nova scotia health

# Policy & Procedure

| Policy Title: | Falls and Injury Reduction | |
|---|---|---|
| Applies To: | All Team Members | |
| Related Procedure(s): | See PROCEDURE Section for list | |
| Approved: April 5, 2022 | Effective: May 3, 2022 | Next Review: April 5, 2026 |
| Sponsor: | Senior Director, Interprofessional Practice and Learning | |
| Approval Authority: | VP, Research, Innovation and Discovery | |
| Number: CL-SR-010 | Manual: Interdisciplinary Clinical | |

## PURPOSE

This policy provides Team Members with direction on reducing the rate of Falls and related injuries to patients.

## COMPETENCY REQUIREMENTS

1. All Team Members must obtain initial education on Universal Falls Precautions.
   1.1. Team Members must perform a self-assessment of competence annually, or more frequently if indicated in their applicable Falls procedure(s).
2. Team Members responsible to complete assessments and develop interventions must obtain initial education found in LMS.
   2.1. They must perform an ongoing self-assessment of competence and address any deficits identified with immediate supervisor or repeat education if indicated in their applicable Falls procedure(s).

## POLICY STATEMENTS

1. All Team Members must implement Universal Falls Precautions in their respective work areas (refer to Appendix B).
2. All Patients must be assessed for Falls risk.
   2.1. Clinical leadership in each program/setting is responsible to:
      - Select an evidence based validated tool/method to assess Falls risk (as per the applicable procedure), and

- ☐ Ensure Team Members responsible to complete assessments receive training.

3. A Falls risk assessment must be performed (at a minimum):
   - On initial contact or on admission
   - When there is a change in condition
   - At Transitions of Care, and
   - Post Fall

> **NOTE:** In Long-term care (LTC) settings, falls risk assessments are performed on a monthly basis.

## Strategies to Reduce Number of Falls and Falls Related Injuries

4. Settings that use care plans must ensure that patients deemed high risk for Falls have a Fall and injury reduction care plan.
   4.1. Interventions identified must be included in the patient's care plan.
   4.2. Team Member must engage the patient in the development of the care plan.
5. Team Members must refer to Relevant Local Policy related to Least Restraint when providing interventions.
6. Education must be offered to the patient and their support persons, encouraging them to play an active role in Falls and injury reduction.
7. Falls and injury reduction strategies must be included in the discharge plan, if required.

## Documentation of Falls Risk Assessment and Interventions

8. All assessments and interventions, including if clinical judgment is used, must be documented in the patient's health record.
9. If interventions and/or education are refused, this must be documented in the patient's health record.

## Communication of Falls Risk and Interventions

10. For internal and external transfers, Falls risk and care plan must be communicated to the receiving care Team Member using local documentation tool (e.g., Ticket to Ride, Transfer of Accountability (TOA) form) and/or verbal communication.
    10.1. If Falls risks identifiers are used as a communication strategy, they must be ordered from Library Services.

## Safety Improvement and Management System (SIMS) Reporting and Quality Review

11. All Falls including near miss and no harm events must be reported in SIMS and followed up as per NSHA AD-QR-015 Patient Safety Incident Management.

***This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.***

12. Falls that are Serious Reportable Events (SREs) must be reviewed as per NSHA AD-QR-005 Quality Review.

### Evaluation

13. The effectiveness of the Falls and injury reduction strategies and education/information must be regularly evaluated by clinical leadership and results used to make improvements.
14. Audits must be performed monthly (at a minimum) using organization-wide data collection tool.
    14.1. Additional audits are not required but encouraged for Quality Improvement (QI) monitoring purposes.

## PRINCIPLES AND VALUES

1. Everyone, including staff, volunteers, patients, and family members has a role in Falls and injury reduction.
2. Patient choice to live with risk is to be respected.
3. It is important to regularly evaluate whether current practices are effective and are meeting client, family, and team member needs.
    3.1. Effectiveness can be evaluated through a variety of means (e.g., informal discussions, interviews, surveys, audits, or evaluation processes).

## PROCEDURE

1. Refer to the following Falls and injury reduction procedures, as applicable:
    - **Long Term Care** (CL-SR-010.01)
    - **Inpatient Rehabilitation Services** (CL-SR-010.02)
    - **Ambulatory Cancer Care** (CL-SR-010.03)
    - **Primary Health Care** (CL-SR-010.04)
    - **Women's and Children's Health** (CL-SR-010.05)
    - **Renal Services** (CL-SR-010.06)
    - **Laboratory Services** (CL-SR-010.07)
    - **Mental Health and Addictions** (CL-SR-010.08)
    - **Emergency Departments** (CL-SR-010.09)
    - **Patients' Homes** (CL-SR-010.10)
    - **Inpatient Population** (CL-SR-010.11)
    - **Critical Care** (CL-SR-010.12)
    - **Ambulatory Care** (CL-SR-010.13)

*This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.*

- **Day Surgery/Invasive Procedures** (CL-SR-010.14)
- **Diagnostic Imaging** (CL-SR-010.15)

## REFERENCES

Agency for Healthcare Research and Quality. (2013). *Preventing falls in hospitals.* https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3n.html

Benesch, C.G., McDaniel, K.D., Cox, C., & Hamill, R.W. (1993). End-stage Alzheimer's disease. Glasgow coma scale and the neurological examination. *Archives of Neurology, 50*(12), 1309-15. DOI: 10.1001/archneur.1993.00540120024008

