CHATHAM-KENT Health Alliance

CKHA POLICY

Title:	Falls Prevention		**Document Number:** PTS-1-050
Approved by:	Senior Leadership Team	**Date Revised:**	March 1, 2020
Policy Owner:	Professional Practice	**Date of Origin:**	April 11, 2002

BACKGROUND

A fall is considered to be "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level" (World Health Organization, 2018). A fall includes slips and trips (American Occupational Therapy Association, 2015), and can be further categorized as:

- Anticipatory **–** patients exhibit clinical signs that contribute to increased falls risk. This category of falls can be prevented through screening for falls risk factors, communication and implementation of targeted prevention strategies
- Unanticipated – physiological falls that cannot be predicted before first occurrence
- Accidental – the result of a mishap (Healthcare Reciprocal of Canada, 2016).

The number of seniors experiencing falls continues to rise. Falls account for 60% of all reported emergency department visits among Canadian seniors and are the leading cause of injury-related hospitalizations (CIHI, 2019). The risk for falls increases if an individual has a history of falls, a history of cognitive impairment, and any number of the risk factors detailed in Appendix A. While age may place individuals 65 years or older at increased risk, it is imperative that within the Chatham-Kent Health Alliance (CKHA) all patients/patrons are considered at risk for falls.

A fall can result in a number of costs to the individual, such as fractures, decreased confidence, social withdrawal, deconditioning, etc., as well as to the overall healthcare system. It is estimated that up to 90% of serious injuries are preventable (Parachute, 2019). By achieving a 20% reduction in falls among seniors between 2010 and 2035, an estimated 4,400 lives would be saved and $10.8 billion in health-care costs would be avoided. (Parachute, 2019; Public Health Agency of Canada, 2019).

CKHA is committed to reducing the number of fall related incidents and as such will ensure that the following Universal Fall Precautions (S.A.F.E.) are in place for all patients/patrons (Safer Healthcare Now!, 2015):

Safe environment:

- Bottom bed rails are down unless assessed otherwise
- Pathways are clear of clutter and tripping hazards
- Bed and chair brakes are "ON"
- Lights are working and "ON" as required

Assist with mobility:

- Safe and regular toileting
- Transfer/mobility assist as required
- Glasses, hearing and mobility aids within patient's reach

Fall risk reduction:

- Call bell within patient's reach
- Bed lowered to patient's knee height
- Personal items reachable
- Proper footwear available and in use

Engage Patient and Family:

- Discuss risk factors with patient and family

Mutual Falls Prevention Plan developed

OUTCOME

To promote patient safety by identifying those who are at risk for falls and enable patients and their families to participate in the planning and promoting of falls prevention strategies.

POLICY

- A fall risk assessment (Morse Fall Scale) must be completed on all adult patients (over the age of 18) on admission and daily with the exception of Obstetrical patients. Please refer to the Women and Children's Falls Prevention policy listed in the Departmental Manual for specific actions for this population.
- A fall prevention program will be initiated on all patients as guided by the Morse Fall Scale and the Falls Prevention Action Guide (Appendix E). No assessment tool alone will identify all "at risk" populations. Clinical judgement must always be used in combination with the fall risk assessment when identifying falls risk in a hospital setting (Registered Nurses' Association of Ontario, 2017). Clinical judgement may initiate a fall prevention program as guided by the Falls Prevention Action Guide.
- A reassessment of fall risk will be completed with a change in patient's condition.
- Fall risk status will be communicated at transfer of care, during team rounds, and prior to outings with family.
- When a fall occurs the following persons must be notified:
    - Most Responsible Physician (MRP)
    - With the patient's consent notify family, Power of Attorney (if applicable), or other individual as directed by the patient
- When a patient fall occurs, adhere to the Post Fall Assessment Documentation Guide for practice guidelines (see Appendix C) and initiate an incident report. Refer to PTS-1-019:Reporting Patient Safety and Near Miss
- Utilize the Post Fall Family Notification Form (Appendix D) to guide post fall interventions and as a communication tool to utilize with the patient and their family.
- Alternate approaches to the use of restraints is best practice (Safer Healthcare Now!, 2015). If the use of a restraint is deemed necessary as an intervention, refer to PTS-1-012:Restraints

Fall Prevention Program for Inpatient Units (adult population >18 years)

