Lakeridge Health ☑ Harmonized	**Falls Prevention and Management Adult (18 years of age or older) – Policy and Procedures**	
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	Section: Adult older than 18 years of age	Original Date: 26Mar2013
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	Approved by: Nursing Professional Practice Sub-Committee, Interprofessional Collaboration Committee, Operations, Pharmacy & Therapeutics Committee, Medical Advisory Committee	Review Date: DDMMMYYYY
	Cross Reference to: Falls Prevention and Management, Adult Post Falls Order Set, Fall Prevention Patient Brochure, Critical Incident Management Policy and Procedure, Disclosure of Critical Events and Harm Policy and Procedure, Musculoskeletal Injury Prevention (MIP) – Policy and Procedures	
	Document Applies to: All staff caring for adult patients	
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Introduction

This document outlines falls prevention, including the assessment of risk, implementation of prevention interventions, post fall assessment, management and documentation. Falls risk assessment and falls prevention is a collaborative process that involves the patient, substitute decision maker (SDM) and/or their family, as well as the Interprofessional team.

Policy

Patients cared for at Lakeridge Health will be screened for falls risk by the most responsible nurse, a Regulated Health Care Provider (RHCP), or delegate (e.g. outpatient areas registration clerk), to determine falls risk status, either using the Morse Falls Risk Assessment (Appendix A) or Falls Risk Assessment: Outpatient Trigger Questions (Appendix B) as per clinical area.

A RHCP will review the patient's history on admission and as required to identify falls related risk factors (Appendix C).

Universal falls prevention interventions will be utilized for all inpatient (Appendix D) and outpatient (Appendix E) areas at Lakeridge Health.

Patients identified as being high risk for falls, through screening tools or based on the clinical judgement of the RHCP, will have an individualized set of high risk for falls interventions (Appendix F) included in their plan of care. The health care team will refer to the *Policy of Least Restraints* as appropriate.

Patients who are on medications that place them at risk for falls, as per the pre-defined list (Appendix G) will have a medication review conducted by a RHCP for all inpatient units and outpatient units (as clinically appropriate) at the following times:

a. Transition in care (e.g. admission, transfer, discharge),
b. Following a fall,
c. Significant change in health status,
d. When new medications are prescribed,
e. As required.

All patient care areas will have *What you can do to prevent a fall* posters visible in patient waiting areas, lounges, patient rooms, and/or throughout the clinical area as appropriate. *Falls Prevention: How you can prevent falls and injuries caused by falls* pamphlets will be available on units.

Purposeful rounding will occur every 2 hours for all inpatients, as per the *Purposeful Rounding Patient Care Standard*, to assess for pain, positioning, personal needs, and personal environment, by a RHCP or delegate (e.g. Personal Support Worker (PSW)). (Exclusion: Women's and Children's Program, Critical Care and Emergency Department). Appropriate transfer techniques will be used to mobilize the patient and minimize risk of staff injury (*Refer to Musculoskeletal Injury Prevention (MIP) – Policy and Procedures*).

Information about falls risk for individual patients will be shared between the patient and their family and/or Substitute Decision Maker (SDM), members of the interprofessional team and support staff as required.

All falls or near-misses for a fall, regardless of whether there is an injury to the patient or not, will be reported in the hospital incident reporting system by the Health Care Provider (HCP) that discovered the fall or the most responsible nurse.

A post-fall huddle will be conducted with the interprofessional team following ALL falls involving inpatients (Appendix H) or outpatients (Appendix I).
Ongoing review of falls status will take place at the unit level for all patients who experience a fall or a near-miss fall.

The Falls Prevention Working Group will review monthly data and unit specific feedback to develop, identify and recommend process improvements to improve patient safety.

Definition(s):

See Appendix J

Procedure for Inpatient Areas:

Falls Risk Screening

All admitted Patients excluding, Women's and Children's, Paediatrics & Non-admitted patients in the Emergency Department:

1. All admitted patients will have Falls Risk Assessment completed by the most responsible nurse, RHCP or delegate, using the Morse Falls Risk Assessment Tool within 24 hours of admission. The Morse Falls Risk assessment can be found in the electronic system under

"Falls Risk Screening Tool" or on the WAVE under clinical forms for areas using paper forms Appendix K. Instructions on completing the Morse Fall Risk Assessment can be found in the online documentation and Appendix A
Exception: Patients in the Emergency Department and/or Critical Care will follow the Corporate Falls Standard except patients who are intubated and chemically paralyzed or have a RASS score of -4 or -5. These patients will require Universal Precautions until their condition changes.

2. Reassessment of Falls Risk (Morse Falls Risk Assessment) will be completed by the most responsible nurse, RHCP or delegate:
   - Following a transfer (to be completed by the receiving unit),
   - Following a significant change in health status, (e.g. acute onset of confusion/delirium),
   - After a fall,
   - Weekly (e.g. every Sunday).

3. All Surgical patients are automatically considered high risk for falls for the first 24 hours post-operatively. Falls prevention strategies and interventions will be used to prevent falls in these areas as per standards outlined by the Operating Room Nurses Association of Canada (ORNAC) (Appendix L).
   - Reassessment for surgical patients will be conducted after the first 24 hours post-operatively have lapsed.

Identification of High Risk for Falls Patients

1. For patients identified as High Risk for Falls, the most responsible nurse or HCP will ensure appropriate visual identifiers are implemented and documented.

2. Visual identifiers consist of:
   - A purple high risk for falls wrist band applied to their wrist, or other visual identifier,
   - A magnetic star on white board,
   - A falling stars' sticker applied to spine of chart,
   - Purple non-slip socks (when appropriate footwear is not available)

3. The patient will have an individualized set of interventions included in their plan of care.

Documentation:

1. For all patients, regardless of falls risk, the most responsible nurse or RHCP will document that the defined care has been provided for Universal Falls Prevention in the Activities of Daily Living (ADL) Summary, every shift and as required.

2. Every shift and as needed, the most responsible nurse will consult, reassess, modify and implement the most appropriate High Risk for Falls individualized interventions.

Communication:

The most responsible nurse, RHCP or delegate, will document and communicate patients' risk level as appropriate, with members of the interprofessional team. This will occur when:

- discussing status and plan of care in health care provider's transfer of accountability (TOA) during shift change/report,
- a patient is transported within the hospital (e.g. for diagnostic procedure). The sending staff will notify the receiving staff if the patient has been identified as high risk for falls,
- clinically appropriate (e.g. huddles).

