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Driven by compassion. Guidé par la compassion.

FALL RISK REDUCTION AT THE OTTAWA HOSPITAL – WORKING TOGETHER TOWARDS BEST PRACTICE

SENIOR FRIENDLY HOSPITAL SYMPOSIUM

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OBJECTIVES

- Falls prevalence
- Highlights of TOH fall risk reduction initiatives
- Latest evaluation findings
- Next steps

FALLS IN OLDER ADULTS – DID YOU KNOW?

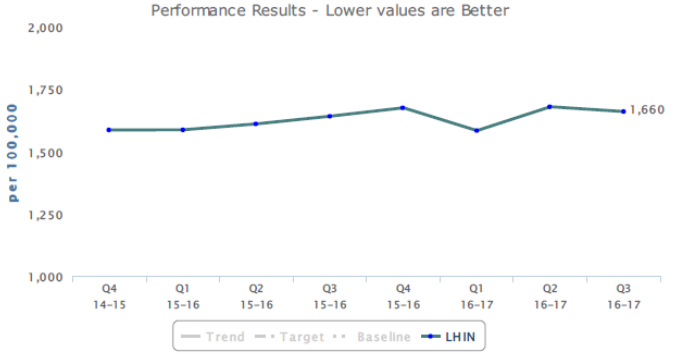
- Sixth leading cause of death among older adults in Canada
- Direct cause of 95% of hip fractures, leading to death in 20% of cases
- Those who experience one or more falls are three times more likely to fall again within the following year
- 50% of falls occur within the home
- Average LOS – 21 days (60% > than average LOS of older adults admitted for other reasons)

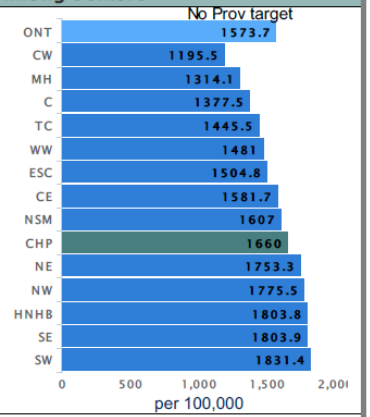
Public Health Agency of Canada, 2014

HEALTH SYSTEM IMPACT

- 2,764 falls related hospitalizations across region in 2013 at an estimated cost of $17.2 million*
- In 2016/17, there were 4,765 older adults who were seen in the two TOH EDs with falls**

Rank: 9	1.8 Fall-Related Emergency Department Visit Rate Among Seniors
Target: None	
Baseline: None	
Progress to Target: N/A	





Notes: Number of falls resulting in emergency department visits per 100,000 people aged 65 or older. Includes people living in the community and in institutional settings.

THE OTTAWA HOSPITAL
FALL RISK REDUCTION & SAFETY PROGRAM

In-Patient

- Multifactorial High Risk Fall Screening/ Assessment
- Communication about Fall Risk
- Interventions:
  - ✓ Universal
  - ✓ Individual

Ambulatory Care

- Personal Fall Risk Screening
- Communication about Fall Risk
- Interventions:
  - ✓ Universal
  - ✓ Individual

Best practice suggests: An interdisciplinary Falls Program that includes screening & multiple strategies to reduce risk

TOH Fall Risk Reduction Workgroup meets on a quarterly basis to build capacity and promote this best practice

IN-PATIENT FALL RISK REDUCTION PROGRAM

- Fall Risk Reduction Policy

ALL admitted patients:

- I**nitial fall risk assessment** and relevant history using the Nursing Patient Admission History within the shift of admission.
- **Universal Fall Risk interventions**.
- **“3Ps & 1T”** interventions are implemented upon hourly rounding.
- **Fall risk status reviewed -** transfer of a patient from one unit to another.

