Falls Risk Management:
What do I need to know?

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Fall Risk Management Program
Senior’s Health Calgary Zone
Calgary Fall Risk Management Program
Discussion points

- Understanding the impact of falls
- Alignment with AHS Level 1 Falls Policy
- Collaborative approach to care
- Best practices in Falls Risk Management
- Factors that increase fall risk or risk of harm from a fall
- Tools and Resources
Falling Can Lead to:

• Injuries

• Fear of falling

• Loss of independence

• $$$$ cost to system
The “Grey Tsunami”

Alberta Population Projections, 2017-2041 (Medium Scenario).
Continuing Care

- Home Living
- Supportive Facility Living
- Long Term Care
- Blended Care Models
Resources and working together

• Provincial Framework and Fall Risk Management Model
  – Province wide as of 2014

• Fall Risk Management Level 1 Policy – 2015

• Zone based initiatives, Provincial Falls Collaborative
Provincial Fall Risk Management

Falls Risk Management

This page provides overarching information, tools and templates to support any clinical unit, program, or site to develop and implement a Falls Risk Management (FRM) program. These resources can be used for any setting and age group for which AHS provides service. Falls Prevention is defined as a critical component of a comprehensive Falls Risk Management Program. Customized zone resources can be accessed to the left.

- Falls Risk Management Policy

General Information

- Framework
  - Framework Background
- Model
- Strategy Development Resource Guide
- Health Promotion/Primary Prevention
- Screening & Assessment Tools
- Interventions for Adults & Older Adults
- Interventions for Pediatrics
- Environmental Factors
  - Community Environmental Falls Checklist
  - Universal Falls Precautions
- Post-Falls Review
- Quality Improvement
- Evaluation & Measurement
- Tools & Resources
- Additional Resources

Quick Reference Links

- Falls Prevention Webinar
- Falls Risk Strategy COP
- NTCE Guideline CG161
- AGS/BGS Guidelines
- Take Action: Prevent a Fall Before It Happens

Reduce Falls & Injurious Falls

Find Balance

www.albertahealthservices.ca
What is a fall?

“All unintentional change in position where the resident ends up on the floor, ground or other lower level, with or without injury” (Canadian Fall Prevention Curriculum 2007)
• Falls are NOT a normal part of aging
• Most falls can be prevented
• Take action to prevent falls
Primary Prevention

- Universal Fall Precautions
- Exercise / Recreation Programs
- Education
- Increasing awareness
Primary Prevention Resources

- Finding Balance AB
  http://findingbalancealberta.ca/

- MyHealth.Alberta.ca – Preventing Slips, Trips, and Falls
  https://myhealth.alberta.ca/Alberta/Pages/resources-fall-prevention.aspx

- Fall Prevention Month
  http://fallpreventionmonth.ca/

- Health Promotion/Primary Prevention on Insite or CCD
Screening

Screen all adults to identify those at risk for falls

- Validated tools available depending on program of care

Screening should include:

- Identifying a history of falls *(AGS/BGS, RNAO)*
- Evaluation of gait and balance/mobility *(AGS/BGS, RNAO)*
- Clinical judgement *(RNAO)*
Communicating Fall Risk

Share results

How is fall risk communicated?

• To client and family

• To other staff
Assessment

- Detailed and systematic
- Multifactorial and Interdisciplinary approach is best practice
- Refer clients to appropriate clinicians or ID team who are:
  - complex
  - multiple co-morbidities or risk factors
  - frequent fallers
Risk Factors

- Residing in facility for 2 or more years
- Fall in last 3 months
- Residing in a secure unit
- Blood Pressure
- Depression
- Environment
- Dizziness
- Muscle Weakness
- Dementia
- Vision
- Toileting issues
- Multiple comorbidities

- Balance
- Delirium
Interventions

Includes:

• Universal Fall Precautions in place for everyone

• Targeted, client-specific interventions to address identified fall risks
Universal Fall Precautions

Insite

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- Evaluation & Measurement

CCD

Image of CCD interface with various options and categories related to Falls Risk Management.
# Fall Risk Management Suggested Interventions

