Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care

Site Applicability

All VCH and PHC Long-Term Care Homes

Practice Level

- All regulated staff in their respective scope of practice.
- All unregulated staff under the supervision and direction of a regulated health care professional and within their respective job roles and expectations

Throughout this document the term person / people will be used to represent residents.

Quicklinks

Requirements

1. On move in, return from acute care, or transfer from another care home, everyone:
    i. is commenced on Universal Falls Precautions (Appendix A)
    ii. is screened for falls risk using Appendix B or equivalent
    iii. has a care plan / guide developed that respects individual choices (See Supporting Choices DST).
2. A fall with an injury that is serious enough to require assessment by a physician or nurse practitioner (MRP) OR requires transfer to hospital **must** be reported to Licensing within 24 hours (refer to Site Incident Management Policy PHC , VCH). A Patient Safety Learning System (PSLS) / incident report must also be completed.

Need to Know

1. ***Everyone is at risk of falling*** and being injured. However, people living in care homes may have additional risk factors such as frailty, underlying medical conditions, and altered communication, cognitive and physical functioning, putting them at higher risk for falls and more serious injury.
2. Falls can lead to reduced quality of life, reduced participation in activities, fear of falling, and hospitalization.
3. People with dementia are at an increased risk of falls and injury with subsequent hospitalization. (CIHI 2018).
4. Current evidence recommends that minimizing falls and fall-related injuries while maximizing the person's freedom of movement, independence, enablement, and autonomy, is best accomplished through an interdisciplinary person centred assessment that considers the following:
    - falls history
    - gait, balance and mobility, strength and muscle weakness
    - pain
    - cognitive impairment, neurological examination, sensory changes
    - osteoporosis risk / fracture risk / prolonged immobility
    - visual impairment / perceptual changes
    - communication difficulties and required communication supports
    - hearing impairment and vestibular disorders
    - urinary continence

- environmental hazards (within care home or during outings)
- postural hypotension, dizziness, hydration
- medication review (increased risk of fall if taking more than 5 medications -refer to Beer's Criteria)
- substance / alcohol use
- perceived functional ability and fear relating to falling
- person's strengths, resources, goals and preferences for mobility / independence, e.g. benefit / risk analysis – See Supporting Choices DST

5. Restraints are known to increase risk of falls, falls related injury and death and should ONLY be considered once ALL other interventions that support freedom of movement have been exhausted (Community Care and Assisted Living Act (2013)). See Supporting Choices DST for guidance regarding weighing the risks and benefits of using any form of restraint while supporting individual choice and informed decision making. Refer to Least Restraint: Guideline for Maximizing Independence DST and regulatory requirements: Division 5 — Use of Restraints
6. Care plans / guides are developed in collaboration with the person / SDM, family and the Interdisciplinary Team.

Procedure

Section 1: Screening, Assessment and Care Planning

Screening and Initial Care Plan: Must be completed within 24 hours of move in, return from acute care or transfer from another care home.

1. **At VCH:** Nurse Screens for Falls Risk using a standardized screening tool –see example in Appendix B and initiates referral to OT/PT/ appropriate discipline for assessment – see Table 1 for guidance.
2. **At PHC:** Falls Risk is flagged by the Clinical Nurse Leader (CNL) on the pre-screen and the usual 24 hour observation tool is initiated (Form ID 1708). OT/ PT assesses for falls risk as part of their initial assessment. In the absence of OT/PT, or on return from acute care, CNL or RN determines falls risk, initiates care plan and refers to OT/PT/ appropriate discipline for assessment – see Table 1 for guidance.
3. Nurse /OT/PT assesses person's ability to transfer and ambulate. The algorithm – Appendix C may be used as a guide.
4. All staff implement Universal Falls Precautions – Appendix A.
5. All staff ask SAFE Questions whenever care is completed:
   i. Do you have any pain or discomfort?
   ii. Do you need to use the toilet?
   iii. Do you need anything else before I leave? E.g. water, mobility aid / device, glasses, call bell etc.
6. An initial care plan is developed with input from the person / SDM, family and interdisciplinary team. Consider a plan that promotes independence and reduces risk of falls related injury. Document and communicate the care plan / guide in accordance with VCH /PHC / care home policy.

Subsequent Assessment and Care Planning: Complete after move in, on transition or change in status using the following documents and assessments as a guide.

1. Gather data from tools e.g. **VCH** "Getting to Know me Form ID CO.0131. **PHC** "Who am I", Residential Care: 24 Hour Close Observation Record (Form ID 1708)
2. Review Goals of Care and use Supporting Choices DST to understand person's wishes and to determine benefits of activities that pose an increased risk of falls.
3. Use existing assessment tools e.g. RAI-MDS. Where a Falls Clinical Assessment Protocol (CAP) is triggered, review RAI-MDS to understand what components contribute to falls risk and refer to appropriate discipline for assessment and care planning. See Table 1
4. Update care plan in collaboration with person / SDM and family and interdisciplinary team e.g. at Care Conference,
5. Develop a safety plan when planning outings or activities that increase risk of falls.