FALLS RISK ASSESSMENT

- The assessment of the risk for falls will be identified by nursing while completing the Nursing History

Safety/Protection–Sécurité/Protection	Init.	
Falls–Chutes	Y–O	N
1. History of falls within last 3 months–Chute au cours des 3 derniers mois?		
2. Impaired mobility, balance and/or gait–Troubles de la mobilité, de l'équilibre ou de la démarche?		
3. Impaired mental status–État mental altéré?		
4. Based on your clinical judgement, is the patient at risk for falling–Selon votre judgement clinique, le patient est-il a risque de tomber?		
If yes to any question, the patient is a fall risk. Complete Fall Risk Management Care Plan NUR 72. **Si oui à une des questions, le patient est à risque de chuttes. Remplissez le « Fall Risk Management Care Plan » NUR 72.**		

The Ottawa Hospital | L'Hôpital d'Ottawa

☐ Civic ☐ General
☐ Heart Institute ☐ TRC

Interprofessional Fall Risk Management Care Plan

PATIENT IS AT RISK FOR FALLS

Interprofessional Fall Risk Management Care Plan

	Fall Risk Identified by	Date (yyyy/mm/dd)	Initial
IDENTIFY	☐ Patient Admission History (NUR 71 A / HEA 43)		
	☐ Change in condition resulting in fall risk (e.g. cognition, mobility)		
	☐ Fall in hospital – Date (yyyy/mm/dd):		
	Date (yyyy/mm/dd):		
	Date (yyyy/mm/dd):		
	☐ Unit specific screening protocol		
EDUCATE	**Unit Fall Risk Communication**		
	☐ Fall risk noted on Kardex in red		
	☐ Fall risk icon on Clinical Whiteboard		
	☐ Fall risk written on Patient Care Board		
	Patient / Family Fall Risk Communication		
	☐ "Teach Back" (patient/family restate instructions in their own words) method used to review fall/injury risk reduction strategies		
	☐ Provide patient handout: *How to reduce your fall risk in hospital* (P306)		
	☐ Provide patient handout: *How to reduce your fall risk at home* (P1223)		
	☐ Provide patient handout: *Staying Independent Checklist* (P1102)		
INTERVENE	**Impaired Mobility**		
	☐ Level of assist required for mobility recorded on Patient Care Board		
	☐ Weight bearing status recorded on Patient Care Board		
	☐ Transfer belt		
	☐ Patient education provided regarding assistive device use (e.g. cane, walker)		
	☐ Patient education provided regarding transfer device use (e.g. lift, pivot disc)		
	☐ Stand by assist while patient is in bathroom		
	☐ Consult Physiotherapy (PHY 69)		
	☐ Consult Occupational Therapy (OCC 66)		
	☐ Consult Occupational Health Physiotherapy: for patient and staff safety for high risk patient populations (e.g. bariatric population)		
	Environmental Safety		
	☐ Place "Getting Up? Call For Help" sign in patient's room (GEN 178)		
	☐ Bed alarm ☐ Chair alarm ☐ Other (specify):		
	☐ Bed Rails × _____		
	☐ Room changed to enable closer observation		
	☐ Mobility aid within reach Type:		
	☐ Commode placed at bedside ☐ Urinal placed at bedside		
	☐ Floor mat at bedside		
	☐ Family asked to bring in proper footwear		
	☐ Non skid socks provided		
	☐ Place picture of a toilet on washroom door (P1228)		
	Muscle Weakness/Prevention of Deconditioning		
	☐ Safe side exit		
	☐ Consult Registered Dietitian (NUT 51)		
	☐ Mobility plan on Patient Care Board		

Patient: Chart no.:

	Impaired Mental Status	Date (yyyy/mm/dd)	Initial
INTERVENE	☐ Family asked to assist at bedside		
	Known Dementia		
	☐ Consult Geriatric Medicine Consult Team (Civic MED 28/General MED 20)		
	☐ Consult Geriatric Psychiatry Behavior Support Team (GER 29)		
	Delirium		
	☐ Consult Geriatric Medicine Consult Team (Civic MED 28/General MED 20)		
	Cardiovascular		
	☐ Monitor for postural hypotension		
	☐ Provide patient handout: *What is postural hypotension?* (P1196)		
	☐ Offer patient fluids with each encounter (if not on a fluid restriction)		
	☐ Maintain head of bed elevation 10 – 20 degrees while sleeping		
	☐ Remind patient to rise in 3 stages prior to standing		
	Alteration in Elimination		
	☐ Implement toileting schedule q2h or after meals		
	☐ Request Constipation Protocol (SPO 226)		
	Medication		
	☐ Review medications and request discontinuation of high risk medications where possible (i.e., antipsychotics, benzodiazepines, sedatives, antidepressants, narcotics, antihypertensives, antihistamines)		
	☐ Consult Pharmacy if assistance with discontinuing high risk medications is needed		
	Other Interventions/Notes		

