OANHSS

LTCHA Implementation
MEMBER SUPPORT PROJECT

Fall Prevention and Management Program

Policy, Procedures and Training Package

Release Date: November 19, 2010
Revised: March 31, 2011

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ABOUT THIS DOCUMENT

The development and implementation of an interdisciplinary program for falls prevention and management is a requirement of Regulation 79 of the *Long-Term Care Homes Act, 2007* (LTCHA). This document contains sample program objectives, policy, procedures and staff training materials and tools that meet the minimum requirements of the LTCHA and regulation.

This package is intended to be used as a resource for OANHSS member homes to modify and customize, as appropriate. This material can also be used by homes to review their current policies, procedures and compare content. Please note: The project team have compiled these materials during the fall of 2010, and as a result, the information is based on the guidance available at this time. Members will need to regularly review the MOHLTC Quality Inspection Program's Mandatory and Triggered Protocols to ensure that your internal policies and procedures align to these Compliance expectations.

Program Evaluation As described in the regulation, core clinical programs must be evaluated and updated at least annually by Long Term Care Homes, in accordance with evidence-based practices and if there are none, in accordance with prevailing practices. **Note: a program evaluation approach is not included in this document**. However, OANHSS is planning to develop resource materials on the topic of integrative program evaluation approaches for its members in the near future.

Acknowledgements

OANHSS gratefully acknowledges the contribution of written practices, resources and tools used in the development of this package from Belmont House, Perley and Rideau Veterans' Health Centre (PRVHC), Providence Healthcare, and Yee Hong Centre.

FALLS PREVENTION AND MANAGEMENT PROGRAM

Purpose

The purpose of the Falls Prevention and Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and management strategies that foster resident independence and quality of life while ensuring safety for the resident and other residents and staff.

The program focuses on reducing the incidence of residents' falls and mitigating risks of falls through a resident focused, team approach which ensures that a resident's environment and social, physical, cognitive and emotional strengths are supported. The program ensures team training, communication and effective care planning.

Program Objectives

- To improve and maintain a resident's optimal functional level and quality of life
- To identify and reduce or eliminate environmental risk factors for residents
- To identify and reduce or eliminate health risk factors for residents
- To reduce the frequency of falls
- To reduce the severity of injuries from falls
- To ensure best practice interventions for residents who have fallen
- To monitor and track trends related to resident falls

Policy

The home shall ensure that a falls interdisciplinary prevention and management program will be maintained to reduce the incidence of falls and the risk of injury to the resident and promote resident independence.

Definition

A fall is any unintentional change in position where the resident ends up on the floor, ground or other lower level (*Resident Assessment Instrument (RAI) RAI-MDS 2.0 User's Manual*, Canadian Institute for Health Information, September 2010).

- Includes witnessed and un-witnessed falls
- Includes if resident falls onto a mattress placed on the floor
- Includes whether there is an injury or not.

A near fall/near miss is a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips or trips that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling.

An un-witnessed fall occurs when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there.

Serious Injury includes: fractures, laceration-requiring sutures, and any injury requiring assessment in Emergency or admission to the hospital.

Procedure

The following section outlines the interdisciplinary team approach to roles and activities for fall risk assessment and strategies for prevention of falls. Roles and functions assigned may vary across homes due to availability of these resources. These steps are samples that homes may use as a guide for their specific program procedures.

A: Fall Prevention

Registered Nursing Staff:

1. Collaborate with resident/ substitute decision-maker (SDM) and family and interdisciplinary team to conduct the fall risk assessment (e.g. RAI-MDS 2.0)
   - within 24 hours of admission (e.g. using RAI-MDS 2.0)
   - quarterly (according to the RAI-MDS 2.0 schedule)
   - when a change in health status puts them at increased risk for falling such as:
     - 2 falls in 72 hours
     - more than 3 falls in 3 months
     - more than 5 falls in 6 months

- significant change in health status
- falls resulting in serious injury

2. Determine the resident's level of risk as Low or High. Any risk should be care planned and treated.
3. Initiate a written plan of care within 24 hours of admission based on resident's assessed condition, fall history, needs, behaviours, medications and preferences using the *Interventions/Strategies to Reduce the Risk of Falls* (Appendix B) as a guide.
4. Continue to update the care plan based on the RAI-MDS 2.0 assessment and complete the care plan within 7 days after admission.
5. Refer the resident to the interdisciplinary team based on their level of risk and/or as deemed appropriate and initiate strategies/activities to reduce/minimize the risk of falls (e.g. to Physiotherapy for assessment).
6. Assess for and implement nursing restorative/rehabilitation activities as part of RAI-MDS 2.0 care planning
7. Monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team. If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary.
8. Communicate to the team, the resident/Power of Attorney (POA)/ Substitute Decision Maker (SDM) whenever there is a significant change to the care plan regarding falls prevention and/or risk mitigation/management on an ongoing basis and annually at the care conference.
9. Request that Resident/Family/POA/SDM assist in ensuring that the resident has proper footwear (refer to Appendix C-Foot wear Guidelines).
9. Request that Resident/Family/POA/SDM assist in ensuring that the resident has proper eye glasses/hearing aid and other assistive devices or are purchased and in good working order.