Table 1 Interdisciplinary Assessment Components (Multifactorial Assessment)

Use the following table to guide assessment and interdisciplinary team member roles

Component	Responsible interdisciplinary team member or Referrals to consider
Falls history (Reason, nature of fall, frequency, timing, injury, impact on quality of life, lessons learned)	Nursing / MRP / PT / OT
Gait, balance, vestibular disturbance, mobility, strength and muscle weakness	PT/OT/RD/MRP/Audiology
Pain	All disciplines and MRP
Cognitive impairment / altered mental state, neurological examination	PT/ OT/ MRP/ Older adult mental health team (OAMHT) / Geriatrician
Osteoporosis risk / fracture risk / prolonged immobility	MRP / PT / OT / RD
Visual impairment / perceptual changes / communication changes / sensory changes	Ophthalmology / OT / SLP / PT
Urinary/ bowel continence	Nursing / OT / PT
Environmental hazards (within care home or during outings)	All disciplines
Postural hypotension / dizziness / hydration	Nursing / MRP / RD / OT / PT / Respiratory Therapist / SLP / Audiology/
Medication review	Pharmacist / MRP / Nursing
Substance / alcohol use	MRP / Nursing / Social Work / Regional Addictions Program
Perceived functional ability and fear relating to falling	All disciplines and MRP
Person's strengths, resources and goals and preferences for mobility / independence	PT/OT/RecT/SW/ Nursing/MRP

Section 2: Post Falls Assessment and Management First 24 Hours

In the event of a finding a person who has experienced a fall, an assessment for injury must be performed before moving the person

Procedure:

1. Call for assistance.
2. Inform Nurse.
3. Reassure and provide comfort while the person is being assessed.
4. Nurse to assess:
   a. Level of Consciousness
   b. Presence of acute pain, bruising, swelling, hematoma, bleeding, skin tears, colour, warmth, movement, and sensation -CWMS)
   c. **Witnessed fall** with **NO** head injury: baseline Vital Signs. **Unwitnessed fall or head injury suspected:** baseline Neuro Vital Signs (NVS)**,** orientation to time, person and place, change in pupil size, ability follow directions or use **VCH** Neuro Vital Signs Record Form ID m-216 and **PHC** Neuro Vital Signs Form (Form ID: 4024)
   d. Signs and Symptoms of Serious Injury
      - **Serious Head injury**
        - loss of consciousness (LOC)
        - clinical suspicion of skull fracture / orbital fracture (e.g. redness / swelling)
        - new vomiting
        - seizure

        - new neurologic deficit e.g. unilateral limb weakness
        - asymmetric pupils
    - **Spinal injury** (if suspected initiate spinal precautions by immobilising head and neck in position found)
        - new mid-line neck pain
        - new numbness /tingling arms or legs
    - **Fracture**
        - deformity, swelling or point tenderness
        - lower limb shortening or rotation
        - new inability to weight bear
        - severe / acute pain with movement
    - **Open wound needing repair**
        - gaping laceration more than 1 cm
        - actively bleeding wound
e. Clinical history: anti-coagulation therapy or bleeding disorder e.g. low platelets
f. Goals of care.

If any of signs and symptoms of serious injury present, call and discuss assessment findings and goals of care with MRP immediately to determine if person's care needs can be managed in the care home or acute transfer is required.

Acute Transfer

1. Contact EMS.
2. Make person as comfortable as possible in position found.
3. Monitor VS, NVS if head injury / suspected head injury and CWMS – see Post Fall Monitoring Guide
4. Notify family / SDM immediately – see Communication Post Fall
5. Document as per documentation section.
6. Notify Licensing and complete incident report / Patient Safety Learning System report (PSLS) see p 7 for guidance.

Post Fall Care Managed in the Care Home

1. Transfer off floor, following care home specific policy for safe transfer
2. Determine post fall assessment and monitoring requirements – see Post Fall Monitoring Guide and update care plan/care guide as needed
3. Inform family / SDM –see Communication Post Fall
4. Inform MRP – see Communication Post Fall
5. Based on assessment, update care plan / guide to manage symptoms/ injuries/ distress and to prevent further falls.
6. Refer to other members of the interdisciplinary team where appropriate.
7. Document as per documentation section.

Post Fall Monitoring Guide First 24 hours after a fall

When determining monitoring frequency use clinical judgement in addition to this guide.

Have a low threshold for increasing frequency of monitoring if person's status changes or there are significant risk factors.

