DEER LODGE CENTRE *Making lives better*			Level:
	Policy Name: **Falls Management: Assessment & Intervention**	WRHA Policy #:	Page 1 of 7
	Approval Signature: *Original Signed by Sylvia Ptashnik, DORS*	Section: Safety & Comfort	
	Date: September, 2012	Supercedes: February 2012	

1.0 PURPOSE:

1.1 To ensure falls assessment and management is carried out in a prompt and consistent manner utilizing validated best practice assessment tools.
1.2 To identify patient fall risk factors
1.3 To provide direction for the interdisciplinary team to incorporate and develop best practice fall prevention strategies.
1.4 To decrease the incidence of falls and fall injuries.

2.0 DEFINITIONS:

2.1 For a listing of position classifications with definitions, refer to the Deer Lodge Centre (DLC) shared file: H:\Administrative P & P\Clinical Policy & Procedure Manual
2.2 Routine Practice for Falls: Mechanism developed for Long Term Care facilities for fall assessment applicable to all patients regardless of fall history. This shall be used throughout Deer Lodge Centre.
2.3 Patient – For the purposes of this policy, patient is equivalent to patient/resident/client

3.0 POLICY:

3.1 The patient care plan shall be developed and updated to include individualized and appropriate interventions to prevent falls and reduce the risk of injury based on risk assessments.
3.2 If a patient has a fall, an assessment shall be undertaken to assess the risk for further falls and determine additional strategies to reduce fall and injury risk.
3.3 Regardless of risk, fall risk factors and interventions shall be reviewed by the interdisciplinary team at least quarterly and after every fall.
3.4 All patients shall be placed on an hourly rounding routine for the first 72 hours of admission.
3.5 Documentation in patient's health record(s) shall be completed according to program/unit protocol. Document all unusual observations and patient/resident responses.

4.0 PROCEDURE:

4.1 **Refer to Falls Protocol Algorithm** (CL0261 – W Appendix A).

4.1.1 On admission, review the patient pre-admission documentation including a review of fall history and risk factors.

4.1.2 Initiate Routine Practice for Falls for **all** patients on admission.

- **F- Family** and substitute decision makers and/or patient will communicate falls risk and history of falls prior to or at admission
- **A- Assess**—pain, elimination status, hunger, thirst, ability to use call bell, vision, hearing, communication, cognition, adaptation to environment, mobility.
- **L—Look** at environment and reduce hazards.
- **L—Lying** and sitting/ standing Blood Pressure
- **S—Show** surroundings – orient patient to environment

4.1.3 Initiate Hourly Rounding for **all** patients for the first 72 hours after admission.

- All new admissions should be placed on hourly rounding for the first 72 hours (patients newly admitted are at increased risk for falls).
- After 72 hours, Integrated Progress Note (IPN) documentation is required outlining any noted fall risk patterns and whether hourly rounding is to continue or to be discontinued.
- Utilize hourly rounding as one of many fall intervention options for any patient who staff feel would benefit from the strategy.

4.1.4 Complete the Falls Risk Assessment Tool (FRAT # CL0221-5 Appendix B) within 24 - 48 hours for **all** patients. Note: For Personal Care Home program the FRAT is completed along with the Minimum Data Set (MDS). A Falls Resident Assessment Protocol (RAP) may be triggered when completing the MDS which will lead to further risk assessment.

- Determine risk classification level from page one of the FRAT tool and complete page two which identifies specific risk factors that may also be impacting fall risk.
- If a patient is deemed to be at HIGH RISK FOR FALLS, note as a Focus Problem on the chart and place a Fall Risk decal at head of bed. Consult appropriate disciplines and review need for fall related equipment (See Fall Equipment Selection Algorithm (CL0262 -W Appendix C).
- If the patient has a recent fall history prior to admission to Deer Lodge Centre and the FRAT indicates a LOW/MEDIUM RISK FOR FALLS, consider the patient HIGH RISK FOR FALLS and proceed as above.
- Once the patient is considered a HIGH RISK you do not need to repeat the FRAT with each new fall but FRAT tool needs to be reviewed for possible risk factor changes.
- Review Interventions and Care Plan regularly including as applicable: after a fall, at Post Admission Conference and at Inter-Disciplinary Quarterly Team meetings.(Hint: Regardless of fall risk, re-doing the FRAT prn or quarterly may be helpful but is optional)

4.1.5 A Care Plan shall be formulated by the interdisciplinary team which includes individualized multi-factorial fall and injury prevention strategies to address risk factors identified from the FRAT tool regardless of the patient's level of risk. Use: H:\Administrative P & P\Clinical Practice Guidelines\WRHA Falls Prevention CPG 2011.pdf

4.2 Refer to policy: Falls Management: Management of a Fall H:\Administrative P & P\Clinical Policy & Procedure Manual\2 - Safety and Comfort\Falls Management - Managing a Fall.pdf when dealing with a fallen patient (i.e. checking for injury, assisting and monitoring patient, documentation).

