QUINTE HEALTHCARE CORPORATION

Emergency – Fall Prevention and Post-Fall Management

Title: Emergency – Fall Prevention and Post-Fall Management		**Policy No:**	**3.7.5**
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Approved By:	Nursing Practice Committee		

1. POLICY

This policy and procedure outlines the expectation that all Emergency Patients at Quinte Healthcare Corporation (QHC) who are 16 years of age or older will be assessed for potential risk of falling. All patients under the age of 16 years of age will be considered at risk for falls based on their phase of growth and development.

The risk of falls is elevated in the hospital setting due to the environment, physiologic factors such as illness or medical condition, medication use, and equipment. Strategies to reduce patients' risk of falling are considered for all patients.

The purpose of this policy and procedure is to enhance patient safety through the assessment and identification of risk factors that can increase the potential for falling and through the implementation of interventions that assist in the mitigation of a fall and decrease the likelihood of injury if a fall occurs.

Patients who do experience a fall at QHC will be assessed and provided with care and interventions following evidence based practice. Standard falls precautions are the minimum standard of care in a falls prevention program. 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 use a standardized tool, 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 (Single mechanical fall) – These falls are often due to environmental factors and result in a person slipping, tripping or having a fall by accident. 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.

ED Falls Risk Assessment Tool

The following fall risk assessment tool is approved for use at QHC

1. ED Fall Risk Assessment Tool (Adapted from public domain, Memorial Hospital ED, Colorado Springs, CO).

3. PROCEDURE

A. Falls Risk Assessment

1. The ED Fall Risk Assessment will be completed on all adult patients (16 years of age and over) presenting to the Emergency Department.
2. All patients will be assessed for falls risk following triage or within 60 minutes of triage, after a fall or near miss (almost a fall), and when there has been a change in patient condition (Appendix A – ED Fall Risk Assessment Tool).
3. A score will be calculated indicating category of risk for the patient. The department tracker will highlight the room number in black when patient is determined as a high risk for falls.
4. Categories of risk are low risk (score 1 – 2 points), moderate risk (score 3 – 4 points) and high risk (score 5 points or more).
5. Standard fall precautions will be implemented for ALL patients. Standard fall precautions include call bell within reach at all times, stretcher/bed in lowest position, orientation to surroundings, clutter-free room, recommend proper footwear, ensuring personal items are within patient's reach and ensuring brakes/locks are in place on movable furniture/aids (Appendix B - Falls Prevention and Management Standard Falls Precautions).
6. Parents/caregivers of paediatric patients will be instructed not to leave young children unsupervised in order to assist in ensuring their safety.
7. Implement any additional interventions most appropriate to risk identified for the patient. Document interventions implemented on the Fall Prevention Intervention screen in EDIS.
8. Place Fall Prevention sign above the stretcher for patients identified as high fall risk (Appendix C- Fall Prevention Poster).
9. Apply a yellow (pre-printed) Fall Risk bracelet to the wrist of patients identified as being a high fall risk.
10. For patients identified at moderate and high risk a chair alarm or non-skid socks when used can be an effective method in the prevention or reduction of falls (where available).
11. Discuss fall assessment and review interventions with the patient/family.
12. Provide the patient/family with the Falls Prevention in the ER Handout (Appendix E – Paediatric Handout or Appendix F – Adult Handout).
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 will be reassessed and documented every 12 hours on 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 D − Post Fall Assessment and Intervention)

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 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 1 hour 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**
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 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 <u>OR</u> 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 a 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. The nurse will document all actions, assessments and communication as per QHC documentation policy including details of the fall and outcome.
16. 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, HSR, 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 − ED Fall Risk Assessment Tool
Appendix B − Falls Prevention and Management Standards Falls Precaution
Appendix C − Falls Prevention Poster
Appendix D − Post Fall Assessment and Intervention Algorithm
Appendix E − Pediatric Falls Patient Family Falls Prevention Handout
Appendix F − Adult Patients Falls Handout

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