Unwitnessed Fall or Head Impact	**Witnessed Fall – No Head Impact**
1. Assess NVS Form (PHC: ID 4024) and Colour, Warmth, Movement, Sensation (CWMS): ➢ q1h x 4 post fall then if no change from pre-fall status q8h x 24 hours 2. Observe for changes in level of consciousness, persistent severe headache, persistent post traumatic amnesia, persistent abnormal alertness/behaviour/cognition or vomiting and signs / symptoms of fall injury identified in assessment 3. Assess for increased risk of bleeding	1. Assess VS and CWMS: ➢ q once 1 hour post fall ➢ then if no change from pre-fall status q8h x 24 hours 2. Observe for change in pain, alertness / behaviour / cognition. 3. Assess for increased risk of bleeding 4. Initiate Care Aide Observation Tool (or equivalent) use clinical judgement to determine duration **At PHC** initiate 24 hour Close Observation Record (Form ID 1708) use clinical judgement to determine duration.

4. **At VCH** initiate Care Aide Observation Tool (or equivalent) for minimum of 72 hours **At PHC** initiate 24 hour Close Observation Record (Form ID 1708)	

Communication Post Fall

	Fall With Injury	Fall Without Apparent Injury
MRP **Manager**	• **VCH**: Nurse to inform MRP and / manager/Administrator on Call (AOC) immediately. • **PHC:** nurse to inform MRP and / CNL / Manager On Call (MOC) • Confirm plan and any specific MRP orders or directions from manager • Document notification and plan.	• Follow local procedures. e.g. Communication book, Shift Report, office voicemail. There is no need to call the MRP/manager outside of regular office hours. • Consider calling MRP/Manager/AOC outside of regular office hours if there are new recurrent falls or an increasing number of falls that may indicate a change in condition.
SDM / Family If no SDM confirm with person / check chart for directives regarding contacting family	• Nurse notifies the family/SDM as soon as possible • Document notification and family/SDM's response in progress notes or as per site specific practices.	• Nurse to inform the family/SDM: ○ Falls between 0800 and 2100, inform family/SDM as soon as possible or as per family/SDM's documented preference. ○ Falls between 2100-0800, notify family/SDM in morning or as per family/SDM's documented preference.
Licensing / SLS	• Complete PSLS / Incident Report within 24 hours and Notify Licensing	Falls without injury do not always need a PSLS / Incident Report completed. However, there are instances where a fall or near fall MUST be entered. See Licensing Notification.
Other Team Members	• Refer to/discuss with interdisciplinary team. Update care plan / guide as needed and inform all team members.	• Refer to/discuss with interdisciplinary team. Update care plan / guide as needed and inform all team members.

Section 3: On-going Post Falls Assessment, Monitoring and Care Planning (24 hours post fall)

Nurse in collaboration with the interdisciplinary team as appropriate:

1. Identify risk factors for late onset complications (Box 1).
2. Determine need for and frequency of on-going assessment and monitoring of VS / NVS when:
    i. there is a risk of late complications (see Box 1)
    ii. altered Level of Consciousness (LOC) compared to baseline
    iii. evidence of injury e.g. pain, swelling, bruising, skin breakdown
    iv. other changes from baseline e.g. cognitive / behavioural, physical function, emotional, engagement in social activities.
3. **At VCH** Implement Care Aide Observation Tool Appendix C when risk factors for late onset complications AND / OR evidence of injury are present for 72 hours minimum. **At PHC** use 24 hour Close Observation Record (Form ID 1708). If person is otherwise stable (based on VS/NVS and no apparent injury or risk factors for late onset complications, consider need for Care Aide Observation Tool / PHC**:** Close Observation Record (Form ID 1708).
4. Review circumstances and reason for fall and discuss with Interdisciplinary Team, Appendix E may be used as a guide. Update care plan / care.
5. Implement changes to care plan in collaboration with Interdisciplinary Team, MRP / person/SDM and family as needed

Box 1 Risk Factors for Late Onset Complications Secondary to a Fall

- anti-coagulation or bleeding disorder
- unwitnessed fall or head injury sustained
- high impact / severe head injury
- communication / cognitive concerns
- sensory or perceptual deficits
- previous history of brain injury
- prolonged immobility /osteoporosis
- localized pain / swelling / bruising / laceration or other skin breakdown after fall.

Note: When a person is experiencing multiple falls, the care home team in collaboration with the person and family member, should develop a person specific plan that includes:

i. Interventions to reduce risk of fall and fall related injury that support freedom of movement and are acceptable to the person / SDM – **See Supporting Choices DST**

ii. Instructions for post-falls care and monitoring that take into consideration the person's wishes regarding goals of care e.g. when / if the person would like to remain in the home to manage care needs when the injury is serious.

Licensing Notification

Licensing must be informed within 24 hours of a fall when:

1. The fall resulted in an injury OR
2. The MRP sees the person because of the fall even when no injury is found OR
3. There are delayed complications or injuries as a result of the fall.