Fall Risk Management Care Plan re-evaluated q 7 days

RE-EVALUATE	Date (yyyy/mm/dd)	Initial	Date (yyyy/mm/dd)	Initial	Date (yyyy/mm/dd)	Initial	Date (yyyy/mm/dd)	Initial

SIGNATURES	Print Name	Signature	Initial

EXAMPLES OF INDIVIDUALIZED INTERVENTIONS

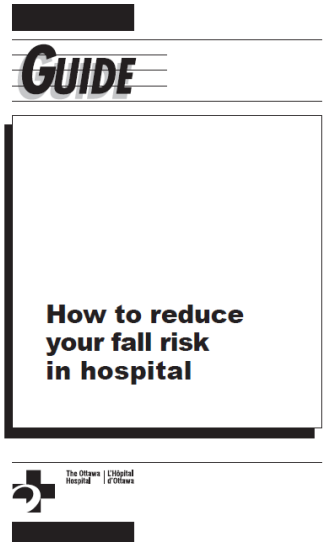
- Encourage family at bedside
- Mobilize at least 3 x/day
- Place floor mat at bedside
- Non-skid socks if appropriate
- Monitor BP lying & standing/sitting
- Toilet routine (e.g. q2h)
- Complete the CAM (Confusion Assessment Method) for patients upon admission and with sudden onset ‘confusion’
- Try bed/chair alarms
- All interdisciplinary staff can initiate

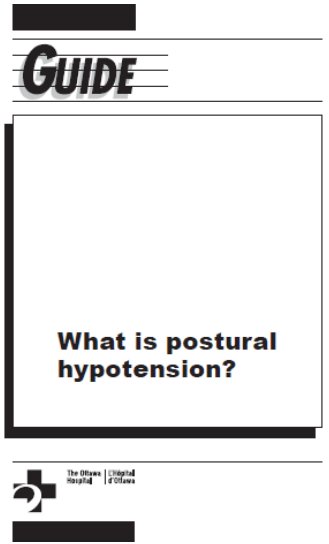
ESSENTIAL INTERVENTIONS – INTERPROFESSIONAL COMMUNICATION:

- Write in red **"FALL RISK"** on the Interprofessional Kardex for any patient who is at risk
- Also indicate Fall Risk on clinical white board (on all units)
- Write fall risk on patient care board
- Bedside shift report – identify risk