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Interventions to Consider</th>
<th>Suggested Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Cognition   | • Use “NOC” (Name, Occupation, Date).  
              • Give clear, simple instructions and give the resident time to process the instruction. Consider verbal and written reminders, use pictures, involve family.  
              • Assess for signs of delirium (i.e. CAM).  
              • Review personal directive.  
              • Consider enhancements to care or environment to decrease risk (i.e. recruit family or suggest private companion to sit with high risk resident, provide directional activities and increased observation at high risk times).  
              • Consider formal mental status assessment.  
              • Reinforce safe transfer technique/use of aids. | • Provide anticipatory nursing care (i.e. Comfort Rounds) — scheduled toileting, ensure assistive devices are within resident’s reach, encourage hydration/nutrition as appropriate, ensure pain is managed.  
              • Harm reduction strategies (may include hip protectors, padded flooring, head protection, bed alarm).  
              • Consider motivation for unsafe behaviors that the resident cannot express (i.e. hoarding, toileting, fear, pain). | PT  
              QM  
              Rec Therapy  
              NP |
| Behavior    | • Consider behaviour change strategies to address resident’s needs for safety recommendations.  
              • Address anxiety, fear of falling.  
              • Consider Negotiated Risk Agreement.  
              • Consider behaviour mapping. | • Address financial hardship or constraint issues.  
              • Address sleep hygiene, promote sleep continuity.  
              • Be aware of harm reduction strategies for managing alcohol and/or other substances. | SW/Psychologist  
              Physic/Psychiatrist  
              Psychiatrist  
              NP |
| Medication  | • Review medications (Best Possible Medication History — BPMH).  
              • Refer to physician or pharmacist for medication review — provide written context for conservative.  
              • Assess and note side effects of medications which may result in drops in blood pressure, behavioral change, decreased level of consciousness.  
              • Refer to physician for review. | • Vitamin D and dietary calcium intake for fracture prevention (increased risk of fracture related to osteoporosis/osteopenia).  
              • Develop care plan to deal with behavioral issues to help decrease use of medications (i.e. antipsychotics).  
              • Anti-coagulation or anti-platelet therapy — watch for increased risk of bleeding. | Physician  
              Pharmacist  
              Dietitian  
              NP |
| Physical Status | • Check for postural hypotension. Monitor lying and standing/sitting BP. Notify physician of postural drop > 20 mm systolic or > 10 mm diastolic.  
              • Check pulse — investigate irregularities.  
              • Note history of dizziness, fainting or “Blacking out”. | • Review medications.  
              • Educate resident and staff to change position slowly.  
              • Ensure adequate hydration and nutrition.  
              • Assess for sedation.  
              • Consider referral for vestibular/balance evaluation. | NP  
              Pharmacist  
              PT  
              Physician  
              Dietitian |
Fall?

Primary Prevention

Screening and Identification

Post Fall Assessment

Assessment

Interventions

Fall?
Post Fall

1. Assess
2. Monitor
3. Huddle
4. Change Care Plan
• Site professional nurse to complete post falls Head to Toe

• Notify physician and family as per protocol

• Notify RN / Supervisor of all falls
• Vital signs and pain for all falls

• Neural Vital Signs (GCS) for all unwitnessed falls AND witnessed falls with suspected head injury

• Monitor for 24-48 hours.
Concussion and Traumatic Brain Injury

37% of seniors with fall-related traumatic brain injury are admitted to hospital........

Injury Prevention Centre 2017
**Post-Fall Clinical Monitoring**

**Part A:** Complete for any client that experiences a fall. Abnormal findings must be documented in narrative charting. Refer to Blood Glucose monitoring if client is diabetic.

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>1st Check</th>
<th>Q 30 mins x 1 hour</th>
<th>Q 1 hour x 3 hours</th>
<th>Q 8 hours x 48 hours</th>
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<tbody>
<tr>
<td>Date:</td>
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<td></td>
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<tr>
<td>Time:</td>
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<tr>
<td>BP</td>
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<tr>
<td>Pulse</td>
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<tr>
<td>Resp. rate</td>
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<tr>
<td>Temp</td>
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<tr>
<td>O₂ sat.</td>
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<tr>
<td>Staff Initials</td>
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</table>
**Part B:** Complete if fall was unwitnessed, if the client is anticoagulated, or if the client hit their head. Document abnormal findings in narrative charting.