5.0 REFERENCES:

5.1 Registered Nurses' Association of Ontario. (January 2007). Falls Prevention: Building the Foundations for Patient Safety

5.2 Winnipeg Regional Health Authority (2011). Falls Prevention and Management: Regional Clinical Practice Guidelines.

5.3 Winnipeg Regional Health Authority (2010). Falls Management in Personal Care Homes – Assessment of Risk-Routine Practice for Falls, Policy #110.130.100.

Policy Contact: Clinical Nurse Specialist

Appendix A: FALLS PROTOCOL ALGORITHM

Patient / Resident admitted to DLC (Rehab / Chronic Care / PCH / Day Hospital)

Initiate Routine Practice for Falls Prevention

- **F** amily to provide fall history
- **A** ssessment of needs and abilities
- **L** ook at environment / hazards
- **L** ying/standing BP
- **S** how surroundings and orientate

Initiate Hourly Rounding on admission for 72 hours

Administer Falls Risk Assessment Tool (FRAT)

(On admission)

High Risk
(Note as Focus problem)

Low / Medium Risk

Provide High Risk Decal

If resident falls after admission = HIGH RISK
(Re-do FRAT)

Consult:
Physician – prior & new medical problems, medications, orthostatic hypotension
Physiotherapy – mobility / gait aids / transfers
Occupational Therapy – equipment / wheelchair
Pharmacy - medication review
Nutrition services – nutrition / hydration

Consider:
- **Falls Equipment** (refer to Falls Equipment Selection Algorithm – Form # CL0262-W)

- **Refer to Falls Assessment and Management Regional Clinical Practice Guidelines.**
- **Interventions / Care Plan should address Risk Factors identified on FRAT Tool**
- **Reassess need for Hourly Rounding after 72 hours**

Review Interventions / Care Plan regularly: after a fall; at Post Admission Conference; at Inter-Disciplinary Quarterly Team meetings.

(Optional: Regardless of fall risk, re-doing the FRAT prn or quarterly may be helpful)

Appendix B: FALLS RISK ASSESSMENT TOOL

PART 1: FALL RISK STATUS

HISTORY OF FALLS Note: For an accurate history, consult resident / family / health records.

Falls prior to this admission: home or referring facility ☐ and/or during current stay ☐
Fell in past 30 days ☐
Fell in past 31-180 days ☐

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS (To score this, complete history of falls above)	none in last 12 months…… one or more between 3 and 12 months ago…… one or more in last 3 months…….. one or more in last 3 months while a resident /inpatient ….	2 4 6 8
MEDICATIONS (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-hypertensive, Hypnotics, Narcotics)	**Categories of medications:** not taking any of these…… taking one…….. taking two…….. taking more than two……	 1 2 3 4
PSYCHOLOGICAL (Anxiety, Depression, ↓Cooperation, ↓Insight or ↓Judgement **esp. re mobility)**	does not have any of these…….. mildly affected by one or more…… moderately affected by one or more…… severely affected by one or more……	1 2 3 4
COGNITIVE STATUS (MMSE: Mini Mental Status Exam) (CPS: Cognitive Performance Scale)	MMSE 25 **Or** CPS 0 **Or** intact…… MMSE 19 **Or** CPS 2 **Or** mildly impaired…… MMSE 15 **Or** CPS 3 **Or** mod. impaired……. MMSE 5 **Or** CPS 6 **Or** severely impaired	1 2 3 4

BP lying _____ BP sitting/standing_____

Pulse _____ Pulse _____

Automatic High Risk Status: (*if one of the following applies, circle* **HIGH** *risk below*)

