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The Home Health Falls and Injury Reduction page has been created as a central site for falls and injury reduction practice resources can be accessed from: Home Health Falls & Injury Reduction

The following list includes examples of resources that can be found on the Home Health Falls & Injury Reduction website:

Facilitators Resources

- Home Health PowerPoint Slide Deck (editable version)
- Regional Falls & Injury Prevention Education Resources including video clips

Practice resources in Patient Education Catalogue (PDF or Printshop order)

- Home Activity Program (HAP)
  - SAIL 1 – Sitting SAIL Level 1
  - SAIL 2 – Standing SAIL level 2
  - SAIL 3 – Moving SAIL level 3
- Your Guide to Independent Living
- What You Can Do to Prevent Falls
- Choosing Good Footwear
- Common Visual Deficits
- FReSH Start booklet (Fracture Recovery for Seniors at Home)
- Hip protectors - Always on your side
- Head protectors - always on your side (Under Review)
- Home Safety Checklist
- Medications and the risk of falling
- If you fall or witness a fall do you know what to do? - Public Health Agency of Canada

Practice Resources from Print Shop only

- Universal Falls Precautions (SAFE) Poster - Home Health & Community (#258605)
- Ask Clients - 3 Screening Questions Poster (#258606)
- Pocket card - Universal Falls Precautions & 3 Screening questions (2 sided) (#258603)

Practice Resources in Clinical Policy Office

- Home Health Clinical Practice Guideline and tools CDST Catalogue - Falls: Home Health - Reduction of Falls and Related Injuries
- Mobility: Assessment – Clinical Practice Guideline CDST Catalogue - Mobility: Assessment - Clinical Practice Guide

LearningHub Modules

Please search these topics at the LearningHub**:**

- Fraser Health Falls and Injury Reduction (Online)
- SAIL Training for Home Health Professionals (HHP)
- SAIL Training for Community Health Workers (CHW)
- SAIL Home Activity Program (HAP)
- Focus on Fall Prevention: Vision Screening for Older Adults (under development)

FH Resources and Community Partnerships

- Falls Prevention Mobile Clinic - information and referral form
- General e-mail inquiries for the Fraser Health Falls and Injury prevention team fallsprevention@fraserhealth.ca
- ***Get Up & Go!*** Exercise class information in FH communities
- Carefit Education and Resources

- Osteofit Program: Provincial Resource Site

Post Fracture Resources and Programs

- The Healthy Bones Clinic (Peace Arch Hospital)
- Outpatient rehabilitation – See Referral to Outpatient Services on Rehabilitation Program intranet site
- Learning Hub modules available:
    - BC Hip Fracture Redesign Education Module
    - Hip Fracture Team Site

Other Web Resources

- Fraser Health Falls and Injury Reduction
- Welcome to Strategies and Actions for Independent Living© - SAIL Fall Prevention
- Finding Balance BC – BC Fall & Injury Prevention Coalition
- Understanding and reducing the risk of falling for people with Parkinson's (VCH Education link)

INTRODUCTION

All people live at risk of falling and sustaining a fall-related injury. Clients receiving Fraser Health services can have additional risk factors associated with aging, acute and/or chronic condition(s) which may increase their likelihood of a fall with or without an injury. This clinical practice guideline (CPG) will support evidence informed practice for reduction of falls and fall-related injuries in the home and community setting. This CPG is designed to inform both Fraser Health staff responsible for assessing and planning care and for those providing care.

This guideline was developed by a cross program/site and interprofessional Fraser Health Shared Work Team to reflect a standardized and integrated approach to client centered reduction of falls and fall-related injuries across the continuum of acute to community care. This guideline introduces the common approaches to falls and injury reduction practice followed by interventions specific to home health and community care.

Fraser Health advocates for health promotion, injury prevention, recovery, and independence based on the needs of each unique individual. This guideline applies evidence informed best practice within the context of an individual's care needs, health status, and environment with the knowledge and understanding that not all falls and injuries can be prevented.

This clinical guideline aims to support staff in applying evidence informed fall and injury risk reduction practices across home and community care settings and includes specific support tools and appendices designed to promote collaboration and communication. The specific services it supports are Home Health and Home Support, Health Services for Community Living, Day Programs for Older Adults, Assisted Living and Respite Care. All staff are required to work within their scope of practice while enhancing a culture that balances client safety, independence, and autonomy.

1. FOCUS

1.1. To identify and minimize risks related to falls and fall-related injuries while maximizing the client's safety, freedom of movement and autonomy by:

- Implementing Universal Fall Precaution interventions (**S**afe environment, **A**ssist with mobility promotion, **F**all risk reduction, **E**ngage client and family/care giver)
- Implementing additional targeted interventions/Actions/Strategies for clients based on individual risk factors for injuries and falls
- Providing education and resource materials for clients and family/caregivers
- Standardizing communication to ensure the client's risks and mitigation strategies are documented and shared with all care providers
- Providing education and resource materials for all staff

1.2. This CPG is founded on three principles:

- ***All clients are at risk for falls and fall-related injuries*** justifying the need for a core set of fall and fall-related injury reduction actions being applied universally.
- ***Clients have the right to live at risk*** and chose not to adopt interventions to reduce risk. Client decisions cannot put FH care providers at risk.
- ***Everyone has a role in fall and injury reduction*** (including client, /caregivers and all care & support staff).

