Falls and Injury Prevention Guideline in the Community

Site Applicability

All VCH Home & Community Care sites (excluding Mental Health & Addictions) where VCH provides service.

These may include:

- private homes and supportive living sites such as supported housing,
- Assisted Living, Adult Day Centres, Short Term Assessment and Treatment Centre (STAT),
- Transitional Care Units and Ambulatory Care Programs

This document does not cover Long Term Care sites. Please refer to the Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care

Quick Links:

- Assessment
- VCH Falls Screen
- Care Planning
- Evaluation
- Appendix C: Fall Report Sample
- Documentation
- Appendix B – Risk Factors & Possible Interventions for Falls

Practice Level

Skill Level: Basic skills for the following professions, within their respective scope of practice of and according to the team member's competencies and clinical decision making skills.

- NP, RN, RPN, LPN
- Dietitian (RD)
- OT
- PT
- SW
- SLP
- Recreation Therapist
- Pharmacist

Basic skills for Rehab assistants (RA); Activity Workers, & Community Health Workers (CHW)

Policy Statement

The team implements and evaluates a fall prevention strategy to minimize the impact of client falls which:

- Identifies the populations/individuals at risk for falls.
- Addresses the specific needs of the population/individual at risk for falls.
- Evaluates on an ongoing basis: trends, causes, and degree of injury.
- Uses evaluation information to improve its fall prevention strategy for clients.

The team conducts a safety risk assessment for each client receiving services in the home.

- Safety risk assessment completed for each client at the beginning of service.
- The safety risk assessment includes a review of: internal and external physical environments; chemical/biological, fire and fall hazards; medical conditions requiring special precautions; client risk factors; and emergency preparedness.
- Information from the safety risk assessment is used to plan and deliver clients services. This information is shared with partners who may be involved in providing care.
- Team regularly updates the safety risk assessment and the plan of care.
- Team educates clients/families on home safety strategies identified in the risk assessment.

Reference: Accreditation Canada – Required Organizational Practices, Feb 2011

Need to Know

Background:

Fall: An unintentional coming to rest on the ground, floor or other lower level, with or without injury (B.C. Ministry of Health, 2006).

Everyone is at risk for falling, however as we age the consequences of a fall may become more severe. Fifty percent of those 65 years and older who sustain an injurious fall will not return to their prior level of mobility. Falls are a leading cause of death and disability among adults 65 years and older with 1 in 3 experiencing at least one fall a year. In addition to reduced mobility, falls can often lead to depression and anxiety associated with fear of falling and isolation as people begin to avoid activities viewed as potentially hazardous, and may result in placement into Long Term care facility.

There are a number of factors that can contribute to a client falling and the risk factors for one client will not be the same as those for another client. Due to the multi-factorial nature of falls it is essential that all clients receive a complete assessment upon their initial assessment to identify the risk factors that are unique each individual client. All fall risk factors must be assessed to create a comprehensive, individualized care plan which will address identified risk factors. Evaluation of the effectiveness of the intervention and care plan should be documented. This cycle should be repeated at regular intervals and after a fall or change of health status.

Definitions: See Appendix A – Definitions

Equipment and Supplies

The following is a recommended list of equipment and supplies to assist in the assessment and intervention of fall risk factors

- Equipment for discipline-specific assessments
- High/Low Beds,
- Hip protectors
- Mobilization and transfer aides and lifts
- Non slip socks or shoes
- Drop mats; non-slip, beveled edge
- Alarm systems for bed and chair
- Non-slip, non-glare floor surface
- Compliant flooring
- Motion detection system
- Vision Screening Tool
- Physical interior has contrasting paint colours
- Appropriate lighting and night lights

Equipment for Timed Get Up & Go (see VCH Falls Screen for details)

- Chair with arm rests
- Tape measure
- Watch

Practice Guideline

Purpose: To provide interdisciplinary team members with evidence-based tools and recommendations for fall prevention and injury reduction when assessing, care planning, and evaluating care.

A. ASSESSMENT

Screen and/or assess each client to determine their risk for falls and fall related injury:

- On referral at intake
- On initial assessment
- Post fall
- At regular intervals for clients who are receiving clinical services (annually and quarterly)
- When significant changes in the client's status is likely to increase risk for falls.

All assessment and screening at these points must include the question: "Have you fallen in the last 90 days?"

A **multi-factorial fall risk assessment** on initial assessment includes review/assessment of: (Appendix B – Risk Factors & Possible Interventions for Falls)

- **Fall history**, recurrent falls, circumstances of falls, fall related injuries such as a prior fracture and fall related hospitalizations and emergency visits.
- **Fear of falling** to the extent the fear is realistic, contributes to de-conditioning and compromises quality of life
- **Medical history** for conditions that contribute to the client's risk for falls and the status of the underlying medical conditions.
- **Cognitive status** of client for any cognitive changes or decline (RAI Cognitive Performance tool or MMSE). Cognitive impairment is a significant risk factor for falls.
- **Medication** including medication interactions and side effects. Fall risk is associated with poly-pharmacy when at least one established fall risk increasing drug is part of the daily drug regimen. Medications should be reviewed on admission, at regular intervals and when there is a change in client's status that places the client at risk for falls. (Refer to Drugs and Risk of Falling).
- **High risk behaviors** (i.e. agitation, wandering) that may contribute to falls and fall related injuries. Assessment includes a site specific behavior pattern assessment tool. Assess client's safety awareness of high risk behavior.
- **Musculoskeletal pain** and pain interfering with daily activities. More severe or disabling pain is associated with a greater risk for falls in older adults.
- **Nutrition and hydration** (minimum of 1500 cc per day) problems that may be an underlying cause of falls and fall related injuries such as a fracture (i.e. weakness, osteoporosis). Review supplements client is taking i.e. Vitamin D and Calcium supplements
- **Environmental** risk factors that are a safety hazard and increase the client's risk for falls. This includes both indoor and outdoor factors.

Physical exam for risk factors should include:
- Heart rate and rhythm
- Postural pulse and blood pressure lying, sitting and standing
- Examination of client's feet for feet problems that interfere with mobility
- Screen for visual impairment. The Vision Screening Tool could be used (requires additional training, check LearningHub for availability).
- Screen for hearing impairment.

