BEST PRACTICE FOR PREVENTION OF FALLS

In Partnership with the RNAO Best Practice Spotlight Program

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THIS LEARNING PACKAGE

This 2 part learning package has a short introduction with a list of learning objectives and learning content.

- Part One must be reviewed by all healthcare staff.
- Part Two must be reviewed by all health professional staff.

This package also has:

- Three short case scenarios to help you to review your learning.
- A self-test for all healthcare professionals.

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PART ONE: FOR ALL HEALTHCARE STAFF

What is Best Practice for the Prevention of Falls Program at HHS?

GOAL: CREATE A CULTURE OF SAFETY FOR OUR PATIENTS

1. The goal of HHS is to promote patient centred care and safety for all patients.
2. All staff will be knowledgeable and respond appropriately to all patients.
3. All staff , even non-clinical staff, will be able to identify those at high risk by recognizing the falls sign.
4. Foster a mindset of patient injury prevention.

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BEST PRACTICE shine

LEARNING OBJECTIVES

At the end of this e-learning module, you will be able to:

- Explain that everyone is responsible for fall prevention
- Recognize that all patients are at risk for falls
- Identify falls risk factors and be able to identify those patients who may be at higher risk for falls
- Describe Universal Fall Precautions
- Discuss interventions for patients who are at high risk for falls and
- Explain your responsibilities if a patient has fallen while in hospital.

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FACTS ABOUT FALLS

Did you know…?

- In Canada, falls are the sixth leading cause of death among older adults.
- Falls are the leading cause for injury admissions to Ontario Acute Care Hospitals.
- It is estimated that 1 in 40 people are hospitalized as a result of a fall. Of those, only 50% will be alive one year later.

RNAO (2007). Falls Prevention: Building the Foundations for Patient Safety, A Self Learning Package.

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FACTS ABOUT FALLS – HOSPITALS

- The incidence of falls is greater for elderly hospitalized patients than for older persons living in the community.
- 29-48% of hospital falls result in injury.
- 4-7.5 % of hospital falls result in serious injuries.
- One in one thousand seniors admitted to hospital fractures a hip during their stay.
- Many hospital falls are judged to be preventable.

Taking Aim at Fall Injury Adverse Events: Best Practices and Organizational Change, Healthcare Quarterly, 2007.

CIHI Survey, In Hospital Hip Fractures in Canada, Healthcare Quarterly, 2004

PATIENT SAFETY

- We have the opportunity to prevent injuries and save lives through fall prevention
- Accreditation standards require hospitals to have fall prevention strategies
- Hospital teams must:
  - Identify their populations at risk for falls,
  - Use strategies to address their population's specific needs,
  - Evaluate their fall prevention strategies, and
  - Use information from the evaluation to make improvements.

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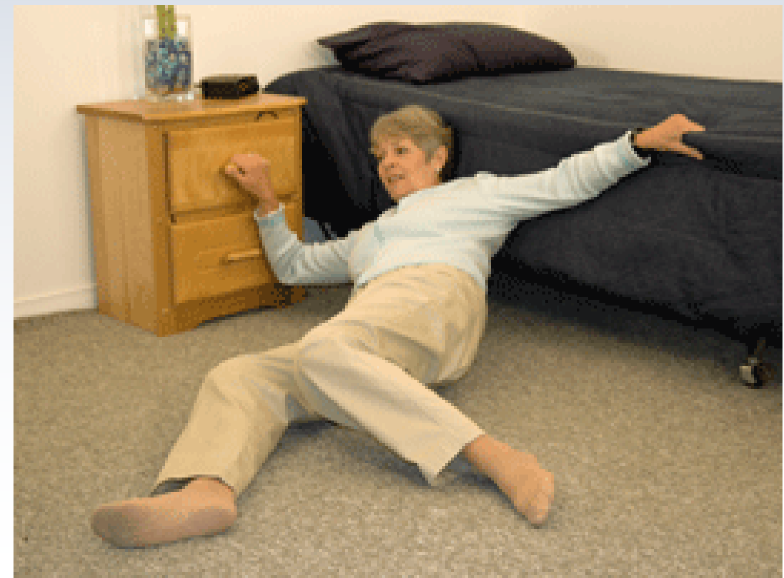
DEFINITION OF A FALL

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

It is important to have a definition of a fall, so that we can be consistent in our collection of data within our hospital and with other hospitals.



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WHY DO PEOPLE FALL?

What are the risks that contribute to falls?

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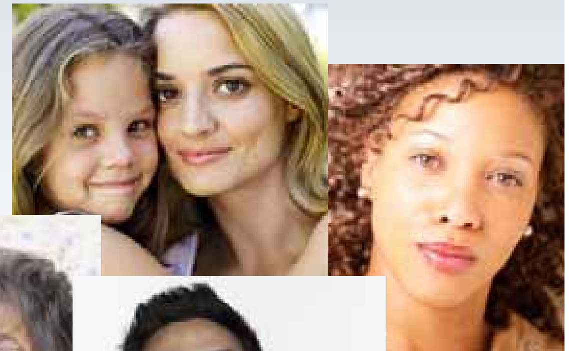
WHY DO PEOPLE FALL?

