Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE

CATERGORY:	SUBJECT:	SECTION:
Resident Care	**Fall Prevention and Management**	**F**
		POLICY:
		1
DATE:	**Administrator's Signature:**	
June 2015, January 2025		

FALL PREVENTION AND MANAGEMENT PROGRAM POLICY

POLICY:

The Home shall ensure that a falls interdisciplinary prevention and management program will be maintained to reduce the incidents of falls and the risk of injury to the resident and promote resident independence.

Definition:

A fall is any unintentional change in position for a resident who is found on the floor, ground, or other lower level.

- Includes witnessed and unwitnessed falls
- Includes resident falls onto a mattress on the floor
- Includes injury or no injury

A **near fall/near miss** is a sudden loss of balance that does not result in a fall or injury. This can include a person who slips, trips or stumbles but is able to gain control prior to falling and does not result in a fall or other injury.

An **unwitnessed fall** occurs when a resident is found on the floor and neither the resident or anyone else knows how he or she got there.

Serious injury includes fractures, lacerations requiring sutures, and any injury requiring assessment in emergency or admission to hospital.

PROCEDURE:

The following outlines the interdisciplinary team approach to roles and activities for fall risk assessment and strategies for prevention of falls.

<u>Falls Prevention</u>

Fall Prevention Committee

The committee members will meet quarterly, and as needed for special projects. The committee shall review all residents who are high risk for falls and those who have had falls. All Fall Incident Reports will be reviewed. The Committee shall review current interventions for effectiveness and revise where needed. Strategies to reduce the number of falls shall be reviewed and formulated as required. (See Attached Committee Membership)

Registered Staff

Collaborate with resident POA/Substitute Decision Maker (SDM), family, and interdisciplinary team to complete the Fall Risk Assessment:

- Within 24 hours of admission
- Quarterly
- Return from Hospitalization
- Change in Resident Health Status
- Repeat Falls
- More than two falls in 24 hours
- More than three falls in 7 days

The Fall Risk Assessment includes the resident risk level. The Morse Fall Scale will produce a numerical value that corresponds to a category of low risk, moderate risk, and high risk for falls. All risk levels are to have Care Plan interventions.

A written plan of care will be initiated within 24 hours of admission based on the resident's assessed condition, fall history, needs, behaviours, and medications. The Care Plan shall be completed within 21 days of the admission. Nursing Restorative Care shall be implemented if the resident qualifies.

Upon admission, and infra red sensor will be put in place, unless it is determined that the resident does not require it. Two weeks after admission an infra red audit will be conducted by PSWs through POC charting for one week. After one week the registered staff will evaluate if infra red sensor can be discontinued, the resident's POA will be contacted and asked if they are in agreement.

The Care Plan will be evaluated minimally quarterly for effectiveness. If the interventions have not been effective in reducing falls, alternative approaches and strategies shall be initiated by the Registered Staff and Restorative Care Co-ordinator in consultation with the PSW's, OTA and DNPC.

The resident POA/SDM shall be contacted whenever there is a significant change to the Care Plan regarding fall prevention/management and annually at the care conference.

An instructional information sheet for the management of falls, to be used by PSW's and Registered Staff, will accompany the policy.

Personal Support Workers (PSW)

The outlined interventions shall be followed for each resident with assistance with ADL's as outlined on the Care Plan, on communication sheets and the directions of the Registered Staff.

- Assist and report a resident who appears unsteady.
- Promote adequate fluid intake to avoid dehydration and confusion.
- Report if the resident is having or demonstrating behaviours that indicate a change in status such as: pain, reduced range of motion, change in ADL abilities, food/fluid intake.

Physiotherapist/OTA

- To assess resident upon admission to determine resident's abilities and limitations and recommend a physiotherapy strategy as needed.
- If resident is deemed at risk for falls, will work with Registered Staff to create a Plan of Care to prevent/manage falls.
- Recommend equipment, supplies or devices and assistive aides to prevent falls.
- Recommend Care Plan strategies for Restorative/Rehabilitative interventions.
- Complete assessments requested through the referrals on the Fall Report.
- **Fall and Post Fall Assessment and Management**
    - When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs.
    - The person witnessing the fall or finding the resident after the fall:
    - Ensure the resident is safe. Do not move resident.
    - If alone, call for help and alert Registered Staff.

Registered Staff

- Assess resident for injury. Check range of motion in all extremities.
- If no injury is determined: a) if the resident can stand up themselves, they may be assisted to feet and be assessed or weight bearing ability.
- b) If resident is unable to stand then a mechanical lift (as per home no lift policy) will be used to lift resident to a proper surface such as a bed/wheelchair/recliner chair.
- If injury is assessed:
    - Provide first aide interventions as indicated and interventions for wounds per medical directives
    - Utilize the Acute Change in Status Assessment Tool when notifying the Physician to assist in medical decisions and/or transfer to hospital.
- Update the POA/SDM of the fall, any injury/transfer to hospital and any updates to the Care Plan.
- Complete Head Injury Routines Report for all witnessed and unwitnessed falls where the residents are unable to identify an injury. Initiate head injury routines if

a resident struck their head with an associated injury.