Functional assessment, including assessment of:
- gait, balance, mobility and transfer level. (Examples include the TUG, Berg Balance Scale, Tinetti Tool, Fullerton Advanced Balance Scale)
- standing/sitting balance, lower extremity **muscle strength** and joint function, assess ability to use mobility aid (cane/walker) and wheelchair safety.
- activities of daily living including toileting and bathing

A.1 On referral at intake

Complete screen for risks for falls and fall related injury as per intake guidelines. Determine pre-intake status regarding history of falls, risk factors for falls and client's goals and expectations. Obtain information from client/caregiver and from the client's history.

- Identify individual and environmental risk factors for falls to guide priority designation.
- Complete intake screener including mobility level, use of mobility aide, the transfer method and the assistance required for mobility and transfer
- Make referral to appropriate discipline(s).
- Communicate and document on the appropriate VCH Home and Community Care documents.

A.2 On initial assessment

- Complete assessment for risk for falls and fall related injury within priority time lines. First healthcare professional to see the client complete an initial assessment. Some examples of initial/core assessments are Initial Assessment Tool (IAT), RAI-MDS, and the Palliative Assessment Tool.
- Obtain collateral information to determine status regarding history of falls, risk factors for falls and client's goals and expectations.
- Identify individual and environmental risk factors for falls to guide care planning and intervention choices aimed at minimizing risk for falls and fall related injury.
- Complete a mobility assessment. This could include the VCH Falls Screen which includes the Timed Up and Go.
- Complete a transfer assessment. This could include the SAFE Pre-Transfer Checklist.
- Document mobility level, use of mobility aide, the transfer method and the assistance required for mobility and transfer on the appropriate VCH Home and Community Care documents.
- Communicate client's risk for falls to interdisciplinary team members and client/caregiver.

A.3 Ongoing assessment and observations at regular intervals for clients who are receiving clinical services

- Observe client during care giving activities and/or include social/recreation activities for physiological, functional, cognitive and behavioral changes that put the client at risk for falls. Report change in status to the appropriate discipline.
- Observe client's environment for safety hazards during all activities.
- Perform regular and ongoing assessment / re-assessment for falls risks at regular intervals – at least annually.
- Document assessment findings when there is a significant change in the client's physiological, functional, cognitive and behavioral status that increases the risk for falls or a fall related injury.

A.4 Post fall assessment

A.4.1. Witnessed

1. Follow Safety Learning System (SLS) procedure for recording a fall and follow site specific policies.
2. Re-assess client's fall risk factors including collecting all possible information related to the causes and circumstances to assist with determining best approach / interventions for addressing any modifiable risk factors identified.
3. Develop a new / modified care plan aimed at minimizing risk for falls and fall related injury.
4. Communicate incident and assessment findings with all members of the interdisciplinary team including client/caregiver.

A.4.2. Unwitnessed

1. Follow site specific protocols for recording an unwitnessed fall. This could include recording in SLS, on a paper-based fall report (Appendix C) and/or in the client's chart.
2. Re-assess client's fall risk factors related to the causes and circumstances around the current fall to assist with determining best approach / interventions for addressing any modifiable risk factors identified.
3. Develop a new / modified care plan and intervention choices aimed at minimizing risk for falls and fall related injury.
4. Communicate incident and assessment findings with all members of the interdisciplinary team including client/caregiver and any involved contracted care providers.

B. CARE PLANNING & FALL PREVENTION INTERVENTIONS

Risk factors associated with falls are multi-factorial therefore during the development of the interdisciplinary care plan multiple strategies must be considered by team members to target the specific risk factors identified.

Implement Fall Prevention Interventions that target multiple individual risk factors (refer to Appendix B for individual risk factors contributing to falls) and/or increase the monitoring of clients at risk for falls or fall related injury, if appropriate. An important consideration is the inter-relationship of individual risk factors when selecting interventions. Refer to Appendix B for a summary table of Risk Factors and Possible Interventions for Falls.

B.1 Client/Caregiver Education

- Educate client/caregiver about the client's risk factors for falls and possible fall prevention strategies.
- Orient client and caregiver to new surroundings as needed.
- Educate client about the importance of staying active
- Discuss with client/caregiver alternatives to restraint use and the dignity of individual choices related to living at risk (i.e. interdisciplinary team meeting with client/caregiver) and document outcomes of discussion.
- Review current client/caregiver educational materials. e.g. "Stay on your Feet" booklet. Available in four languages: English, Chinese, Punjabi and Persian. To order copies of this and other educational materials go to the Patient Health Education Materials Resource Catalogue.

B.2 Client/Caregiver Counseling (Behaviour Change)

The focus of care planning in fall prevention is to maximize the abilities and freedom of movement of the client guided by client's responses and activity tolerances.

- Involve client/caregiver in setting goals of care and care planning.
- **Address fear of falling:** Explore fears with client and the impact fears have on participating in daily activities. Collaborate with client/caregiver to address fears i.e. improve pain management, offer hip protector, reassess mobility.
- Facilitate self-management support to change behaviour related to fall prevention.

B.3 Formal (Paid) & Informal (Unpaid) Support Activities

Determine which fall risk factors may be addressed by support activities. Discuss with client/caregiver which support activities will be managed informally and those that must be supplemented with formal supports. Facilitate support activity management through the care plan.

Examples include:

- Enhance supervision for clients at high risk for recurrent falls or fall related injury, either temporarily or permanently
  - 1:1 companion
  - Institute routine client safety checks (fall watch) e.g. AM/PM Check-in either in person or by telephone.
  - Before leaving the client ask the SAFE Questions
- Utilize volunteer services e.g. Walking program, transportation
- Community Caregiver Programs
- SAIL – Strategies and Actions for Independent Living. (see Definitions - Appendix A)

B.4 Equipment/Environmental Modification

Prescribe equipment and/or make changes to the environment to meet the client's goals to remain in their home safely and as independently as possible.