Post Fall Care and Monitoring:

1. If a patient has fallen, immediately take steps to assess the patient and implement appropriate care.

3. Regardless of the type of fall, the following must be completed and follow (Appendix M)- Post Falls Assessment and Management Algorithm), as per clinical setting:
   - Provide immediate care as required,
   - Assessments:
     - Vital Signs (T, P, RR, BP, O2 Saturation)
     - Neurological Assessment (Glasgow Coma Scale)
     - Neurovascular assessment (pain, pallor, pulse, paresthesia, and paralysis)
     - Musculoskeletal (circulation, sensation and movement) e.g. swelling over an area, shortening or external rotation of a limb
     - Integumentary changes (e.g. skin tears, hematoma, bleeding)
   - Notify MRP and consider use of Post Fall Order Set as clinically appropriate,
   - Review individualized falls prevention interventions that were in place at the time of the fall and select new individualized interventions, as appropriate,
   - Complete and document a new Falls Risk Assessment (Morse),
   - Complete a Confusion Assessment Method (CAM) (if patient is 65 years and older), as clinically appropriate
   - Notify the family/SDM by the most appropriate provider
   - Notify appropriate health care team members, as required,
   - Document in Patient Care Notes, outlining the details of the fall and all of the above (e.g. immediate care provided, assessments, etc.) using FAIR canned text format (Appendix N),
   - Complete WeCare,
   - Conduct a post falls huddle (Appendix H) with available members of the interprofessional team to identify what caused the fall and what actions were implemented (i.e. immediate actions taken to prevent subsequent fall).

Fall Types:

A. Fell and sustained injury (e.g. head injury or fracture) OR Unwitnessed fall with one of the following: complains of new pain suggestive of head injury or fracture OR patient at increased risk of bleeding

(Increased risk of bleeding**:** known coagulopathy, receiving non-ASA antiplatelet (e.g. clopidogrel, ticagrelor) **OR** therapeutic anticoagulant (e.g. warfarin, apixaban, treatment dose dalteparin))

- DO NOT move patient, until safe to do so. If in doubt, do not move patient.
- Call for assistance
- Keep patient comfortable/reassure the patient
- Complete physical assessments, as appropriate to clinical setting, including Glasgow Coma Scale and vital signs.
- Point of care Glucose meter testing (POCT) as appropriate as per the *Emergency Situations Medical Directive.*
- Notify MRP ***immediately*** and communicate all assessments, including if patient is on anticoagulants
- Consider implementing the *Adult Post Falls Order Set* (ordered by MRP)
- Continue to monitor (all assessments) as per *Adult Post Falls Order Set*

Note: Should the patient deteriorate at any time, notify MRP/Code Blue/CCOT/ call 9-911 (off site locations).

B. **Fell with no apparent injury and did not hit head:** A witnessed fall AND patient does not complain of pain suggestive of head injury or fracture.

- Complete physical assessments including pain assessment and vital signs
- Notify MRP and communicate assessments as appropriate. In cases of overnight falls (between the hours of 2200h and 0800h), the MRP will be notified at 0800.

Note: Should the patient deteriorate at any time, notify MRP/Code Blue/CCOT/ call 9-911 (off site locations).

Concerning symptoms that require prompt notification to MRP, Code Blue, or CCOT (LHO, LHAP, & LHB), if required

- seizure
- more than 1 episode of vomiting
- more than 30 minutes retrograde amnesia of events immediately post fall
- development of agitation or abnormal behavior
- development of severe or increasing headache
- development of new pain
- if GCS drops by 1 point or more

Post fall Huddle and Leadership Review process

1. A post-fall huddle will be conducted with the interprofessional team following **ALL** patient falls.

2. The post-fall huddle will be conducted and completed (Appendix H) **on the same shift, within 24 hours of a fall, or as soon as possible,** after a fall event. The focus of the discussion and event review is to identify possible risk factors that contributed to the fall to help guide interventions to mitigate future falls.

3. The completed huddle form will be submitted to the Patient Care Manager and/or Clinical Practice Leader to assist with hospital incident reporting documentation, investigations and supporting the team with quality improvement initiatives to mitigate potential patient falls. Manager and/or Clinical Practice Leader to conduct a follow up investigation of the event using the WeCare event details as a starting point.

4. In the event that a fall results in death, serious disability, injury or harm to a patient, follow the *Critical Incident Management (Patients) Policy and Procedures*.

5. If an event is considered to be critical, follow the *Disclosure of Critical Events and Harm Policy and Procedure.*

6. Fall rates including severity and contributing factors will be reviewed minimally on a quarterly basis for the purpose of Quality Improvement.

Procedure for Outpatients:

Falls Risk Screening

All registered patients in Ambulatory Care, Diagnostic Imaging, Treatment/Procedure Areas and non-admitted patients located in the Emergency Department, excluding Women's and Children's program patients:

1. All Outpatients will have Falls Risk Assessment completed by the most responsible nurse, RHCP or delegate (e.g. registration clerk), on initial visit/admission into the program, and as determined by the program (e.g. all visits).

2. Falls Risk Assessment will be completed in one of the following ways:

   a) Utilize Morse Falls Risk Assessment as outline in the inpatient process, if applicable
   OR
   b) Utilize the Outpatient Trigger Questions (Appendix B) to identify patients at risk for falls The 3 trigger questions are found in the electronic documentation system (e.g. Falls Risk Screening Tool), as well as a paper version (Appendix B) for units that do not have electronic documentation and/or for computer downtime (Appendix K).

   AND/OR
   c) Observation and clinical judgement. This method involves assessing the patient while mobilizing. The RHCP observes the patient's ability to go from sit to stand, to walk, and to use their mobility aid (if applicable). If there is observed weakness or impairment to gait, the patient will be considered high risk.
   Note: observation and clinical judgement utilization will be program specific.

3. Re-assessment for falls risk will be completed by the RHCP or delegate:
   - Significant change in health status,
   - Post hospitalization,
   - Post a fall,
   - As per clinical setting.

Identification of High Risk for Falls Patients

1. For patients identified as High Risk for falls, the most responsible nurse, RHCP or delegate will ensure appropriate visual identifiers are implemented and documented.