Health Care Aides (HCAs)/Personal Support Workers (PSW):

1. Follow the interventions as outlined on the care plan.
2. Assist and report any resident who appears unsteady.
3. Promote adequate fluid intake to avoid dehydration and confusion.
4. Report if the resident is having or demonstrating behaviours that indicate pain.
5. Remember that a resident with a Urinary Tract Infection may need more frequent help to the bathroom

Physiotherapist (on referral):

1. Review results of RAI-MDS 2.0 assessment as appropriate
2. Assess residents identified as being at risk for falls may use one or more of the following evidence-based assessment tools. Examples:
   - Functional Reach Test
   - Timed Up and Go Test

- Timed Chair Stand (30 sec) Test
- Rapid Step Test (2 minutes)
- Tinneti Scale or Berg Balance Scale

2. Implement strategies based on the assessment findings (e.g. Gait/balance/transfer training).
3. Share strategies that can be used by the interdisciplinary team to promote resident independence and safety.
4. Recommend equipment, supplies, devices and assistive aids to prevent falls; and
5. Recommend care plan strategies for nursing restorative/rehabilitation interventions.

Physician/Pharmacist/RN Extended Class (on referral):

1. Conduct a medication review.
2. Consider bone supplement.
3. Refer to specialists if required

Activation/Recreation Staff:

1. Assess leisure and recreational interests and activity patterns and pursuits.
2. Engage the resident in activities that are meaningful to the resident ensuring the level of activity is safe and the equipment and level of supervision meet the resident's individual needs and wishes.
3. Contribute to nursing restorative/rehabilitation activities identified on the care plan in collaboration with nursing.

The interdisciplinary team:

1. Communicate regarding their roles and responsibilities in falls prevention as outlined on the resident's care plan
2. Monitor, evaluate and document resident progress and outcomes.

<u>B. Fall and Post Fall Assessment and Management</u>

When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs.

Person witnessing the fall or finding the resident after the fall:

1. Assess the environment, before mobilizing the resident, for clues as to objects which may have struck the resident during the fall or caused the fall.
2. Not move the resident if there is suspicion or evidence of injury until a full head to toe assessment has been conducted and appropriate action determined. (e.g. transfer to hospital).
3. Notify the registered nursing staff.

Registered Nursing Staff:

1. Complete the head to toe assessment
2. Move the resident, ensuring that the proper lifting procedures are performed (2 person lift if the resident is able to weight-bear, otherwise a 2 person lift using a mechanical lift).
3. Observe for pain or difficulty weight bearing if no injury is evident.
4. Notify the attending physician, POA/ SDM of the fall, interventions and status of the resident.
5. Initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.
6. Monitor every hour for the first 4 hours and then every 4 hours for 24 hours post fall for signs of neurological changes (e.g. facial droop, behaviour changes, and weakness on 1 side).
7. Complete an incident investigation and an incident report including all contributing factors.
8. Complete the on-line *MOHLTC Critical Incident Report* if the fall resulted in the resident being transferred to the hospital or admitted to the hospital.
9. Follow the homes *Disclosure of Adverse Events Policy and Death Protocols* if the fall has resulted in resident death.
10. Document in the progress notes:
    - date and time of the incident, location of the incident, whether the fall was witnessed or un-witnessed, status of the resident (e.g. type and severity of injury, if any)
    - which assessments were completed (e.g. Morse Fall) and outcome of the assessment
    - who was notified of the falls (e.g., physician, POA/ SDM), probable cause of the fall, resident outcomes and interventions taken to prevent further falls or related injury
    - if the resident was sent to the hospital
11. Redo the Fall Risk Assessment and complete a *Post Fall Screen for Resident/Environmental Factors* (Appendix D) form, review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team.
12. Communicate to all shifts that the resident has fallen and share detail regarding the interventions initiated.
13. Emphasize the details of the fall, interventions and outcomes and stress the need for ongoing follow-up in subsequent shifts at the intershift report.
14. Arrange a care conference for residents who fall frequently as indicated by:
    - 2 falls in 72 hours
    - more than 3 falls in 3 months
    - more than 5 falls in 6 months

The interdisciplinary team:

1. Conduct an interdisciplinary conference to determine the possible cause of falls and develop changes to prevent reoccurrence based on a quality improvement methodology of Plan, Do, Study, Act.