Note: Alternatives to restraint use must be considered and implemented. If all appropriate alternatives have been trialed and proven to be ineffective, only then may a restraint be considered. (e.g. physical, chemical, environmental, electronic)

Examples include:

- Implement SAFE Universal Fall Prevention Strategies for all clients
- Appropriate adaptive mobility equipment e.g. walking aid, wheelchair
- Hip protectors to reduce the risk of fracture. Check regularly to ensure client has hip protector on, in correct position and comfortable.
- Supportive footwear
- Referral to other internal team members as needed.

B.5 Other Therapeutic Activities

Therapeutic activities are discipline-specific activities, including hands-on care, and/or collateral activities.

When selecting therapeutic activities for an individualized care plan, ensure that the activities chosen target specific fall risk factors identified during the assessment phase.

The following are some examples of therapeutic activities that address fall related risk factors. This list is not meant to be exhaustive. (Appendix B)

- **Mobility issues:**
  - Individualized and/or group strength and balance exercises
  - Sit to stand exercises
  - Walking / Activity Program
  - Transfer and bed mobility training
- **Chronic medical conditions with respect to fall risk:**
  - Chronic conditions are often underlying causes of pain and discomfort, cognitive impairment, gait disorders, decreased bone density, orthostatic hypotension, weakness and dizziness.
  - Review chronic conditions at regular intervals by the interdisciplinary team.
- **Acute clinical problems with respect to fall risk**
  - May present as weakness (infection), hypoxia, or a sudden change in gait, in activity function, behavior or cognition (delirium).
  - A sudden change in status and/or delirium requires immediate medical attention.
- **Skin / wound care**
  - Treat and manage skin and/or wound issues
- **Pain Management**
  - Manage pain that interferes with mobility and facilitate pharmacological and non-pharmacological pain management interventions.
- **Medications.**
  - Common medication side effects are orthostatic hypotension, weakness, dizziness, gait abnormalities and delirium. (Refer to Drugs and Risk of Falling).
- **Dietary intake and nutritional status**
  - Support recommended nutrient and fluid intake e.g. Vitamin D, folate, B12, calcium & protein to maintain balance and bone density, prevent falls and reduce fall related fractures.
- **Continence**
  - Recommend strategies to manage incontinence. For example a toileting routine.
- **High risk behaviors**
  - Develop a behavior management plan to address behaviours such as agitation and wandering

B.6 Supporting Activities

- **Refer:** make any relevant referrals, e.g. hearing test, podiatrist, diabetic clinic, etc.
- **Screen vision:** Screen for visual impairment on admission and annually through out clients length of stay. Recommend that the client see an optometrist, as required.

Expected Client/Caregiver Outcomes

- Client will experience a decreased risk of falls and fall related injuries.
- Client's care plan will be current for care needs with regards to fall risk and interventions.
- Client/caregiver goals to optimize the client's medical status and quality of life will be met, so that the client remains in his/her home and participates in their community within their ability.
- Client's functional level will be maintained and their number of falls will be reduced or eliminated.
- All potential risk factors related to falls are identified and appropriate interventions are in place.

Client/Caregiver Education

Refer to section B.1 Client / Caregiver Education and section B.2 Client / Caregiver Counseling (Behaviour Change) above.

Evaluation

A. **OF CLIENT**

- Fall prevention care plan / response to intervention
  Monitor and document the client's response to interventions intended to prevent and reduce falls and minimize fall related injuries. Evaluate change in outcome measure or functional status after implementing intervention(s):
  - if goals are met – review for discharge
  - if goals are not met – re-assess and modify individualized care plan as required
- Fall prevention care plan should be reviewed every 3 months, annually, post fall and when there is a change in client's status.
- Re-assessment data: e.g. IAT, MDS, TUG, Berg

B. **OF FALL PREVENTION PROGRAM**

- Use the Patient Safety Learning System (PSLS) or similar documents (Fall Incident Report) as well as data from RAI: MDS and/or IAT to track all falls and fall related injuries for individual clients and for the facility/site.
- Use the facility/site wide data to determine if effective changes were made to reduce fall risk and to determine where, when and why falls are occurring as well as fall rate per client days/visits.

C. **OF DATA ANALYSIS -** 3 measures are recommended:

- Percentage of Falls Causing Injury (outcome measure)
- Completed Fall Risk Assessment on Admission (process measure)
- Percentage with Documented Fall Protection or Injury Reduction Plan (process measure)

Documentation

- Initial assessment, includes the identification of fall risk factors (see Appendix B – Risk Factors & Possible Interventions for Falls).
- VCH Falls Screen or other site specific fall risk screening, such as the Falls Risk Assessment Tool (FRAT).
- Client Care Plan: includes all individualized and universal interventions to address fall risk factors
- Fall Incident Report (Appendix C), completed if client falls (in SLS or per site protocol).

- Post Fall Evaluation, which is created from the incident reports with the possible addition of other information.
- Meetings: outcomes of any interdisciplinary team and/or caregiver meetings / discussions
- Referrals
- Service coordination (e.g. Home Service Support Summary)
- Client-centered goals

Related Documents

- What we do for Falls
- Adult Older Adult Fall Prevention Program List (Appendix E)
- Adult Older Adult Fall Prevention Process (Appendix F)
- Safe Patient Handling Standard
- PARIS Guidelines
- Musculoskeletal Injury Prevention Standard
- Ethical Decision Making Framework
- Risk Assessment Tool
- Personal Assistance Guidelines
- Patient Health Education Materials: (To order copies, go to Patient Health Education Materials Resource Catalogue
    - Stay on your Feet booklet (Catalogue # BE.250.5798)
    - First Step booklet (Catalogue # BE.250.F519)

References

See Appendix G for extended list.

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Developed by

Task Group: Regional Community Fall Prevention Clinical Practice Guideline Working Group

CPD Developer Lead: Project Manager, VCH Fall and Injury Prevention

Other members:

Advanced Community Physiotherapy Practice Leader – Vancouver
Advanced Community Occupational Therapy Practice Leader – Vancouver
Occupational Therapist, Home & Community Care – North Shore
Physiotherapist, Home & Community Care – North Shore
Transition Services Coordinator (Acute-to-Community)
Transition Services Coordinator (Acute-to-Community)
Manager, Transition Services Coordinator (Acute-to-Community)
Project Manager, VCH Fall and Injury Prevention

Endorsed by

Regional SharePoint 2nd Reading - Endorsement by:

Health Authority Profession Specific Advisory Council Chairs (HAPSAC)
Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC)
VCH Operations Directors
VCH Professional Practice Directors

Final Sign-off & Approved for Posting by

Regional SharePoint Final Sign-off by CNO:

Chief Nursing Officer & Executive Lead Professional Practice - VCH

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Appendix A – Definitions

Adaptive Equipment, Recommend: prescribed equipment required to meet client's goals to maintain their function, to meet their needs of independent or supported activities of daily living (ADL), or for alternate means of communication

Assessment: clarifying the nature and causes of a condition or situation and identifying its impact on the client.