- The patient/family/delegate will be involved in fall prevention strategies. In collaboration with the patient and family, identify and implement alternatives to restraints.
- **Low Risk (score of <25 on Morse Fall Scale)**
  - Universal falls precautions (S.A.F.E.)
    - **S**afe environment
    - **A**ssist with mobility
    - **F**all risk reduction
    - **E**ngage patient and family
  - Call bell within reach and if possible, clipped to the patient
  - Toileting devices and personal items within reach
  - Clear pathways in room, bathroom, and shower room
- **Moderate Risk (score of 25-45 on Morse Fall Scale)**
  - All actions under Low Risk
  - Provide a Falls Prevention pamphlet to the patient and their family
  - Place an orange "Call, Don't Fall" bracelet on patient and any gait aid (walker, cane, etc.) utilized by the patient for identification
  - Place an orange fall sign, with fall prevention strategies circled in collaboration with the patient, above the patient's bed. On Psychiatry if staff have safety concerns regarding signage, this sign may be placed outside the patient's room with a smaller fall symbol placed above the patient's bed.
  - Highlight the patient's name in orange on the Kardex, medication record, care plan, etc.
  - Place an orange magnet by the patient's name on the rounds board for flagging during Team Rounds
  - Consider an Occupational Therapy (if cognitive concerns) and Physiotherapy (if balance/gait concerns) referral
- **High Risk (score of >45 on Morse Fall Scale)**
  - All actions under Low and Moderate Risk
  - Consider providing Q1 rounding asking (Safer Healthcare Now!, 2015):
    - Do you need to use the toilet?
    - Do you have pain or discomfort?
    - Do you need anything before I leave?
  - Consider moving the patient closer to the nursing station
  - Apply bed and/or chair alarms as indicated with the delay settings set to no longer than 2 seconds. Refer to the skills video on the Intranet for assistance with bed alarm set-up http://ckhaintranet.ckha.on.ca/Site_Published/ckintranet/teamdetails.aspx?twocolumn_left.QueryId.Id=67113&rightside.QueryId.Id=587
  - Consider the use of a Centrella bed (lower height) and safety mats if available
  - Pharmacy will complete a medication review for those patients identified as High Risk in order to identify opportunities to reduce, withdraw, or discontinue medications that are associated with falling. Prescription medications such as benzodiazepines, antidepressants, and antipsychotics, have been associated with

an increased risk of falls, particularly when used by seniors (Accreditation Canada, 2017).
- If a patient scored "at risk" on the malnutrition screen, request a dietitian referral. The involvement of a dietitian to guide interventions to optimize bone health can be effective in reducing falls resulting in injury (Registered Nurses' Association of Ontario, 2017).
- Contact a Professional Practice Leader to investigate if hip protectors may be appropriate for those patients with an anticipated prolonged length of stay that are demonstrating confusion and wandering. Literature at this time does not definitively support the use of hip protectors in a hospital setting (Registered Nurses' Association of Ontario, 2017).

Fall Prevention in the Paediatric Population (age 0-18 years)

- Please refer to the Women and Children's Falls Prevention policy listed in the Departmental Manual for specific actions for this population.

Fall Prevention Program for Outpatient Units (adult population >18 years)

- All patients accessing Outpatient Units presenting to Admitting will be asked if they have had a fall in the previous 3 months. If the answer is "yes", an orange "Call, Don't Fall" bracelet will be placed on the patient for identification. For serial patients, it is the responsibility of the healthcare provider to note this falls risk, and determine as a department how to flag this for subsequent visits/interventions.
- All Outpatient Units will ensure that Universal falls precautions (S.A.F.E.) are in place
  - **S**afe environment
  - **A**ssist with mobility
  - **F**all risk reduction
  - **E**ngage patient and family

APPENDICES

Appendix A: Potential Interventions by Risk Factor
Appendix B: Morse Fall Scale Assessment and Definitions
Appendix C: Post Fall Assessment Documentation Guide
Appendix D: Post Fall Family Notification Form
Appendix E: Falls Prevention Action Guide

LINKS

PTS-1-012: Restraints
PTS-1-019: Reporting Patient Safety and Near Miss
COM-3-001: Deaf, Deafened and Hard of Hearing: Assistive Communication Strategies and Devices
COM-2-002: Over the Phone Interpretation Services
Refer to the skills video on the Intranet for assistance with bed alarm set-up
http://ckhaintranet.ckha.on.ca/Site_Published/ckintranet/teamdetails.aspx?twocolumn_left.QueryId.Id=67113&rightside.QueryId.Id=587

