

TITLE

FALLS RISK MANAGEMENT FOR PATIENTS

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To outline evidence-based practices in the prevention, **screening, assessment**, management, reporting and quality improvement activities aimed at reducing **falls** and falls-related injuries sustained by **patients** to support the delivery of safe, collaborative, and patient and family centred care.

PRINCIPLES

Reducing falls and falls-related injuries is a critical component of patient care. It enhances quality of life, preserves mobility, helps prevent pain and psychological distress, reduces the risk of death, significantly shortens hospital stays, and lowers overall health care costs.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Points of Emphasis

- 1.1 Programs and sites may produce detailed processes or resources based on the care setting and health services provided to patients (e.g., *Maternal and Newborn Fall Prevention Management* Guideline, program-specific falls risk toolkits).

- a) Any program- or site-based processes or resources must meet the minimum standards set out in this Policy.
 - b) In the event of a conflict between this Policy and any program or site-based processes or resources, the Policy takes precedence, unless the program or site-based processes or resources set a higher standard than what is required by this Policy.
- 1.2 Each program or site must determine the specific roles and responsibilities of each **health care provider**, according to their role, training, and scope of practice, in preventing, screening, assessing, managing, communicating, and documenting information related to patient falls and falls-related injuries.
- 1.3 In alignment with AHS' *Shared Commitments*, patients and if applicable, **designated family / support person(s)**, are vital partners in falls prevention and risk management. Their active participation may include, but is not limited to, engaging in discussions to identify falls risks and previous falls history, and collaborating with health care providers to develop and implement prevention strategies that support collaboration and promote safe, patient and family centred care.
- 1.4 If the patient is unable to provide information (e.g., unconscious, cognitive impairment), information related to falls risk may be obtained from their **alternate decision-maker(s)** and/or, in accordance with the *Health Information Act* (Alberta), any person, including the patient's designated family / support person(s).
- 1.5 It is important to recognize that, despite the best efforts of health care providers, patient falls may still occur.

2. Safe Physical Environment

- 2.1 Programs and sites must implement **universal falls precautions** for all patients regardless of falls risk. These may include but are not limited to:
- a) conducting ongoing safety checks of the physical environment in the care setting and public areas (e.g., clean and dry floors, keeping pathways clear, minimizing clutter, adequate lighting);
 - b) providing and encouraging the use of mobility and personal aids appropriate for the patient (e.g., walkers, handrails, non-slip shoes, glasses or hearing aids if applicable, etc.);
 - c) patient positioning (e.g., bed at appropriate position); and/or
 - d) patient monitoring and assistance (e.g., ensuring call bells within reach [if applicable], safety/comfort rounds).

3. Screening

3.1 Screening for falls risk:

- a) is a responsibility of all **health care professionals** when providing **direct care**, according to their role, training and scope of practice;
 - (i) Health care providers not providing direct care must ensure that any information pertaining to a patient's falls risk is communicated to a **clinical leader**.
- b) should be done in a manner that engages the patient and if applicable, the patient's designated family/support person(s); and
- c) indicates if further assessment is required (see Section 4 below).

3.2 Implementation of a universal (regardless of the patient's falls history or known risk factors for falls) or selective screening (for patients with a falls history and/or known risk factors for falls) varies across care settings because of differences in care requirements. Refer to the *Process Overview* documents on the *Preventing Falls & Reducing Injuries from Falls* Insite page.

- a) In some care settings (e.g., patient's home, community), the program may allow patients to self-screen.

3.3 According to program or site processes (as determined in section 3.2 above), health care professionals must screen patients for falls risk:

- a) on admission;
- b) when there is a significant change in the patient's clinical health status, such as after a procedural intervention;
- c) upon **transfer of care**;
- d) post-fall;
- e) at regular intervals; and/or
- f) based on clinical judgment.