2. Visual identifiers consist of:
   - Applying a purple wristband on the patient, as clinically applicable,
     Note: A patient wearing a purple wristband band will serve as an alert to staff to use appropriate precautions.
   - Applying a purple sticker in a visible, intuitive location (e.g. on the patient's chart/clipboard/shirt),
   - Applying a purple ribbon to the patient's gait aid, as clinically applicable,
   - Visual flagging on the patient's electronic chart (e.g. status board), as applicable.

3. Have an individualized set of interventions included in their plan of care, as clinically appropriate.

Documentation:

1. Ambulatory care and diagnostic/Procedure areas utilize a standard set of falls prevention interventions as part of the standard of care.

2. Documentation of falls prevention interventions is not required unless an intervention is outside of the defined set of universal falls prevention interventions for out-patients.

Communication:

The most responsible HCP or delegate, will document and communicate patients' risk level as appropriate, with members of the interprofessional team. This will occur when:
- discussing status and plan of care in health care provider's transfer of accountability (TOA), as applicable,
- a patient is transported within the hospital (e.g. for diagnostic procedure). The sending staff will communicate falls risk with the receiving staff,
- clinically appropriate.

Post Fall Care and Monitoring:

1. If a patient has fallen, immediately take steps to assess the patient and implement appropriate care.

2. Regardless of the type of fall, the following must be completed and follow (Appendix M)- Post Falls Assessment and Management Algorithm), as per clinical setting:

   - Provide immediate care as required,
   - Assessments:
     - Vital Signs (T, P, RR, BP, O2 Saturation)
     - Neurological Assessment (Glasgow Coma Scale)
     - Neurovascular assessment (pain, pallor, pulse, paresthesia, and paralysis)

  - Musculoskeletal (circulation, sensation and movement) e.g. swelling over an area, shortening or external rotation of a limb
  - Integumentary changes (e.g. skin tears, hematoma, bleeding)
- Notify MRP, as clinically appropriate
- If required, call Code Blue,9-911 (off site locations),
- Complete and document a new Falls Risk Assessment (Morse or 3 trigger questions),
- Determine the most appropriate provider to notify family/SDM, as applicable,
- Review individualized falls prevention interventions that were in place at the time of the fall and select new ones, as clinically appropriate,
- Notify appropriate health care team members, as required
- Document in Patient Care Notes, outlining the details of the fall and all of the above (e.g. immediate care provided, assessments, etc.) using FAIR canned text format (Appendix N), as clinically appropriate
- Complete WeCare,
- Conduct a post fall huddle with available member of the interprofessional team to identify what caused the fall and what actions were implemented (i.e. immediate actions taken to prevent subsequent fall)

Fall Types:

A. Fell and sustained injury (e.g. head injury or fracture) OR Unwitnessed fall with one of the following: complains of new pain suggestive of head injury or fracture OR patient at increased risk of bleeding (Increased risk of bleeding: known coagulopathy, receiving non-ASA antiplatelet (e.g. clopidogrel, ticagrelor) **OR** therapeutic anticoagulant (e.g. warfarin, apixaban, treatment dose dalteparin))

- DO NOT move patient, until safe to do so. If in doubt, do not move patient,
- Call for assistance,
- Keep patient comfortable/reassure the patient,
- Complete physical assessments including vital signs, as appropriate to clinical setting, including Glasgow Coma Scale and vital signs,
- Point of care Glucose meter testing (PCOT) for patients with Diabetes Medical Directive or as appropriate,
- Notify MRP *immediately,* as per clinical setting and communicate all assessments, including if patient is on anticoagulants, as applicable,
- If appropriate call Code Blue/9-911 (off site locations),
- Communicate all assessments,

Note: Should the patient deteriorate at any time, notify MRP/Code Blue/call 9-911 (off site locations).

B. Fell with no apparent injury and did not hit head: A witnessed fall AND patient does not complain of pain suggestive of head injury or fracture.

- Complete physical assessments including pain assessment and vital signs, as clinically appropriate, As per Lakeridge Health Vital Signs Patient Care Standard, if no concerns,
- Notify MRP as clinically appropriate and communicate assessments as appropriate.

Note: Should the patient deteriorate at any time, notify MRP/Code Blue/ call 9-911 (off site locations), as clinically appropriate.

Post fall Huddle and Leadership Review process:

1. A post-fall huddle will be conducted with the interprofessional team following **ALL** patient falls.

2. The post-fall huddle will be conducted and completed (Appendix I) **on the same shift, within 24 hours of a fall, or as soon as possible,** after a fall event. The focus of the discussion and event review is to identify possible risk factors that contributed to the fall to help guide interventions to mitigate future falls.

3. The completed huddle form will be submitted to the Patient Care Manager and/or Clinical Practice Leader to assist with hospital incident reporting documentation, investigations and supporting the team with quality improvement initiatives to mitigate potential patient falls. Manager and/or Clinical Practice Leader to conduct a follow up investigation of the event using the WeCare event details as a starting point.

4. In the event that a fall results in death, serious disability, injury or harm to a patient, follow the *Critical Incident Management (Patients) Policy and Procedures*.

5. If an event is considered to be critical, follow the *Disclosure of Critical Events and Harm Policy and Procedure.*

6. Fall rates including severity and contributing factors will be reviewed minimally on a quarterly basis for the purpose of Quality Improvement.

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Appendix A- Morse Falls Risk Assessment

Variables		Score
History of Falls	No	0
	Yes	25
Secondary Diagnosis	No	0
	Yes	15
Ambulatory Aid	None/Bedrest/Nurse Assist	0
	Crutches/cane/walker	15
	Furniture	30
IV or IV access	No	0
	Yes	20
Gait	Normal/Bedrest/Wheelchair	0
	Weak	10
	Impaired	20
Mental Status	Knows own limits	0
	Overestimates, or forgets limits	15
	Total	

Morse Fall Scale	
High risk	45 and higher
Moderate risk	25-44
Low Risk	0-24

Appendix B: Falls Risk Assessment: Outpatient Trigger Questions (Ambulatory Care, Diagnostic Imaging, Treatment/Procedure Areas and Patients located in the Emergency Department)

Lakeridge Health

Falls Risk Assessment:
Outpatient Trigger Questions

To be utilized in Outpatient Areas: Ambulatory Care, Diagnostic Imaging, Treatment/Procedure Areas and for Patients located in the Emergency Department – 3 Trigger questions

1. Have you fallen in the last year? Yes ☐ No ☐
2. Do you use a cane, walker, wheelchair or crutch? Yes ☐ No ☐
3. Do you lose your balance, feel confused or dizzy? Yes ☐ No ☐

Automatic High Risk: If any 1 question is answered "yes", patient is categorized as high risk for falls. Patient will remain at high risk for the duration of their visit as an outpatient.