REFERENCES

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APPENDIX A: Potential Interventions by Risk Factor

Consider the following interventions in addition to those outlined in the Falls Prevention Guide:

History of recent fall	– Assess previous pattern of falling and establish safety guidelines with patient and family – Ensure a safe environment (free from clutter, easy access to bathroom, bed in low position, brakes working, hand rails where possible) – Assess patient's level of pain especially if fall is fairly recent – could impede mobility when needed. This can be done during initial interview and ongoing with rounding.
Agitation/disruptive behaviours	– Reinforce activity limits and safety needs to patient and family – Involve the patient and family in care planning as much as possible – Move client closer to nurses station – Assess need for sitter supervision – Decrease stimuli (noise & light) – Consider medication, dehydration, nutritional or electrolyte balance as possible causes – Actions as indicated from results of CAM assessment
Urinary Alterations	– Ensure easy access to bathroom – Hourly rounding to assess patient's need to visit bathroom – Encourage timed voiding – Assess unusual patterns of urination – Encourage patient to wear easily removable clothing – Use bedside commode during sleep hours for those with nighttime confusion, frequency, dizziness on rising
Visual Deficits (i.e. reduced visual capacity, cataracts, poor night vision, etc.)	– Encourage use of glasses when up – Ensure patient given ample time for eyes to adjust when moving from brightly lit to dark areas and vice versa – Consistent furniture placement and remove unnecessary items from room – Use contrasting color to increase visibility (avoid blue/green combinations) – Leave bathroom light on with door slightly open
Hearing Deficits (i.e. reduced levels of hearing in one or both ears, use of hearing aid(s), etc.)	– Speak as loudly as needed to communicate – Check effectiveness of hearing aid (i.e. batteries) – Use written communication as needed to ensure understanding – Refer to COM-3-001-Deaf, Deafened and Hard of Hearing Assistive Communication Strategies and Devices- http://manuals.ckha.on.ca/d.aspx?f=0a05B28bUcYG
Communication Deficits (i.e. aphasia, English as a Second Language, etc.)	– Establish effective communication system – liaise with Speech Language Pathology as needed – Access interpretation services as needed to obtain informed consent, communicate safety instructions, complete health teaching, etc. Refer to COM-2-002-Over the Phone Interpretation Services- http://manuals.ckha.on.ca/d.aspx?f=a30f94FqdKt9
Postural Hypotension	– Perform initial assessment of BP in lying, sitting, standing positions – Provide education regarding slow, gradual position changes
Mobility Deficits/Weakness (i.e. impaired balance & gait, impaired mobility, generalized weakness, etc.)	– Assess mobility status and use of assistive devices—refer to Physiotherapy as needed – Ask family to bring in personal mobility aides and non-skid footwear – Ensure assistive devices are at the appropriate height and safe – Encourage progressive daily increase in activity (utilize MOVE principles)
Medications	– Do not administer diuretics past 1800 when possible – Consult with Pharmacy for a medication review when medications prescribed that are associated with an increased falls risk (i.e. benzodiazepines, antidepressants, and antipsychotics)

APPENDIX B: Morse Fall Scale Assessment and Definitions

RISK ASSESSMENT

Risk of falls will be determined by looking at the following six variables. The total score will identify the level of risk.