3.4 When required by their program or site processes as per Section 3.2 above, health care professionals must screen patients using evidence-informed tools (provided in the **clinical information system [CIS]**), which include but are not limited to:

- a) Schmid Fall Risk Assessment Tool;
- b) Falls Risk for Older People in the Community Screen (FROP-Com);
- c) Scott Fall Risk Screen (SFRS);

- d) Kinder Fall Risk Assessment Tool (KINDER1); and
- e) Pediatric Falls, Entanglement, Strangulation and Entrapment (F-ESE).

Note: Separate screening may not be needed if a comprehensive falls assessment tool is used.

- 3.5 Screening results should be communicated to all relevant health care providers (e.g., health care providers in diagnostic imaging), including health care providers that are not providing direct care (e.g., volunteers), patients, and if applicable, designated family / support person(s).

4. Falls Assessment and Management

- 4.1 If the screening indicates a falls risk, the health care professional, subject to section 4.2, must complete a comprehensive falls assessment as outlined by the program or site, using evidence-informed tools provided in the CIS.
- a) A comprehensive falls assessment may include but is not limited to:
 - (i) a medical history (e.g., stroke, diabetes, congestive heart failure, epilepsy);
 - (ii) a medication review;
 - (iii) a physical examination (e.g., balance, gait, strength, range of motion); and/or
 - (iv) other additional relevant assessments (e.g., client safe handling, interRAI, functional mobility assessments).
 - b) The comprehensive falls assessment must be timely and based on the falls risk identified during the screening and should include an interdisciplinary approach.
- 4.2 If the health care professional does not have the required **competency** to complete a comprehensive falls assessment, they:
- a) should refer the patient to another health care professional with the necessary competency, either within or outside of the organization; and
 - b) must follow the appropriate site and program processes to ensure referrals are timely, comprehensive, and aligned with the level of risk identified during the screening.
- 4.3 Based on the comprehensive falls assessment, the health care provider must collaborate with the patient and if applicable, the patient's designated family / support person(s), to develop patient-specific falls interventions which aim to reduce falls and falls-related injuries. These patient-specific falls interventions may include but are not limited to:

- a) reviewing medications;
 - b) assessing the need for and/or appropriately using mobility and personal assistive devices (e.g., walkers, canes, transfer belt, lift, railings, non-slip footwear; glasses, hearing aids);
 - c) review of potential **hazards** in the patient's environment (see Section 2);
 - d) reassessing the patient, as appropriate, as outlined by program and site processes; and/or
 - e) providing education and/or resources to the patient and if applicable, designated family / support person(s).
- 4.4 Comprehensive falls assessment results and patient-specific falls interventions should be communicated to all relevant health care providers (e.g., health care providers in diagnostic imaging), including health care providers that are not providing direct care (e.g., volunteers), patients, and if applicable, the patient's designated family / support person(s).
- 4.5 Patients, and if applicable, designated family / support person(s) may perceive falls risk and acceptable levels of risk differently than determined by clinical assessments. When there are differences in perspectives, health care providers may use available resources and supports (e.g., *Dispute Prevention and Resolution in Clinical Settings* Policy Suite, AHS Health Law Team, Clinical Ethics Team, *Behavioural Safety Program*, *Managed Risk Agreement* Guideline used in continuing care settings) to guide decision-making in order to ensure safe, collaborative, patient and family centred care.

5. Post-Falls

- 5.1 After a patient falls or reports a fall while in an **AHS facility**, the health care provider who witnessed the fall or received the report must, in accordance with their role, training and scope of practice, either provide care or ensure the following actions are completed by the appropriate health care provider(s):
- a) provide immediate assistance (e.g., call for help, stay with patient);
 - b) assess and treat the patient for injuries;
 - (i) For any head or spinal injury, do not move the patient until a comprehensive assessment has been completed.
 - c) inform the appropriate clinical leader (including the patient's **most responsible health care practitioner [MRHP]**);
 - d) observe and monitor the patient for injuries not immediately apparent, at a frequency as determined by the patient's MRHP, or when the MRHP is not readily available, in accordance with the program or site processes;