C. Staff Training and Education

Orientation for Direct Care Staff:

1. Provide orientation and training on the falls prevention and management program (policy, procedures, tools) including the importance of the program and the risk to residents' health due to falls.
2. Registered staff (RNs and RPNs) completes the Registered Nurses' Association of Ontario (RNAO) Falls Prevention Self-Learning Package or equivalent.

Ongoing Training for Direct Care Staff:

1. Review the falls prevention and management program training annually.

APPENDIX A: OVERVIEW OF PROCESS FOR FALLS PREVENTION AND MANAGEMENT

Fall Prevention

Identify Resident at Risk

-Environmental Safety Scan
-on-slippery floor
- Adequate lighting
- no clutter

Pre-Admission

Review CCAC note
- Interview Family

Not at risk

At risk

On Admission

Assess for risk of falling (e.g. Morse Falls Assessment)

Normal Activities

Intervention

Health Changes

Nurse/PT
Conduct Fall Assessment

Nursing
- Refer to PT
-Place high risk logo on mobility aid
-Customize Care Plan
- Regular Safety checks

Physio
- Assess mobility
-Gait/Balance
-Transfers
Appropriate mobility aids

Physician
Pharmacist
-Medication Review
-Consider bone supplement

Activation
Engage residents in supervised activities

Family
-Appropriate foot-wear
-Appropriate eyeglasses/ hearing aid

Document
(resident chart, MDS, care plan,

Fall Management

Resident Falls

Immobilize Resident

Nurse to assess

Rule out injuries

No Injury → Normal Activities with increased monitoring

Mild Injury → First Aid → Investigation and treatment

Severe Injury → Hospital transfer and treatment → Complete Unusual Occurrence Form

Document
(resident chart, incident report, MDS, care plan

Adapted from Yee Hong

Post Fall Management

Identify Cause → Nurse/PT Conduct Fall Assessment

Limb weakness
Unsteady gait
Inappropriate use of mobility aide
Inappropriate transfer technique → Refer to PT

Adverse drug effect → Refer to Physician

Slippery Floor/Clutter → Refer to Home staff

Impaired Judgement
No safety awareness (e.g. CPS>3) → Nursing Safety check

Equipment Malfunction → Refer to Vendor or Maintenance

Inappropriate Footwear
No glasses or hearing aide → Speak with Resident/Family, POA/SDM

Personal needs not met (e.g. Toileting, thirst, hunger) → Speak with HCAs

Document
(Progress notes, MDS, care plan)

APPENDIX B: INTERVENTIONS/STRATEGIES TO REDUCE RISKS FOR FALLS

Risk	Interventions/Strategies
Low Falls Risk Must Do:	Orientate resident to unit (e.g. washroom) and mechanisms (e.g. call bell, phone)
	Ensure commonly used items are within reach (e.g. tissues, water)
	Place resident's bed at lowest position
	If resident uses visual or hearing aids, ensure they are clean (glasses) and batteries are inserted properly (hearing aid)
	Wheel locks on chair are on chair and bed and are operational
	Keep environment uncluttered (remove excess equipment and supplies from room and hallway)
	Provide resident/family/POA/SDM/ re information re safety and risks. (e.g. Footwear Guidelines)
	Lighting conductive to both activity and rest (e.g. pathway to bathroom)
	Ensure proper footwear (refer to Footwear Guidelines)
	Ensure mobility aids (canes, walker) are accessible
	Ensure proper transfers (e.g. does resident need 1 person or 2 person assistance?)
	Establish toileting routine
	Ensure that resident's pain is managed
Risk	**Interventions/Strategies**
High Falls Risk Must Do:	**All strategies listed for low falls rate PLUS:**
	Communicate fall risk to all staff
	Conduct balance and strength assessments
	Review medications for potential fall risk
	Evaluate treatment for pain
	Ensure that all staff are aware of strategies to prevent/minimize falls
High Falls Risk Consider Doing:	Hip protectors
	Reviewing the need for bedrail use (Caution: if the intent is to restrain, the bedrail will be considered a restraint)
	Strongly recommending involvement in an exercise program
	Utilizing alternatives to using restraints (reference Restraint Policy)
	Collaborating with resident/POA/SDM – engage in fall prevention strategies as able (one on one, stagger visits)

APPENDIX C: FOOTWARE GUIDELINES

The features outlined may assist in the selection of an appropriate shoe.