Client Education: education of client regarding presenting health conditions, its implications, requirements for care/treatment and the prevention of factors contributing to presenting health conditions.

Counseling: supporting the client and their family/caregivers through their concerns associated with health transitions by assisting with the development of appropriate goals to facilitate change and growth; this may include resource, supportive, and/or therapeutic counseling

Environment, Modify: make changes to environment to meet client's goals to remain in their home safely, to meet their needs of independent or supported activities of daily living (ADL), or for alternate means of communication

Fall: unintentionally coming to rest on the ground, floor, or other lower level, with or without injury.

Family/Caregiver Education: education of family/caregiver regarding client's presenting health conditions, its implications, requirements for care/treatment and the prevention of factors contributing to presenting health condition

Formal Support Activities: referrals or care co-ordination with internal or external agencies, programs, partners

Informal Support Activities: activities by unpaid helpers, volunteers, neighbours and family who support client with client's defined goals of health and independence

Monitoring: reviewing the course of a condition or situation as the basis for deciding to continue, change, or stop interventions

Post Fall Evaluation: determining the reason(s) why a client fell or continues to fall

Required Organization Practice (ROP): an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. In Qmentum (Accreditation Canada) there are 35 ROPs identified in six patient safety areas. Fall Prevention falls under Risk Assessment.

Restraint: any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement (adapted from Community Care and Assisted Living Act Residential Care Regulation [includes amendments up to B.C. Reg. 10/2010, January 15, 2010]

SAIL – Strategies and Actions for Independent Living – the SAIL program consists of multi-factorial interventions that are targeted towards seniors who are in need of on-going home support but are not yet in need of institutionalized care. The core elements of the SAIL program are: a falls prevention training program for community health workers (CHW) and home health professionals (HHP), a falls monitoring and reporting system, the implementation of a client-centered risk assessment and prevention tool, and protocols for identifying and addressing those determined to be at high risk for falls. For more information and/or training contact the VCH Fall & Injury Prevention Program.

Self Management Support: the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

Therapeutic Activity: discipline-specific activities, including hands-on care, and/or collateral activities

Appendix B – Risk Factors & Possible Interventions for Falls

★ This is not intended to be an exhaustive list, but an aide to assist with selecting interventions that may be appropriate for risk factors identified during assessment

Risk Factor	Possible Interventions
Biological Risk Factors	

Muscle Weakness
• Deconditioning due to lack of physical activity
• May be due to:
  ○ Pain / discomfort
  ○ Fatigue
  ○ Medical conditions e.g. arthritis, osteoporosis, Parkinson's, Fibromyalgia
	• Educate on value of daily physical activity and discuss options that may interest the client.
	• Recommend community resources: exercise programs at community centres, senior's programs, Vancouver Parks and Recreation, adapted fitness, mall walking, Osteofit programs, personal trainers, as appropriate to physical health status, etc.
	• Refer to physiotherapist, kinesiologist or personal trainer as needed for individualized exercise program with strengthening component.
	• Educate on and/or recommend hip protectors, especially for individuals with increased risk of injury, such as those with osteoporosis.

Impaired Gait / Balance
• Unsteady with transfers or ambulation
• Medical conditions:
  ○ Inner ear problems
  ○ Neuromuscular disease
  ○ Any condition that affects vision, vestibular system or somatosensory system
	• Individualized exercise program with a balance component.
	• Recommend mobility aid or safely rails/ grab bars, hip protectors, if appropriate.
	• Refer for gait / balance assessment.
	• Educate on using recommended walking aid.
	• Educate on and/or recommend hip protectors, especially for individuals with increased risk of injury, such as those with osteoporosis.

Visual Deficit
• Bifocals
• Low / inadequate lighting / contrast
• Diseases:
  ○ Glaucoma
  ○ Age related macular degeneration
  ○ Cataracts
  ○ Diabetic Retinopathy
	• Vision Screening Test – check CCRS or contact VCH Fall & Injury Prevention for availability of training.
	• Recommend that client see an optometrist if it has been more than a year since last check up
	• Consult with GP and make recommend for referral to an ophthalmologist if client has eye disease that is not already being followed
	• Consider any environmental modifications that may assist functioning, such as increasing contrast, improved lighting, reducing glare, remove physical hazards, use night light
	• Educate use of glasses
	  ○ clean glasses with non-glare cleaner and soft cloth
	  ○ remove bifocals and reading glasses when walking
	  ○ wear sunglasses when in the sun
	• Educate to pause and give eyes time to adapt to changes in light, especially when going from a bright environment to a darker environment.

Hearing Deficit • Hearing aid – fit, battery • Wax buildup in ear • Inner ear problem • Injury to head	• Educate on use of hearing aids e.g. clean hearing aids, check batteries • Consult with GP and make recommend for referral to EENT specialist as required • Check for underlying disease processes • Clean ear wax with e.g. mineral oil, olive oil, or prescribed medication.

Acute / Chronic Illness
• Musculoskeletal conditions
  ○ osteoporosis, arthritis
• Cardiovascular conditions
  ○ CHF, arrhythmias, syncope
• Neurological conditions
	• Consider the main risk factor associated with the condition and refer to appropriate section of table. eg. Osteoporosis – main concerns would be risk of fracture, nutrition, and need for strengthening.
	• Cardiovascular & Respiratory:
	  ○ Educate client about resting positions, breathing and relaxation exercises and increasing physical activity.