Patient Safety Learning System (PSLS) or Equivalent Incident Reporting System

In order to understand and learn from falls it is important to capture the frequency, fall circumstances and severity of injuries associated with falls in the Patient Safety Learning System or equivalent PHC, VCH. Not every fall requires an entry however, there are instances where a fall or near fall should be entered.

Complete an entry for:

1. Fall with injury within shift.
2. Fall where the person is seen by the MRP even if no injury sustained. Complete within 24 hours
3. Fall that requires a transfer of care i.e. transfer to Emergency Department / Acute Care admission.
4. Fall where there are delayed complications / injuries related to the fall. Complete as soon as identified.
5. Fall without Injury or near miss and no immediate assessment by MRP required – use clinical judgment to determine whether a PSLS is required.

6. Multiple Falls **without** injury – where a person is experiencing multiple falls use clinical judgment to decide whether a PSLS should be completed.
7. Environmental Hazards e.g. A slip on a wet floor Complete a Hazard Report in PSLS as soon as possible.

Documentation

1. *Assessments and Interventions*-document on NVS /VS Form, (PHC: ID 4024) on chart, in progress notes, care plan / care guide as per VCH /PHC Documentation Policy.
2. *Fall*-document the following in progress notes and care plan / care guide:
    i. Date, time, location, nature (e.g. slip / trip), cause (e.g. wet floor, postural hypotension), witnessed or unwitnessed, head to toe and other assessments, physical, psychological / emotional harm sustained, change in clinical status / behaviour, actions, interventions, referrals, outcomes and follow–up assessments.
    ii. Frequency of falls.
    iii. Date and time family / SDM / MRP / Manager / Licensing informed.
    iv. Other disciplines informed.

3. *Interdisciplinary Meetings*-document:
    i. Date and time of meeting
    ii. Attendance (e.g. Interdisciplinary Team members / person/ SDM / family)
    iii. Reason for meeting
    iv. Discussion
    v. Changes to Care plan / guide and who has been informed of care plan changes
    vi. Review date

Patient and Family Education

"Call Don't Fall Poster" Available in multiple languages:

- *https://vch.eduhealth.ca/PDFs/BE/BE.250.F33.pdf*
- https://vch.eduhealth.ca/PDFs/BE/BE.250.F33.CN.pdf
- https://vch.eduhealth.ca/PDFs/BE/BE.250.F33.PU.pdf
- https://vch.eduhealth.ca/PDFs/FA/FA.200.R43.pdf

Related Documents

Incident Management (Patient/Client/Person): **PHC, VCH**

Additional Resources

RNAO - Fall Prevention Guideline and useful assessment tools and interventions

Interdisciplinary Assessment Tools https://my.vch.ca/dept-project/Professional-Practice-Physiotherapy/Physiotherapy-Clinical-Resources/Seniors-Health/Pages/default.aspx (Copy and paste link into Google Chrome)

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Definitions

Falls

Fall: an event that results in a person coming to rest unintentionally on the ground or floor or other lower level, with or without, injury (B.C. Ministry of Health, 2006).

Fall Injury: an injury that results from a fall, which may or may not require treatment. The injury can be temporary or permanent and vary in the severity of harm.

Near Fall: is a slip, trip, stumble or loss of balance such that the individual starts to fall but is either able to recover (witnessed or unwitnessed) and remains upright because their balance recovery mechanisms were activated and/or caught by staff/other persons, or they were eased to the ground or floor or other lower level, by staff/other persons (i.e. could not stop or prevent falling to the ground, floor or lower surface).

Unwitnessed fall – this is where the person is unable to explain the events and there is evidence to support that a fall has occurred (Canadian Patient Safety Institute, p19. 2019). With unwitnessed falls head injury needs to be considered.

Functional mobility: the ability of people to move freely in their environment (with or without mobility aids) in order to participate in chosen activities of daily living.

Restraints: are any form chemical (i.e. sedative / antipsychotic), electronic, mechanical, physical, environmental or other means of controlling or restricting a person's freedom of movement or having normal access to his or her body. It is the effect the device or chemical has on the person that classifies it as a restraint, not the name or label given to the device, nor the purpose or intent of the device, including whether it was prescribed for improved positioning or its calming effect (Community Care and Assisted Living Act 2013).