2. BACKGROUND

Falls can cause serious injuries or death, take away confidence and freedom of movement, result in hospitalizations, and increase hospital length of stay (LOS), all of which can have a major impact on one's quality of life.

Falls account for the majority of safety events and approximately 30% of falls result in physical injury, with 2-5% resulting in serious injury such as hip fractures. Consequently, fall-related injuries are one of the main reasons for admission to residential facilities (Scott, Peck & Kendal, 2004).

Falls and fall-related injuries are associated with a combination of Behavioral, Biological/Medical, Environmental, and Communication risk factors. The risk of falling increases dramatically as the number of individual risk factors increase (Tinetti, Williams, & Mayewski, 1986).

Restraints are reported to be ineffective for the prevention of injuries and can themselves pose a set of negative outcomes (Wang, & Moyle, 2005). ***Fraser Health Home Health & Community supports the FH Least restraint policy***. This includes Home Health, HSCL, Home Support, DPOA, Assisted Living, and Respite.

Assessment of safe mobility strategies and safe client handling methods minimizes risk of injury for both clients and caregivers. This practice guideline aligns with the **Fraser Health Mobility: Assessment** clinical practice guideline and tools.

All health professionals and care providers have a role in the ongoing assessment/monitoring of falls risk and related injury reduction. This CPG will apply to all staff/health care providers who contribute to client care within their scope of practice. **Interprofessional teams** bring professionals with specific expertise together to promote better outcomes for clients and families. Identifying the need for profession specific expertise in assessment and interventions for falls and injury reduction based on the needs and goals of the client demonstrates effective interprofessional collaboration.

3. DEFINITIONS

Caregiver: A person who provides direct care for children, elderly people, or the chronically ill (Merriam-Webster Dictionary, 2012).

Fall: An unintentional *coming to rest* on the ground, floor or any other lower level surface, whether or not the person is injured (BC Ministry of Health, 2006).

- ***Accidental fall*:** fall due to extrinsic environmental risk factors: spill on floor, clutter, tubing/cords on the floor, etc.
- ***Anticipated physiological fall*:** factors associated with known fall risks as indicated in the Overview of Risk Factors for Falls and Fall related Injuries **(Appendix C)**
- ***Unanticipated physiological fall*:** factors associated with unknown fall risks that were not predicted during the risk assessment such as unexpected orthostasis, hypoglycemia, stroke, sudden death
- ***Near miss fall***: An intentional coming to rest on a lower level while being supported by a person or object whether or not an injury occurs.

Hip protectors: A device worn over the greater trochanter (upper part) of the femur, designed to absorb and deflect the energy away from the hip joint created by a fall. The soft tissues of the surrounding thigh absorb the energy.

Health Care Professional (HCP): any regulated health professional employed by Fraser Health to provide service to clients.

Situation, Background, Assessment, Recommendation (SBAR): A reporting framework to concisely present a clinical situation relevant to a client. In HH this is used to document exceptional care and to communicate with others.

Unregulated Care Provider: an unregulated care provider employed by Fraser Health, contracted agencies or by clients who provide care as recommended by Health Professionals. Includes Community Health Workers and Rehabilitation Assistants.

4. EXPECTED OUTCOMES

4.1. All FH health care providers will follow the Clinical Practice Guideline: Falls: Home Health and Community Care - Reduction of Falls and Related Injuries

4.2. All FH health care providers will be aware that all clients are at risk of falls and injuries.

4.3. All of FH health care providers will be confident and competent in applying Universal Falls Precaution interventions (Safe environment, Assist with mobility promotion, Fall risk reduction, Engage client and family/caregivers) within their scope of practice.

4.4. All clients will have individualized fall and injury risk factors identified and appropriate interventions identified as part of assessment, planning and ongoing follow up.

4.5. All care plans will be developed in collaboration with clients and caregivers.

4.6. All FH clinical care providers will have access to care plans that indicate risk factors, interventions and reporting requirements if the client's status changes.

4.7. All Clients and family/caregivers will have access to evidence informed resource materials to support informed decision making.

4.8. When someone falls, a review of risks factors, interventions and collaborative care planning is completed.

4.9. All Home Health and community based services will report incidence of falls and severity of injuries quarterly and initiate quality improvement action plans as needed using agreed upon tools (e.g. PSLS, Procura Mobile Reports)

5. ASSESSMENT

5.1. All staff can apply universal falls precautions – **SAFE (Appendix A)** and screen for mobility and falls risk within their scope of practice. All staff will be familiar with the following tools:

- Three screening questions **(Appendix B)**
  - Have you fallen in the past 12 months?
  - Do you have any problems with walking or balance?
  - Are you limiting your activities because you are afraid of falling?
- Overview of Risk Factors for Falls and Fall related Injuries **(Appendix C)**
- Algorithms from the Mobility: Assessment – Clinical Practice Guideline
  - Mobility criteria for care in the home
  - Ambulation
  - Standing Transfer

5.2. **Initial Assessment:**

Each client will have a fall and injury risk assessment completed. All professional staff will assess fall and injury risk factors **(Appendix C)** using Home and Community Care standardized tools (e.g. InterRAI, Interprofessional Assessment in PARIS) within their scope of practice. **(Appendix D)**

The fall and injury risk assessment will include:

- Fall and injury history:
  - Number of slips/trips/falls and or near-falls (e.g. where, when, why, how)
  - Type of injuries sustained (e.g. location, degree of harm, treatment)
  - Fall and or injury outcome (e.g. increased level of care, fear, isolation, deconditioning)
- Strategies the client, family, or caregiver uses to mediate fall and injury risk factors (e.g. hip protectors, assistive device)
- History of low impact fractures (from standing position or lower level)