- People of all ages can fall
- There are many different reasons a person may fall
- A person may be at risk of falling due to their physical and mental condition
- A person may be at risk of falling due to their environment
- Many falls can be prevented



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WHO IS AT INCREASED RISK?

F allen previously

A ge (>65 years)

L osses in cognition

L ots of obstacles

S pills and pills

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FALL PREVENTION PROGRAM AT HHS

HHS is implementing a Falls Prevention Program that will include:

- Universal Fall Precautions for **all** patients, and
- Initial falls risk assessment of **all** patients within twenty four hours of admission/transfer to a unit

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FALL PREVENTION FOR ALL PATIENTS

Universal Fall Precautions:

- Place bed in lowest position with brakes locked.
- Keep floor surfaces clean and dry of spills.
- Reduce clutter and ensure that furniture is in good condition.
- Use effective lighting.

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FALL PREVENTION FOR ALL PATIENTS

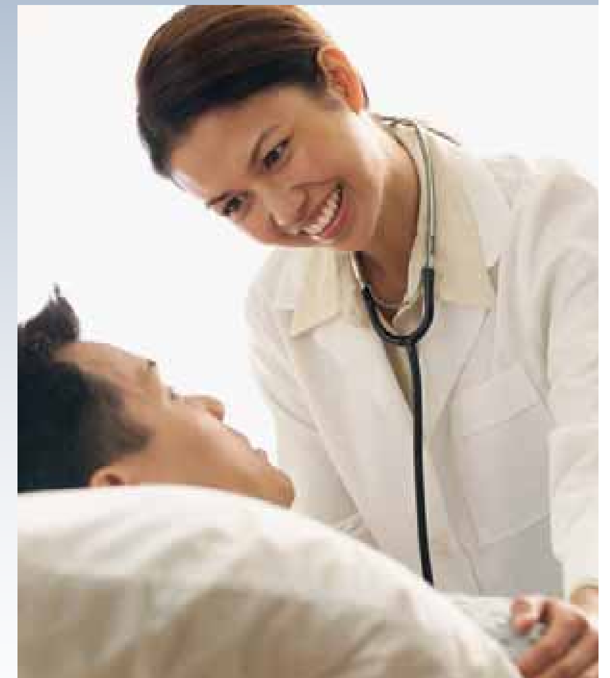
Universal Fall Precautions:

- Ensure that the patient knows where personal possessions are and can safely access them.
- Ensure patient footwear is fitted, non-slip and used properly.
- Maintain call bell in reach and have patient demonstrate ability to call for assistance.

FALL PREVENTION FOR ALL PATIENTS

Universal Fall Precautions:

- Monitor patient regularly and reassess level of risk for falls when medical condition changes.
- Appropriate adherence to the Least Restraint Policy.
- Establish a plan of care to maintain bowel/bladder function.
- Educate patient and family regarding fall prevention strategies.



FALL PREVENTION PROGRAM AT HHS

- All patients will be reassessed after a fall or a significant change in condition.
- All falls will be documented, a safety occurrence report will be completed.
- Fall/injury rates will be monitored and strategies evaluated.

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FALL PREVENTION PROGRAM AT HHS

High Risk Patients:

- Will be identified by Falls sign at bedside
- Will have appropriate "high risk for falls" interventions implemented by the health care team.

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FALLS SYMBOL

This is the Falls Symbol Sign that must be used to indicate that a patient has a risk of falling.

It will be located above the head of the bed.

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HOW CAN WE PREVENT FALLS?

What is in place at HHS?

ENVIRONMENTAL MODIFICATIONS

- Make sure furniture wheels are locked
- Perform regular preventative maintenance on mobility aids and equipment
- Mop up spills quickly
- Ensure assistive equipment is within reach
- Ensure seating is appropriate to the patient's needs

ENVIRONMENTAL MODIFICATIONS

- Keep beds in the lowest position
- Use bedrails appropriately
- Reduce clutter
- Have patient wear non-slip footwear
- Ensure adequate lighting
- Use caution signs to warn of wet floors and remove when the floor is dry

WHAT RISKS CAN YOU IDENTIFY?

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WHAT RISKS CAN YOU IDENTIFY?

Is the bed in the lowest position?

Is assistive equipment within reach?

Are the bed wheels locked?

Call bell is out of reach

Personal belongings out of patient's reach

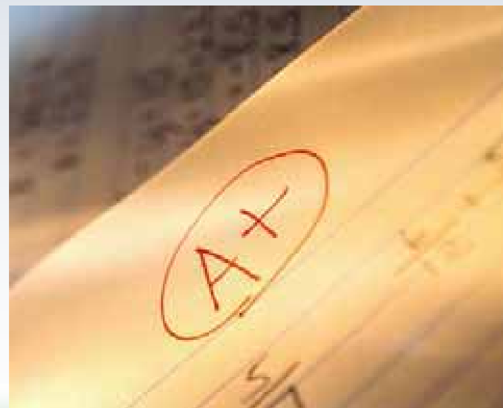
Area is a bit cluttered as chair is in the way

Cup lid on floor

Wet floor – if not, sign should be removed

CASE SCENARIOS

Test yourself!



FOR THE FOLLOWING CASE SCENARIOS, KEEP IN MIND…

- There is usually more than one right answer to any case scenario.
- Think through your options. Consider patient safety and injury prevention.
- The goal of HHS is to promote patient centred care and safety for all patients.