Universal Fall Precautions: forms the foundation for reducing falls and fall related injuries for all people who are receiving care services. These include targeted actions that promote**:**

SAFE Questions

S - Safe environment

A – Assistance with mobility

F – Falls Risk Reduction Interventions

E – Engagement with the Person / SDM and Family

Questions to ask when care is completed:

- Do you have any pain or discomfort?
- Do you need to use the toilet?
- Do you need anything else before I leave? e.g. water, mobility aid / device, glasses, call bell

Appendix A: Universal Falls Precautions

UNIVERSAL FALL PRECAUTIONS

ADAPTED FOR LONG-TERM CARE (courtesy of Fraser Health Authority)

Everyone is at risk of falls

Everyone has a role in reducing risk of falls while promoting independence

Safe environment

- Bed rails down and bed set at appropriate height unless assessed otherwise
- Room and floors clear of clutter and tripping hazards
- Bed Brakes on at all times
- Wheelchair, commode, mobility device - brakes on for transfers

Assist with mobility

- Consider opportunities for mobilising as often as possible
- Personal mobility and other aides within reach. For people who self-propel their wheelchair brakes "off" when not transferring
- Documented Care Plan outlining assistance required for transfers / mobility
- Individualised toileting plan

Fall Risk Reduction

- When in bed / in an armchair place everyday items needed within reach e.g. Call bell, phone, glasses, water
- Well fitting, non-slip foot-ware available and being used

Engage Person / Substitute Decision Maker and Family

- Discuss risk factors with person / SDM and family
- Develop shared safe mobility (falls prevention) plan

Ask **SAFE** Questions when care is completed:

- **Do you have any pain or discomfort?**
- **Do you need to use the toilet?**
- **Do you need anything else before I leave? e.g. water, mobility aid / device, glasses, call bell**

Appendix B: VCH Long-Term Care Falls Risk Screen

Affix Name and Demographic Label

VCH Long-Term Care Falls Risk Screen

Refer to DST – Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care(BD-00-07-400028)

If "Yes" to Any – Assess effect of risk factor on person's ability to walk, transfer, or move around and developcare plan to address needs. Refer to appropriate health discipline as needed.

Risk Assessment to be completed ☐ On Move-in ☐ On Return from Acute Care ☐ Change of Status

Risk Factor	Yes	No
2 or more falls in last 6 months	☐	☐
Orthostatic hypotension / Vertigo Consider medications e.g. Diuretics, anti-hypertensives, ACE inhibitors	☐	☐
Cognitive Alterations: (Circle all that apply) Neurological / Brain Injury, delirium, dementia, memory deficits, communication difficulties, impaired judgement, insight or attention, psychosis, depression, withdrawn, agitation, impulsive behaviours, lack of safety awareness	☐	☐
Mobility Alterations: (Circle all that apply) balance, gait, weakness, endurance, ability to transfer, new mobility aids / ability to use mobility aids / footwear	☐	☐
Sensory / Perceptual Alterations: (Circle all that apply) Vision, Visual field, spatial neglect, pain, hallucinations, sensory neuropathy	☐	☐
Elimination Alterations: (Circle all that apply) Nocturia, frequency, urgency, continence, diarrhea, urinary / suprapubic catheter	☐	☐
Taking five or more medications or any of the following: (Circle all that apply) Medications with sedative properties, e.g. sedatives, opiates, anxiolytics, anti-histamines, antipsychotics, substance use, antidepressants.	☐	☐
Date: **Signature** **Designation**		