- Previous hospital visits or admissions related to a fall

5.3. Other history including recent decline that informs falls risk and potential intervention:
- Medical history including vision changes and cognition
- Mobility, ambulation, ADL status and equipment used to support mobility or reduce falls risk in environment
- Cognition level and communication barriers (language, hearing, aphasia)
- Symptoms that impact functional mobility (pain, fatigue, shortness of breath)
- IADL status
- Environment risk factors
- Social determinants of health increasing falls risk (Housing, finances, support for IADL)
- Medication profile and any recent changes
- Nutrition Status (malnourished or at risk of malnutrition)

5.4. **Functional Assessment (profession specific).** This includes demonstration within the client's home and community environment. Depth of assessment depends on scope of practice.
- Mobility status - level of independence or assistance required for bed mobility, transfers, walking, toilet, and climbing stairs.
- ADL (bathing/showering, dressing, feeding, toileting, grooming)
- IADL (laundry, cleaning, shopping, finances, communication, transportation)
- Equipment used to support mobility or reduce falls risk – impact on falls risk
- Environmental risk factors (e.g. clutter, cords, loose rugs, lighting, lack of railings or supports)
- Assessment of nutrition status (e.g. malnutrition, dysphagia, dentition, hydration status, micronutrient deficiencies)
- Vision screening results (acuity and contrast)
- Cognitive performance (e.g. ability to follow directions, orientation, safety awareness, depression, memory impairment)
- Medication Management – ability to understand and administer medications effectively
- Ability to access food (ADL and IADL)
- Communication Barriers (e.g. language, vision/hearing impairment, aphasia)

5.5. **Secondary assessments** – Include standardized tests and more in depth assessment with triggers from above.
- **Standardized assessments** are completed to assist with risk identification and to track changes over time. Some tools that are appropriate to use in Home and Community Care include:
  - Timed Up and Go (TUG)
  - Sit to Stand (specify repetitions)
  - Braden Scale
  - Pain Rating Scales
  - Functional Reach
  - Berg Balance Scale

- **In depth clinical assessments** are completed to assist with risk identification and to plan interventions. These are for more complex problems and are professional specific depending on the client specific need and likely intervention.
- **Ongoing assessments** are completed at each encounter, as part of routine follow ups, reassessment after a fall or with any reported changes in clinical status.

- Annual review of falls and injury reduction risks for clients with long term active files will be completed and will include evaluation of mobility, environmental safety, medications, and vision

6. INTERVENTIONS

6.1. All FH care providers will implement applicable interventions to reduce client risk factors related to falls and injuries.

- All - Universal Fall Precautions (**SAFE**) interventions for Home and Community. (**Appendix A**)
- Professional staff will recommend and support implementation of interventions based on their scope of practice and unique professional skill set (**Appendix D**)
- All interventions are developed in collaboration with clients and family/caregivers. Clients have the right to decline interventions or adapt strategies to support safe mobility.

- Sometimes clients and family/caregivers develop unique interventions to support mobility. However, if FH is providing support for mobility then standardized safe client handling procedures must be followed to minimize risk of injury to the client and to the care provider.

6.2. Client and family/caregiver education and collaboration will be demonstrated in practice and include:

- Discussion of individual fall and injury risk factors, risk reduction interventions, and plan of care.
- Discussion of client and family/caregiver's need/ability to participate in fall and injury risk reduction.
- Discussion of ongoing risks for potential of falls and injuries while receiving care. This includes informing client and family/caregiver that all staff must follow FH standards of practice for fall and injury reduction, mobility, least restraint, and safe client handling.
- Providing "Your Guide to Independent Living" brochure on admission.
- Providing relevant information regarding equipment that reduces risk of harm (e.g. hip protectors, protective head gear, non-slip footwear) and supports safe functional mobility (e.g. Walking aids, ADL equipment, grab bars) and funding sources as applicable.
- Review of applicable fall and injury reduction resources. (E.g. Information brochures/websites, community activity programs, equipment resources, home modification, funding sources.)
- Connection with self-management support resources in community (e.g. caregiver support, health coaches)

6.3. Individualized intervention/care plans will be developed in collaboration with the interdisciplinary team and client and reviewed/revised as needed

6.4. Post-fall Assessment and Management

- If a client falls while you are present, address their immediate needs/injuries as per the Post Fall Assessment and Management algorithm (Appendix F)
- Communicate any new risks or changes in care plans using the Post Fall Safety Huddle as a guide (Appendix G). Ensure that all partners are included in communication.

7. DOCUMENTATION

7.1. Documentation in the client health record will include:

- Assessment of fall and injury risk factors including mobility, environmental safety, medications, and vision.
- Identification of client specific high risk activities. Identify when walking, transfers, or toileting are high risks.

- Application of Universal Fall Precautions any additional interventions or recommendations for risk reduction.
- Client, family, and/or caregiver decision to implement recommendations or not and associated risks.
- Plans to follow up or track fall/injury assessment interventions and outcomes e.g. on applicable client flow sheet, multi-disciplinary clinical record.
- All fall and injury education/resources/referrals reviewed and provided to client/family/caregivers and response.
- Client/family/caregiver discussion of ongoing risk of falling and possibility of a fall-related injury.