Aranda-Gallardo, M., Morales-Asencio, J.M., Canca-Sanchez, J.C., Barrero-Sojo, S., Perez-Jimenez, C., Morales-Fernandez, A., Enriquez de Luna-Rodriguez, M., Moya-Suarez, A.B., & Mora-Banderas, A. (2013). Instruments for assessing the risk of falls in acute hospitalized patients: a systematic review and meta-analysis. *BMC Health Services Research, 13*(122). https://doi.org/10.1186/1472-6963-13-122

da Costa, B. R., Rutjes, A. W., Mendy, A., Freund-Heritage, R., & Vieira, E. R. (2012). Can falls risk prediction tools correctly identify fall-prone elderly rehabilitation inpatients? A systematic review and meta-analysis. *PloS one*, *7*(7), e41061. https://doi.org/10.1371/journal.pone.0041061

Gardner, R.C., Dams-O'Connor, K., Morrissey, M.R., & Manley, G.T. (2018). Geriatric traumatic brain injury: Epidemiology, outcomes, knowledge gaps, and future directions. *Journal of Neurotrauma, 35*(7), 889-906. https://doi.org/10.1089/neu.2017.5371

Jagoda, A.S., Bazarian, J.J., Bruns, J.J., Cantrill, S.V., Gean, A.D., Howard, P.K., Ghajar, J., Riggio, S., Wright, D.W., Wears, R.L., Bakshy, A., Burgess, P., Wald, M.M., & Whitson, R.R. (2008). Clinical Policy: neuroimaging and decision-making in adult mild traumatic brain injury in the acute setting. Annals of Emergency Medicine,52(6): 714-48. https://doi.org/10.1016/j.annemergmed.2008.08.021

Lee, J., Geller, A.I, & Strasser, D.C. (2013). Analytical review: focus on Fall screening assessments. *Physical Medicine & Rehabilitation, 5*(7), 609-21. https://doi.org/10.1016/j.pmrj.2013.04.001

Matarese, M., Ivziku, D., Bartolozzi, F., Piredda, M., & Grazia De Marinis, M. (2014). Systematic review of fall risk screening tools for older patients in acute hospitals. *Journal of Advanced Nursing*, *71*(6), 1198–1209. https://doi.org/10.1111/jan.12542]

Park S. H. (2018). Tools for assessing fall risk in the elderly: a systematic review and meta-analysis. *Aging Clinical and Experimental Research*, *30*(1), 1–16. https://doi.org/10.1007/s40520-017-0749-0

Registered Nurses' Association of Ontario. (2017). Appendix K: Components and example of universal falls precautions. In *Preventing falls and reducing injury from falls* (4th ed., pp. 113-115). https://rnao.ca/sites/rnaoca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf

Royal College of Physicians and Surgeons of Glasgow. (n.d.). *The Glasgow structured approach to assessment of the Glasgow coma scale*. https://www.glasgowcomascale.org/

Schonnop, R., Yang, Y., Feldman, F., Robinson, E., Loughlin, M., & Robinovitch, S.N. (2013). Prevalence of and factors associated with head impact during falls in older adults in long-term care. *Canadian Medical Association Journal, 185*(17), E803-10. DOI: 10.1503/cmaj.130498

Swartzell, K. L., Fulton, J. S., & Friesth, B. M. (2013). Relationship between occurrence of falls and fall-risk scores in an acute care setting using the Hendrich II fall risk model. *Medsurg Nursing*, *22*(3), 180–187.

## RELATED DOCUMENTS

**Policies**

CEHHA 308-016 Least Restraint

CBDHA A-3-024 Least Restraint

CDHA CC 05-030 Least Restraint

NSHA CL-SR-001 Use of Pinel Restraints for Rapid Physical Restraint

PCHA 10-r-10 Least Restraint

SSH-NU-100-785 Least Restraint

NSHA CL-AP-045 Use of Patient Attendants

**Other**

Patient Education Material

**Appendices**

Appendix A: Definitions

Appendix B: Universal Falls Precautions

## Appendix A: Definitions

| | |
|---|---|
| **Fall(s)** | Fall is the unintentional coming to rest on the ground, floor, or other lower level with or without an injury. |
| **Relevant Local Policy** | Policies of the former district health authorities that are in effect until superseded by Nova Scotia Health policy. |
| **Serious Reportable Events (SREs)** | All matters which reach the levels of severe incident or death in the SIMS severity rating scale and includes but is not limited to Serious Reportable Events (SREs) as identified in the Nova Scotia Health & Wellness Serious Reportable Event Reporting Policy. |
| **Team Members** | Refers to all employees, physicians, learners, and volunteers. |
| **Transitions in Care** | Refers to the movement of the patient from one setting of care to another. Setting of care may include a different facility or different units/departments within the same facility. |

***This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.***

## Appendix B: Universal Falls Precautions

### Safe Environment

- Bottom bed rails down unless assessed otherwise
- Pathways are clear of clutter and tripping hazards
- Bed and chair alarms are “on”
- Lights are working and “on” as required

### Assist with Mobility

- Mobilize at least twice a day
- Safe and regular toileting
- Transfer and mobility assist documented
- Keep eyeglasses, hearing, mobility aides within patient’s reach

### Falls Risk Reduction

- Call bell in 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/Injury reduction plan developed

## Version History

| Version: | Effective: | Approved by: | What's changed: |
|---|---|---|---|
| Original | 2017-06-01 | ELT | N/A |
| Revised / Reaffirmed | 2022-05-03 | VP, Research, Innovation and Discovery | • Implementation of Universal Falls Precautions in all areas.<br>• Added clinical judgment as an appropriate method to assess.<br>• 15 program/area specific procedures added.<br>• Recommended unit/area audits using RED Cap system. |

*This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.*