Falls Risk Management

AHS Falls Risk Management

Post-Falls Review

What is it?

- The Falls Risk Management (FRM) Post-Falls Review sets out to describe the elements that are required for a post-falls review within a comprehensive FRM strategy[1] to support patient safety and quality improvement.
- A description of each of the elements is provided, along with the planning that needs to occur and links to a range of evidence-based information and practical tools that are available to support operational units (site/program/facility/unit) in their strategy development.
- These Recommendations will also support local operational units to meet the requirements of the Accreditation Canada ROP: Falls Prevention Strategy and the AHS Falls Risk Management Level 1 Policy.

[1] A falls risk management strategy is an overarching term that encompasses falls prevention, harm reduction, and decreasing the impact of falls risks. The Alberta Health Services (AHS) Falls Risk Management Strategy (FRM) is supported by policy and is described more fully in the AHS Falls Risk Management Strategic Development Resource Guide (refer to FRM home page).

AHS Falls Risk Management (FRM)

Post-Falls Review

Introduction

It is important to provide care for patients who fall or report a fall, as not all falls can be prevented. It is essential, after attending to the immediate needs of the patient, to observe for any delayed injuries, determine what may have contributed to the fall, and decrease the risk of future falls (for that patient and others). A post-falls review guides this process.

There are four key steps in a post-falls review:

1. Assess for injury and provide immediate care (refer to Fall? in the FRM Strategy Development Guidelines)
2. Monitor for 24-48 hours
3. Conduct a post-falls huddle and reassess falls risk factors
4. Modify the care plan/interventions

Differences due to patient age are required as well as for sites and operational units with different acuity of illness and staffing models.

Additionally, differences in whether neurovital signs are monitored or not will depend on whether the patient has sustained a head injury or where head injury cannot be excluded (unwitnessed falls), as well as for those patients who are at higher risk (those on anticoagulant or anti-platelet therapy, hemophilia).

Definitions

Throughout this document the term *patient* means an adult or child who receives or has requested health care or services from Alberta Health Services and its health services providers or individuals authorized to act on behalf of Alberta Health Services. Patient is inclusive of residents, clients and outpatients. *Family* refers to any person who is part of the informal or natural support network as defined by the patient.

Guidelines

Monitoring

Monitoring the patient who has fallen for injuries that are not immediately visible or are delayed is important for identifying a serious change in medical condition. Such injuries include head injury, intracranial bleeding, fracture, and spinal cord injury. Any patient who falls should

be monitored by assessing vital signs and pain, changes in mental status (relative to pre-existing condition), vomiting, seizures, and amnesia.

If unwitnessed falls and witnessed falls with suspected head injury have occurred, neurovital signs must also be assessed. This can be done with a Glascow Coma Scale (GCS). For pediatrics, a pediatric version of the GCS is available.

Frequency of monitoring will vary depending on the setting. Refer to the chart in Appendix A for additional information.

For patients with hemophilia, or those receiving anticoagulant or anti platelet therapy, monitoring must always be done regardless of whether their fall is witnessed or not.

When a patient has fallen in the last 24-48 hours where:

- the fall was in hospital and now he/she is leaving to go out on pass within 48 hours since the fall; or
- the fall was not while receiving care, and within 48 hours they are seen in a public health or ambulatory setting for a regular, unrelated appointment and then return home;

provide instructions on what should be monitored and for how long. These instructions should indicate that if symptoms or signs occur or get worse, they should go to the nearest emergency department or contact EMS. Teaching sheets are currently available on https://myhealth.alberta.ca . Specifically look for the information on concussion/mild head injury https://myhealth.alberta.ca/alberta/Pages/Concussion-Mild-Traumatic-Brain-Injury-After-Your-Visit.aspx . You can also use this information sheet developed in the Calgary Zone. http://www.albertahealthservices.ca/hp/if-hp-cbi-concussion-mild-brain-injury-information-handout.pdf

For patients returning from a pass who experienced a fall while on pass, monitoring will depend on both the time since the fall event and clinical judgment.

Huddle

Equally as important as monitoring for injury is the process of determining what caused the patient to fall. A post-falls huddle (also known as discussion or event review) identifies possible risk factors that contributed to the fall. A huddle is defined as the time when two or more staff meet to identify these risk factors. As there are over 100 falls risk factors, this process requires critical thinking. The huddle should occur within the same shift or within 24 hours of the fall event. Identification of contributing risk factors will guide subsequent interventions.