7.2. **Communication with care providers:**

- Client and family: A Health Improvement Plan – mutually agreed upon plan with the client and family will include actions each party will undertake and planned follow up.
- Home Support:
  - Specific tasks to minimize risk of falls will be documented in the PARIS Home Support Plan in the Mobility tab under Falls Prevention Program. The LPN supervisor will enter this information in Procura Mobile for the Community Health Worker.
  - Client Mobility Record (CMR) Safe client handling methods are recorded on the CMR in paper or electronic form. The LPN supervisor will enter this information in Procura Mobile. If lengthy this may be placed in paper form in the client's home.

- **Day Programs for Older Adults:**
  - Fall and injury risks, interventions, and follow up are shared between DPOA and the authorizing professional using **Appendix H**: Process: Addressing Falls Risk or Mobility Concern with Day Program for Older Adult (DPOA) Clients

- **HSCL program:**
  When an eligible client is identified at risk of falls by either HSCL staff or a care provider of client, the HSCL staff will offer support to the provider through education. This may take several forms such as:

  - Discussion with Agency/Care provider to develop a fall prevention plan following assessment of the risk, interventions required to mitigate the risk and a follow up discussion to assess effectiveness of plan.
  - Providing written recommendations for the caretakers, offer in services for safe transfer techniques, and discuss mobility devices that may assist client & caregivers.
  - Providing checklists for caregivers to evaluate safe transfers.
  - Referral to HSCL OT's for input on risk identification and mitigation.
  - Forwarding any concerns identified to the most responsible party involved in care of client which could take the form of a Supervisor/Manager or Facilitator with CLBC. If caregivers report being uncomfortable with reporting to an immediate Supervisor, the duty of HSCL would be to report the concern identified to the most responsible party to mitigate risk to client outcome and follow up that the risk has been mitigated.

- **Assisted Living:**
  - Fall and injury risks and interventions identified and recorded in Health Improvement Plans or Home Support Plans will be noted in the client's Service Plan.
  - Incidences of falls with or without injury or immediate concerns about changing mobility will be communicated to the Assisted Living Case Manager/CCP. Fall and injury risks will be included in quarterly review of client's status.

- **Respite Care:**
  - Nurse to nurse communication tools are used to share fall and injury risks and interventions as people enter and leave respite care
  - Clients must follow FH safe client handling techniques while in respite even if their methods of mobility might be different at home.

7.3. In the event of a fall, document outcomes and modifications to interventions in progress notes by:
- Documenting in client record the fall, interventions, outcomes and involved caregivers notified.
- Detailed documentation of first few falls for new clients to identify patterns
- With clients who are documented regular frequent fallers where risk mitigation is optimized, then the fall will be documented only if there is a change in status, care plan, or need for medical intervention.

8. EDUCATION

8.1 Fall and injury reduction practice support will be available for all clinical staff at orientation and on an ongoing basis.
- The Home Health Falls & Injury Reduction page provides staff with a central location for practice resources Home Health Falls & Injury Reduction
- Resources available for Safe Client Handling in Home Health including mobility assessment algorithms and procedures for using client handling equipment and assistive devices are here: Home Health - Safe Client Handling
- The following Online e-Learning modules are available through Learning Hub (LH). These modules are included in all health professionals' orientation.
  - Fraser Health Falls and Injury Reduction
  - SAIL Training for Home Health Professionals
  - SAIL HAP (Home Activity Programs)
  - Mobility Assessment CDST – online module
  - Focus on Fall Prevention: Vision Screening for Older Adults

8.2 All FH health care providers will have fall and injury reduction education content included in their initial orientation. Content will vary according to role and scope of practice.

8.3 Annual education review:
- All staff will complete the Fraser Health Falls and Injury Reduction online module on Learning Hub.

8.4 Guidance, support, and expertise are available through the regional Fraser Health Fall and Injury Reduction team who partner with Home Health and other programs to provide services.

9. EVALUATION AND MONITORING

9.1 Falls and Injury incidence will be reported as per Fraser Health guidelines using individual site/program tools and processes.

9.2 Fall and Injury Reduction Program and site/program leaders will follow up on incidence reporting and review injury rates quarterly. Appropriate actions will be implemented as per FH, Provincial, and Accreditation Canada Fall and Injury Reduction practice standards.

9.3 Completion of applicable Falls and Injury Reduction online learning modules will be monitored by site/program leaders

10. RELATED RESOURCES

10.1 Fraser Health Mobility Assessment CPG - Mobility: Assessment - Clinical practice guideline

10.2 Fraser Health Least Restraint Clinical Practice Guideline

10.3 Work Place Health and Safety –Home Health Safe Client Handling site

10.4 Falls and Injury Reduction Program intranet site

10.5 FH Home Health – SBAR Situation Background Assessment Recommendation (Online) FH Home Health - SBAR Situation Background Assessment Recommendation (online)

11. REFERENCES

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APPENDICES

CPG Quick Summary Sheet: Practice and support tools

Apply SAFE (Appendix A)

UNIVERSAL FALLS PRECAUTIONS for all clients receiving Fraser Health services:

- **S**afe environment
- **A**ssist with mobility promotion
- **F**all risk reduction
- **E**ngage client and family

Ask about Fall & Mobility Risk

Screening questions (Appendix B)

1. Have you fallen in the past 12 months?
2. Do you have any problems with walking or balance?
3. Are you limiting your activities because you are afraid of falling?