Result: Universal Falls Prevention ☐ High Risk for Falls ☐

Date (DD/MM/YYYY)	Name (Print)	Signature	Designation

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Appendix C: Fall-related Risk Factors

Biological and medical risk factors	• Advanced age • Previous falls • Muscle weakness and reduced physical fitness • Impaired mobility, balance and/or gait • Physical disabilities • Malnutrition and dehydration • Cognitive impairment (dementia, delirium, depression) • Incontinence • Visual impairment • Acute illness • Chronic illness/ disability (e.g. stroke, Parkinson's disease, Diabetes, Arthritis, Heart Disease)
Behavioral or psychological risk factors (activity-related)	• Hurrying; not paying attention • Taking risks (e.g., climbing on a chair) • Physical inactivity • Incorrect use of assistive devices • A history of previous falls (one of the best predictors of a future fall) • Fear of falling • Wearing unsafe/inappropriate footwear • Substance use (i.e., drugs and/or alcohol) • Lack of sleep
Environmental or situational factors	• Polypharmacy (multiple medications) • Use of certain medications (e.g. antipsychotics, anticonvulsants, tranquilizers, antihypertensive, opioids/narcotics, sedative/hypnotics, antidepressants) • Prolonged hospital stay • Use of restraints/side rails • Poor building design and/or maintenance (e.g. stairs, poor lighting, slippery or uneven surfaces, obstacles and tripping hazards) • Lack of: o Handrails o Curb ramps o Rest areas o Grab bars
Social and economic factors	• Inability to pay for home modifications or assistive devices • Inability to purchase or prepare foods to meet nutritional requirements • Inability to purchase proper footwear • Poor family support and/or lack of support networks and social interaction • Poor living conditions • Illiteracy/Language barriers (e.g. unable to read instructions) • Living alone

Source: Registered Nurse' Association of Ontario. (2017). Preventing Falls and Reducing Injury from Falls. (4th ed.). Toronto, ON.

Appendix D: Universal Falls Prevention Interventions for Inpatient Areas S.A.F.E. (Safe environment; Assist with mobility; Fall-risk reduction; and Engage client and family).

Environment	• Place bed, chair, stretcher or procedure/exam table in lowest or most appropriate height (ideally so that patient's feet can touch the floor) • Brakes are functional and engaged on wheeled equipment • Call bell in reach and working properly (or another method to contact care provider established) • Personal items in easy reach (e.g. glasses, hearing aids, TV control, telephone, commode, urinal, gait aid); provide assistance as required • Broken equipment reported (enter repair it) • Ensure adequate lighting (e.g. bathroom light on at night) • Clear out obstacles and clutter when possible • Ensure auditory alerts such as chair and bed alarms are implemented and turned to the "on" position • Use chairs with arm rests (helps to stand from sitting position) • Clean up spills immediately • Ask the patient if anything else is required prior to leaving the room
Physical Status	• Optimize mobility • Follow Physiotherapist/Occupational Therapist mobility recommendations • Provide education about falls prevention • Provide education about safe self-repositioning, as applicable • Patient up for meals, when applicable • Encourage use of properly fitting clothing and footwear (non-slip) • Ensure patient has appropriate gait aids (e.g. walker, cane) • Ensure adequate nutrition; refer to Dietitian if required • Ensure appropriate fluid balance for patient situation • Assess appropriateness of urinary catheter daily, and discontinue ASAP, as applicable • Ensure tethered equipment is minimized (e.g. IV, oxygen) • Incontinence precautions (safe and regular toileting) • Assess and treat pain, as applicable • Encourage patient to reposition/reposition bed bound patients' minimally q2h and as required • Ensure sensory aids are in use and functional (e.g. glasses, hearing aids)

Appendix D: (cont'd)

Cognition	• Orientation to patient to environment • Develop consistent plan of care • Ensure sensory aids are in use and functional (e.g. glasses, hearing aids) • Assess for weakness, dizziness, confusion, responsive behaviours, infection • Pain assessment and interventions • Remind patient to call for assistance • Follow Least Restraints: Prevention, Administration and Management Policy and Procedures • Asses for delirium using Confusion Assessment Method (CAM) and implement appropriate interventions for positive CAM
Communication	• Communicate falls risk to team members (e.g. Transfer of Accountability) • Provide education on mobility (e.g. mobility pamphlet), on admission, PRN • Provide education on falls risk factors and risk reduction (e.g. falls pamphlet), on admission, PRN • Patient instructed to call for assistance if required; ability to do so assessed • Advise patient and/or family/SDM that care provider will make regular checks (Purposeful Rounding)
Medications	• Review medication list, when appropriate, for drugs which may predispose patient for falls

Appendix E: Universal Falls Prevention Interventions for Ambulatory Care, Diagnostic Imaging, Treatment/Procedure Areas and Patients Located in the Emergency Department S.A.F.E. (Safe environment; Assist with mobility; Fall-risk reduction; and Engage client and family).

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 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/commode • Place bed, chair, 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 in use 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 (e.g. 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 wheelchair/Staxi where needed or upon patients' 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 should 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 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) • Ensure appropriate fluid balance for patient situation

Appendix E: (cont'd)

Cognition	• All ambulatory areas have adequate signage • Orientate patient to surroundings, where appropriate • Encourage family/SDM to accompany patient to appointments • Ensure appropriate supervision as required (e.g. volunteer to sit with patient)
Communication	• Refer high risk patients to follow up with primary care provider re: community supports • Refer high risk patients to appropriate outpatient follow-up (e.g. GAIN clinic) • Make pamphlet entitled "Your Guide to Preventing Falls and Falls-Related Injuries", available to all patients • Communicate falls risk to team members
Medications	• Review medication list, when appropriate, for drugs which may predispose patient for falls