○ Parkinson's, recent TIA, stroke • Respiratory conditions ○ Sleep apnea, COPD	○ Avoid places where air is polluted or smokey. ○ Review dietary intake. ○ Recommend an annual flu shot and one time pneumonia vaccine.
Cognitive Impairment • Delirium, dementia. • Poor judgment and/or insight • Anxiety • Decreased ability to concentrate	• Provide strategies: breaking complex tasks down into component tasks, write lists, post signs, take frequent breaks, avoid rushing to do tasks • Recommend mental exercises such as playing games, word search, puzzles, cross words, etc. • Recommend staying physically active. • Check for underlying causes such as loneliness, depressions, grief, loss, or medications. Refer to counseling as needed.
Age - over 75	• Non-modifiable risk factor – do not list in problem list or care plan
Female	• Non-modifiable risk factor – do not list in problem list or care plan
Medications • 4 or more medications (prescription or non-prescription) • Anti-depressants, antipsychotics, anti-hypertensives, sedatives • Recent changes to prescriptions	• Medication review and modification • Refer to Appendix C • Review types of medications with physician; look for psychotropics, antiarrhythmics antidepressants, diuretics, nitrates, antihypertensives, digoxin, NSAIDS, analgesics and sedatives. • Attempt to minimize total medication. • Use the lowest effective dose. • Use dosettes/bubble packs to avoid medication errors. • Consider non-pharmacological treatments as able such as strategies to improve sleep rather than sedatives. • Educate about avoiding alcohol when taking prescription medication
Bladder / Bowel Incontinence • urgency, frequency • infections • constipation • prostate problems • medication side effect • changes in eating / drinking habits	• Review medications, especially diuretics. • Educate on management of constipation, such as eating high fibre diet (vegetables, fruit, whole grains), drinking plenty of fluids, and exercise. • Educate on management of diarrhea, such as drinking plenty of fluids, bland diet (e.g. rice, potatoes, and yogurt) • Discuss strategies for urinary continence management, such as: ○ avoid bladder irritants: caffeine, alcohol, citrus fruits/juice, tomato based products, artificial sweeteners, chocolate, carbonated beverages. ○ fluid management ○ muscle re-training (strengthening exs.) ○ timed voiding schedule ○ protective clothing/pads • Recommend any needed equipment e.g. commode chair, night light, loose clothing, firm chair • Recommend having a safe pathway to access bathroom.
Dehydration / Malnutrition	• 1500 mL of fluid recommended per day. • Review supplements i.e. Vitamin D and Calcium.
Dizziness / Postural Hypotension • Complains of dizziness with sitting / standing	• Monitor blood pressure lying, sitting and standing • Education to client to sit for a few minutes before rising to stand, then stand until dizziness resolves before walking • Review medications. • Review fluid and food intake • Educate to not go for more than 5 hours without eating and to avoid dehydration • Check hearing / ears and vision.
Foot Conditions	• Recommend properly fitting supportive shoes with low heels that are

• deformities • loss of sensation • swollen • circulatory disease	enclosed and have a non-skid sole. • Consult with GP and make recommend for referral to podiatrist or foot care nurse for care of calluses, bunions, corns, or ingrown toenails. Corn plasters are not recommended for people with diabetes, heart or blood vessel disease. • For swelling, recommend elevating legs above hips when lying down. • Educate to avoid tight fitting socks or stockings that may cut off circulation and cause numbness in feet. • Educate to avoid wearing socks on linoleum or tile flooring.
Pain	• Refer to doctor for management of pain. • Review pain management strategies.
Sleep Disturbance • Difficulty falling asleep or staying asleep • Napping during the day • stimulants after 4 p.m. e.g. coffee, tea, alcohol, colas, chocolate, etc	• Establish a normal sleeping pattern e.g. older adults need ~ six hours a night, can awaken twice during the night with 20 minutes to go back to sleep • Educate to avoid caffeinated foods and drinks after 4 pm., recommend warm milk instead if not contraindicated due to medications and/or timing • Recommend to avoid napping in late afternoon or early evening. • Recommend to avoid activities which promote stimulation before bedtime • Teach relaxation techniques
Use of assistive device	• Educate on appropriate use of assistive device.
Behavioural Risk Factors	
History of Falls • Fall in the last 90 days • Recurrent falls • Fall causing injury	• Take detailed fall history in order to determine possible causes and modifiable risk factors – develop and implement care plan to address modifiable risk factors with respect to goals • Detailed history to include: number of falls, cause, location, degree of injury • Refer to interdisciplinary team if two or more falls in the last 90 days or a single fall with an injury requiring treatment. • Provide educational materials on fall prevention (eg Stay on your Feet)
Substance use • aid sleep / relieve aches/pains • loneliness / depression / grief / stress etc • alcohol / non-prescription / 'soft drugs'	• Recommend alternative management techniques. • Referral to Senior's Well Aware Program, or Senior's Peer Counseling • Community centers/ churches/ support groups/ activities
Fear of falling • To the extent the fear is realistic or contributes to de-conditioning and compromises quality of life	• Discuss fears with client or refer as needed. • Teach client how to safely get up off the floor • Address fears with interventions to modify environment and/or improve physical function
Inappropriate footwear / clothing	• Recommend properly fitting supportive shoes with low, enclosed heels. • Loose shoes can be modified with insoles or extra socks
Hurrying / Not paying attention	• Educate on importance of taking ones time and scanning environment for potential hazards.
Habits, Patterns & Preferences	• Consider safety checks • Ability to adapt to unfamiliar surroundings & others who are close to them
Lack of exercise	• Discuss options for physical activity and explore which options might be of interest to the client. Provide resources / refer to those options that client is interested in. • Discuss ways to increase daily activity.
Agitation, wandering	• Reduce environmental risk factors • Consider if alarm systems are appropriate e.g. Alzheimer Wandering Register • Recommend strategies to decrease agitation e.g. objects or tasks to soothe