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CASE SCENARIO #1

An Environmental Aide comes into a patient's room and observes the patient leaning over to the bedside table at the foot of the bed and knocking over their water.

What would you do if you were the EA?

CASE #1 – CORRECT ANSWERS

1. Encourage the patient to sit back while you get them another glass of water.
2. You mop up the spill and place the appropriate wet floor sign.
3. Place the bedside table and the call bell at reach of the patient.
4. Remind the patient to call **before** you get up if you need assistance.

CASE SCENARIO #2

A social worker walks by a patient's room. The patient has a falls sign above their bed. The patient is attempting to get out of bed.

What would you do if you were the Social Worker?

CASE #2 – CORRECT ANSWERS

1. The social worker helps the patient get their walker, and supervises the patient until the patient is safely in their chair.

2. The social worker asks the patient not to get up, turns on the patient call light for assistance and remains with the patient until help arrives.

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CASE SCENARIO #3

During a busy afternoon a cafeteria worker notices a patient in a wheelchair standing up to fill their cup with hot coffee.

What would you do if you were the cafeteria worker?

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CASE #3 – CORRECT ANSWERS

1. The staff person helps the patient until they are safely back in their chair.

2. The cafeteria staff is busy, so the staff person asks another staff member to assist the patient.

This is the end of Part One of the Best Practice for Falls Prevention learning package.

PART TWO: FOR ALL HEALTHCARE PROFESSIONALS

What are your responsibilities?

WHY DO PEOPLE FALL?

People of all ages can fall.
There are many risk factors for falls.

Intrinsic Risk Factors

- Risk factors that are due to the patient's internal condition
- These may be physical or cognitive

Extrinsic Risk Factors

- Risk factors that are in the patient's external environment

INTRINSIC RISK FACTORS

These risk factors include:

- History of falling
- Cognitive impairment or a change in mental status
- Increased age (over 65)
- Incontinence or urgency, nocturia
- Balance and gait disorders
- Weakness of the lower extremities
- Dizziness, vertigo

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INTRINSIC RISK FACTORS

- Postural hypotension
- Heart disease, arrhythmias
- Clinical depression, anxiety
- History of seizures
- History of alcohol abuse &/or intoxication

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INTRINSIC RISK FACTORS

- Impaired vision
- Impaired hearing
- Acute illness

  Examples include:

  - ✓ 24 hours after surgery
  - ✓ Pneumonia, urinary tract infections
  - ✓ Dehydration

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INTRINSIC RISK FACTORS

Medication

More than 5 medications:

- ✓ Sedatives, tranquilizers
- ✓ Psychotropic drugs
- ✓ Narcotics
- ✓ Anesthetics
- ✓ Hypoglycemic agents
- ✓ Antidepressants
- ✓ Anti-seizure
- ✓ Anti-arrhythmics
- ✓ Anti-cholinergic
- ✓ Hypotensive agents
- ✓ Diuretics, laxatives

Extrinsic Risk Factors

Environmental risks include:

- Poor lighting
- Unsafe stairs
- Slippery or wet floors
- Cluttered patient rooms
- Lack of supports (call bell, mobility aids)
- Unsafe footwear
- Beds (position, brakes that are not locked)
- Seating (not individualized to patient's needs)

PREVENTION OF FALLS

What can we do to prevent falls?

1. Assess fall risk on admission.
2. Assess fall risk after a fall.
3. Multidisciplinary team implementation of multi-factorial fall interventions.
4. Medication review.
5. Patient education.
6. Environment modifications.
7. Least restraint policy.
8. Staff education.

Based on RNAO Best Practice Guideline Practice Recommendations for Prevention of Falls and Fall Injuries

FALLS RISK ASSESSMENT

Assessment performed and documented:

- Within 24 hours of admission
- Within 24 hours of transfer to unit
- If the patient's condition changes significantly
- If the patient falls, or a near miss occurs.

FALLS RISK ASSESSMENT

Assessment consists of asking the following questions:

1. Has the patient fallen in the past 90 days?
2. Does the patient have cognitive impairment or a change in mental status?
3. In the nurse's clinical judgment, is the patient at risk for falls?

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Falls Risk Assessment

If the answer is yes to any question, the patient is at high risk for falls.

You will need to:

- Further assess the patient for specific intrinsic and extrinsic risk factors.
- Implement appropriate interventions for patients at high risk for falls.
- Document in the health record.

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WHAT DO I NEED TO DO?

What is my role in Fall Prevention?

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HIGH RISK PATIENTS

- Each health care team member has a role to play in falls prevention.
- Multidisciplinary members need to be notified as specific risk factors are identified.