<table>
<thead>
<tr>
<th>Neuro Vital Signs</th>
<th>1st Check</th>
<th>Q 30 mins x 1 hour</th>
<th>Q 1 hour x 3 hours</th>
<th>Q 8 hours x 48 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Pupils**

<table>
<thead>
<tr>
<th>Size:</th>
<th>Left</th>
<th>Right</th>
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<tbody>
<tr>
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</table>

**Reaction:**

<table>
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<tr>
<th>Left</th>
<th>Right</th>
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</table>

**Glasgow Coma Scale**

<table>
<thead>
<tr>
<th>1 mm</th>
<th>2 mm</th>
<th>3 mm</th>
<th>4 mm</th>
<th>5 mm</th>
<th>6 mm</th>
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</tbody>
</table>

N – Normal  S – Sluggish  F – Fixed
• Share and problem solve
• Identifies contributing risk factors
• Document and communicate with rest of team

Example of Huddle:
  – 5 Why’s
5 Whys? Why did Mary fall?

1. She forgot to use her walker

2. Why did the Mary forget to use her walker?
   She has trouble remembering

3. Why does the resident have trouble remembering?
   She did not sleep well last night? Is her memory worse?

4. Why did the resident not sleep well last night?
   Too much coffee during the day? Up 5 times to the bathroom?

5. Why did the resident drink too much coffee?
   Coffee was too accessible. She forgot how much she’d already had and staff offered her more.
Communication

• Post Fall Report / Log Book

• Clients / Families - Disclosure

• Physicians / Physician Partnerships

• Inter-Facility Patient Transfer
# Inter-Facility Patient Transfer

To request Inter-Facility Transfer, please use iRequest or call 1.877.661.6710 Provincially

Form faxed to receiving facility if requested/required?  □ Yes  □ No

<table>
<thead>
<tr>
<th>Transfer Information</th>
<th>Green area to be completed by Sending Facility</th>
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</thead>
<tbody>
<tr>
<td>Physician order for IFT</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Date of transfer</td>
<td>□ Yes  □ No</td>
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<tr>
<td>Patient ID band on?</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Primary language</td>
<td>□ 1  □ 6  □ 10  Other  ___</td>
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<tr>
<td>Interpreter required?</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Legal status</td>
<td>□ N/A  □ Voluntary  □ Formal, Form #</td>
</tr>
<tr>
<td>Notification of transfer</td>
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</tr>
<tr>
<td>Patient aware</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Family</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Family physician</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Receiving physician</td>
<td>□ Yes  □ No</td>
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<tr>
<td>Physician’s Name</td>
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<tr>
<td>Personal Directive</td>
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<tr>
<td>Goals of Care order</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Goals of Care Designation</td>
<td>R [<strong>] M [</strong>] C [__]</td>
</tr>
<tr>
<td>*Where these exist, an original must accompany the patient</td>
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</tr>
<tr>
<td>Sending Practitioner</td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td></td>
</tr>
<tr>
<td>Principal diagnosis/problem</td>
<td></td>
</tr>
<tr>
<td>Reason for transfer</td>
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</tr>
<tr>
<td>Next of kin</td>
<td>□</td>
</tr>
<tr>
<td>Caregiver</td>
<td>□</td>
</tr>
<tr>
<td>Guardian</td>
<td>□</td>
</tr>
<tr>
<td>Substitute decision maker</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Family Physician</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Living arrangements</td>
<td>□ Independently  □ Residential facility  □ In-home support</td>
</tr>
<tr>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Unit</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>
Reporting

• Awareness
• Contributes to client safety
• Allows for benchmarking and goal setting
Evaluation & Measures

How do you know your fall risk management process is working?

Some resources:
• AHS Evaluation and Measures
• Quarterly trending report (QTR)
• Retrospective chart audit tool (AHSaudit.ca)
Quality Improvement

• Ensures a process to support client safety and promote continuous review

• Encourages improvements in practice
Staff:
- AHS Post Falls eLearning module (Insite MLL & CCD)
- Presentations / Webinars

Client / Family:
- Newsletters / Bulletin boards / Brochures
- Resident Council / Caregiver Support Groups

Are there other ways that your organization delivers info?
Resources

AHS Level 1 Falls Risk Management Policy and Strategy Information
  • AHS Insite  http://insite.albertahealthservices.ca/10210.asp
  • Continuing Care Desktop  https://cc.qwogo.ca/#ENG
  • Calgary FRM Program http://insite.albertahealthservices.ca/10214.asp or cal.frmp@ahs.ca

AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons

RNAO BPG Preventing Falls and Reducing Injuries From Falls
http://rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries

Safer Healthcare Now Reducing Falls and Injuries From Falls – Getting Started Kit

Public Health Agency of Canada Senior’s Falls in Canada: Second Report
Discussion and Next Steps
Calgary Fall Risk Management Program

cal.frmp@ahs.ca