	or keep their attention focused
Environmental Risk Factors	
New Surroundings	• Orient to new environment.
Indoor hazards • Poor lighting or glare • Lack of color contrast on walls/ floors, around light switches • Lack of grab bars, handrails, rest areas • Transition areas, changes in elevation • Slippery / uneven surfaces • Obstacles – scatter rugs, cords, pets, clutter • Poor maintenance of stairs	• Check environment for slip, trip and fall hazards and correct as appropriate. • Chairs/bed height just above knee height to facilitate independent transfers if appropriate. • Recommend non-slip wax on floors. • Recommend storing frequently used and heavier items on lower shelves. • Recommend home safety and adaptive equipment as needed ○ e.g. non-glare bulbs of 100 watts or greater, install handrails, remove or secure loose carpet/rugs, use non-glare bulbs, long handled reacher etc • Educate about alternative transportation i.e. HandyDartt, taxi, bus
Outdoor hazards • Stairs – no handrail, slippery • Uneven terrain • Wet / ice surfaces • Poor lighting or glare	• Inspect rubber cane tip regularly. If rubber is shiny and cracking, recommend replacing. • Recommend “ice pick” attachment for bottom of cane for icy weather. • Recommend using a motion sensor on outdoor lights. • Recommend keeping walk ways clear.
Restraints	• Current restraint used and rationale for restraint • Monitor
Socioeconomic Risk Factors	
Communication Barriers • Use of operational hearing aide. • Ability to understand others & make self understood • Language or cultural barriers • Limited literacy	• Check hearing aide batteries, replace as needed. • Arrange for a translator to be present during sessions. • Provide materials in the client’s language. • Avoid using jargon. • Check for understanding by asking questions about what has been discussed.
Inadequate Income	• Investigate alternatives financial resource available to client (e.g. 3rd party funding sources, Ministry funding, extended medical, Red Cross, SAIL program) • Second hand, recycling or consignment programs e.g. South Vancouver Seniors Network
Lack of Access to Health Services	• Consider which services are required. Help navigate health system and provide appropriate referrals • Identify barriers and recommend strategies e.g. language barrier > provide an interpreter; connect client to a GP that does home visits
Living Alone	• Encourage/support informal networks • Recommend developing an informal network of friends and neighbours / volunteers to check in daily • Connect client to seniors centres or activities at local community centres
Limited personal health practices and coping skills	• Refer to counseling services • Educate client at a language level appropriate to enhance their understanding

Appendix C – Fall Report - pg 1

Sample only – your form will look different, but content should be similar.

Fall Report©

Modified June 02, 2008

Entered in data base _____ (dd/mm/yy)

Place client label here (complete address on paragraph on rear):

Client Name: _____

MRN/ PHN: _____

Age: _____

A fall is defined as **intentionally** coming to rest on the ground, floor or other lower level, **whether or not the faller is injured.** Complete a separate form for each fall.

Complete & attach a copy of this report to the client's chart for all incidents involving a client fall.

1. Name of person completing this form: _____ **Date completed:** (dd/mm/yy)_____

2. Fall Witnessed/Unwitnessed: ☐ No ☐ Yes, by _____ **Date of fall:** (dd/mm/yy)_____

3.Time of fall: ☐ Unknown ☐ 7:00am-12:59pm ☐1:00pm-6:59pm ☐7:00pm-12:59am ☐1:00am-6:59am

4. Location of fall *(check one only)* ☐ Unknown

- ☐ Bedroom
- ☐ Bathroom
- ☐ Hallway
- ☐ Dining/living area
- ☐ Stairs
- ☐ Kitchen
- ☐ Laundry/utility area
- ☐ Transition area, e.g. doorway
- ☐ Yard or surrounding outdoor area
- ☐ Public outdoor area e.g. sidewalk
- ☐ Public building, e.g. store, clinic
- ☐ Other _____

5. Activity at time of fall *(check one only)* ☐ Unknown

- ☐ Walking
- ☐ Turning
- ☐ Bending/Reaching
- ☐ Bathing
- ☐ Using toilet
- ☐ Dressing/Undressing
- ☐ Carrying/lifting an object
- ☐ Getting in/out of bed
- ☐ Standing up/Sitting down from seat
- ☐ Climbing (eg. on/off ladder/stool/chair, etc)
- ☐ Other _____

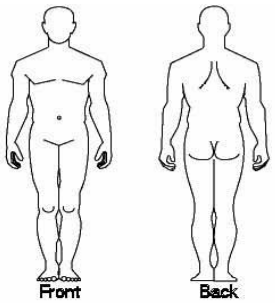
6a. Fall description and contributing factors if known: Briefly give your impressions of why this fall happened, e.g. had flu; was rushing to toilet; tripped over phone cord _____

6b. Additional Information: (*check all that apply*): ☐ Client used call bell or personal alarm to call for help ☐ Client called for assistance ☐ Client found on the floor ☐ Client wearing hip protector at time of fall

7a. Does resident report, or appear to have, pain or injury from the fall? ☐ Yes ☐ No

If "Yes", **briefly describe injury.** Indicate which injuries are suspected OR confirmed, e.g., **confirmed** bruise to right arm above the elbow OR **suspected** fracture to left wrist: _____

7b. Location and Type of Injuries *(Using the letter codes A to G (see below), mark the exact location of **all** suspected or confirmed injuries*



A. Pain
B. Cut/Scrape/Abrasion
C. Bruise
D. Bump/Redness/Swelling
E. Sprain/Strain/Dislocation
F. Fractured bone
G. Concussion

Indicate if following injuries were confirmed:
☐ Sprain/Strain/Dislocation
☐ Fractured bone
☐ Concussion

7c. Actions Taken *(check all that apply)*

- ☐ Comfort measures only
- ☐ First Aid e.g. ice pack, wound dressing
- ☐ Notified Manager/supervisor
- ☐ Notified physician
- ☐ Notified other health professional
- ☐ Notified family
- ☐ Phone call to BC Nurse Line
- ☐ Visit from health professional
- ☐ Visit to /or from physician
- ☐ Ambulance or Fire Dept. visit without transfer to Emergency Dept.
- ☐ Taken to Emergency Dept.
- ☐ Care Plan reviewed for prevention
- ☐ Other *(specify)*: _____

8. Recommendations and follow-up actions *(see on reverse)* _____

9. H&CC: If report linked to client's calendar, circle X to indicate a Falls Report has been completed for this fall ☐ Done

1

INSTRUCTIONS ON USING AND COMPLETING THE FALL REPORT FORM:

- Fall Report forms to be printed on goldenrod paper to distinguish from other forms.
- The cover page of this form may be copied onto the back of an existing in-house incident reporting system - it is recommended that goldenrod paper be used for the new 2-sided form.
- Complete a Fall Report form for every fall, regardless of where the fall occurred; whether or not it was witnessed, and whether or not there was an injury.
- Completed Fall Reports must be copied and original linked to client record for prevention planning.
- In Home & Community Care, original is given to health professional(s) caring for client/patient.
- Use Regional protocols regarding where copies of the Fall Report are sent, for example copied are typically **not** forwarded to Quality and Patient Safety.
- A data entry program is available to be used to track trends/patterns of falls over time, within, or across sites. This is important for site-wide or region-wide falls prevention planning.