- Occupational therapist
- Physiotherapist
- Pharmacist
- Geriatric clinician
- Social worker
- Dietitian
- Health care aide
- Environmental aide
- Nurse
- Physician

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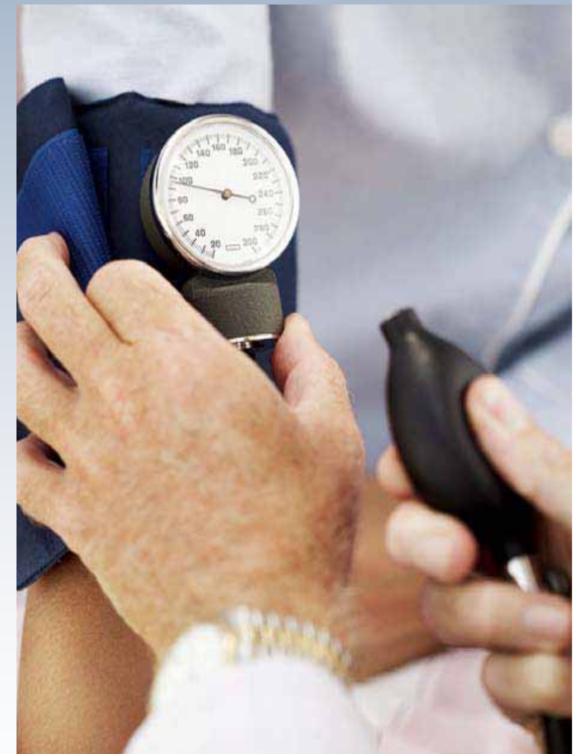
HIGH RISK PATIENTS

In addition to Universal Fall Precautions:

- Ensure the falls symbol sign is at the bedside.
- Label the spine of the patient's chart and the kardex with the falls symbol sticker.
- Consider placing the patient in a room near the nursing station or in an area of high visibility.

HIGH RISK PATIENTS

- Reorient the patient to his/her surroundings as needed.
- Monitor the patient regularly and reassess level of risk for falls when his/her medical condition changes.
- Communicate high risk for falls during the **Transfer of Accountability**.
- Identify specific risk factors and make multidisciplinary referrals.



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HIGH RISK PATIENTS

- Assist with patient transfers and ambulation
- Orient the patient/family to the unit and fall prevention strategies
- Encourage family cooperation
- Provide patient education materials

MEDICATIONS

Medications can affect risk for falls by:

- Affecting alertness, judgment, and coordination
- Some medications may increase postural hypotension (significant drop in blood pressure with a change in position resulting in dizziness)
- Altering the balance mechanism
- Impairing mobility by causing stiffness or weakness

MEDICATIONS

- Identify those patients taking more than five medications.
- Medications should be reviewed periodically with the patient, pharmacist, physician and other members of the health care team.

MEDICATIONS

- Pay special attention to medications that impact on falls:

  sedatives, tranquilizers, psychotropic drugs, narcotics, anesthetics, hypoglycemic agents, antidepressants, antiseizure drugs, antiarrhythmics, anticholinergics, hypotensive agents, diuretics and laxatives.

- Medications should be used at lowest possible dosages to obtain desired results.

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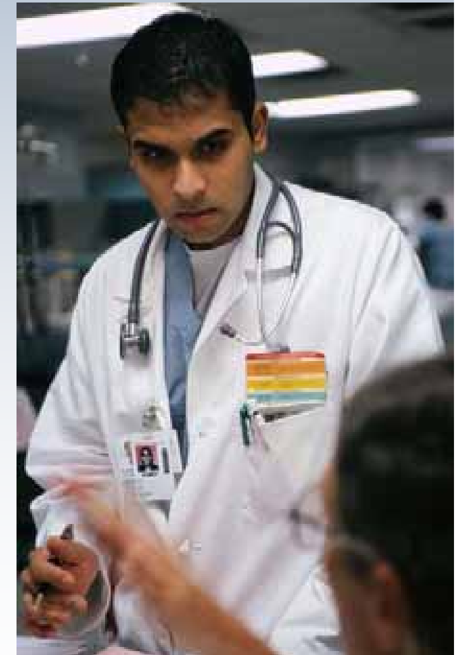
PATIENT EDUCATION

Involve the patient and family in fall prevention:

- Explain to the patient and family the risk for falls.
- Discuss the the patient's specific fall risk factors.
- Ensure the patient knows how to use the call bell, and any assistive devices.
- Orient the patient to their environment.
- Provide patient education materials to reinforce the health teaching provided.



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LEAST RESTRAINT

Restraint use :

- Does not reduce the rate of serious falls.
- Results in de-conditioning (which can increase risk of falls).
- Can increase patient agitation and increase the possibility of patient getting up unassisted.
- May lead to more severe injuries than if the restraints had not been used.

Refer to Least Restraint Policy at HHS

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LEAST RESTRAINT

Alternatives to least restraint can be implemented :

- observational care
- family involvement as appropriate
- bed exit alarms
- high-low beds

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OBSERVATIONAL CARE

Regulated Health Professionals can assign Health Care Aides fall prevention interventions for high risk patients.

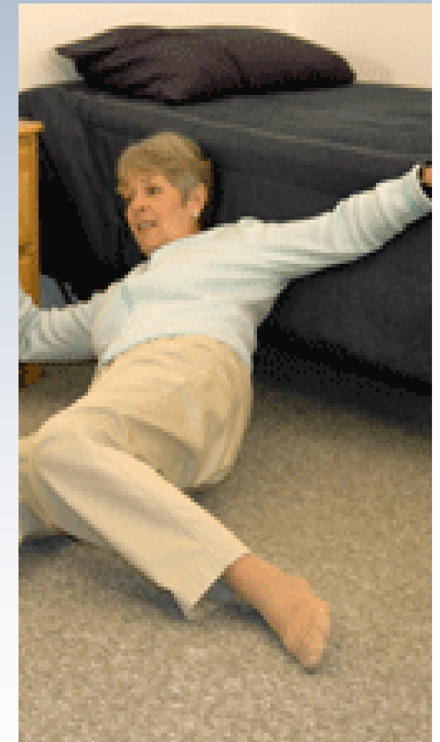
The Nurse needs to:

- Ensure that the HCA knows what to observe and monitor.
- Give a report to the HCA.
- Ensure that the Daily Patient Observation Flow Sheet is completed by the HCA.
- Receive a report from the HCA.
- Document.
- Evaluate observational care for effectiveness.