- e) debrief with the patient's health care providers to determine causative factors (e.g., post-fall huddle);
 - f) reassess for falls risk factors;
 - g) update the patient's plan of care and/or **health record**; and
 - h) communicate any changes to other relevant health care providers (e.g., health care providers in diagnostic imaging), including health care providers that are not providing direct care (e.g., volunteers), the patient, and if applicable, the patient's designated family / support person(s).
- 5.2 When a patient falls or reports a fall in care settings such as their home, in community care, or during virtual care, health care providers must follow their program or site processes.
- 5.3 Health care providers must follow the processes outlined in AHS' *Patient Safety Policy Suite*, including recognizing, managing, reporting and disclosing near falls (e.g., **close calls**), patient safety hazards, or falls event as a **clinical adverse event (CAE)**.
- a) In accordance with the AHS *Disclosure of Harm* Procedure, health care providers must disclose to patients any harm, potential future harm, or changes in care or monitoring resulting from a falls event or near fall.
 - (i) Health care providers may also disclose this information to the patient's designated family / support person(s), or others, as requested by the patient.

6. Reporting and Documentation

- 6.1 In accordance with the AHS *Clinical Documentation Policy Suite*, clinical documentation in the patient's **health record** must be accurate and complete, and should include, when applicable, the following:
- a) falls screening;
 - b) comprehensive falls assessments and reassessments;
 - c) patient-specific falls interventions;
 - d) progress or evaluation of the patient-specific falls interventions;
 - e) any education offered to the patient, and if applicable, the patient's designated family / support person(s); and/or
 - f) falls event, near falls, or hazards, if applicable.

- 6.2 If there is a near fall or falls event, health care providers should submit a report to the AHS Reporting and Learning System (RLS), as per the AHS *Recognizing and Responding to Hazards, Close Calls, and Clinical Adverse Events* Policy.

7. Continuous Learning

- 7.1 Programs and sites must offer continuous learning activities for health care providers, delivered through a variety of platforms (e.g., in-person education, online training [such as *MyLearningLink*], simulations, awareness campaigns, reflective practice, and mentorship initiatives).
- a) These continuous learning activities may include:
- (i) the importance of falls prevention and injury reduction as a safety practice;
 - (ii) prevention strategies engaging all health care providers; and
 - (iii) procedures to follow when a patient falls or sustains a falls-related injury; and/or
 - (iv) strategies for health care providers to reduce their own falls risk and risk of falls-related injuries when providing care to patients.
- 7.2 Participation in continuous learning activities by health care providers is a key component in preventing and reducing in falls and fall related injuries sustained by patients.
- 7.3 Continuous learning activities should be documented in a manner as determined by the program or site.

8. Quality Improvement

- 8.1 Health care providers have a responsibility to participate in quality improvement initiatives. Quality improvement activities may include feedback from patients, and if applicable, designated family/support person(s).
- 8.2 Programs and sites must conduct data collection, measurement, analysis and evaluation related to the falls risk, falls events, and the implemented strategies to address them on an ongoing basis.
- a) The **accountable leader**, in collaboration with other health care providers, must ensure ongoing review of falls events, prevention, and management practices, which may include:
- (i) data from RLS reports;
 - (ii) data within or outside of CIS;

- (iii) patient experience reports (e.g., leader rounding, patient relations, Protection for Persons in Care reports);
 - (iv) continuous learning activities (see Section 7 above); and
 - (v) compliance with this Policy.
- b) Evaluations may include completing screenings and assessments, documentation, number of at-risk patients, appropriate patient-specific interventions, and/or patient education.
- c) Quality improvement learnings and experiences should be shared with programs/sites, health care providers, relevant partners, and/or patients, and if applicable, designated family / support person(s).