Screen for risk factors (Appendix C)

Screen for safe mobility - Mobility Assessment algorithms

- Mobility Criteria for Care in the Home
- Ambulation
- Standing Transfer

Assess to Identify Risks

Assess within your professional scope of practice (Appendix D)

Use best practice recommendations from this guideline and from profession specific resources. **Consider:**

- **Fall history and contributing factors**: This includes mobility/ambulation status; number of falls/slips/trips including injuries & outcome; visual/hearing impairments; medication profile; history of bone disease; low impact fractures; cognitive impairment and any communication barriers
- **Functional assessment**: This includes demonstration within the client's home and community environment. Depth of assessment depends on scope of practice. Include observation of any strategies used to decrease risk of falls.
- **Consider financial barriers** and any other social factors that might increase risks
- **Secondary assessments:** based on client specific need and professional scope of practice.
    - Standardized tests – TUG, BERG, 5x Sit to stand, functional reach
    - Profession specific assessments
- **Ongoing:** (for each encounter, change in status or mobility, and after a fall)
    - Continually assess risk factors
    - Effectiveness of interventions
    - Use Mobility algorithms

Recommend Interventions (Appendix E)

- **General interventions:** Activity/exercise, well-fitting/non-slip footwear, hip protectors, vitamin D and calcium, a safe environment, and vision testing.
- **Harm reduction and safe mobility:** Hip protectors and/or head protectors for high likelihood of falls. Recommended methods for safe walking and transfers
- **Referrals to interprofessional team for specific care planning**
- **Referral to external providers and programs**

Care Plan

- **Collaborate** with interprofessional team and client/caregivers to develop care plan.
- **Offer alternatives** including low cost options to overcome barriers to adopting risk reduction strategies.
- **Communicate** falls/injury risks and interventions for safe mobility to all care providers using agreed upon tools/mechanisms
- **Revise care plans** as needed and communicate with client/family and care team

After a fall

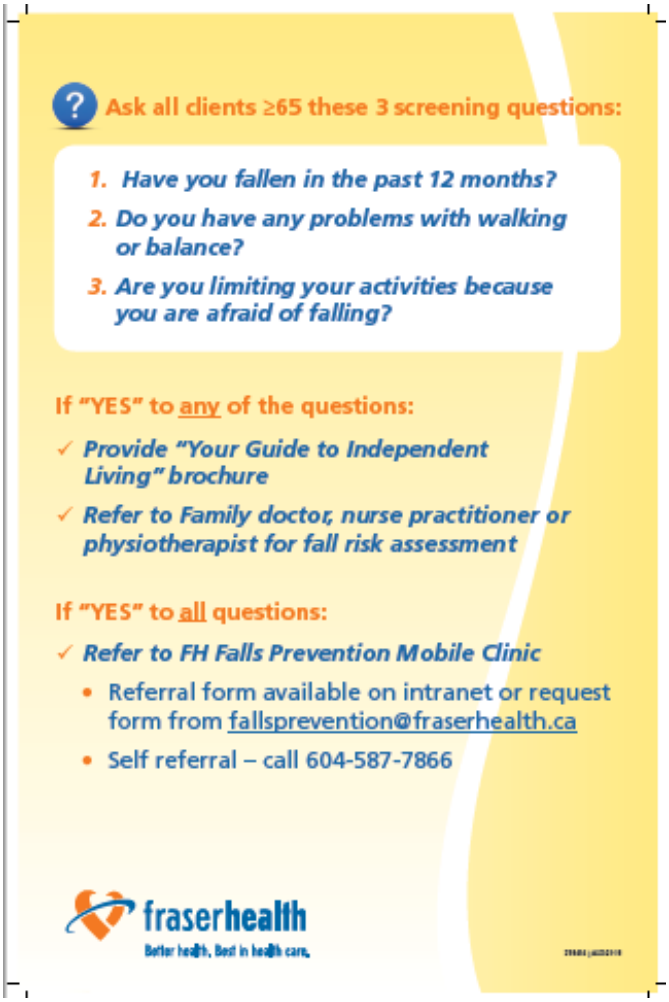
- Follow Post fall assessment and management algorithm **(Appendix F)**
- Conduct a post fall safety huddle **(Appendix G)**

Documentation and follow up

- Use agreed upon documentation tools (e.g. InterRAI, IPA in PARIS, Home Support Plan, Health Improvement Plan)
- Reason/contributing factors resulting in the fall
- Identified risk factors, interventions, and follow up
- Identify education provided client/ family including resources provided, discussion of risk factors, interventions, and participation in plan of care
- Identify fall risks and share fall and injury reduction strategies for authorized care providers using agreed upon communication tools and processes. (e.g. **Appendix H**)

Appendix A: Universal Falls Precautions (SAFE) Poster for Home Health & Community (PS# 258605) **or Pocket Card** (PS #258603)

Appendix B: Ask Clients – 3 Screening Questions Poster (PS#258606) **or Pocket Card** (PS #258603)



Appendix C: Fall and Injury Prevention Pocket Card Home Health and Community Version (PS #258603)

- **Front of Pocket Card** - Universal Falls Precautions (SAFE) – HH & Community
- **Back of Pocket Card** - Ask Clients – 3 Screening Questions