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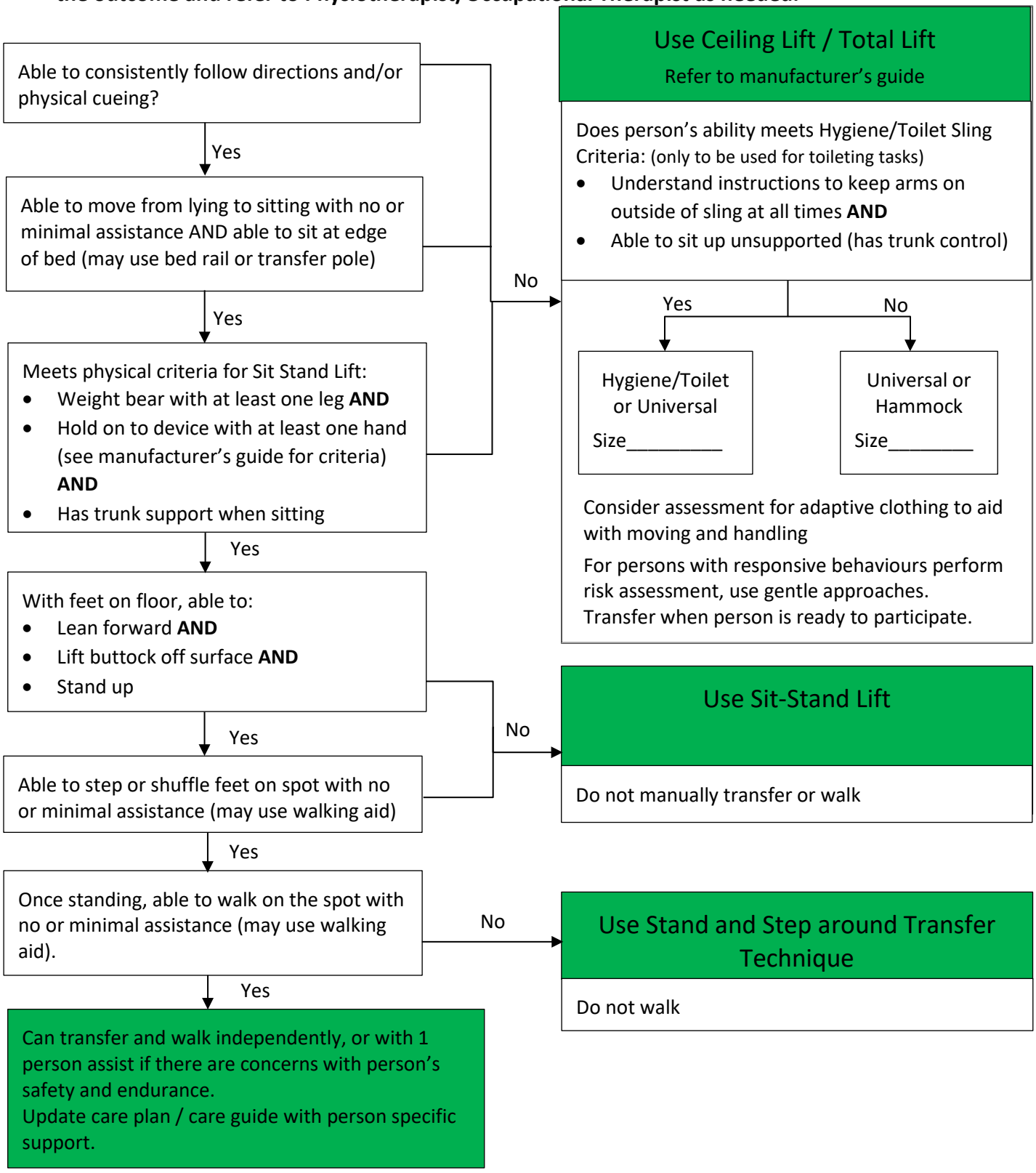
Appendix C: Algorithm: Assessing Person's Ability to Perform Transfers and Walk. Document the outcome and refer to Physiotherapist/Occupational Therapist as needed.



Appendix D p1: VCH Long-Term Care - Care Aide Post Falls Observation Tool

Refer to DST Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care (BD-00-07-400028)

To be used for people who have risk factors for late complications related to a fall or when clinical judgement suggests late complications may arise:

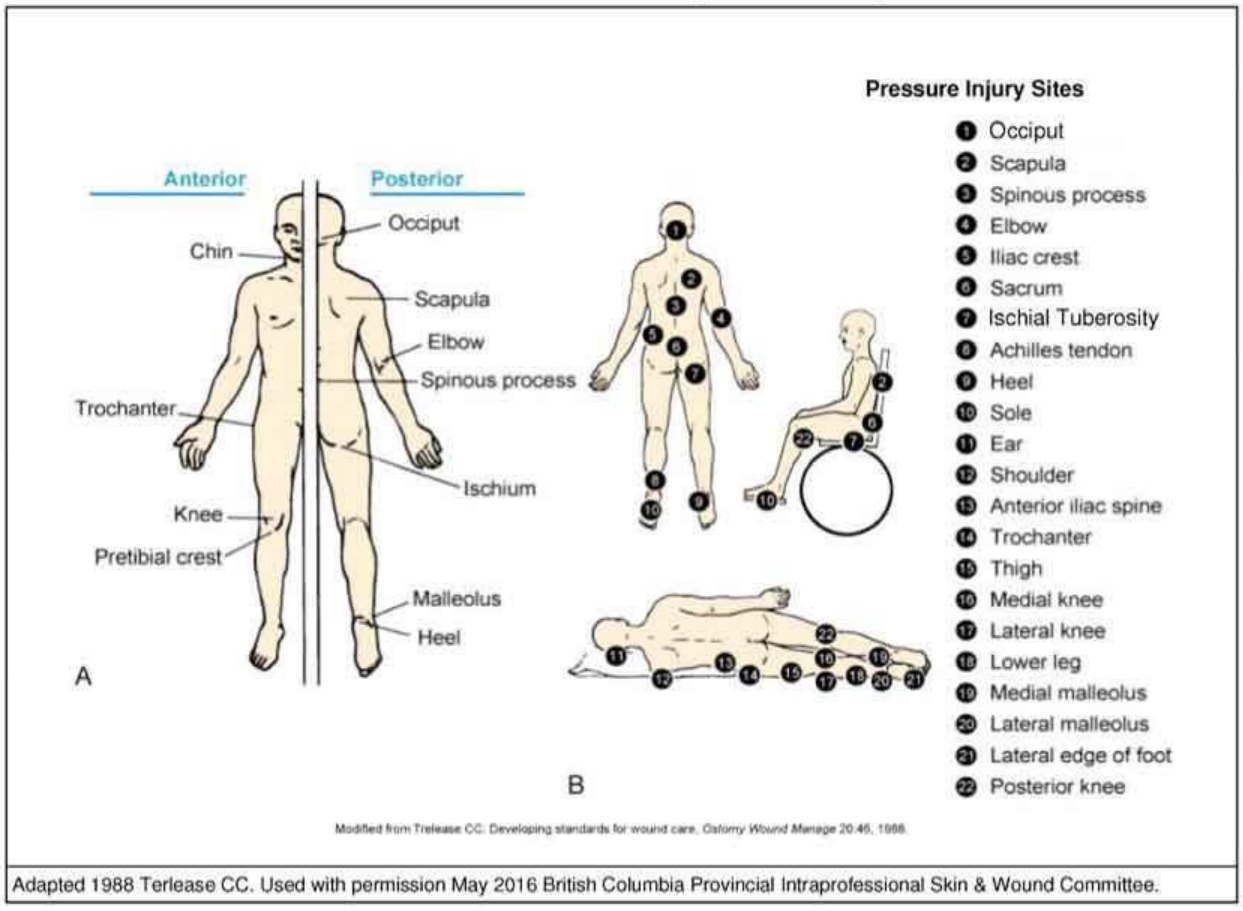
- **Care Aide:** complete each shift **(P=Present A=Absent N= Not Observed)** for next_____days (as determined by nurse) and report changes observed to nurse for assessment
- **For Pain/ Bruising / bump / skin tears or wounds arm leg deformity / weakness indicate location on Body Diagram on Reverse**