Appendix F: High Risk for Falls Individualized Prevention Interventions

RISK FACTOR	INTERVENTION
Acute or Chronic Illness (e.g. Stroke, Cancer, Multiple sclerosis, hypotension, Low hemoglobin, Dehydration, Hypoglycemia, Psychiatric illness, Dialysis, 24 hour post surgery)	• Advise patient to dangle at bedside before standing/walking • Advise patient to sit down when feeling dizzy • Check for postural hypotension • Evaluate and treat for pain • Review laboratory results for falls risk (e.g. anemia) • Assess wake/sleep patterns • Involve family/SDM in care
Bleeding Risks (e.g. Hemophilia, antiplatelet therapy, anticoagulation therapy, thrombocytopenia, liver or kidney disease, etc.)	• Review hemoglobin, INR, APTT, etc. • Review anticoagulant/antiplatelet medications
Fracture Risk (e.g. Renal bone disease (dialysis), history of more than one fracture, osteoporosis, osteopenia)	• Consult MD/NP about implementation of calcium and vitamin D regimens & bisphosphonate • Review relevant diagnostics (bone mineral density)

Appendix F: (Cont'd)

Cognitive Impairment (e.g. delirium, depression, dementia)	• Hourly or more frequent monitoring • Purposeful Rounding Q2h • Engage bed &/or chair alarm when leaving patient • Ensure bottom bedrails are down • Room near team station • Minimize excess stimulation • Minimize change in routine • Reorientation to date and time of day • Enlist the support of family members to remain with patient • Provide activities (e.g. magazine, puzzles) • 1:1 nurse/family/SDM/other to stay with patient, as appropriate
Mobility (e.g. impaired strength and/or balance, non-ambulatory adults (primarily in wheelchair)	• Ensure call bell is within reach • Instruct patient to call for help before getting up • Ensure bottom bedrails are down • Bed by the bathroom • Raised toilet seat and/or bedside commode • Assess level of activity every shift • Accompany patient when ambulating, as applicable • Investigate reasons for bed exiting (e.g. needs bathroom) • PT & OT mobility recommendations followed/optimize mobility • Purposeful Rounding Q2h (assistive devices are within reach) • Floor mats
Hearing and Vision Impairment	• Refer to appropriate services (vision and hearing) • Purposeful Rounding Q2h (assistive devices are within reach)

Appendix F: (Cont'd)

Elimination	• Commode/urinal at bedside • Supervise when toileting • Regular toileting Q2h (Purposeful Rounding) • Consider timing of medications (laxatives, diuretics, etc.) • Follow urinary catheter protocol • Ensure proper fit of incontinence products • Encourage use of own, if applicable (e.g. pull-ups)
Poor Nutrition and Hydration	• Ensure food/hydration within reach (Purposeful Rounding • Consider Speech Language Pathologist referral for concerns with swallowing • Complete Nutrition screening tool • Consider Dietitian referral for poor intake •
Medications	• Review high-risk meds and timing (e.g. Opioids, sedatives) • Pharmacist referral if high risk medications utilized

Appendix G: Medications and Risk for Fall/Injury from Fall

B-2 Quick Reference Chart - 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 G: (cont'd)

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

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Appendix G: (cont'd)

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

Retrieved from: Safer Healthcare Now! (2019). Reducing Falls and Injuries from Falls Getting Started Kit. Pg. 125-127.
https://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Reducing%20Falls%20and%20Injury%20from%20Falls/Falls%20Getting%20Started%20Kit.pdf#search=high%20risk%20for%20falls%20medication

Appendix H: Post Falls Huddle Template for Inpatient Areas

Lakeridge Health

INPATIENT POST FALL HUDDLE

This form is to be completed during the **same shift of the fall** or within **24 hours of the fall**. Submit the completed form to your manager/clinical practice leader. **This form is for quality improvement purposes ONLY and not to be added to patient chart.**

Attendance at Huddle:

☐ Unit Coordinator ☐ Nurse ☐ CPL ☐ PT ☐ OT ☐ RA ☐ SLP ☐ Dietician ☐ Pharmacist
☐ Social Worker ☐ Manager ☐ Physician/MRP ☐ Other: _____

Was the Fall Witnessed: ☐ Yes ☐ No | **Date/Time of Fall:**

Brief Description of the Fall: (location of fall? sustained injury? current mobility status? assistive devices used?)

Environmental Contributing Factors (check all that apply):

☐ Lighting ☐ Footwear ☐ Wet floor ☐ Clutter ☐ Equipment/Supplies out of reach ☐ Equipment broken
☐ Inadequate/Inappropriate use of assistive devices ☐ Bed/Surface height ☐ Brakes not on equipment/bed
☐ Lines/tubes (e.g. Foley/IV/O_2) ☐ Restraint Use ☐ # Bed rails up: _____
☐ Other:

Patient Related Contributing Factors (check all that apply):

☐ History of falls ☐ Impaired balance ☐ Impaired strength ☐ Unsteady gait ☐ Fatigue ☐ Pain
☐ Dizziness/Vertigo ☐ Incontinence/Urinary urgency ☐ Cognitive impairment
☐ Poor judgment ☐ Confused/Disoriented ☐ Agitation ☐ Depression ☐ Instructions not followed
☐ Sensory impairment (vision, hearing, neuropathy)
☐ Other:

Medical Contributing Factors (check all that apply):

☐ Sedative/Sleeping aids ☐ Antidepressants ☐ Diuretics ☐ Laxatives ☐ Narcotics/Opiates ☐ Antianxiolytic
☐ Anti-diabetic agents ☐ Anti-epileptic ☐ Anti-Parkinsons ☐ Anti-psychotics ☐ Blood pressure agents
☐ Muscle relaxants ☐ Delirium ☐ Recent acute illness ☐ Urinary tract infection (UTI)
☐ Recent change in lab values ☐ Recently changed medication(s)
☐ Other:

Individualized Fall Prevention Plan

☐ Implement high risk for falls identifiers
☐ Move patient closer to nursing station
☐ Provide patient with Hi-Low bed
☐ Ensure bed/surface height is set at lowest position, as appropriate
☐ Provide patient with falls mats
☐ Provide patient with commode at bedside
☐ Consult with allied health team member
☐ Implemented bed and/or chair alarm
☐ Other individualized fall prevention interventions: _____
☐ Implement routine toileting schedule
☐ Reassess need for tubes/lines (e.g. Foley, IV, O_2)
☐ Reassess mobility status
☐ Review medication list
☐ Provide patient, family and/or SDM with Inpatient Fall Prevention brochure
☐ Educate patient, family and/or SDM family on fall prevention strategies