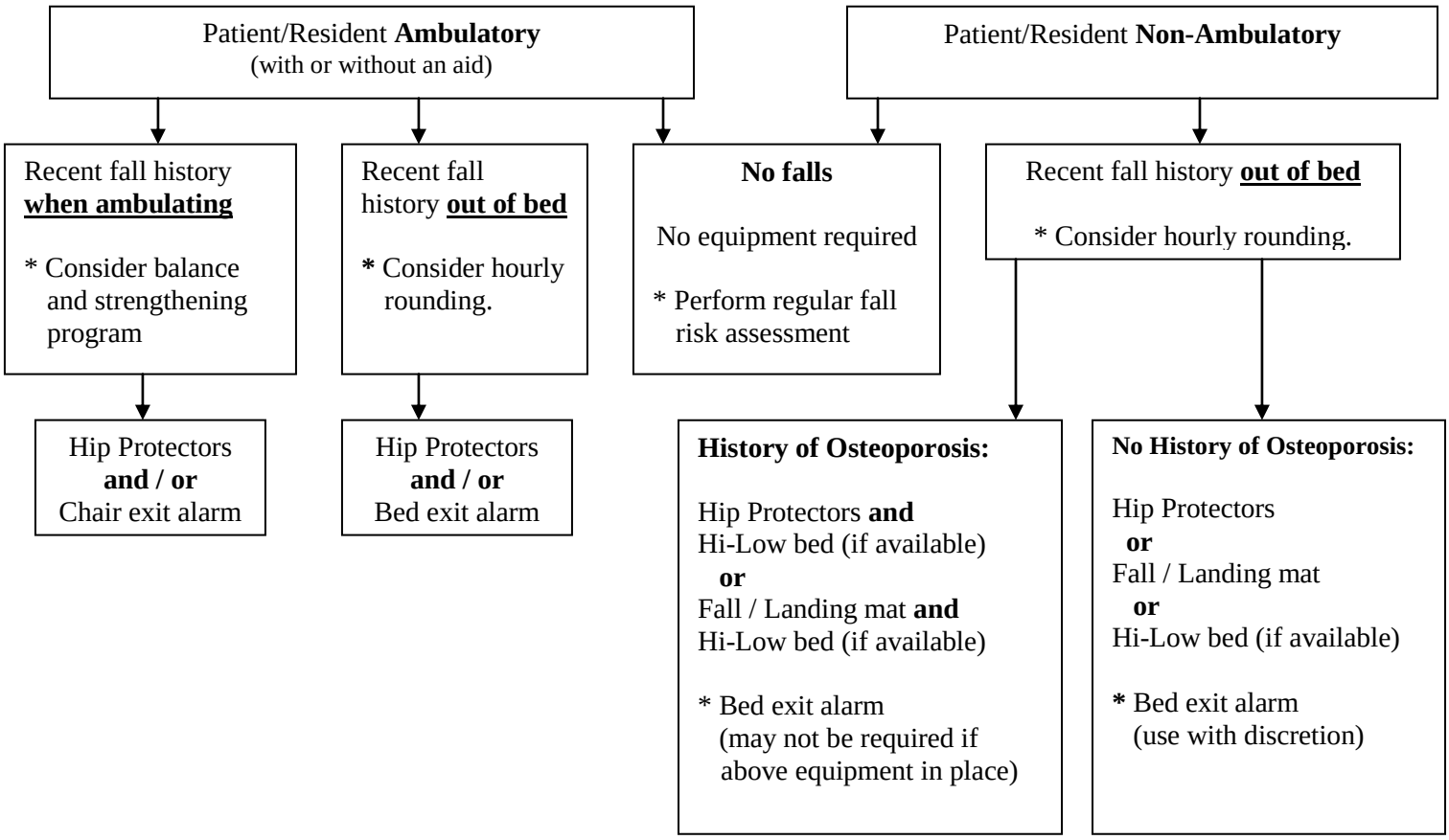
☐ Recent change in functional status affecting safe mobility
☐ Dizziness / orthostatic hypotension

(Low risk: 5-11 Medium Risk: 12-15 High Risk: 16-20) **RISK SCORE** **/20**

PART 2: RISK FACTOR CHECKLIST ***Refer to the WRHA PCH Falls Assessment and Management Clinical Practice Guideline for recommendations on interventions for all risk factors marked with a Y (yes).***		**Y/N**
Vision	Reports / observed difficulty seeing – objects / signs / finding way around	Y N
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid	Y N
Behaviours	Observed or reported agitation, confusion, disorientation	Y N
	Difficulty following instructions or unaware of limitations.	Y N
Activities of Daily Living (A.D.L.'s)	Observed risk-taking behaviours, or reported from previous facility	Y N
	Observed unsafe use of equipment	Y N
	Unsafe footwear / inappropriate clothing	Y N
Environment	Difficulties with orientation to environment i.e. areas between bed / bathroom / dining room	Y N
Nutrition	Underweight	Y N
	Low appetite	Y N
	Not taking Vitamin D supplement	Y N
Hydration	Shows signs and symptoms of dehydration: dry mouth, decreased urine output/amber colored urine, poor skin turgor.	Y N
Continence	Reported or known urgency / nocturia / incontinent episodes	Y N
Other		Y N

Appendix C: FALLS EQUIPMENT SELECTION ALGORITHM

- **Complete Falls Risk Assessment Tool (FRAT)**
- **Refer to Falls Policy and Procedures and Clinical Practice Guidelines**
- **Create individualized Care Plans based on identified risks**



- Equipment options listed above need to be individualized and it **may not be appropriate** to use all equipment for a particular patient/resident.
- If the patient/resident has not fallen in the past 30 days, please reassess and return the equipment to CSR for cleaning so it can be utilized for individuals who are more actively falling and acutely at risk.
- For questions related to falls management, refer to the Falls Management Policy and Falls Protocol Algorithm (Appendix A).

Appendix D: Hourly Rounding Schedule

DEER LODGE CENTRE
Making lives better

KEY for Intervention	
C=	Comforting
T=	Toileting
P=	Positioning
S=	Sleeping

- Place code(s) from the KEY along with staff initials in scheduled rounding periods
- Provide IPN rationale for continuing or discontinuing hourly rounds after 72 hours

Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	
Date																
Nights	0000		0100		0200		0300		0400		0500		0600		0700	
Days	0800		0900		1000		1100		1200		1300		1400		1500	
Evenings	1600		1700		1800		1900		2000		2100		2200		2300	

CL0268 - 7 (2012/07)

Hourly Rounding Flow Sheet
Nursing