ESSENTIAL INTERVENTIONS – COMMUNICATION OF FALL RISK TO PATIENT AND FAMILY

- Patient care board, bedside shift report, education guides





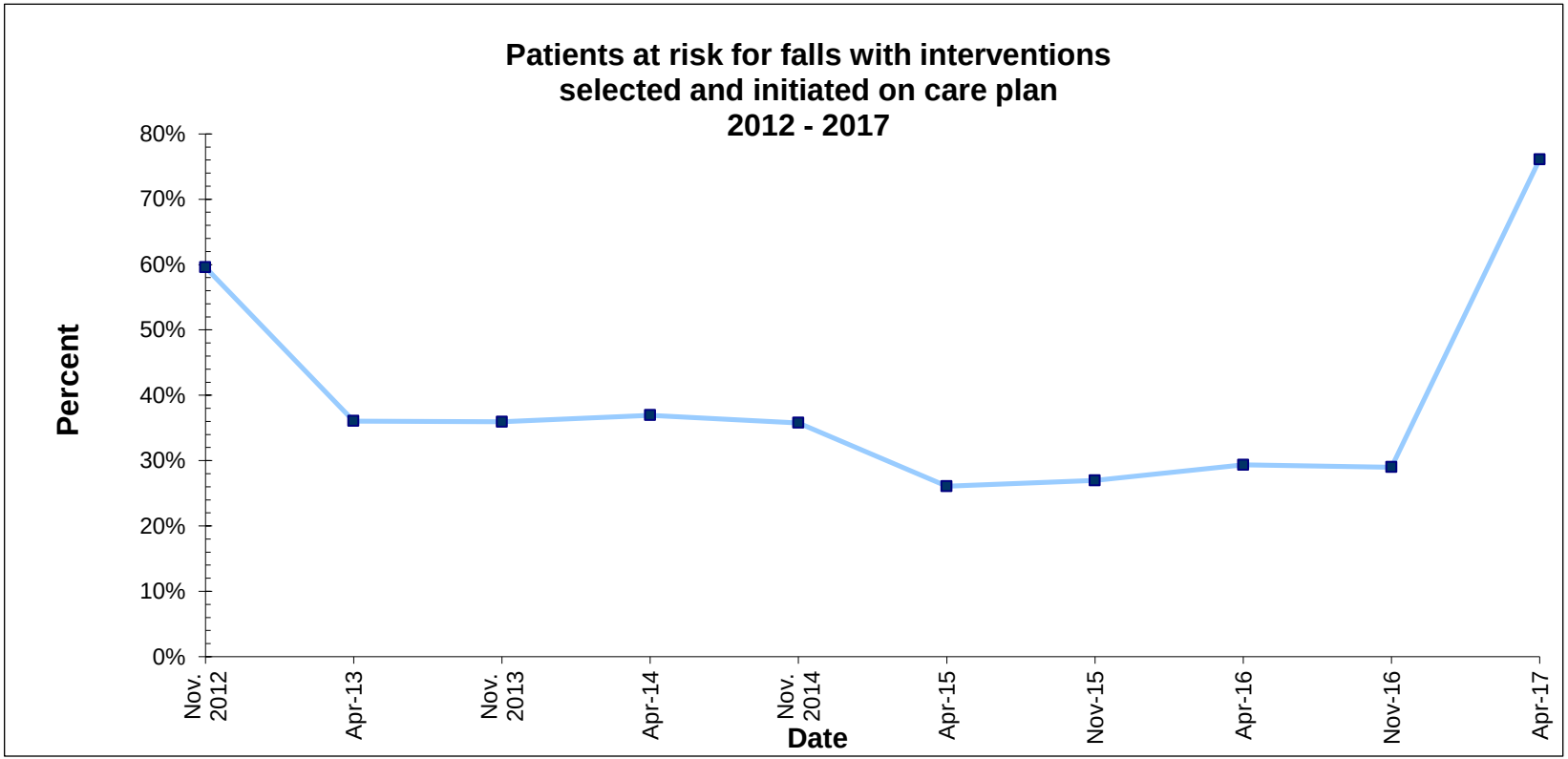
AMBULATORY CARE CLINIC / WAITING ROOM SETTING

- Universal fall risk interventions
- **Patients will self screen their own fall risk** using:
  - "Are You at risk for FALLS?" poster prominently displayed in ambulatory care settings. i.e.: waiting areas, exam rooms
- Patient handouts made available and located under posters:
  - Staying Independent. Check Your Fall Risk
  - How to reduce your fall risk at home