IF THE PATIENT FALLS…

Implement a "post-fall protocol" for all patients:

- Post fall assessment by health care team
- Ensure high risk fall prevention interventions in place
- Safety occurrence reporting:
  - ✓ Patient activity at time of event.
  - ✓ Environmental factors leading to occurrence.
  - ✓ Equipment factors leading to occurrence.
  - ✓ Description of injury.
  - ✓ Pre-occurrence condition
- Communication with patient and family



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Resources

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- Registered Nurse's Association of Ontario (2007). *Falls Prevention: Building the Foundations for Patient Safety. A Self Learning Package*. Toronto, Canada: Registered Nurses' Association of Ontario.
- Registered Nurse's Association of Ontario (2005). *Prevention of Falls and Fall Injuries in the Older Adult (Revised)*. Toronto, Canada: Registered Nurses' Association of Ontario.
- VHA National Center for Patient Safety, Fall Prevention and Management Falls Prevention Toolkit. http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html
- Thyen, M, Identifying Patients Using a Falling Star (St. Cloud), Falling Star Logo Training, http://www.patientsafety.gov/SafetyTopics/fallstoolkit/resources/educational/Identifying_Patients_Using_a_Falling_Star_StCloud.ppt

Falls-Related Medication Side Effects

Class of Drugs	Falls Risk
Anti-convulsants	• Confusion • Drowsiness • Poor balance • Altered co-ordination • Unsteady walking
Anti-depressants	• Drowsiness • Less co-ordination • Poor balance • Unsteady walking • Confusion • Blurred vision (tricyclics)
Anti-hypertensives	Postural hypotension (dizziness/lightheadedness) *** *leading to:* • altered perception • less co-ordination • unsteady mobility • poor balance (usually for the 1st week or so of treatment)
Anti-nauseants (vestibular suppressants)	• Poor balance • Unsteady walking • Stiffness • Drowsiness • Parkinsonism
Anti-Parkinson agents	• Altered co-ordination • Poor balance • Unsteady walking • Confusion • Postural hypotension (dizziness/lightheadedness)
Diuretics	• Urinary urgency/frequency • Postural hypotension (dizziness/lightheadedness)
Narcotics	• Drowsiness • Poor balance • Less co-ordination • Altered perception • Unsteady mobility
Psychotropics	• Poor balance • Unsteady walking • Altered perception • Drowsiness • Occasional postural hypotension (dizziness, lightheadedness) • Dry eye - difficulty seeing • Stiffness (short term) • Parkinsonism (long term)
Sedatives	• Unsteady mobility • Poor balance • Altered perception • Less co-ordination • Drowsiness
Vasodilators/Cardiac	• Postural hypotension • Dizziness • Lightheadedness

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December 14, 2007

There are many ways to take a tumble

Don't Fall For It!

Ask us how to make your stay a safe one

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Don't Fall For It: Slips and Pills

The following medications can put patients at an increased risk of falls

PSYCHOTROPICS

Antidepressants

SSRIs

Generic	Brand
Citalopram	Celexa
Escitalopram*	Lexapro
Fluoxetine	Prozac
Fluvoxamine	Luvox
Paroxetine	Paxil
Sertraline	Zoloft

* Non-formulary item

TRICYCLIC (TCA) ANTIDEPRESSANTS

Generic	Brand
Amitriptyline	Elavil
Clomipramine	Anafranil
Desipramine	Norpramin
Doxepin	Sinequan
Imipramine	Tofranil
Nortriptyline	Aventyl

OTHERS

Generic	Brand
Bupropion	Wellbutrin, Zyban
Maprotiline	Ludiomil
Mirtazepine	Remeron
Moclobemide	Manerix
Trazodone	Desyrel
Venlafaxine	Effexor XR

Benzodiazepines

LONG ACTING

Generic	Brand
Chlordiazepoxide	Librium
Clonazepam	Rivotril
Diazepam	Valium
Flurazepam	Dalmane

INTERMEDIATE ACTING

Generic	Brand
Alprazolam	Xanax
Bromazepam	Lectopam
Clobazam	Frisium
Lorazepam	Ativan
Nitrazepam	Mogadon
Oxazepam	Serax
Temazepam	Restoril

SHORT ACTING

Generic	Brand
Midazolam	Versed
Triazolam	Halcion

OTHER CNS-ACTIVE AGENTS

Anticonvulsants

Generic	Brand
Carbamazepine	Tegretol
Divalproex	Epival
Gabapentin	Neurontin
Lamotrigine	Lamictal
Oxcarbazepine	Trileptal
Phenobarbital	Phenobarb
Phenytoin	Dilantin
Pregabalin*	Lyrica
Topiramate	Topamax
Valproic Acid	Depakene
Vigabatrin	Sabril

