearing deficits, cognitive impairment, previous stroke, previous falls, delirium, and acute diseases. Risk screening is an effective method for identifying fall-prone individuals.

3.2 A competent adult has the right to take risks. Some falls cannot be prevented and in these cases the goal is to minimize fall injury and reduce the number of falls.

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3.3 The AGH/FVM administration support the use of Universal falls risk interventions (Appendix A) guided by the acronym S.A.F.E. (**S**afe environment; **A**ssist with mobility; **F**all-risk reduction; **E**ngage client and family) (Safer Healthcare Now!,June 2013 – measures revised April 2015).

3.4 The Quality and Improvement Risk Management (QIRM) Committee shall regularly review core measures including the fall rate, the percentage of falls causing injury, the percentage of patients/residents with a fall assessment following a fall or change in condition and restraint use.

4. DEFINITIONS:

4.1 Fall: "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level." (World Health Organization [WHO], 2016). An "unintentional change in position" where the person may come to rest at a lower level is also considered a fall (Health Quality Ontario Long-Term Care Falls, 2015)

Unwitnessed Fall: An unwitnessed fall occurs in the absence of a reliable witness that can describe the circumstances of the fall.

Witnessed Fall: occurs where there is a reliable witness to describe the circumstances of the fall including whether or not the patient struck his/her head as a result of the fall.

Assisted Fall: occurs in the presence of a person who assists the faller to rest on a lower level.

Near Fall: Occurs when the patient starts to fall due to a slip or loss of balance but is able to recover, are caught or were eased to a lower level.

4.2 Inter-professional Team: may include the nurse, physician, physiotherapist, occupational therapist, pharmacist and others as designated.

5. PROCEDURE:

5.1 The Morse Fall Risk Scale (as found in the Adult Admission Assessment) shall be done in the Electronic Medical Record (EMR) as a mandatory part of the assessment of all admitted AGH non-obstetrical patients. Other members of the interdisciplinary team may be required to complete assessments and assist with appropriate universal fall risk interventions. On CCC and Med/Surg staff receives visual cues regarding moderate to high fall risk patients/residents on the digital whiteboard.

Obstetrical patients shall be assessed postnatal using the "Obstetrical Falls Risk Assessment" (as found in Cerner powerforms) in the EMR.

Fairview Manor shall perform the falls risk assessment in Mede-care within 24 hours of admission, quarterly and with any change in clinical status. Other interdisciplinary risk assessment tools may be used in conjunction with the risk assessment. A person in FVM with a high Falls Risk is identified on the High Risk Flag Sheet and the falls risk assessment is updated weekly.

The Patient handbook is to be provided to admitted patients and/or their family to review the fall prevention information for patients at high risk for a fall. Review safe mobilization and appropriate transfer techniques with the patient and family. Provide individualized education to family and caregivers as needed. Repeat policies that may impact fall risk such as least restraint or no restraint practices.

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5.2 Falls Risk Prevention

- It is important to communicate the results of the fall risk assessment to the client, family and interdisciplinary health care team.
- Universal fall risk interventions will be implemented and individualized to the patient/resident's specific risk factors.
- The interdisciplinary team will participate in rounds to discuss interventions. Rounds will include post fall assessments to discuss contributing factors.
- Nursing should review the fall risk assessment and implemented fall risk interventions at the beginning of every shift.
- Ensure that interventions are documented in the nursing careset and/or in the progress notes.
- Provide the patient and family with education on the universal fall risk interventions.
- All Outpatient and Inpatients in AGH with a high fall risk will be identified by a green arm band. Patients in AGH will be asked 2 screening questions by the registration clerk/triage nurse/OBS nurse to identify risk:
    1) Have you fallen in the past 12 months?
    2) Are you presenting with an injury as the result of a fall?

  If the patient answers yes to either question, they are considered a fall risk.
  Any in-patient with a Morse Fall Risk Assessment that puts them at a moderate or high risk of falls will have a green armband applied. Obstetrical patients who score high for the risk of falls will have a green arm band applied. Nursing and Allied Health can use clinical judgement to apply the green arm band to any individual they feel is at risk of a fall. If an Inpatient or Outpatient becomes agitated and refuses to wear the green arm band, a green dot will be placed on the chart to indicate falls risk.