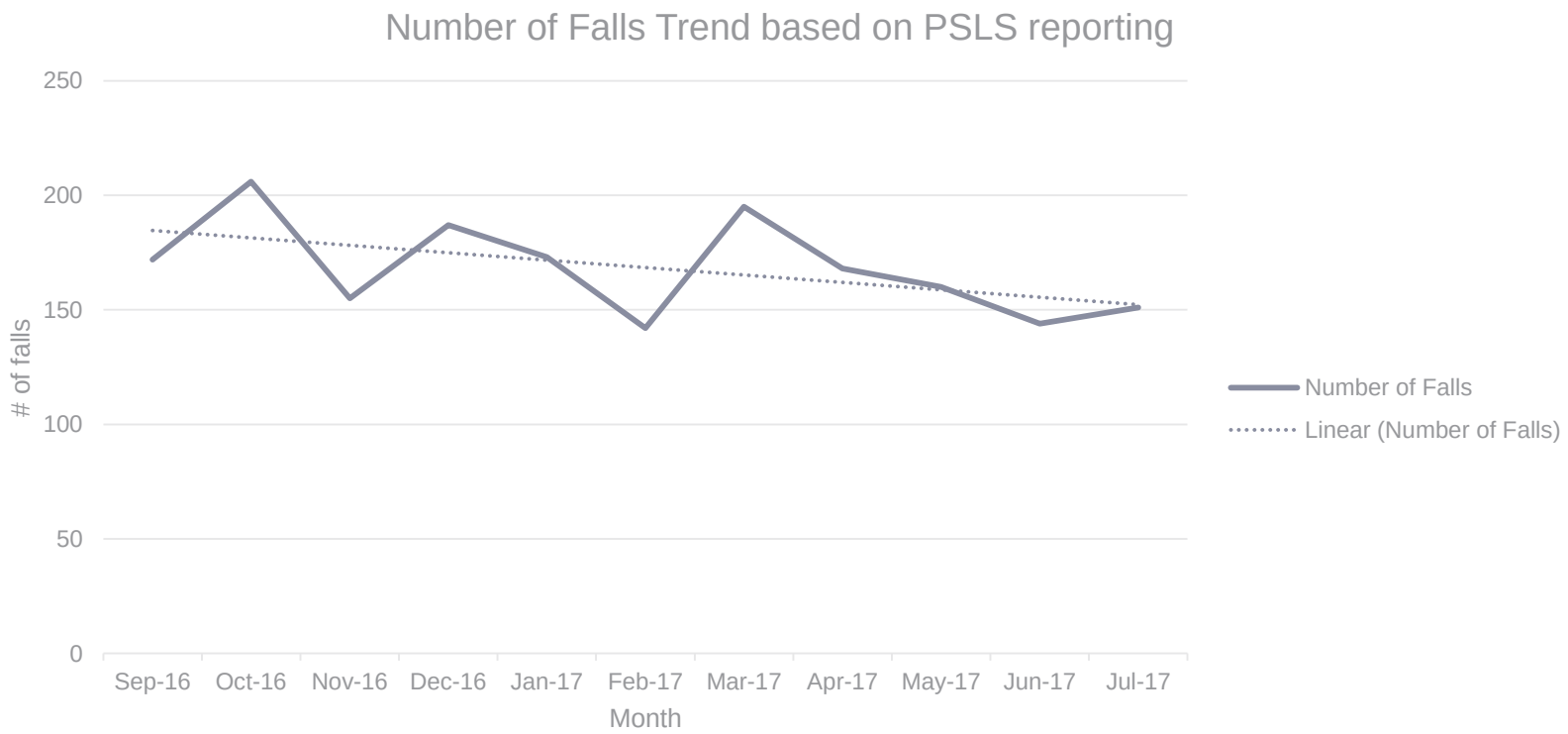
IF PATIENT FALLS WHILE IN HOSPITAL

- Policy includes algorithms for staff to follow when patient falls within inpatient and ambulatory care areas:
  - Patient assessment for injury
  - Monitoring
  - Communication – MD, Team, Manager, Family
  - Documentation/PSLS Reporting