Appendix D: Overview of Risk Factors for Falls and Fall-related Injuries

Biological/Medical
General
History of falls and injuries
Family history of low impact fall-related fractures
Acute illness or exacerbation of chronic condition/disease
Age
Increased risk with age, especially over 75 years of age
Frailty – increased score on Clinical Frailty Scale (energy, physical ability, cognition, health status)
Sleep disturbance
Cardiorespiratory System
Shortness of breath
Hypoxia
Increased work of breathing
Orthostatic hypotension
Sudden onset weakness or dizziness due to arrhythmias, or syncope,
Suspected cardiac-related discomfort
Anemia
Peripheral edema
Neurological system
Impaired/altered cognition (e.g. memory impairment, poor safety awareness, impulsivity, lack of insight, confusion, delirium, inattention, impaired comprehension, impaired thought/language processing)
Sensory impairment (e.g. visual, hearing, tactile, pain, temperature, proprioception, acute or chronic vertigo, neuropathy)
Motor impairment (e.g. general weakness, one-sided weakness, decreased range of motion, impaired coordination, altered reflexes, changes in muscle tone, spasticity)
Vision impairment
Hearing impairment
History of concussions
Seizure disorder
Musculoskeletal system
Bone disease/deformity
Motor impairment (weakness, decreased range of motion, inhibition due to pain)
Gait impairment/walking tolerance
Deconditioning
Limb loss
Impaired balance (change in center of gravity e.g. edema, ascites, obesity)
Physical Status
Malnutrition
Underweight or unintentional weight loss
Poor appetite
Micronutrient deficiencies
Gastrointestinal System
Bowel incontinence, urgency, and frequency
Dehydration
Genitourinary system
Bladder incontinence, urgency, and frequency
Pain (acute/chronic)
Impaired/altered mobility/stance

Appendix D (cont)

Fatigue
Anxiety
Agitation
Delirium
Psychological
Fear of falling
Anxiety/depression
Hallucinations/delusions/illusions
Inattention
Agitation and restlessness
Substance misuse (illicit, recreational or prescription drugs, alcohol)
Medication use
Type/dosage/adverse effects/withdrawal (including anesthetics)
Anticoagulant/antiplatelet medication
Environmental
Unsafe physical environment (e.g. clutter, wet floors, uneven flooring, scatter rugs, cords, slippery surfaces, lack of safety equipment, locked doors)
Missing or inadequate stair rails, safety rails, grab bars
Poor lighting, limited access to light switches
Heavy doors
Inappropriate bed /chair height
Inappropriate bed/ chair location
Inappropriate or misuse of mobility/transfer aids (e.g. wrong size or type, poor technique)
Noisy and unfamiliar surroundings
Mobilizing with or near medical and non-medical equipment that can cause tripping, slipping, or entanglement
Inappropriate or ill-fitting prosthetics/orthotics/splints/casts/braces
Mobility aids/vision aids /personal items out of reach
Slippery bed surfaces and linen products
Lack of visual contrast to highlight hazards such as stair edges, furniture, etc.
Inappropriate or ill-fitting footwear or clothing
Broken equipment (e.g. brakes, over bed tables, alarms)
Behavioral
Poor safety awareness (e.g. lack of insight/ judgment/ rushing client and/or family/ caregiver)
Over estimation of mobility and functional abilities
Sedentary lifestyle
Refuse use or inappropriate use of interventions (e.g. footwear, mobility aids)
Fear of falling that results in self-limiting of activity
Risk taking behavior (client/ family/ care giver)
Being cared for by family/caregivers that are suffering from exhaustion/fatigue/ drowsiness, under the influence of sedating medications/illicit drugs/alcohol, or influenced by any medical/mobility impairment
Communication (includes both sender and receiver)
Communication barrier (e.g. language, aphasia)
Literacy level
Speech, vision, hearing impairment

Appendix E: Application of CPG within professional scope - Home & Community

Appendix E: Application of CPG within professional scope in context of home and community practice							
	Nurse (HH and DPOA)	OT/PT (HH and DPOA)	Social work	Pharmacist	Dietitian	Home support LPN supervisor?	Unregulated care providers (CHW, RA, Recreation Programmer/Workers)
Universal Falls Precautions	✓	✓	✓	✓	✓	✓	✓
Quick Assessment							
Mobility Algorithm	✓	✓	✓	✓	✓	✓	✓
Cognition level	✓	✓	✓	✓	✓	✓	✓
Environment	✓	✓	✓	✓	✓	✓	✓
Communication barrier	✓	✓	✓	✓	✓	✓	✓
Detailed Assessment							
Mobility	✓	✓					
Falls history	✓	✓	✓	✓	✓	✓	
Cognition level	✓	✓	✓	✓	✓	✓	
Bone health/fractures	✓	✓		✓	✓		
Medication profile/changes	✓			✓	✓		
Environment	✓	✓	✓			✓	
Communication barriers	✓	✓	✓	✓	✓	✓	
Complex care needs: Equipment and Safe Client Handling	✓	✓				✓	
Possible Recommendations							
Physician visit/follow-up	✓	✓	✓	✓	✓		
Non-skid Footwear/Walking shoes	✓	✓	✓	✓		✓	
Mobility aids	✓	✓					
SAIL or other Home activity programs	✓	✓					
Safety equipment (e.g. Lifeline, bathroom bars)	✓	✓					
Harm reduction: Hip protectors, helmets, bed or wheelchair	✓	✓					
Referrals							
Mobile Falls Clinic	✓	✓	✓	✓	✓		
Vision screening	✓	✓	✓	✓			
Specialized Seniors Clinic	✓	✓	✓	✓	✓		
Other Fraser Health Clinics	✓	✓	✓	✓	✓		
Home Health Physiotherapy	✓	✓	✓		✓		
Home Health Occupational Therapy	✓	✓	✓		✓		
Home Health Nursing	✓	✓	✓		✓		
Home Health Dietitian	✓	✓	✓	✓	✓	✓	
Home Health CCP/CM	✓	✓	✓		✓		
Fraser Health programs accessed through CCP/CM only - cost associated "							
**Home Support- Long term and short term	✓	✓	✓				
**DPOA	✓	✓	✓				
**Assisted Living	✓	✓	✓				