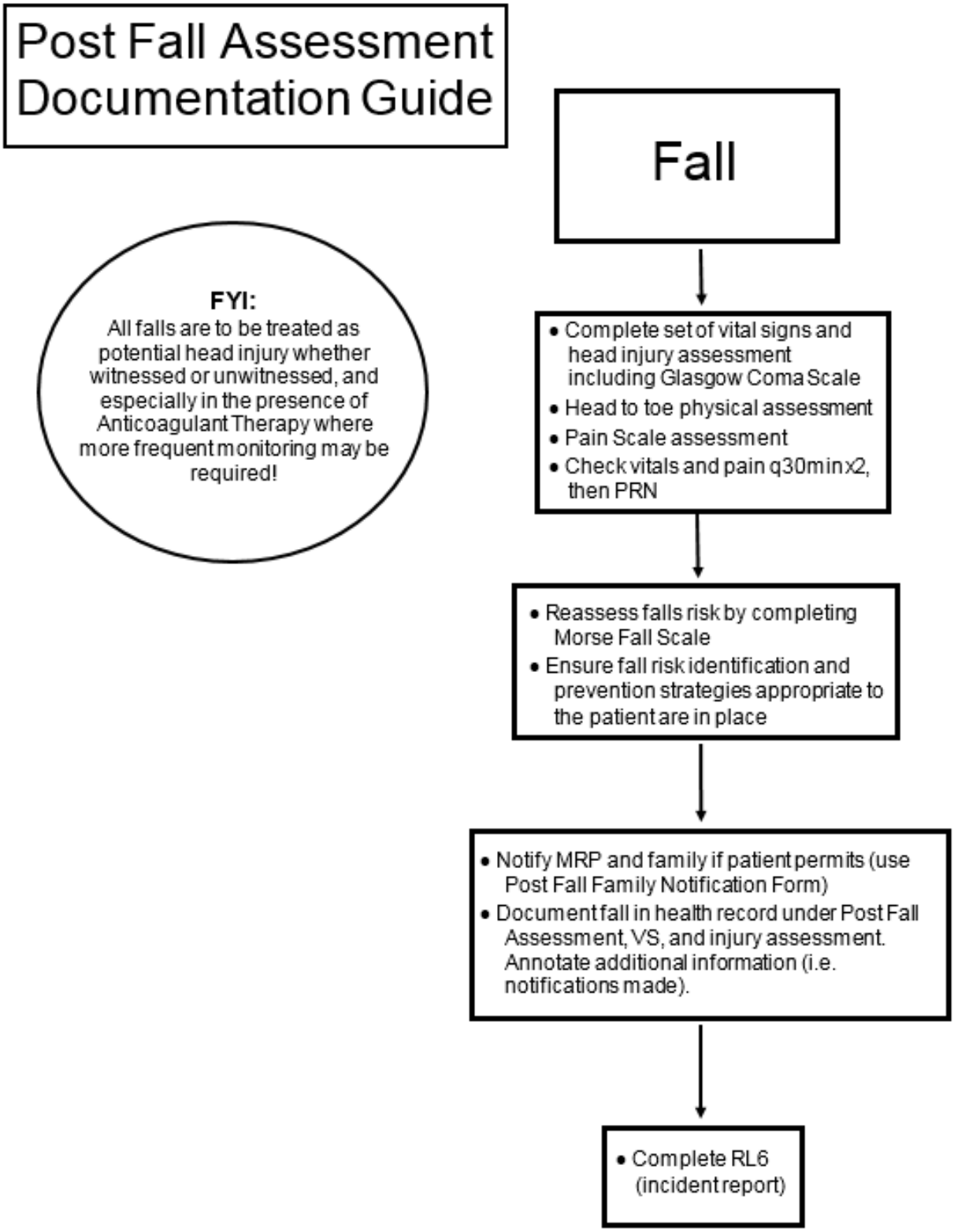
Low Risk: 0-20 **Medium Risk: 25-45** **High Risk: >45**

Item	**Scoring**	
1. History of falling; immediate or within 3 months	No	0
	Yes	25
2. Secondary diagnosis	No	0
	Yes	15
3. Ambulatory aid	None/bed rest/staff assist	0
	Crutches/cane/walker	15
	Furniture	30
4. IV / Saline Lock	No	0
	Yes	20
5. Gait / Transfer	Normal/bedrest/immobile	0
	Weak	10
	Impaired	20
6. Mental Status	Oriented to own ability	0
	Forgets limitations	15
TOTAL FALL RISK SCORE		

MORSE FALL SCALE DEFINITIONS:

1. **HISTORY OF FALLING**	Score 25	if a previous fall was recorded during the present hospital stay, or if there is a history of falling within 3 months prior to admission
2. **SECONDARY DIAGNOSIS**	Score 15	if there is more than one medical diagnosis on the patient's chart
3. **AMBULATORY AIDS**	Score 0	if the patient ambulates without an aid (even if assisted by the nurse) uses a wheelchair, or is on bedrest
	Score 15	if the patient uses crutches, a cane or walker for ambulation
	Score 30	if the patient ambulates clutching onto the furniture for support and balance
4. **INTRAVENOUS THERAPY**	Score 20	if the patient has an intravenous infusion / saline lock
5. **GAIT/TRANSFERRING**	Score 0	if the gait is normal characterized by walking with the head erect, arms swinging freely at the side and striding without hesitation
	Score 10	if the gait is weak evidenced by a stooped stance, short steps, and the patient may shuffle their feet
	Score 20	if the gait is impaired evidenced by the patient having difficulty rising from the chair, cannot walk without assistance, head is down and requires a person or walking aid for support
6. **MENTAL STATUS**	Score 0	if the patient's self-assessment of their abilities is consistent with their mobility status
	Score 15	if the patient's assessment of their mobility is unrealistic since they are considered "forgetful of their limitations".