- Conduct a “fall” huddle with staff on shift to gather information about the fall and complete the Fall Report. Include all contributing factors in the Report. Review current fall interventions and develop additional interventions if required to prevent falls: Utilize instructional sheet to assist PSW’s, OTA.
- Notify DNPC if resident was sent to hospital so that a Critical Incident Report is completed as needed.
- Document all findings and interventions in the multidisciplinary nursing notes.
- The OTA, PT/PTA, DNPC review all Fall reports daily in the electronic documentation and assist in re-evaluating the fall risk and determining if other interventions are required. The MDS Co-ordinator prints the report for review and signature by the Administrator and the Doctor who reviews and signs during scheduled rounds.
- If resident sustained an injury, assess for recovery Care Plan and actions.
- Communicate via Shift Report and E notes details about the fall and any changes required in care.

Restorative Care Program

The Restorative Care Coordinator will oversee the program. The coordinator duties include:

- Assessing the residents for participation in the program and determining which aspects of the restorative care activities will be required by each resident. Provide activities that promote strengthening and balance for resident at risk for falls.
- Monitoring residents and activities assigned monthly. The activities will be evaluated for effectiveness and continued, altered, or discontinued where necessary.
- Assess the Restorative Care Flow Sheet and change where necessary.
- Liaise with the Physiotherapist, Kinesiologist and OTA to provide the most effective and beneficial activities for residents within the restorative/rehabilitative program.

Fall Prevention and Management Committee Members

The Fall Prevention and Management Committee will consist of the following:

- The Director of Nursing and Personal Care
- The Associate Director of Nursing and Personal Care
- Physiotherapist
- Kinesiologist
- Occupational Therapist Assistant
- Restorative Care Coordinator
- MDS RAI Coordinator
- Registered Nurse (2)

- Registered Practical Nurse (2)

May 2015

Leamington Mennonite Home
PSW/REGISTERED STAFF

Instructional Information Sheet for the Management of Falls

1) If a resident falls when you are with them, try to break the fall with your body, but do not support his/her weight. Maintain proper body alignment yourself.
2) If you find a resident on the floor after he/she has fallen, use the emergency 3-ring call to signal a Registered Staff to the location of the resident. If help does not arrive quickly – ensure resident safety/comfort pillow under head/cover with blanket and seek help.
3) Allow the Registered Staff to assess the resident before moving him/her.
4) The Registered Staff will determine the extent of the injuries: lacerations, abrasions, deformities. The Registered Staff will check ROM of all limbs and hips and determine if the resident has any pain.
5) Ask the resident or the witness how the fall occurred.
6) The Registered Staff shall direct the movement of the resident off of the floor with the help of the PSW's, depending on the extent of the injuries. Staff are to adhere to the No Lift policy and utilize the mechanical lift to lift off the floor.
7) The Registered Staff shall notify the Physician if injuries are extensive, further investigation is required, or transfer to hospital is needed.
8) The Registered Staff will hold a fall huddle to discuss the fall and contributing factors, complete a Fall Report and the corresponding assessments required. The team will review the current interventions for effectiveness and develop/implement any additional measures required.
9) The Registered Staff shall notify the Resident Family and the POA of the fall and if an injury has occurred. The Registered Staff inform them of any new or additional interventions being trialled or developed to assist in fall prevention.
10) The Registered Staff will initiate Head injury Routine Report (HIRR) if the resident's fall included hitting his/her head or if the resident is unable to report an unwitnessed fall.
11) If a resident is found climbing out of bed or upon admission having a history of climbing out of bed resulting in falls noted on the CCAC profile, the Registered Staff will initiate the following protocol.

Protocol for Residents Climbing and/or Falling Out of Bed

1) Inform the POA of the resident's behaviour of climbing and/or falling out of bed. Inform the family of the implementation of the possible interventions: infra Red sensor/fall/crawl out mat/perimeter mattress/bed in low position/Hi Lo bed, and document that the family has been contacted and consulted.
2) Staff will initiate a DOS to evaluate possible triggers to resident's behaviour of exiting the bed and to complete a referral to LMH-BSO team as required.
3) The Registered Staff may request a medication review by the Pharmacist/Physician for medication which may be a root cause for sleep time agitation or sleep interference.
4) The Registered Staff will initiate a routine toileting schedule for the resident

while in bed and evaluate the need for a product and or a night brief to promote sleep.

5) Registered Staff evaluate Bedrail use: evaluate resident's exiting style. It may be beneficial to leave the side rail down on a Hi/Lo bed to allow crawling out without injury.
6) If "crawling" or "climbing" out of bed continues then the Registered Staff will evaluate the need for a Hi Lo bed. Check the availability of a Hi Lo bed from the list on the nurse server for the resident and transfer the available Hi Lo bed to the resident's room. If no bed is available, inform the DNPC who shall make a bed available.
7) The Registered Staff initiating the Protocol will add this to the Resident Care Plan and inform the family.
8) The use of safety devices will be reviewed on an ongoing basis and at the annual Multidisciplinary Care Conference with the resident POA.