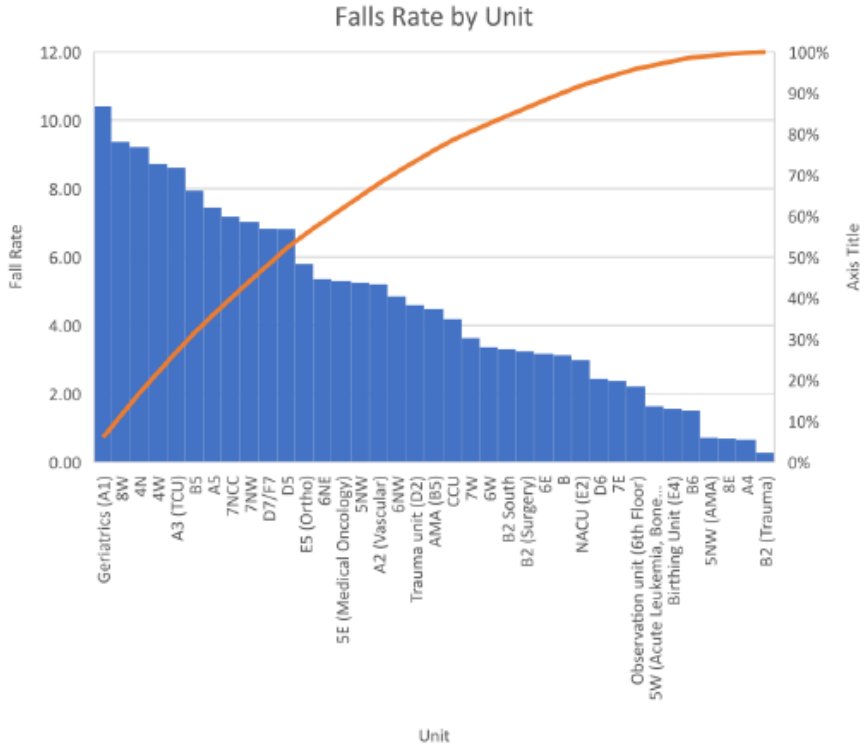
PREVALENCE OF CARE PLAN USE

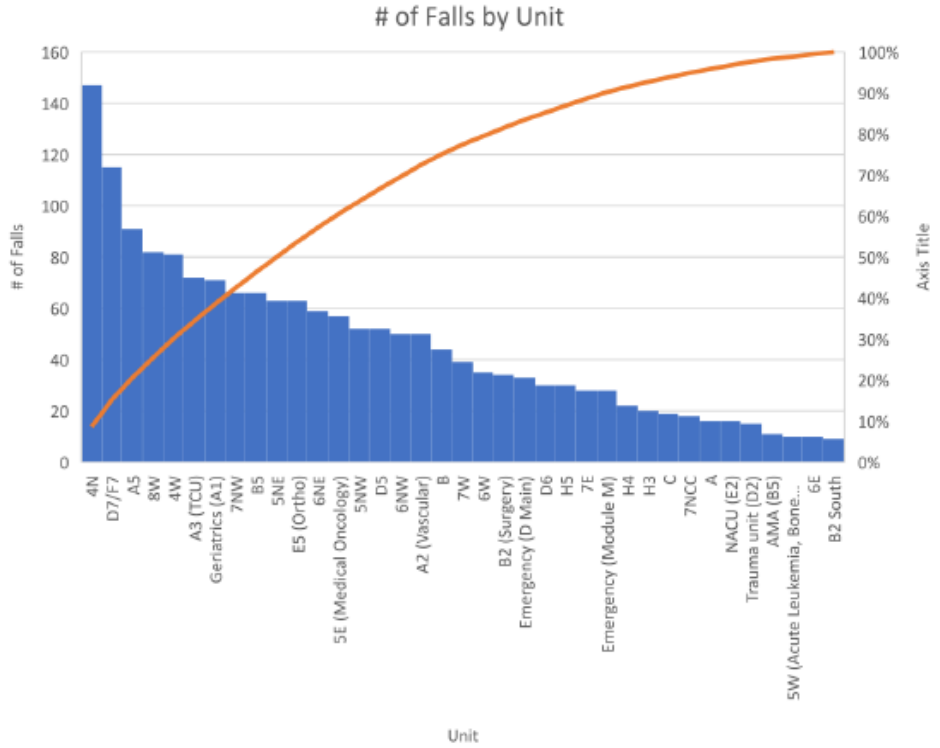


FALLS DATA


Number of Falls Trend based on PSLS reporting
250
200
150
100
50
0
# of falls
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Month
Number of Falls
Linear (Number of Falls)