When doing the huddle, consider that the first and/or obvious reason for a fall may not be accurate, and that more than one factor is involved in any fall event.

While the reasons that a patient fell may seem obvious, upon closer review, other reasons may be discovered. For example, it could be that Mrs. Smith fell because she tripped over something in her garden. Upon further questioning, it may be discovered that she did not trip, but that she blacked out. This would then indicate a need for a cardiac assessment not necessarily an environmental or mobility assessment.

Another reason for a huddle is that a fall results when two or more risk factors occur at the same time. Identifying the multiple factors will also guide interventions. For example, Mr. Jones falls at the toilet. Upon questioning, it may be discovered that he has weak leg muscles and cannot stand up very easily; he forgets to use the toilet armrests, he has poor balance, and he is not able to manage his clothes. Together these four factors, (weakness, memory, balance and dressing skills), contribute to Mr. Jones' fall. Each of these four risk factors would require an intervention.

Each site, setting, and operational unit will identify who will be involved in the huddle, how the information collected will be documented and stored, and with whom the information will be shared. The huddle could include housekeeping, volunteers, porters, and food services staff.

Tools

There are several tools that can be used to guide a post-falls huddle. Two examples are the "5 Why's" and a post-falls report.

The "5 Why's" is a strategy whereby the question "why?" is asked, and for every response, another "Why?" question follows. This is repeated five times or more, as long as answers are continue to help identify the root cause of the fall. This would then guide the intervention(s) and changes to the care plan. For example:

Problem: Ms. Young fell on the floor
--***Why*** did she fall on the floor?
- Because her feet slipped out from under her.

--***Why*** did her feet slip out from under her?
- Because she was not wearing gripper socks.

--***Why*** wasn't she wearing gripper socks?
- Because the supply bin with gripper socks was empty.

--***Why*** was the supply bin empty?

- Because the gripper socks had not been ordered in a timely manner.

--***Why*** had they not been ordered in a timely manner?

- Because the person in charge of supply orders was on vacation and did not have a replacement.

The intervention would then address the process to ensure the supply of gripper socks is adequate. In addition, the intervention would address Ms. Young's footwear and the reason she was not wearing the gripper socks.

Another example of a tool facilitating a post-falls huddle is a post-falls report. This report is a list of various falls risk factors and those relevant to the fall are selected. The four-part model in the Canadian Falls Prevention Curriculum© provides a holistic approach to the identification of risk factors. Using the categories in this model, biological/intrinsic, behavioural, socioeconomic and environmental, the multiple factors are easier to identify. The sample attached in Appendix B is the Fall Report© provided by the Canadian Falls Prevention Curriculum©. Other considerations include, but are not limited to, medications, restraint use, alarms in use, the time of day and the day of the week.

Reassess Falls Risk Factors

Completion of a falls risk assessment to determine any changes to the patient's risk factors after a fall event is important in order to determine any additional or risk factors that need to be addressed. The falls risk assessment used initially can be used again for this step.

Modify Care Plan/Interventions

The purpose of this step is to decrease the risk of the patient falling again. It uses information from the post-falls huddle and the reassessment of falls risk factors. Each site, setting, and operational unit will identify the team member responsible to coordinate this step, and identify how and with whom the changes will be communicated. Communication strategies should consider shift change and transitions of care.

Care plan modifications (e.g. referrals to other health care providers and/or programs, medication changes, alternate footwear), should be discussed with the team and family. Consider developing enhanced protocols for patients who have experienced two or more falls (e.g., a special identifier or increased intensity of interventions).

In addition, learnings from the huddle may be applied to the operational unit to reduce the risk of falls for all patients.

Reporting and Documentation

Documentation of the falls event in the Reporting and Learning System (RLS) or similar reporting system is encouraged. Written details such as the time of day, specific location of the fall, and specific details about what the patient was doing (reaching, transferring, turning, trying to dress, using the sink, etc.) are recommended to assist with learnings. This may be in a narrative format.

Documentation for the paper or paperless chart must occur as per site and professional protocols.

If the physician discontinues the monitoring this must be documented.

References

Fox, J.A., Fox, M.A. Falls in older people – An overview for the acute physician. Acute Medicine. 2011,10;99-102.