Date Initiated: **Nurse signature:** **Designation:**

P=Present, A=Absent N= Not Observed **Date of Fall:** _____ ***What has changed since fall?***	**Date**																					
	Shift	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Pain (self-report / non-verbal expressions)	**At rest**																					
	On movement																					
Bruising / Swelling / Bump (indicate location on reverse)																						
Skin tears / wound (indicate location on reverse)																						
Arm or leg deformity – shorter, rotated or bent out of shape **(indicate location on reverse)**																						
Change in level of consciousness – e.g. appears more sleepy / difficult to wake																						
Nausea / Vomiting																						
Headache																						
Seizures																						
Arm or leg weakness (indicate location on reverse)																						
Behaviour / understanding - e.g. more confused, agitated, irritable / reacting differently to care or surroundings, not usual self, more vocal or quieter than usual																						
Fear of falling																						
Nurse informed (Y/N) - Inform nurse if any of the above observed																						
Completed by (Care Aide Initials)																						
Nurse Initials - Nurse to complete assessment on same shift & document in progress notes																						

Appendix D p2: Braden Risk and Skin and Assessment Diagram

Skin Assessment Flowsheet (Head-to-Toe)



Adapted 1988 Terlease CC. Used with permission May 2016 British Columbia Provincial Intraprofessional Skin & Wound Committee.

Appendix E: Long-Term Care Post Fall Risk Assessment

Vancouver CoastalHealth

Long-Term Care

POST FALL RISK ASSESSMENT

Site:_____

To be completed during the post-fall safety huddle after a resident has fallen or has experienced multiple falls
Refer to DST Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care (BD-00-07-400028)

1. Resident activity at time of fall (*Check all applicable*) ☐ Unknown		
☐ Walking ☐ Getting in or out of chair alone ☐ Getting in or out of bed alone	☐ Going to the toilet (includes commode) ☐ Moving in a wheelchair ☐ Performing a task (e.g. dressing/carrying)	☐ Bending / reaching ☐ Standing / turning ☐ Sleeping or turning in bed ☐ Other (Specify) _____
Comments:		

2. Environment at time of fall – Physical/Social (*Check all applicable*) ☐ Not known ☐ N/A		
☐ Uneven surface ☐ Footwear (none or poorly fitting) ☐ Move to or within care home in past month ☐ No or low lighting or glare ☐ New arrangement of objects ☐ Unequal weight distribution in wheelchair or walker	☐ Clutter/obstacles in path ☐ Call bell unavailable ☐ Clothing or bedding is obstructive/slippery ☐ > 2 meters to nearest hand support ☐ Crowded conditions	☐ Loud noise or hit / struck by an object ☐ Lack of handrail ☐ Physical interaction with another resident (e.g. pushing or hugging) ☐ Wet/slippery surface ☐ Objects outside of resident's reach ☐ Other (Specify) _____
Details of above/comments:		