Appendix E continued

Appendix E: Application of CPG within professional scope in context of home and community practice							
	Nurse (HH and DPOA)	OT/PT (HH and DPOA)	Social work	Pharmacist	Dietitian	Home support LPN supervisor?	Unregulated care providers (CHW, RA, Recreation Programmer/Workers)
Fraser Health community partnerships - not associated "							
**Get Up & Go! exercise classes	✓	✓	✓				
**TIME program		✓					
Linkages to:							
Primary Care (GP or Nurse practitioner)	✓	✓	✓	✓	✓		
External programs - not associated							
**Community Exercise Programs	✓	✓					
**Equipment providers and funders	✓	✓					
**Private Physiotherapy/ Occupational	✓	✓	✓				

Appendix F: Falls & Injury Risks and Interventions – Home and Community

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Appendix F – Fall & Injury Risks & Interventions - Home and Community

Fall & Injury Risks	Risk Reduction Interventions All recommendations are offered to client/family in collaboration.
General - all Professionals can screen	
• History of falls/injuries • Increasing frailty/underweight/weak • Bone disease/Osteoporosis/bone metastases • Change in cognition impacting safety awareness/inattention/judgement • Change in gait/balance/mobility/function • Syncope/hypotension/dizziness • Over the age of 75 years • Impaired vision • Medications- Best possible medication history • Language barrier	**Identify risk factors to client and family and provide information on activity, environmental safety, vision, and medications within scope of practice.** **Communicate with primary care team (GP/NP and Interprofessional team)** **Encourage use of protective equipment (hip /head protectors)** **Refer for evaluation for specific risk reduction interventions:** • **OT/PT/Pharmacy/Dietitian/Optometrist** • **Falls Prevention Mobile Clinic** • **Specialized Seniors Clinic** **Engage Translation services**
Impaired vision	
• Change in vision impacting function or safety • Disease related changes to vision	**Refer for eye exam- Optometrist or GP/NP** **Identify Low vision resources through Shop CNIB** **Refer for risk reduction interventions:** • **OT/PT for mobility in environment** • **Vision Loss Rehabilitation Canada**
Medications	
• Five medications or more • Medication side effects or interactions • Medication not effective to control pain/symptoms to support mobility • Person needs assistance with medication management	**Refer to Pharmacist, Physician or NP for Medication review** **Collaborate with interprofessional team re impact of medications on function** **Refer to Nursing for medication management**
Gait/Balance/Ambulation	
• Need for exercise/activity prescription • Need for mobility aids (walking, ADL, transfer) • Complex or declining gait/balance/mobility (including need for caregiver training • Conservative Pain/Symptom Management	**Recommend self management resources** **Recommend Carefit/ Get up & Go! classes/ or other community based programs** **Recommend SAIL HAPs or activity plan for home** **Refer to Physiotherapy**

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Fall and Injury Prevention,
Home and Community August 2018

Appendix F (cont.)

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Appendix F – Fall & Injury Risks & Interventions - Home and Community

Fall & Injury Risks	Risk Reduction Interventions Offered to client/family in collaboration.
Functional Status- ADL, IADL	
• Complex or declining activities of daily living • Need for mobility aids (walking, ADL, transfer) • Complex Care which needs with safe client handling recommendation • Significant or complex environmental modification to home required	**Recommend self management resources** **Recommend Equipment resources** **Refer to OT**
Nutrition	
• Poor/limited intake (food or fluids) • Bone disease/inadequate calcium, vitamin D intake • Frail/underweight or unintentional weight loss • Low vitamin B12 status	**Refer to Dietitian for medical nutrition therapy and development of nutrition care plan**
Continence	
• Urinary/bowel frequency, urgency, incontinence • Nocturia • Unable to safely access toilet	**Encourage regular toileting (Q1-2hrs)** **Avoid rushing or use toilet alternatives such as commode or urinal** **Refer for medical/continence management (GP, NP, or specialist Nurse/PT)**
Social Determinants of Health	
• Finances or housing situation impacts falls risks and interventions	**Refer to Social Work to:** • **Assess alternative housing options** • **Provide information/support in connecting with government programs/grants or community resources**
Interrelated Risks that require interprofessional collaboration	
• Anticoagulants • Seizures • Impact of Depression, Delirium, & Dementia (3D's) • Safety awareness/risk taking behaviour/judgement • Complex mobility plus impaired cognition • Complex safe client handling/mobility support	**Create interprofessional care plan** **Reinforce importance of harm reduction including** • **Protective equipment: (e.g. hip protectors, head protector padded helmet, bed & wheelchair alarms)** • **Proactive care** **Include external supports in care planning (Geripsych, Mental Health, Palliative Care, Workplace Health)**