Guidelines for Mild Traumatic Brain Injury and Persistent Symptoms. Ontario Neurotrauma Foundation. 2013.

Initial Management of Closed Head Injury in Adults. New South Wales Institute of Trauma and Injury Management. 2011.

Oliver, D. Preventing falls and fall injuries in hospital: A major risk management challenge. Clinical Risk. 2007; 13,173–78.

Scott, V., Fall Prevention Programming: Designing, Implementing and Evaluating Fall Prevention Programs for Older Adults. Lulu Publishing, Canada: 2012.

Appendix A: Monitoring Schedule

	Adults and Older Adults	Pediatrics
Public Health/ Ambulatory care	If GCS is 15/15 for at least 4 hours post time of injury, have a responsible person available to take home and observe for **24** hours. Go to emergency or call EMS if deterioration occurs. Provide discharge advice for what to monitor.	If GCS is 15/15 for at least 4 hours post time of injury, have a responsible person available to take home and observe for **48** hours. Go to emergency or call EMS if deterioration occurs. Provide discharge advice for what to monitor.
Home care	Have a responsible person available to observe for **24** hours after the time of the event. Go to emergency or call EMS if deterioration occurs. Provide discharge advice for what to monitor. If event was more than 24 hours before event is reported, assess and provide interventions for new problems. Inform physician.	Have a responsible person available to observe for **48** hours after the time of the event. Go to emergency or call EMS if deterioration occurs. Provide discharge advice for what to monitor. If event was more than 24 hours before event is reported, assess and provide interventions for new problems. Inform physician.
Supportive living	• If you have trained and available staff, monitor for 24-48 hours, otherwise arrangements must be made to have someone else who is trained to monitor. If monitoring is not possible, call EMS or have resident transported to ER. If family is available to monitor, use discharge advice sheet. • Facilities will need to determine their own specific protocols.	NA
Acute care/rehab	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours, then every 8 hours for a total of 48 hours	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours, then every 8 hours for a total of 48 hours
Long term care	Every hour for 4 hours, then every 8 hours for 48 hours	Every hour for 4 hours, then every 8 hours for 48 hours
Cancer care (inpatient)	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours, then every 8 hours for a total of 48 hours	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours, then every 8 hours for a total of 48 hours
Addictions and mental health	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours
Corrections	Every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours	NA

Figure 2

Fall Report©

Modified Sept 19, 2007

Insert client label OR complete:
Client Name: _____ **MRN/PHN** (*Mgr*)_____

A fall is defined as **unintentionally** 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.

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

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

3. Time of fall: ☐ 7am-11:59am ☐ 12pm-4:59pm ☐ 5pm-9:59pm ☐ 10pm-6:59am ☐ *Unknown*

4. Location of fall *(check **one** only):*

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

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

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

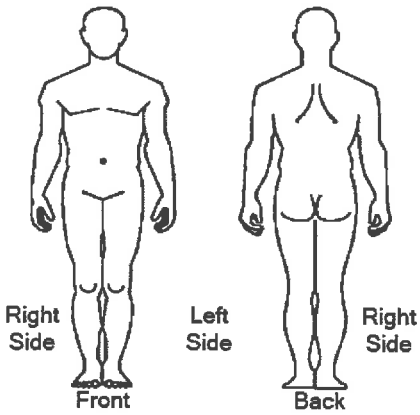
6a. Fall description and additional information: Briefly give your impressions of why this fall happened, e.g., had flu; was rushing to toilet; tripped over phone cord _____

6b. (complete all that apply): ☐ Client used pendant (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? ☐ No ☐ Yes

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: _____

b. Location and Type(s) of Injury *(use an arrow to mark the exact location of **all** suspected or confirmed injuries with the appropriate letter(s) on the diagram):*



A. Pain
B. Cuts/Scrapes/Abrasions
C. Bruises
D. Bump/Redness/Swelling
E. Sprain/Strain/Dislocation
F. Fractured bone(s)

Indicate if following injuries were confirmed:
☐ Sprain/Strain/Dislocation
☐ Fractured bone(s)

c. Immediate interventions *(check **all** applicable)*

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

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

_____

_____

9. If report linked to client's calendar, mark day a fall occurred with an X and circle the X to indicate a Falls Report has been completed for this fall ☐