3. Were any of the following aids, equipment or restraints in use at the time of the fall? (*Check all applicable*) ☐ Not known ☐ Resident does not use these aids or equipment		
☐ Wheelchair ☐ Walker ☐ Glasses ☐ Cane	☐ Hip protectors ☐ Transfer belt ☐ Bedside pole or mechanical lift ☐ Reclining arm chair with foot rest	☐ Bed sensor or alarm ☐ Tilt chair with foot rest ☐ Wheelchair with seatbelt ☐ Wheelchair / recliner with table ☐ Other (Specify) _____
Were any of the above items defective or improperly used: ☐ Yes ☐ No If yes, please describe:		
Does the resident normally use aids or equipment that were **NOT** used at the time of the fall? ☐ Yes ☐ No		
If yes, please list:		

Vancouver CoastalHealth

Long-Term Care
POST FALL RISK ASSESSMENT

Site:_____

Were any of the following medications taken in the 24 hours prior to fall or newly prescribed within the past week? (*Check all applicable*) ☐ No medication of any kind taken

Psychotropics	**Psychoactive**	**Painkillers**
☐ Anti-anxiety	☐ Anti-hypertensives	☐ Non-narcotic analgesics
☐ Sedatives / hypnotics	☐ Diuretics	☐ Narcotic analgesics
☐ Anti-psychotics	☐ Beta-adrenergic (betablockers)	☐ Muscle relaxants
☐ Anti-depressants	☐ Cholinesterase inhibitors (Aricept)	
☐ Other medication (Specify) _____		**Other Medications** ☐ Antibiotics ☐ GI stimulants

Comments:

5. Health conditions apparent at the time of the fall? (*Check all applicable*) ☐ None

Balance / Gait Problems	**Neurological / Behavioral**	**Acute Health Condition**
☐ Dizziness	☐ Responsive behavior (physical)	☐ Changes in urinary/bowel continence/urgency/dysuria
☐ Postural sway	☐ Pacing/restlessness/wandering	☐ Postural hypotension
☐ General weakness in legs and knees	☐ Tremors or uncontrollable shaking	☐ Acute bacterial/viral infection,
☐ Foot problem, e.g. ulcer, deformity	☐ Confusion/drowsiness	☐ Weight loss or gain > 5% in past month
☐ ☐ Other health problems: (Specify) _____		

Comments:

Care Plan/Interventions updated based on new information from this assessment? ☐ Yes ☐ No

Additional Comments:

INFORMATION TO BE USED FOR RE-EVALUATION OF CURRENT INTERVENTIONS, CARE PLAN ANDPSLS/INCIDENT REPORT INVESTIGATION

Date: Signature: Designation:

First Released Date:	September 27, 2011
Posted Date:	August 25, 2021
Last Revised:	August 25, 2021
Last Reviewed:	August 25, 2021
Approved By: *(committee or position)*	PHC, VCH
	Endorsed By: PHC Professional Practice Standards Committee (Regional SharePoint 2nd Reading) Health Authority Profession Specific Advisory Council Chairs (HAPSAC) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HAIAC) Operations Directors Professional Practice Directors **Final Sign Off:** Lorraine Blackburn, Vice President, Professional Practice & Chief Nursing Officer, VCH
Owners: *(optional)*	PHC, VCH
	Development Lead(s): • RN, Clinical Nurse Specialist – Long-Term Care and Assisted Living Professional Practice Team, VCH • RN, Regional Professional Practice Initiatives Lead / Nurse Manager – Long-Term Care and Assisted Living Professional Practice Team, VCH • OT, Interim Regional Professional Practice Initiatives Lead / Allied Manager – Long-Term Care and Assisted Living Professional Practice Team, VCH • OT, Regional Professional Practice Initiatives Lead / Allied Manager – Long-Term Care and Assisted Living Professional Practice Team, VCH **Working Group:** • CNS Long-Term Care VCH –Coastal • RN Director of Care Windermere Care Centre, Vancouver, VCH • RN, Education Coordinator, VCH Interdisciplinary Long-Term Care Team • Quality and Safety, VCH, • RN Educator – Long-Term Care and Assisted Living Professional Practice Team, VCH • PT, PHC

	• PT – Long-Term Care and Assisted Living Professional Practice Team, VCH • OT Clinical Resource Therapist VCH • OT PHC • RN, Education Coordinator, – Long-Term Care and Assisted Living Professional Practice Team, VCH • RPN PHC, Program Specialist Dementia – Geriatrics • RN Director of Professional Practice Long-Term Care and Assisted Living, VCH • RN, Manager Clinical Excellence and Program Education, PHC **Expert Reviewers** • RN, Educator Long-Term Care Richmond Lion's Manor, VCH • RN Educator Long-Term Care Minoru Residence, VCH • RN , Educator Dogwood, VCH • Peer Care Aide VCH Interdisciplinary Long-Term Care Team • Peer Care Aide VCH Interdisciplinary Long-Term Care Team • Peer Care Aide, VCH Interdisciplinary Long-Term Care Team

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May 31, 2019 – Removed PHC and changed "Residential Care" to "Long Term Care".

August 25, 2021 – Major content updated.