- Outpatients attending AGH Physiotherapy & Rehabilitation Centre and AGH Day Hospital Program will be screened for fall prevention as appropriate. Those identified as a fall risk will not be required to wear an arm band or have a dot placed on their chart due to the nature of their relationship with staff and the close supervision provided while they are in the rehabilitation department.
- All residents of FVM are considered a falls risk and will not be required to wear an arm band.
- Nursing is to ensure that an accurate Best Possible medication History (BPMH) is completed on admission. The BPMH should be reviewed for medications which increase fall risk including: antidepressants, antipsychotics, sedative hypnotics, opioids. Patients taking more than 5 medications also have increased fall risk. A pharmacist referral for medication review is recommended.

5.3 There are key messages to provide to health care providers:

<u>In patient/Residents</u>

- Always screen for fall risk on admission
- Continued assessment is required if there is a change in condition, if the patient/resident experiences a fall or on transfer to another unit

<u>Ambulatory Care</u>

- Ensure that self-screening of fall risk and fall risk reduction strategies are available for patients in ambulatory care

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- Members of the outpatient team will identify and correct fall hazards in their environment.
- Implement universal fall risk interventions as appropriate.

5.4 Staff Education

Staff will be oriented to the Falls Risk Assessment, universal fall risk interventions and post fall assessment during orientation to the unit.

The Falls Risk Assessment and Post Fall Intervention Policy should be reviewed by all members of the interdisciplinary team annually.

Staff is encouraged to complete the RNAO Falls Prevention Building the Foundations for Patient Safety Self-Learning Package available at https://rnao.ca/sites/rnao-ca/files/Falls_Prevention_-_Building_the_Foundations_for_Patient_Safety._A_Self_Learning_Package.pdf

5.5 In the Event of a Fall

Call for assistance and stay with the patient until a preliminary assessment for injury can be completed. If there is a suspicion of spinal injury or long bone deformity the patient/resident should not be moved.

If the patient gets up on their own initiative assist them to a bed or chair and complete a full assessment.

- The assessment should include a history of the event including whether the event was witnessed or unwitnessed, possible head injury or seizure activity, an examination for visible injuries such as bleeding, deformities or a decreased range of motion.
- The patient should have a full set of Vital signs including blood pressure, heart rate, respiratory rate, oxygen saturation, temperature and blood sugar level. The patient/resident should be monitored for signs of shock. Assess for pain and initiate first aid including covering wounds.
- In AGH use the Cerner “Post Fall Monitoring” powerform and follow the post fall assessments.
- In FVM chart the fall on the Fall Tracking Tool and monitor using the Head Injury Assessment Tool if the fall was unwitnessed or there has been a head injury.

Frequency of Post Fall Assessment

If fall unwitnessed or if head injury suspected, assess neurological status with BP, HR, RR, oxygen saturation, pupil size and GCS with frequency as follows:

	Frequency	**Duration**
Every 15 minutes	X 4 then	1 hour
Every 30 minutes	X 4 then	2 hours
Every 60 minutes	X 4 then	4 hours
Every 4 hours	X 24	24 hours
Reassess frequency after this time		

If fall was witnessed or without head injury assess BP, HR, RR, oxygen saturation:

	Frequency	**Duration**
Every hour	X 4	4 hours
Every 2 hours	X 6	12 hours
Every 4 hours	X 8 (or as directed by physician	

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Notify the physician immediately if there is any change in observations including a drop of >2 points on the Glasgow Coma Scale. Continued monitoring is essential post fall as injury may not become apparent until 24-48 hours later.

Communication

Contact the most responsible physician or the physician on call.
Notify the manager or Admin on Call
Ensure that the closest family member or emergency contact is contacted and made aware of the fall.
The date and time of the fall, any assessment findings, contributing factors, interventions and outcomes shall be documented in the respective Progress notes.
Update the Fall Risk assessment and Universal fall risk interventions as needed.
Provide individualized patient teaching with the patient and family regarding the fall risk interventions.
Complete the Patient Incident Report in PRIMS.