1. **Name of person completing form**: Name of person who completed the form
2. **Fall Witnessed/Observed**: Indicate if the fall was witnessed by person completing the form, or if not, state if it was witnessed by the, family member or other.
3. **√ Time of fall:** Select the closest time category.
4. **Location of fall:** Note the exact location of the fall. Check one location only.
5. **Activity at time of fall:** Note the activity **at the time** of fall. If fall was not witnessed, gather information to judge the exact activity at the time of fall. Check one activity only.
6. **Fall description and additional information:**
   a. **Fall description:** Use this section to provide additional information NOT covered in the other sections such as a detailed description of the fall or factors that may have contributed to the fall.
   b. **Additional Information:** Check all applicable.
7. **Injury due to fall and all Interventions:**
   a. **Pain or injury:** Ask about any obvious new injuries and complaints of pain. Describe if these are **suspected** injuries or **confirmed** (obvious or diagnosed injury, e.g. Open wound).
   b. **Location(s) and Type(s) of Injury:** Mark the exact location of the injury on the diagram with the letters **(A – G)** from the type(s) of injury list given.
   c. **Actions Taken:** Mark all actions *(by staff, client, family)*
8. **Recommendations and follow-up actions:** Give your ideas of how the fall could have been prevented and follow-up actions to reduce the risk of future falls, such as having a urinal or commode by the bed if fall happened at night while rushing to the bathroom.

Possible Recommendations and Follow Up Actions:

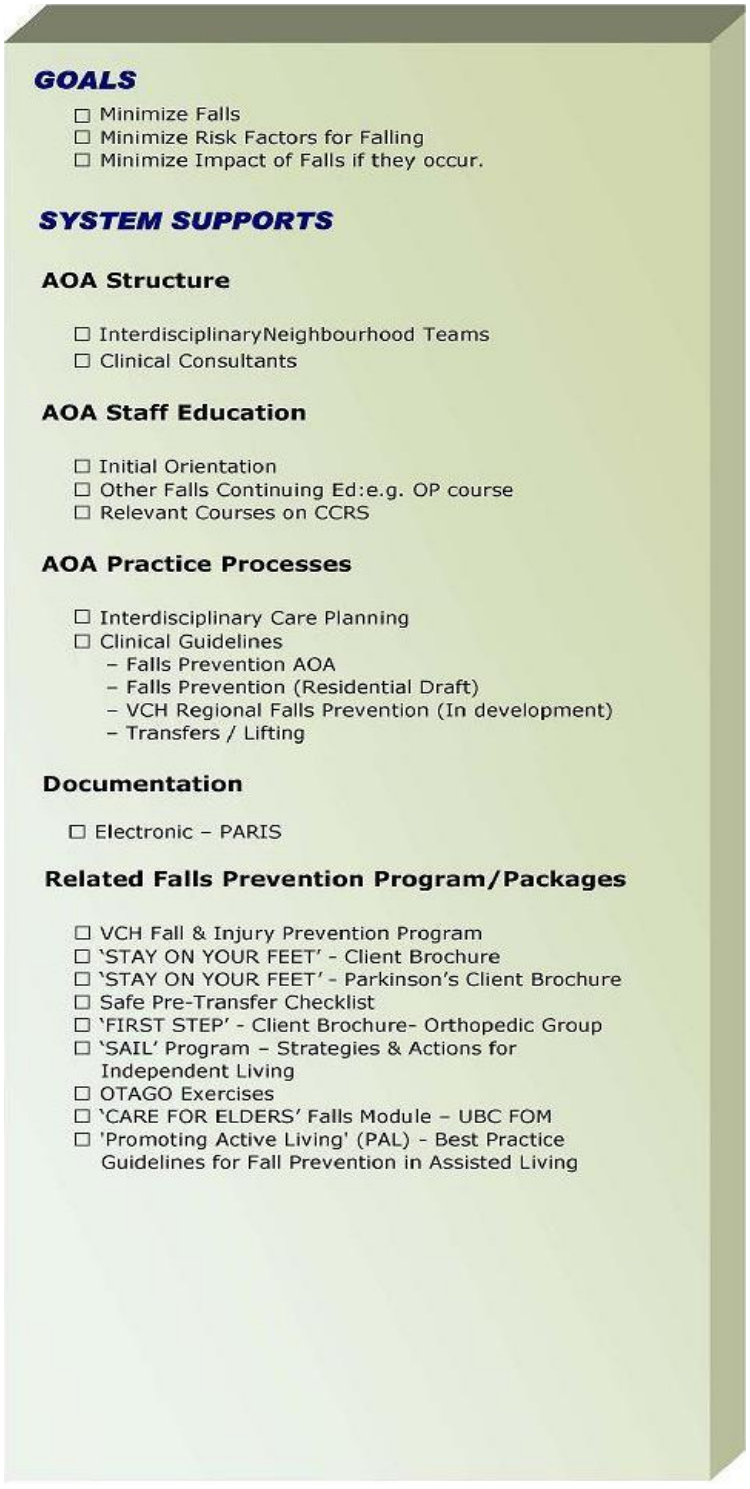
- Use the time of day response to determine behavior patterns that may contribute to risk, e.g., if client falls during the night, ask about toileting habits at night, check lighting and use of nightlights, review sleep medications.
- For frequent fallers, review prior fall reports and for patterns that contribute to falls in order to tailor prevention strategies.
- If possible, have the client show you where the fall occurred. Inspect the location for contributing factors such as scatter rugs, electrical cords, clutter, inaccessible call bell etc. For Home & Community Care: Refer to the Checklist and Action Plan for recommended actions.
- Use the activity information to suggest interventions, e.g., if the client fell while walking, they may need a mobility aide, or training in using the mobility aid correctly, or may need to increase muscle strength and balance through exercise. If they fell while getting out of a bed or a chair, ask them to demonstrate how they do this to look at the risk, e.g., the bed or chair may be the wrong height. If the fall happened while bathing, check to make sure grab bars are in place and are being used.
- Transfer this information to a care plan.

