INTRODUCTION

Falls are the most commonly reported adverse events occurring in the hospital and long term care settings. They contribute to the majority of injuries and extended hospital stays. They cause pain, suffering, and loss of independence. However, falls prevention programs can reduce the number of falls and reduce injuries.

The purpose of the Falls Prevention Policy is to outline a framework to increase the awareness of falls, and to provide the tools to identify risk factors, and implement appropriate strategies to reduce falls. Since 2008 the Falls Prevention Policy (Appendix A) has been in place for most of the Cape Breton District Health Authority. The policy includes the falls risk assessment, interventions and post-fall assessment.

LEARNING OBJECTIVES

Following completion of the learning activities the learner will be able to:

1. Complete a Falls Risk Assessment (Appendix B).
2. Be familiar with identifier to flag potential fallers (Falling Star). (Appendix F)
3. Know intervention strategies for all patients plus those identified as low & high risk for falling.
4. Educate client and family on risk factors using the Falls Prevention Brochure (Appendix C). The Falls Prevention Brochure can be ordered from the Print Shop.
5. Follow the post-fall procedure in the Falls Prevention Policy and fill out a Post-Falls Assessment (Appendix D) and a Patient Safety Learning Report (AEMS).
METHOD
To be deemed competent in this policy the nurse will:

1. Become familiar with the Falls Prevention Policy
2. Review the Learning Module for Falls Prevention.
3. Complete the self-test.

PREREQUISITES
All RNs and LPNs employed by the Cape Breton District Health Authority are required to complete the Learning Module for Falls Prevention.

THEORY
“A fall is unintentional change in position resulting in coming to rest on the ground or other lower level.”

This includes unwitnessed falls where evidence suggests a fall, and near falls (that would have happened if staff had not assisted.)


IMPLEMENTATION
Fill out the Falls Risk Assessment Form on admission, once a month or if the patient’s condition changes.

This form is a rating scale with each category assessed independently from 0 to 3.

- **Days since admission:** The longer a patient is in hospital the higher the score. For example, if the patient is being assessed on admission they would get a score of 0 for this category. If they were being assessed after a month in hospital, they would get a score of 3.

- **Age:** The older the patient is, the higher the score. If a patient is 16 years old they would get a score of 0 but if the patient was 80 years old they would get a score of 3.
• **Falls history:** If the patient has had a fall in the past month, they would get a score of 3 but if the patient had a fall 6 months ago they would only score 1.

• **Mobility:** A patient who uses a wheelchair and needs assistance to transfer scores 0; a person who needs a walker and 2 people to walk scores 1; someone who needs a walker/cane and/or 1 person to walk scores 2 and a patient who ambulates independently scores 3 in this category.

• **Mental state:** A patient who is oriented in all spheres scores 0 but a patient who is disoriented, has impaired judgment or is impulsive scores 3.

• **General health:** Nourishment, sleep, appetite and weight are indicators of general health. A patient who is well nourished and sleeping well scores 0 whereas a patient who is malnourished and has lost weight scores 3.

• **Vision:** If a patient has normal vision they will score a 0 on this category. Severe visual disturbance or blindness scores 3.

• **Speech:** The score will be 0 if the speech is normal. A patient with speech issues but is generally understood would score 1 but a patient who has severe speech issues and is not understood would score 3.

• **Medications:** If a patient is not on any medications then they would score 0 but if they are on both cardiovascular and central nervous system medications they would score 3 on this category. See “Falls Risk Medication List (Appendix E).

• **Chronic illness:** If a patient does not have a chronic illness, they receive a score of 0 but if there are many illnesses the patient would receive a score of 3.
- **Incontinence:** If a person is continent they score 0; if they toilet often the scores is 1; if they toilet at night and/or when sneezing (stress incontinence) the score is 2; and if there is urge incontinence or if there is a catheter in place the score is 3.

**Tabulate the score to identify low or high level of risk.**

For a patient identified as being at high risk for a fall, place an identifier, “Falling Star”, to signal risk to all staff, where appropriate, i.e. wall, bed, chair, chart, kardex. For information on the “Falling Star” see (Appendix F).

Provide education to patient and families on risk factors and give Falls Prevention Brochure. (Appendix C)

Develop a care plan to implement specific safety measures to address all risk factors identified as per Falls Risk Interventions.

Initiate standards of safety of all residents. Add additional interventions when low or high falls risk have been identified. The interventions can be found in the Falls Prevention Policy (Appendix A).

**If a fall does occur a Post-Falls Assessment (Appendix D), Reassessment of Fall Risk Appendix B, interventions as per the Falls Prevention Policy Appendix A and a Patient Safety Learning Report (AEMS) should be done.**
REFERENCES

Falls Management Program, Veterans Services, Camphill Veterans Memorial Building, Halifax, N.S. April 2004


Prevention of Falls $ Falls Injuries in the Older Adult, Nursing Best Practice Guidelines, Registered Nurses of Ontario, March 2005

SELF-TEST for Falls Prevention

Questions

1. What is the definition of a “fall”?

2. What is the definition of a “near fall”?

3. The older the patient is, the higher the score. True or False

4. A patient who ambulates independently scores 0 for mobility. True or False

5. Benzodiazepines such as Lorazepam (Ativan) are a category of drugs that has been associated with falls. True or False

6. For a patient identified as being at high risk for a fall, where should the “Falling Star” be placed?

7. After a fall, it is important to identify the following critical components: (Mark all that apply)
   a. Vital signs including neuro signs
   b. Physical exam
   c. Observation of individual
   d. Assessment of the environment

8. Chronic medical problems may increase an older person’s risk for falling. True or False

9. Full rails (4) are not to be used as a falls prevention strategy and can increase injuries. True or False

10. One of the most effective strategies in fall prevention has been to
    a. Evaluate the environment
    b. Implement gait training
    c. Use signage such as wrist bands, color coded dots and stickers
    d. Educate the staff to raise their awareness and improve their attitudes about falls
**Answers**

1. A fall is unintentional change in position resulting in coming to rest on the ground or other lower level.

2. A near fall would have happened if staff had not assisted.

3. True

4. False

5. True

6. For a patient identified as being at high risk for a fall, the “Falling Star” should be placed on the wall, bed, chair, chart, kardex.

7. a, b, c, d

8. True

9. True

10. d

After completion of the Falls Prevention Learning Module, please fill out an Education & Learning Attendance Record (**Appendix G**).