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Appendix I: Post Fall Falls Huddle Template Outpatient

Lakeridge Health

OUTPATIENT POST FALL HUDDLE

This form is to be completed during the **same shift of the fall** or within **24 hours of the fall**. Submit the completed form to your manager/clinical practice leader. **This form is for quality improvement purposes ONLY and not to be added to patient chart.**

Attendance at Huddle:

☐ Unit Coordinator ☐ Nurse ☐ CPL ☐ PT ☐ OT ☐ RA ☐ SLP ☐ Dietician ☐ Pharmacist
☐ Social Worker ☐ Manager ☐ Physician/MRP ☐ Other: _____

Was the Fall Witnessed: ☐ Yes ☐ No | **Date/Time of Fall:**

Brief Description of the Fall: (location of fall? Sustained injury? Current mobility status? Assistive Devices used?)

Environmental Contributing Factors (check all that apply):

☐ Lighting ☐ Footwear ☐ Wet floor ☐ Clutter ☐ Equipment/Supplies out of reach ☐ Equipment broken
☐ Inadequate/Inappropriate use of assistive devices ☐ Bed/Surface height
☐ Brakes not on equipment/bed ☐ Lines/tubes (e.g. Foley/IV/O_2)
☐ Other:

Patient Related Contributing Factors (check all that apply):

☐ History of falls ☐ Impaired balance ☐ Impaired strength ☐ Unsteady gait ☐ Fatigue ☐ Pain
☐ Dizziness/Vertigo ☐ Incontinence/Urinary urgency ☐ Cognitive impairment
☐ Poor judgment ☐ Confused/Disoriented ☐ Agitation ☐ Depression ☐ Instructions not followed
☐ Sensory impairment (vision, hearing, neuropathy)
☐ Other:

Medical Contributing Factors (check all that apply):

☐ Sedative/Sleeping aids ☐ Antidepressants ☐ Diuretics ☐ Laxatives ☐ Narcotics/Opiates ☐ Antianxiolytic
☐ Anti-diabetic agents ☐ Anti-epileptic ☐ Anti-Parkinsons ☐ Anti-psychotics ☐ Blood pressure agents
☐ Muscle relaxants ☐ Delirium ☐ Recent acute illness ☐ Urinary tract infection (UTI)
☐ Recent change in lab values ☐ Recently changed medication(s)
☐ Other:

Individualized Fall Prevention Plan

☐ Affix a purple high risk for falls sticker to patient's medical chart/flag electronic chart, if not already in place
☐ Affix purple wristband to patient's wrist
☐ Ensure bed/treatment surface height is set at lowest position, as appropriate
☐ Provide patient, family and/or SDM with Outpatient Fall Prevention brochure
☐ Consult with allied health team member
☐ Other individualized fall prevention interventions: _____
☐ Reassess mobility status
☐ Develop individualized fall prevention intervention plan
☐ Educate patient, family and/or SDM family on fall prevention strategies
☐ Inform family physician of potential contributing factors to fall (e.g. medications, blood pressure)
☐ Encourage family members to remain present for future treatment sessions

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Appendix J: Definitions

Fall: an untoward event that results in the individual coming to rest unintentionally on the ground or other lower surface with or without injury. 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.
- Near-miss falls, where the patient is eased to the ground or floor or other lower level, into a chair or bed, by staff or family members

Fall related injury: An injury with any degree of harm, that is sustained from a fall.

Falls Risk Assessment Tool: systematic, validated tool used to assess the risk for falls in patients.

Harm: Any temporary or permanent impairment of physical or psychological body function or structure

High risk fall prevention interventions: interventions designed to prevent a fall for populations who are at higher risk because of a specific risk factor or set of risk factors (Appendix F). Interventions must be tailored to the specific risk factors of the individual patient.

Levels of Harm: for levels of harm refer to *Patient Safety Incident Management-Policy and Procedures*

Morse Fall Scale: a validated tool used to assess the risk for falls in patients

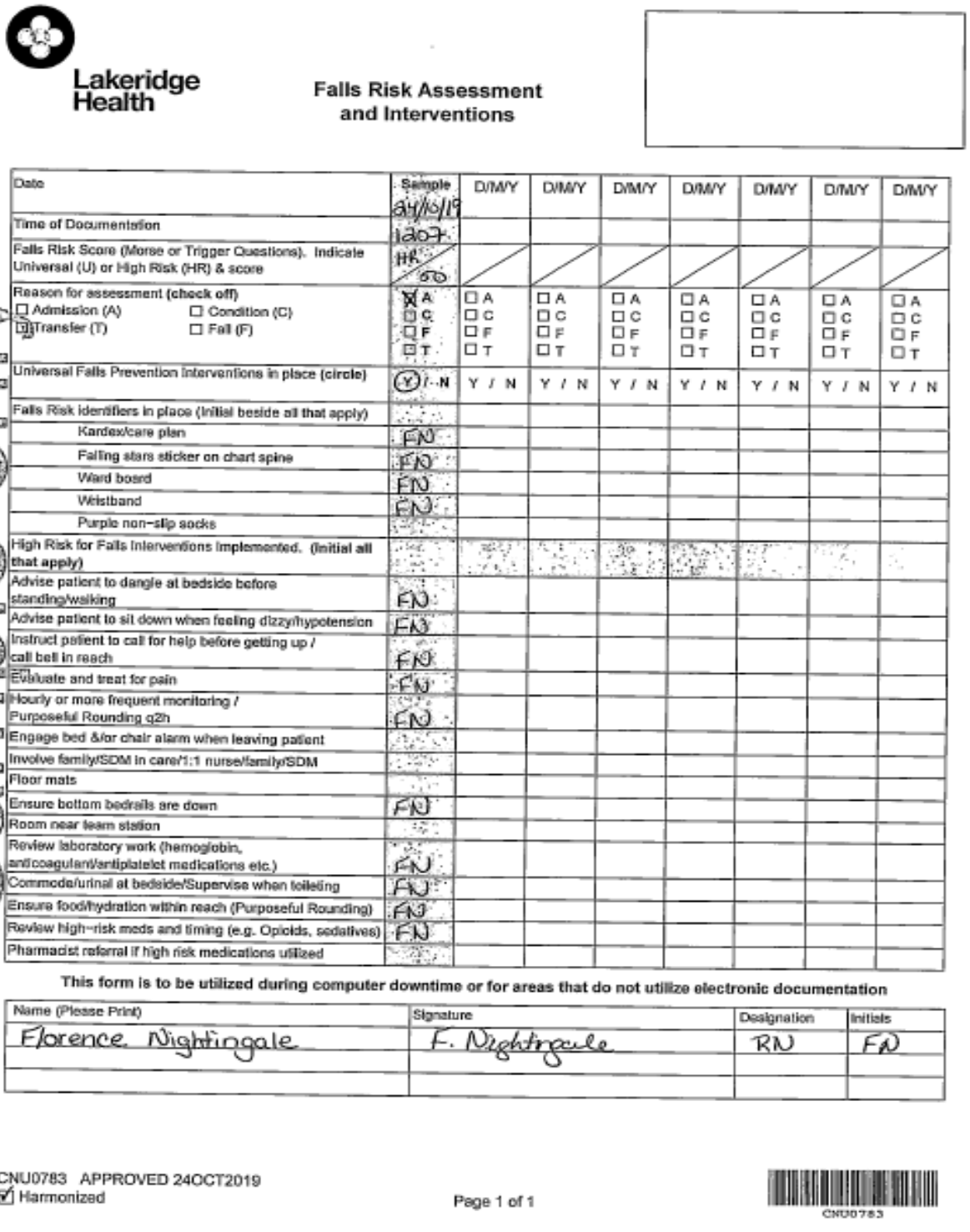
Post Falls Huddle: occurs after a fall by the interprofessional team, to determine the contributing factors that lead to the fall and develop individual patient care plans.