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure consideration and completion of the listed steps in the management of the *Falls Risk Management for Patients* Policy. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but accountability remains at the senior level.

AHS facility means any facility, property, or ground owned, operated, leased, or funded by AHS.

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, a specific decision-maker, a court appointed guardian (adult), a minor's legal guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), an agent in accordance with a personal directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

Assessment means a multifactorial, detailed, and systematic process used to identify modifiable and non-modifiable factors that contribute to a person's increased risk of falling and to develop an individualized plan where interventions are targeted at the identified risk factors.

Clinical adverse event (CAE) means an event that reasonably could or does result in an unintended injury or complications arising from health care management, with outcomes that may range from (but are not limited to) death or disability to dissatisfaction with health care management or require a change in patient care.

Clinical information system (CIS) means a computerized system dedicated to collecting, using, and disclosing clinical information important to the delivery of healthcare. CIS's may be limited in scope (e.g., laboratory systems) or they may be comprehensive and include electronic medical record, transition planning, bed management, and other health enterprise information management.

Clinical leader means the senior leader immediately available to provide immediate management of a clinical adverse event. This may be a charge nurse, on-duty supervisor, administrator on call, most responsible health practitioner, Unit Manager, or other leader as appropriate.

Close call means an event that has potential for harm and is intercepted or corrected prior to reaching the patient.

Competency means the knowledge, skills, attitudes, and judgment that a health care professional requires to safely perform professional health services.

Designated family / support person(s) means one or more individuals identified by the patient as an essential support, and who the patient wishes to be included in any encounters with the health care system, including, but are not limited to, family, relatives, friends, and informal or hired caregivers.

Direct care means the provision of therapeutic services to the patient by a health care provider without any intermediary. Direct care may be offered in face-to-face interactions or over the phone.

Falls means an unplanned descent to, or unplanned assistance by another person to, the floor or other surface with or without injury to the patient.

Hazard means something that has the potential to contribute to harm.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Professions Act* (Alberta), and who practices within scope and role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers, and other persons acting on behalf of or in conjunction with Alberta Health Services, and who practices within their role.

Health record means the collection of all records documenting individually identifying health information, in relation to a single person.

Most responsible health practitioner (MRHP) means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means an individual, inclusive of residents and clients, who receives or has requested health care or services from Alberta Health Services and those authorized to act on behalf of Alberta Health Services. In the context of informed consent or other decision-making, patient also means any alternate decision-maker or co-decision maker for the individual, when applicable.

Screening means a brief, evidence-informed process to proactively identify a patient's health needs and risks that may require further assessment.

Transfer of care means the responsibility of the patient's care has changed to another service or level of care within Alberta Health Services and orders need to be reviewed or rewritten in accordance with local processes. For example, a patient is transferred from the operating room to inpatient unit or from the critical care unit to a step-down unit.

Universal falls precautions means general safety precautions that can be taken to prevent or decrease the risk of a fall for patients. Universal falls precautions apply to all patients in health care settings. They are based on the premise that patients receiving healthcare services will benefit from addressing environmental falls risk factors.

REFERENCES

- Alberta Health Services Governance Documents:
 - *Clinical Documentation Policy Suite (1173)*
 - *Dispute Prevention and Resolution in Clinical Settings Policy Suite (PRR-03)*
 - *Managed Risk Assessment Guideline (PS-102-01)*
 - *Maternal and Newborn Fall Prevention and Management Guideline (PS-96-01)*
 - *Patient Safety Policy Suite (PS-95)*
- Alberta Health Services Resources:
 - *Behavioural Safety Program*
 - *Preventing Falls & Reducing Injuries from Falls*
 - *MyLearningLink*
 - *Shared Commitments*
- Non-Alberta Health Services Documents:
 - *Health Information Act (Alberta)*
 - *Preventing Falls and Reducing Injuries from Falls Required Organizational Practice HSO: 5060: 2024 (Accreditation Canada)*

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