APPPENDIX C: Post Fall Assessment Documentation Guide



Appendix D: Post Fall Family Notification Form

PATIENT STICKER

CHATHAM-KENT Health Alliance

Post Fall Family Notification Form

Use this form to guide post fall interventions and as a communication tool when notifying the patient's family member (if consent obtained) and/or POA. Leave the completed form at bedside for patient/POA/family reference (yellow copy). Place the original on the chart.

Details:				
Date of fall:			Time of fall:	
Individual contacted:			Relationship to patient:	
1. Location of the fall:	☐ Patient room	☐ In hallway	☐ Other:	
	☐ Bathroom	☐ In patient lounge	_____	
2. What was the patient doing at the time of the fall:	☐ Ambulating	☐ Transferring	☐ Sitting	
	☐ Standing	☐ Resting in bed	☐ Other: _____	
3. Did the patient sustain an injury?	☐ Yes	☐ No	Comments:	
4. Does the patient have pending diagnostics related to the fall?	☐ Yes	☐ No	Comments:	
5. Did the patient have the following in place at the time of the fall:				
a. Glasses	☐ Yes	☐ No	☐ N/A	Comments:
b. Hearing aid(s)	☐ Yes	☐ No	☐ N/A	Comments:
c. Gait aid (cane, walker, etc.)	☐ Yes	☐ No	☐ N/A	Comments:
d. Appropriate footwear	☐ Yes	☐ No	☐ N/A	Comments:
Plan:				
6. Interventions being introduced/continued to prevent further falls (based on the Falls Prevention Action Guide):				
☐ Apply bed alarm	☐ Dietitian referral	☐ Medication review	☐PT referral	☐ Other: _____
☐ Apply chair alarm	☐ Initiate hourly rounding	☐ OT referral	☐Relocate patient closer to nursing station	

Signature of Staff Member Completing Post-Fall Assessment:_____

Place original on patient's chart.
Yellow copy to be given to the patient.

APPENDIX E: Falls Prevention Action Guide

Falls Prevention Action Guide

Complete the Morse Fall Scale **daily** and based on the score, ensure the following interventions are in place:

Low Risk (score <25)

- ☐ Universal falls precautions (S.A.F.E.)
  - ⇒ Safe environment
  - ⇒ Assist with mobility
  - ⇒ Fall risk reduction
  - ⇒ Engage patient and family
- ☐ Call bell within reach and if possible, clipped to the patient
- ☐ Toileting devices/personal items within reach
- ☐ Clear pathways in room

Moderate Risk (score 25-45)

- ☐ Actions under Low Risk column AND:
- ☐ Orange bracelet on patient and mobility aids
- ☐ Orange fall sign with fall prevention strategies circled above bed
- ☐ Name highlighted in orange on Kardex, medication record, etc.
- ☐ Orange magnet by name on rounds board
- ☐ Consider OT (if cognitive concerns) and PT (if balance/gait concerns) referrals
- ☐ Provide Falls Prevention pamphlet to patient and families

High Risk (score >45)

- ☐ Actions under Low and Moderate Risk Columns AND:
- ☐ Q1 rounding asking:
  - ⇒ Do you need to use the toilet?
  - ⇒ Do you have any pain or discomfort?
  - ⇒ Do you need anything before I leave?
- ☐ Look at moving the patient closer to the nursing station
- ☐ Apply bed/chair alarms
- ☐ Consider the use of a Hi-Low bed and safety mats
- ☐ Request a medication review
- ☐ If patient scored “at risk” on the malnutrition screen, request a dietitian referral
- ☐ Contact PPL to investigate if hip protectors are appropriate **ONLY IF** prolonged LOS anticipated + confusion + wandering

If any questions or concerns, please contact your Professional Practice Team at ckhaprofessionalpractice@ckha.on.ca