* Non-formulary item

Antihistamines/ Antinauseants

Generic	Brand
Dimenhydrinate	Gravol
Diphenhydramine	Benadryl
Meclizine	Bonamine
Metoclopramide	Maxeran
Prochlorperazine	Stemetil
Promethazine	Phenergan
Scopolamine	Transderm V

Antipsychotics

Generic	Brand
Chlorpromazine	Largactil
Clozapine	Clozaril
Flupenthixol	Fluanxol
Haloperidol	Haldol
Hydroxyzine	Atarax
Lithium	Carbalith, Lithane, Duralith
Loxapine	Loxapac
Methotrimeprazine	Nozinan
Olanzapine	Zyprexa
Perphenazine	Trilafon
Prochlorperazine	Stemetil
Quetiapine	Seroquel
Risperidone	Risperdal
Trifluoperazine	Stelazine

Alzheimer's Drugs

Generic	Brand
Donepezil	Aricept
Galantamine	Reminyl ER
Rivastigmine	Exelon

ANTI-ARRHYTHMIC AGENTS

Cardiac Glycosides

Generic	Brand
Digoxin	Lanoxin

Class 1 Anti-Arrythmic Agents

Generic	Brand
Disopyramide	Rythmodan
Flecainide	Tambocor
Lidocaine	Xylocaine
Mexiletine	
Procainamide	Procan SR
Propafenone	Rythmol
Quinidine	Biquin Durules

ANTI-HYPERTENSIVES

NOTE some patients may be taking combinations of anti-hypertensives

Angiotensin II Receptor Blockers (ARB)

Generic	Brand
Candesartan	Atacand
Eprosartan	Teveten
Irbesartan	Avapro
Losartan	Cozaar
Telmisartan	Micardis
Valsartan	Diovan

ACE Inhibitors

Generic	Brand
Benazepril	Lotensin
Captopril	Capoten
Cilazapril	Inhibace
Enalapril	Vasotec
Fosinopril	Monopril
Lisinopril	Prinvil, Zestril
Perindopril	Coversyl
Quinapril	Accupril
Ramipril	Altace
Trandolapril	Mavik

Beta Blockers

Generic	Brand
Acebutolol	Sectral
Atenolol	Tenormin
Bisoprolol	Monocor
Carvedilol	Coreg
Labetolol	Trandate
Metoprolol	Lopressor, Betaloc
Nadolol	Corgard
Propranolol	Inderal
Sotalol	Sotacor
Timolol	Blocadren

Calcium Channel Blockers

Generic	Brand
Amlodipine	Norvasc
Diltiazem	Cardizem
Felodipine	Plendil, Renedil
Nifedipine	Adalat XL
Verapamil	Isoptin

Vasodilators

Generic	Brand
Clonidine	Catapres
Doxazosin	Cardura
Hydralazine	Apresoline
Isosorbide	Isordil
Methyldopa	Aldomet
Nitroglycerin	Nitro-Dur, Minitran Nitrospray
Prazosin	Minipress
Terazosin	Hytrin

Diuretics

Generic	Brand
Amiloride/HCTZ	Moduret
Furosemide	Lasix
Hydrochlorothiazide	HydroDiuril
Indapamide	Lozide
Metolozone	Zaroxolyn
Spironolactone	Aldactone
Triamterene/HCTZ	Dyazide

NARCOTICS

Generic	Brand
Acetaminophen/Caffeine/Codeine	Tylenol #1/2/3
Acetaminophen/Codeine	Tylenol #4
Acetaminophen/oxycodone	Percocet/Oxycocet
ASA/Caffeine/Codeine	222
Codeine	
Fentanyl	Sublimaze, Duragesic
Hydromorphone	Dilaudid, Hydromorph Contin
Meperidine	Demerol
Methadone	Metadol
Morphine	Statex, MS Contin, Kadian, M-Eslon
Oxycodone	Oxy-IR, Oxycontin
Pentazocine	Talwin
Tramadol/Acetaminophen*	Tramacet

* Non-formulary item

ANTI-PARKINSON AGENTS

Generic	Brand
Amantadine	Symmetrel
Benztropine	Cogentin
Bromocriptine	Parlodel
Entacapone	Comtan
Levodopa/Benserazide**	Prolopa
Levodopa/Carbidopa**	Sinemet
Pramipexole	Mirapex
Ropinerole	Requip
Selegilene	Eldepryl
Trihexphenidyl	

** risk of postural hypotension increases when the patient is also receiving anti-hypertensives

Prevention of Falls & Fall Injuries - Self-Learning Test

1. **A fall is… an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.**

   True ☐ False ☐

2. **All patients will be assessed for falls risk on admission to hospital.**

   True ☐ False ☐

3. **What are 2 questions we ask all patients to assess their fall risk?**

   ☐ Has the patient fallen in the past 90 days?
   ☐ Does the patient have cognitive impairment or a change in mental status?
   ☐ Does the patient have throw rugs at home?
   ☐ What type of shoes does the patient normally wear?
   ☐ Does the patient use a walker?