Heel	• Have a low heel (e.g. less than 2.5 cm) to ensure stability and better pressure distribution on the foot. a straight through sole is also recommended. • Have a broad heel with good round contact. • Have a firm heel counter to provide support for the shoe.
Sole	• Have a cushioned, flexible, non-slip sole. Rubber soles provide better stability and shock absorption than leather soles. However rubber soles do have a tendency to stick on some surfaces.
Weight	• Be lightweight.
Toebox	• Have adequate width, depth and height in the toebox to allow for natural spread of the toes.
Fastenings	• Have buckles, elastic or Velcro to hold the shoe securely onto the foot.
Uppers	• Be made from accommodating material. Leather holds its shape and breathes well however many people find walking with shoes with soft material uppers are more comfortable. • Have smooth and seam free interiors.
Safety	• Protect feet from injury.
Shape	• Be the same shape of the feet, without causing pressure or friction on the foot.
Purpose	• Be appropriate for the activity being undertaken during their use. Sports or walking shoes may be ideal for daily wear. Slippers generally provide poor foot support and may only be appropriate when sitting.
Orthoses	• Comfortably accommodating orthoses such as ankle foot orthoses or other supports if required. The podiatrist/orthotist or physiotherapist can advise the best style of shoe if orthoses are used.

This is a general guide only. Some people may require the specialist advice of a podiatrist for the prescription of appropriate footwear for their individual.

APPENDIX D: POST FALL SCREEN FOR RESIDENT/ ENVIRONMENTAL FACTORS

Resident Name: ____ **Rm #:** ____________

Date of Fall: ____________________ **Date of Assessment**:_______________________

Assessment	**Yes**	**No**	**Not Applicable**	**Nursing Actions to prevent reoccurrence**
This checklist is designed to assist in determining **WHY** the resident fell?				
Was the call bell in reach?				
Was the environment cluttered? Was the clutter on the floor?				
Was the resident wearing footwear? (Proper fit, non-slip soles, etc.)				
Was the residents' mobility aid in appropriate working condition and were they using it?				
Were commonly used items within reach of the resident?				
Was the resident confused? (consider using a bed sensor alarm, or positioning resident in easily observable area)				
Was the resident wearing their glasses and were they clean?				
Was the resident wearing their hearing aid and do the batteries work?				
Does the resident have equal/appropriate muscle strength? (in legs and arms). Consider referring to physiotherapy				
Was the bed at the lowest position?				
Was resident wearing hip protectors? (Assess need for hip protectors)				
Was the resident feeling dizzy (when they sit up/stand up)? Consider taking BP, referring to physician, having medications reviewed or other underlying health conditions assessed.				
Document actions in care plan and determine if they have been effective in preventing further falls.				

Registered Staff signature: ____

APPENDIX E: FALL RISK SCREENING TOOL

For Fall Risk Screening Tool, see attached spreadsheet (Microsoft Word file) included in this package.

APPENDIX F: FALLS TRACKING TOOL

For Falls Tracking Tool, see attached spreadsheet (Microsoft Excel file) included in this package.

APPENDIX G: PRE AND POST FALLS TRAINING TEST FOR STAFF

☐ **Pre-Test** ☐ **Post-Test**

True or False

Statement	T	F
1. Falls are the #1 cause of death in the elderly.	T	F
2. 40% of admissions to nursing homes are the result of falls.	T	F
3. Fall risk assessments should be performed on all admissions.	T	F
4. Anytime there is a change in the resident's treatment, medication or condition, the fall assessment should be updated.	T	F
5. A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.	T	F
6. If a resident trips but does not fall, it is still considered a fall.	T	F
7. New admissions are at higher risk of falling.	T	F
8. With a well-established fall prevention plan, it is not necessary to include the resident or the family and friends in fall prevention efforts.	T	F
9. Electronic monitors which activate call lights and/or an audible alarm when the patient exits the bed, are effective as fall prevention tools, and may help reduce restraint use.		
10. Restraining a resident is a good way to minimize falls.	T	F
11. Only residents who have been identified as being at high risk of falling need to have prevention interventions in place.	T	F
12. Identifying the cause of the fall is critical to preventing the fall from happening again.	T	F
13. The first thing you do when a resident has fallen is get them back into bed so you can assess them.	T	F
14. Each fall must be communicated to all staff members.	T	F
15. The nurse really only needs to involve nursing staff in determining the cause of the fall or interventions to prevent reoccurrence of falls.	T	F
16. The Registered staff is responsible for documenting the fall only on the progress notes.	T	F
17. Relocating a patient to a new room may increase their risk for falling.	T	F

18. Name 3 things you can do for the resident in order to prevent falls.
1) ______________________________
2) ______________________________
3) ______________________________

Signature: ______________________________ Position: ______________________________

APPENDIX H: FALL PREVENTION AND MANAGEMENT TRAINING PRESENTATION

For Fall Prevention and Management Training Presentation, see attached presentation (Microsoft PowerPoint file) included in this package.