Falls Rate vs. # of Falls by Unit





NEXT STEPS

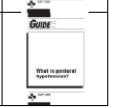
- Sustainability/monitoring of current initiatives
  - Cheat sheets
  - Prevalence Studies
  - Audits
- Data reports
- Revisions of severity scoring

Fall Risk Reduction Equipment – Approved TOH Products

Product Description *(Click on title hyperlinks for additional product information and instructional videos.)*	Product Order #	Product Information	Product Image
Posey KeepSafe® Deluxe Patient Alarm	**SKU: 8374** Obtain by creating an external requisition through iProcurement and indicate Jim Davies as buyer	-Must be used in conjunction with Posey Chair/Bed Sensor -Can be wiped clean with a disinfectant wipe for use between patients -Battery operated with 4 "AAA" batteries (included)	
Posey Chair Sensor	**SKU: 8309** Obtain by creating an external requisition through iProcurement and indicate Jim Davies as buyer	-Must be used in conjunction with the Posey KeepSafe® Deluxe alarm -Can be wiped clean with a disinfectant wipe for use between patients -Store sensor pads flat or hang in a dry, secure environment. DO NOT roll, bend or fold sensor pads, as it may damage internal electronic parts and cause a malfunction. -This product is warrantied for thirty (30) days from date of first use. -The sensor pad may continue to work beyond the 30 day warranty period. Once the sensor pad begins to alarm repeatedly, this indicates it needs to be replaced.	
Posey Over Mattress Bed Sensor	**SKU: 8283** Obtain by creating an external requisition through iProcurement and indicate Jim Davies as buyer		
Posey Floor Cushion – Beveled, Posey Glow	**SKU: 6027R** Obtain by creating an external requisition through iProcurement and indicate Jim Davies as buyer	-Can be wiped clean with a disinfectant wipe. For a more thorough cleaning, wash with a liquid disinfectant and a soft cloth. Allow to dry completely before re-using.	
Posey Fall Management Socks	**SPD Catalogue Item #:** Standard sizes: 260335 (purple) 260340 (red) Large size: 260325 (orange)	-Single patient use only and should be disposed of when soiled (they do not go into the TOH laundry).	

To inquire about educational in-services, product questions or warranty support please contact Scott Crozier at scrozier@chsltd.com

The Ottawa Hospital Fall Risk Reduction Resources

Care Plan	Policy/Printing Reference #	Resource Information	Resource Image
	Corporate-Administration Policy#: 01373 on myHospital	This policy reviews the fall risk reduction strategies that are in place in both inpatient and ambulatory care areas. The policy includes the responsibilities of staff in each of these areas.	
	Printing Reference #: NUR 249	An individualized plan of care for a patient who has been identified as a fall risk. It is used for documenting and communicating individualized fall risk reduction interventions. No two care plans are alike as it is individualized to your patient.	
"Are you at risk for FALLS?" Poster	Printing Reference #: 100763 (English & French) *Contact Kindell Toimie (ktoimie@toh.ca) for limited copies currently available	English and French versions to be posted in all ambulatory care areas. Should always be accompanied by the following two patient guides: -Staying Independent Checklist -How to Reduce your Fall Risk at Home	
"Staying Independent Checklist" TOH Patient Guide	Printing Reference #: P1102 (English & French)	Guide includes a validated self-screening that allows patients to recognize and reduce their individual risk for falls. Should always be available adjacent to "Are you at risk for FALLS?" Poster	
"How to Reduce your Fall Risk at Home" TOH Patient Guide	Printing Reference #: P1223 (English & French)	Guide includes home safety and health checklist, along with instructions on how to: use medications wisely; use gait aids and how to get up if you fall. Should always be available adjacent to "Are you at risk for FALLS?" Poster	
"How to Reduce your Fall Risk in Hospital" TOH Patient Guide	Printing Reference #: P306 (English & French)	Guide reviews different strategies adopted by TOH to keep patients safe and reduce risk of falls while hospitalized.	
"What is postural hypotension" TOH Patient Guide	Printing Reference #: P1196 (English & French)	Guide describes postural hypotension, its causes, and strategies that can be taken to control it. Can be considered for patients in both inpatient and ambulatory care areas.	

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