4. **Bed exit alarms are one effective fall prevention tool and may help reduce restraint use.**

   True ☐ False ☐

5. **Restraint use is an effective fall prevention strategy.**

   True ☐ False ☐

6. **Select the one answer that doesn't correctly explain why patients may be at risk of falling:**

   ☐ Their physical condition
   ☐ Their mental condition
   ☐ Their external environment
   ☐ Their position on capital punishment

7. **Which of the following factors do you think may contribute to being a high falls risk? Select all that apply.**

   ☐ Visual impairment
   ☐ Hearing loss
   ☐ Cognitive problems (eg. dementia or delirium)
   ☐ Neurological conditions (eg. Parkinson's disease)
   ☐ Alcohol addiction
   ☐ Acute infections (eg. urinary tract infection, pneumonia)
   ☐ A history of falling
   ☐ Urinary urgency
   ☐ Has had surgery in the past 24 hours

8. **Medications can increase the patient's risk for falls by which of the following? Select all that apply.**

   ☐ Affecting alertness, judgment, and coordination
   ☐ Some medications may increase postural hypotension (significant drop in blood pressure with a change in position resulting in dizziness)
   ☐ Altering the balance mechanism
   ☐ Affecting mobility by causing stiffness or weakness
   ☐ Keeping the patient sedated
   ☐ Inducing nausea and vomiting

9. Select 4 Universal Fall Precautions from the following list:

- ☐ Ensure that patient knows where personal possessions are and can safely access them
- ☐ Ensure patient footwear is fitted, non-slip and used properly
- ☐ Maintain call bell in reach and have patient demonstrate ability to call for assistance
- ☐ Do not allow any patients to walk to bathroom at night
- ☐ Give each patient a flashlight so that they can use the bathroom at night
- ☐ Posting the Falls sign on the patient's door
- ☐ Use the Caution – Wet Floor signs often

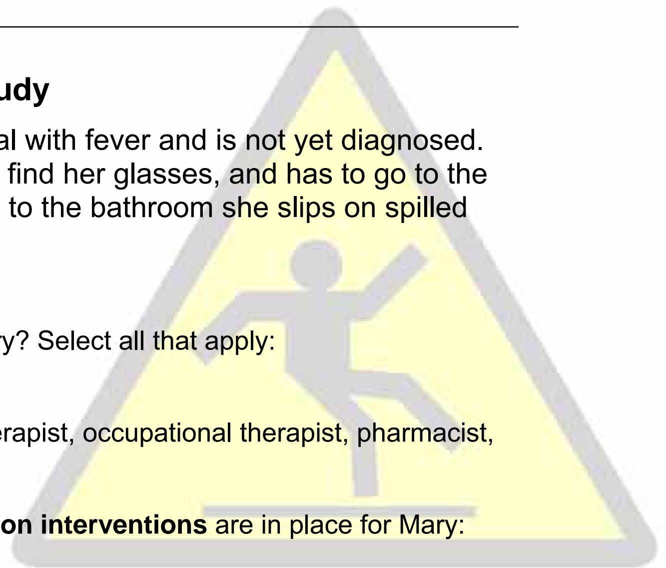
10. Select 4 ways you would communicate to your co-worker that the patient is at high risk of a fall.

- ☐ Falls logo at bedside
- ☐ Transfer of accountability
- ☐ Label spine of patient chart, and Kardex with falls logo sticker
- ☐ Sending an email to the team prior to the end of your shift
- ☐ Putting a sticky note on the patient's chart
- ☐ Telling the patient to let the next shift know he/she is at risk.
- ☐ Your co-worker should already be aware of this by reviewing the patient's chart

11. Which sign is the Falls Logo to identify high risk patients?

12. Select 5 ways to involve the patient and family in falls prevention from the following list:

- ☐ Explain to patient and family the risk for falls
- ☐ Discuss the patient's specific fall risk factors
- ☐ Ensure the patient knows how to use the call bell, and any assistive devices
- ☐ Orient the patient to their environment
- ☐ Provide patient education materials to reinforce the health teaching provided
- ☐ Give the patient a new pair of slippers that fit properly
- ☐ Upon discharge, give the patient the falls sign posted over his/her bed
- ☐ Tell the patient he/she is not allowed to leave the bed until discharge



Case Study

Mary is 44-year-old female who came into hospital with fever and is not yet diagnosed. After an X-ray she comes back to her room, can't find her glasses, and has to go to the bathroom. She is tired and hungry. While walking to the bathroom she slips on spilled water and falls.

How would you **implement** a post-fall protocol for Mary? Select all that apply:

☐ Post falls assessment by the health care team
☐ Involve all members of the team - Nurse, physiotherapist, occupational therapist, pharmacist, physician, social worker, dietitian

Select **9** ways you can **ensure high-risk fall prevention interventions** are in place for Mary:

☐ Ensure the Falls symbol logo is placed at Mary's bedside
☐ Label the spine of the patient chart and Kardex with the Falls symbol sticker
☐ Consider placing Mary in a room near the nursing station or in an area of high visibility
☐ Reorient Mary to her surroundings as needed
☐ Monitor Mary regularly and reassess her level of risk for falls when her medical condition changes
☐ Communicate Mary's high risk for falls during Transfer of Accountability
☐ Identify specific risk factors and make multidisciplinary referrals.
☐ Assist with transfers and ambulation
☐ Provide Mary with patient education materials
☐ Upon discharge, give Mary her own personal copy of the Falls logo