Fall Incident reports will be reviewed by the manager. The manager will work with the patient, family and staff to identify action plans that will reduce the risk.

6. REFERENCES:

Carleton Place and District Memorial Hospital, Nursing Department (May 2016). *Fall Prevention Nursing Policy NS-f-104*

Health Quality Ontario (November 2015). *Health Quality Ontario Long-Term Care Falls*

Queensway Carleton Hospital, Safe Mobility Committee (05/2015). *Post Fall Assessment and Intervention Nursing Policy Number II-f-101*

Queensway Carleton Hospital, Skin Care Committee (Oct, 2015). *Falls Risk Assessment, Prevention & Intervention Nursing Policy Number II-f-100*

Registered Nurses Association of Ontario (Sept, 2017) *Nursing Best Practice Guideline: Preventing Falls and Reducing Injury from Falls* (4th Ed). Retrieved from: https://rnao.ca/sites/rnao-ca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf

Safer Healthcare Now! (June 2013, Measures revised April 2015). *Reducing Falls and Injuries from Falls: Getting Started Kit.* Retrieved from: http://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Reducing%20Falls%20and%20Injury%20from%20Falls/Falls%20Getting%20Started%20Kit.pdf

7. APPENDICES (If applicable):

Appendix A - Universal Falls Risk Interventions

Evaluation

This policy will be reviewed every 3 years.

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Appendix A

Universal Falls Risk Interventions are implemented for **<u>All In-Patients/Residents</u>**	
For patients/residents identified at risk for falls, additional individualized interventions will be implemented after assessment.	
Environmental	• Make sure the person is familiar with the envionment • Provide instruction on using the call bell • Ensure personal effects are within reach • Perform hourly checks and every 2 hour repositioning with documentation • Use appropriate lighting in the patient/resident room and bathroom • Keep the bed height as low as possible • Lock brakes on equipment such as beds, walkers and commodes at all times, even when not in use. • Try to keep patient/resident areas free from clutter including loose carpets or mats • Use color on edges or height variations on the floor to assist with depth perception • Reduce or control sharp edges on bedside furniture • Maintain non-slip services in patient/resident showers • Wipe up spills as soon as possible • Reduce disruptive noises as much as possible
Mobility	• Establish the baseline level of mobility/ambulation • Mobilize when possible following a mobility plan • Ensure that mobility aids have appropriate tips • If no cognitive impairment, ensure that mobility aids are within reach and in good working order. • Encourage patients/residents to wait several seconds after moving from a lying to a sitting position and dangle before sitting or walking • Provide a resting place for patients to sit when they are performing self-care • Provide 1 or 2 side rails up for positioning as requested by the patient/resident • Is the bed check system on for high risk patient's when appropriate • The patient/resident should be wearing comfortable,supportive, non-slip footwear with a low heel when out of bed • Ensure patients/residents do not wear clothing that restricts movement or is too loose at the ankles
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Universal Falls Risk Interventions (con't)	
Cognition	• Use clear communication to educate the patient/resident and family regarding falls prevention and provide written information; use an interpreter if necessary • Do not rush the patient/resident • Ensure that sensory aids such as glasses or hearing aids have been checked recently and are used • Assess mental status daily for delirium, dementia or depression • Strategies such as verbal cueing or picture boards may be needed • Provide behaviour therapy as required and review during rounds
Toileting	• Promote a regular bladder routine • Ensure that the patient has a regular bowel routine to help reduce bladder incontinence • Mobilize the patient/resident to the commode or toilet if they are able
Medications and Pain Management	• Review the patient/resident's medication profile with particular attention to medications which may contribute to fall risk (i.e. sedatives, benzodiazepines, antipsychotics, narcotics, antihypertensives, antidepressants, antihistamines) • Assess regularly for pain and review the need for round the clock opposed to prn • Offer prn analgesia, especially before a planned activity • Ensure that infections are treated appropriately • Review for required supplementation when there are disease processes such as osteoporosis or arthritis
Communication	• Interdisciplinary rounds will provide a continued assessment of a patient/resident's fall risk status

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