ADDRESSOGRAPH INFORMATION

Appendix D – Vision Screening Tool

Please note: To perform the Vision Screening Test, certification is required by the VCH Fall & Injury Prevention Program. To register, visit LearningHub.

Appendix E – Adult Older Adult Fall Prevention Program List



GOALS

- ☐ Minimize Falls
- ☐ Minimize Risk Factors for Falling
- ☐ Minimize Impact of Falls if they occur.

SYSTEM SUPPORTS

AOA Structure

- ☐ InterdisciplinaryNeighbourhood Teams
- ☐ Clinical Consultants

AOA Staff Education

- ☐ Initial Orientation
- ☐ Other Falls Continuing Ed:e.g. OP course
- ☐ Relevant Courses on CCRS

AOA Practice Processes

- ☐ Interdisciplinary Care Planning
- ☐ Clinical Guidelines
  - Falls Prevention AOA
  - Falls Prevention (Residential Draft)
  - VCH Regional Falls Prevention (In development)
  - Transfers / Lifting

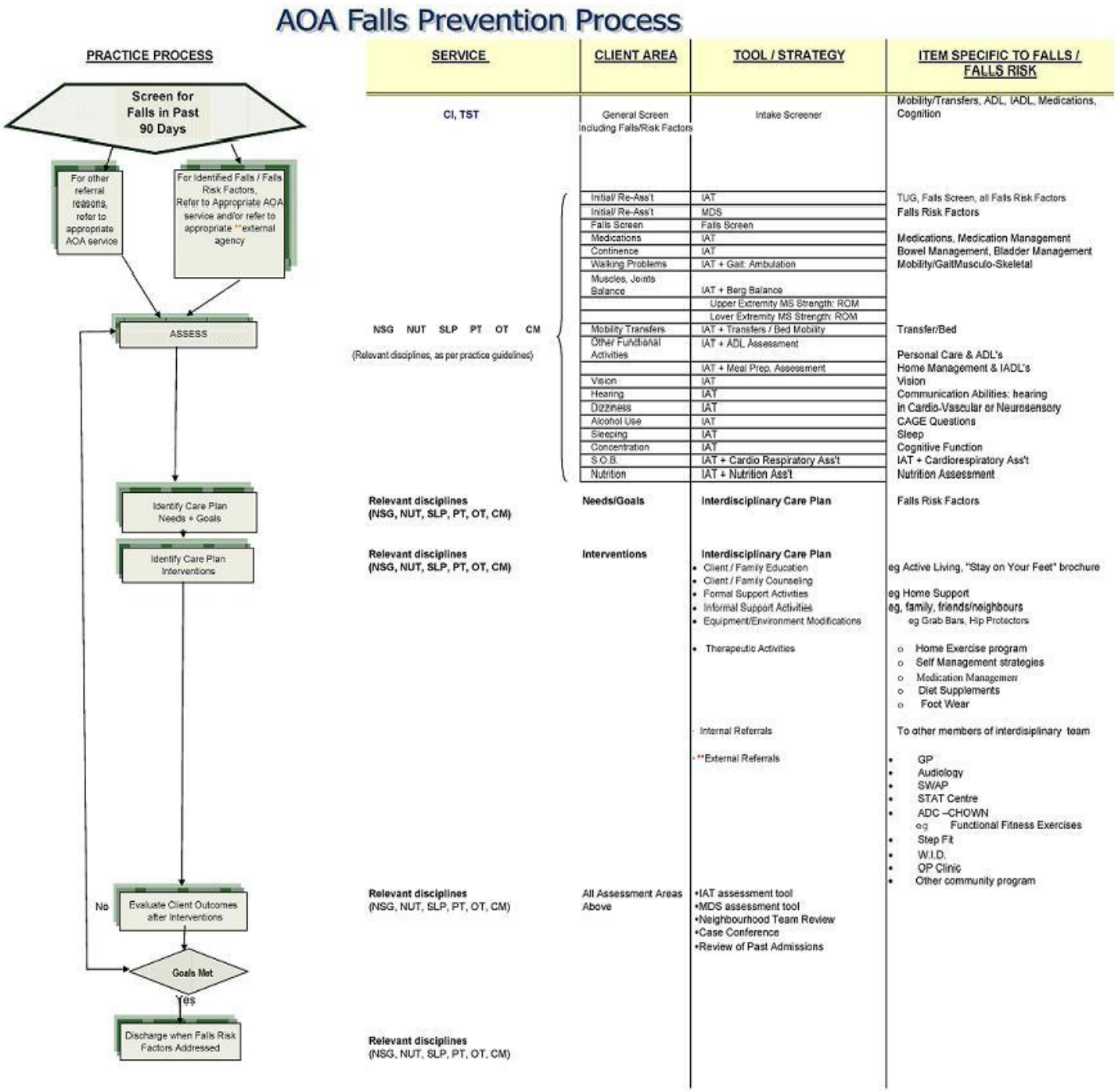
Documentation

- ☐ Electronic – PARIS

Related Falls Prevention Program/Packages

- ☐ VCH Fall & Injury Prevention Program
- ☐ 'STAY ON YOUR FEET' - Client Brochure
- ☐ 'STAY ON YOUR FEET' - Parkinson's Client Brochure
- ☐ Safe Pre-Transfer Checklist
- ☐ 'FIRST STEP' - Client Brochure- Orthopedic Group
- ☐ 'SAIL' Program – Strategies & Actions for Independent Living
- ☐ OTAGO Exercises
- ☐ 'CARE FOR ELDERS' Falls Module – UBC FOM
- ☐ 'Promoting Active Living' (PAL) - Best Practice Guidelines for Fall Prevention in Assisted Living

Appendix F – Adult Older Adult Fall Prevention Process



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