Select **5** things you would include in the **Safety Occurrence report** from the following list:

☐ What Mary was doing at the time of the event
☐ Environmental factors leading up to occurrence (whether the floor was wet/dry, whether bed rails were up/down)
☐ Equipment factors leading to the occurrence
☐ A description of the injury
☐ Mary's pre-occurence condition (alert and oriented, confused/disoriented, combative, sedated, anesthetized, non-responsive)
☐ Whether or not Mary was watching television
☐ Whether or not Mary has a room-mate

Select **3** ways you can **communicate with Mary and family** to reduce the risk of falls:

☐ Orient Mary and her family to the unit and fall prevention strategies.
☐ Encourage family cooperation
☐ Provide patient education materials
☐ Call Mary at home after discharge
☐ Ask the next shift to follow through with the communication to Mary and her family

Tips for reducing your risk for falls

While you are here with us in the hospital.

Why are falls a major concern in the hospital?

Falls lead to injury and loss of independence. 1 in 3 people who have fallen in the past few months will likely fall again.

Am I at risk for falling?

If you can answer yes to any of these questions you are at risk for falling.

- ❒ Have I ever fallen or lost my balance?
- ❒ Do I ever feel unsure or unsteady when I walk?
- ❒ Have I stopped doing things because I am afraid of falling?
- ❒ Are you confused at times?

Here are some ways to help you to reduce your risk for falling and help you maintain your independence:

Get to know your room

Look for:

- ✓ the call bell
- ✓ grab bars
- ✓ overhead light switch

Be safe in your room

- Know your way to the bathroom! Map out a safe, clutter-free path to the bathroom.
- Call for help when getting up until we feel you are safe to do this by yourself.
- Ask for help to clean up spills or to pick up items you may have dropped such as tissues and clothes.
- Do not lean on overbed tables with wheels.
- Keep frequently used items such as the phone nearby.
- Use a “reacher” for hard to reach items.

Clothing

- Should be easy to put on.
- Wear a belt or suspenders to keep those pants up!
- Shoes should have good support, fit well, and have rubber soles.

Get up safely

- Ring the call bell for help when getting up until we all decide it is no longer necessary.
- If you feel lightheaded when you sit up from lying down, pump your feet until the feeling goes away.
- Get up slowly.
- Make sure your feet are flat on the floor before standing.
- Sit down right away if you feel dizzy.

To keep yourself safe

- Do not walk around in socks.
- Do not rush to the bathroom or to answer the phone. It is hard to concentrate on being safe when rushing and this is when most falls happen.
- Don’t wait until the last minute to get help to go to the bathroom.

Equipment

- Keep your wheelchair, walker or cane nearby.
- Lock your wheelchair or walker brakes before you begin to stand up or sit down.
- Lock brakes when not in use.

Wear your glasses and hearing aids when awake.

Participate

- Take an active part in your rehabilitation plan. We will discuss your plan and progress with you.
- Working on your strength, flexibility, and endurance are key ways to prevent a fall!

We kindly acknowledge the work done by the Falls Prevention Committee, Henderson Rehabilitation, Hamilton Health Sciences. This resource has been adapted for hospital-wide use with their permission.

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Hamilton Health Sciences

Best Practice for Prevention of Falls

BEST PRACTICE Watch us shine in the spotlight	There are many ways to take a tumble: **DON'T FALL FOR IT!**
1. **Why is it being implemented?**	• **26% of all HHS patient incidents are fall-related** • **Builds on RNAO Best Practice Spotlight Organization Guideline Strategy that has contributed to a reduction in HHS pressure ulcer incidence from 15% to 9% (2006-2007)** • **Accreditation Required Organization Practice** • **HHS Strategic Initiative for 2007-2008**
2. **How will my unit be impacted?**	• **Builds on fall prevention work being done in many areas** • **All clinical staff receive inservice or e-learning January to June 2008** • **All regulated health care professionals and other staff providing direct care to patients and families are required to complete Part 1 and 2 of the e-learning education** • **Health care providers who are not providing direct care will be required to complete only Part 1 of the e-learning education** • **Fall risk signage to be placed at each bedside on patient charts** • **Medications contributing to fall risk posted on each unit** • **Stryker Bed Alarms connected to unit call bell systems where available** • **Pharmacy-led team review of medications for patients who fall or are identified as at increased risk** • **In depth implementation on RNAO Best Practice Spotlight Units**
3. **Main Message for Staff**	**Patients at increased risk:** • **F allen Previously** • **A ge >65 years** • **L osses in cognition** • **L ots of obstacles** • **S lips and Pills**
4. **Who is sponsoring the initiative?**	• Executive Sponsor, Nancy Fram, VP of Professional Affairs and Chief Nursing Executive • Accreditation Team • Registered Nurses Association of Ontario & MOHLTC of Ontario
5. **How will this impact on patient care?**	• Consistent assessment of fall risk • Early intervention to prevent falls: exit alarms on beds, risk identified on charts and call be systems, fall risk signage at each bedside, patient and family education packages, medications contributing to fall risk posted in medication rooms • Predicted reduction in patient morbidity and LOS associated with severe falls
6. **Questions or Concerns?**	• **Clinical Managers in Patient Care Units** • **Project Lead: Sandra Ireland Extension 44377** • **Project Coordinator: Bev Morgan 46967**