Significant change in health status: refers to a change that may affect the person's risk for falls, such as having a stroke or developing delirium. RNAO, (4th ed., pg. 26)

Universal falls prevention interventions: falls prevention interventions that must be used for ALL patients, regardless of risk status, to prevent the occurrence of fall.

Unwitnessed Fall: Occurs when the fall is not observed by another person and the patient is found on the floor, ground or other lower surface.

Appendix K: Downtime/Paper Falls Risk Assessment and Intervention Documentation Form



Lakeridge Health

Falls Risk Assessment and Interventions

Date	Sample 24/10/19	D/M/Y	D/M/Y	D/M/Y	D/M/Y	D/M/Y	D/M/Y	D/M/Y
Time of Documentation	1207							
Falls Risk Score (Morse or Trigger Questions). Indicate Universal (U) or High Risk (HR) & score	HR 60	/	/	/	/	/	/	/
Reason for assessment (check off) ☐ Admission (A) ☐ Condition (C) ☑ Transfer (T) ☐ Fall (F)	☒ A ☐ C ☐ F ☑ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T	☐ A ☐ C ☐ F ☐ T
Universal Falls Prevention Interventions in place (circle)	(Y) / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Falls Risk identifiers in place (Initial beside all that apply)								
Kardex/care plan	FN							
Falling stars sticker on chart spine	FN							
Ward board	FN							
Wristband	FN							
Purple non-slip socks								
High Risk for Falls Interventions implemented. (Initial all that apply)								
Advise patient to dangle at bedside before standing/walking	FN							
Advise patient to sit down when feeling dizzy/hypotension	FN							
Instruct patient to call for help before getting up / call bell in reach	FN							
Evaluate and treat for pain	FN							
Hourly or more frequent monitoring / Purposeful Rounding q2h	FN							
Engage bed &/or chair alarm when leaving patient								
Involve family/SDM in care/1:1 nurse/family/SDM								
Floor mats								
Ensure bottom bedrails are down	FN							
Room near team station								
Review laboratory work (hemoglobin, anticoagulant/antiplatelet medications etc.)	FN							
Commode/urinal at bedside/Supervise when toileting	FN							
Ensure food/hydration within reach (Purposeful Rounding)	FN							
Review high-risk meds and timing (e.g. Opioids, sedatives)	FN							
Pharmacist referral if high risk medications utilized								

SAMPLE DO NOT USE

This form is to be utilized during computer downtime or for areas that do not utilize electronic documentation

Name (Please Print)	Signature	Designation	Initials
Florence Nightingale	F. Nightingale	RN	FN

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Appendix K: Downtime/Paper Falls Risk Assessment and Intervention Documentation Form (cont'd)

Lakeridge Health

Falls Risk Assessment and Interventions

Name (Please Print)	Signature	Designation	Initials

Morse Falls Risk Assessment

Variables		Score
History of Falling	No Yes	0 25
Secondary Diagnosis	No Yes	0 15
Ambulatory Aid	None/Bedrest/Nurse Crutches/cane/walker Furniture	0 15 30
IV or IV Access	No Yes	0 20
Gait	Normal/Bedrest/Wheelchair Weak Impaired	0 10 20
Mental Status	Knows own limits Overestimates or forgets limits	0 15
	TOTAL:	

Scoring Tool	
High Risk	45 or higher
Moderate Risk	25–44
Low Risk	0–24

A Morse Falls Risk Assessment is done and documented for every patient

- Within 24 hours of admission or transfer to another unit, including diagnostic tests
- After a fall or near–fall
- Following significant changes in patient's condition
- Discharge home or to a long–term care facility

Outpatient Trigger Questions

Ambulatory Care, Diagnostic Imaging, Treatment/Procedure Areas and Patients Located in the Emergency Department Trigger questions

1. Have you fallen in the last year?
2. Do you use a cane, walker or crutch?
3. Do you lose your balance, feel confused or dizzy?

Automatic High Risk:

- If any 1 question is answered "yes", patient is categorized as automatic high risk for falls
- All patients who have fallen within the last year will be considered high risk for falls

Patient will remain at high risk for the duration of their visit as an outpatient

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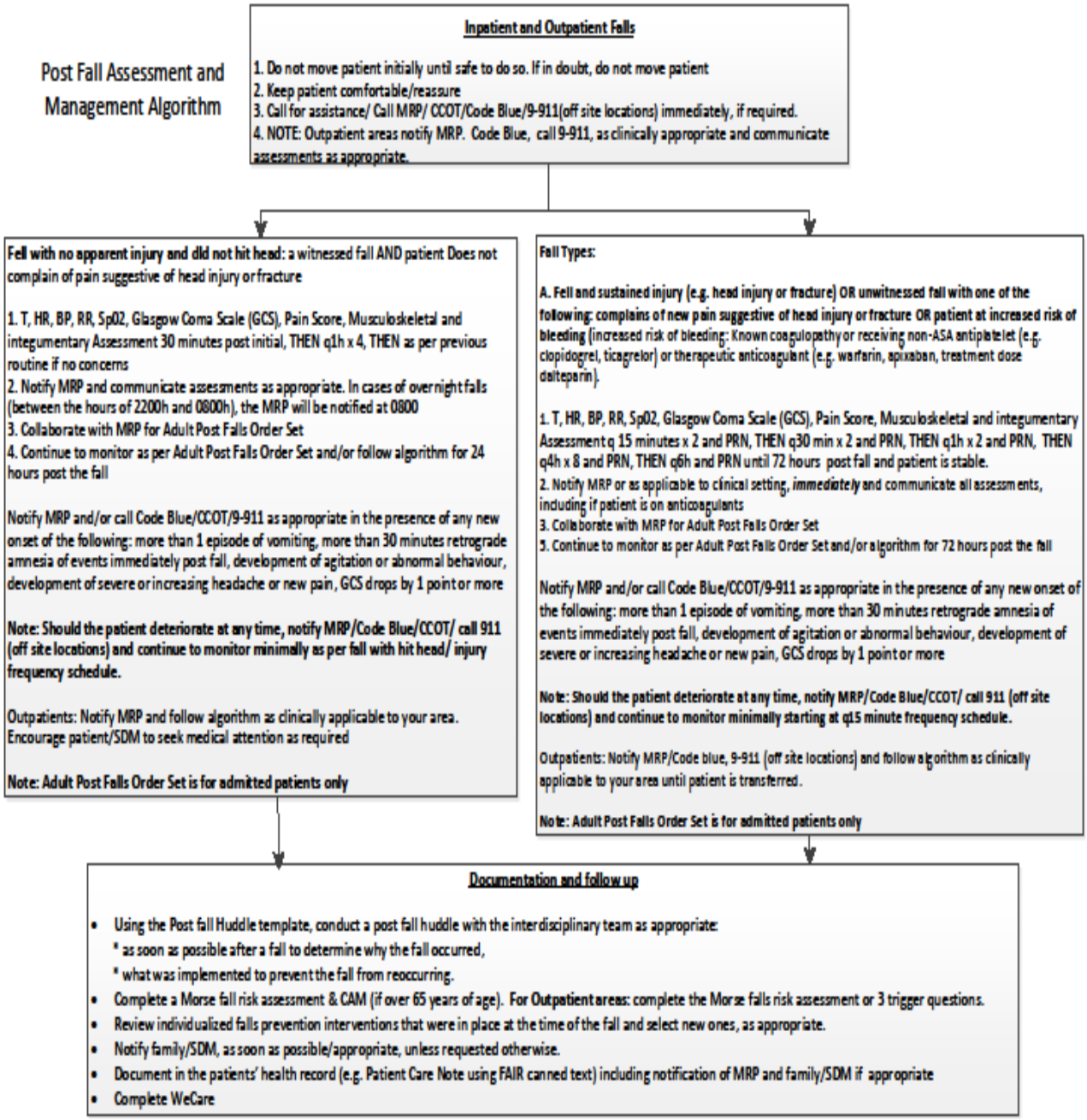
Appendix L: Falls Prevention Strategies/Interventions- Surgical Admission and Discharge Unit/Operating Room/Outpatient Procedure Suites/Post Anesthesia Recovery Unit.

The following strategies/interventions will be implemented for all patients in Day Surgery, Operating Room, Surgical Endoscopy Suite and Post Anaesthesia Recovery Unit.
Neurological: • Ensure visual surveillance of patient until appropriate discharge score is met as applicable
Environment: • Monitor for tripping hazards (e.g. gown, lines) • Glasses/hearing aids available to patient as appropriate • Side rails in the upright position at all times • Procedural stretcher or table placed in the lowest position as appropriate
Activity: • Assess patient prior to ambulation • Accompany/assist patient to the operating/procedure room using method of transportation appropriate to the patients' condition (e.g. wheelchair) • Assist with transfer of the patient to stretcher to table as appropriate • Supports, devices and safety straps applied as per ORNAC Standards (13th rd.). 2017 • Patient is accompanied by staff member, volunteer, Substitute Decision Maker or family member on discharge using appropriate mode of transportation
Toilet: • Offer assistance with toileting as appropriate in the applicable receptacle.

Retrieved from Markham Stouffville Hospital. (2018). Falls Prevention Policy and Procedure and ORNAC Standards (13th rd.). 2017.

Appendix M: Post Fall Assessment and Management Algorithm



Adapted from: Neurological checks for head injuries. January 8,2013. http://www.hcpro.com/ILTC-287387-10704/Neurological-checks-for-head-injuries.html. Observations of patient with head injuries in hospital. NICE, 2019. https://pathways.nice.org.uk/pathways/head#injury. Observation guidelines for adult patients who have fallen. Royal Berkshire. NHS Foundation Trust, Amended Feb 2013. Markham Stouffville Hospital. Falls Risk Reduction and Injury Prevention Program. (2018).

Appendix N: Sample Post Falls FAIR Note

F: Post Fall Assessment

A: Patient found [].

Fall was [] (unwitnessed/witnessed) by [].

Patient states they fell while [].

Patient reports [] (injury to/no injury) [] with [] (pain/no pain) to [].

Patient states they [] (did/did not) hit [] their head.

Injuries noted [].

Vital signs and pupils checked and are documented in the corresponding 'Vital signs' and 'NL:Glasgow Coma Scale Asmt' interventions [].

Contributing factor for fall [].

Falls strategies that were in place are documented in the 'Falls High Risk: Prevention Details' intervention. []

I: Patient transferred to [] (bed/chair/stretcher) with assistance [].

MRP Dr. [] notified and [] (orders received for/no orders received) [].

Family [] notified of fall by [] (writer/doctor/unit coordinator/unit manager).

Family member name: []

Phone number: []

Patient instructed to use call bell to get assistance prior to getting up.

Other strategies used to prevent further falls: [].

R: Patient [] (does/does not) understand own limitations.

Family [].