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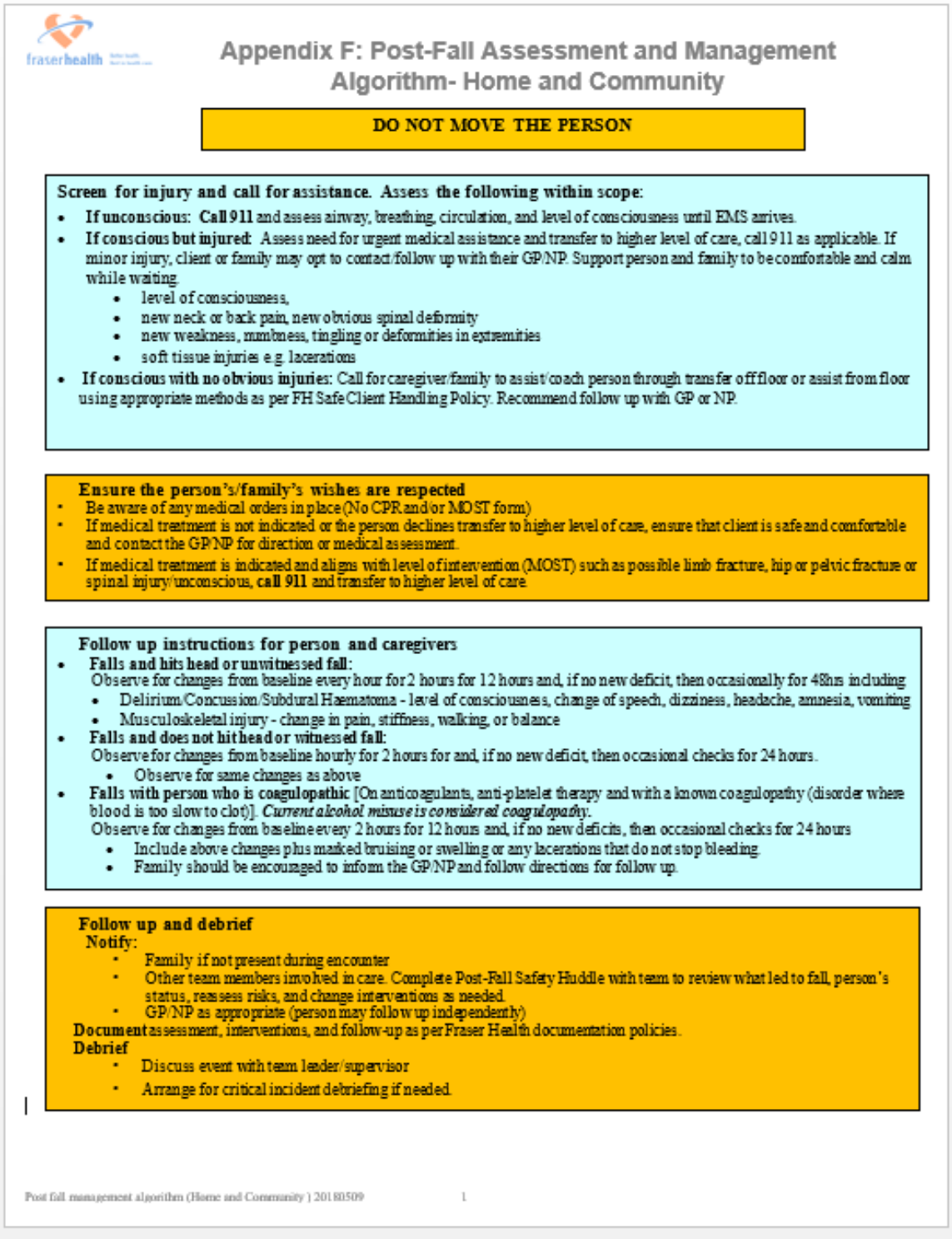
Home and community August 2018

Appendix G: Post - fall assessment and management algorithm – Home & Community



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Appendix F: Post-Fall Assessment and Management Algorithm- Home and Community

DO NOT MOVE THE PERSON

Screen for injury and call for assistance. Assess the following within scope:

- **If unconscious: Call 911** and assess airway, breathing, circulation, and level of consciousness until EMS arrives.
- **If conscious but injured:** Assess need for urgent medical assistance and transfer to higher level of care, call 911 as applicable. If minor injury, client or family may opt to contact/follow up with their GP/NP. Support person and family to be comfortable and calm while waiting.
  - level of consciousness,
  - new neck or back pain, new obvious spinal deformity
  - new weakness, numbness, tingling or deformities in extremities
  - soft tissue injuries e.g. lacerations
- **If conscious with no obvious injuries:** Call for caregiver/family to assist/coach person through transfer off floor or assist from floor using appropriate methods as per FH Safe Client Handling Policy. Recommend follow up with GP or NP.

Ensure the person's/family's wishes are respected

- Be aware of any medical orders in place (No CPR and/or MOST form)
- If medical treatment is not indicated or the person declines transfer to higher level of care, ensure that client is safe and comfortable and contact the GP/NP for direction or medical assessment.
- If medical treatment is indicated and aligns with level of intervention (MOST) such as possible limb fracture, hip or pelvic fracture or spinal injury/unconscious, **call 911** and transfer to higher level of care

Follow up instructions for person and caregivers

- **Falls and hits head or unwitnessed fall:**
  Observe for changes from baseline every hour for 2 hours for 12 hours and, if no new deficit, then occasionally for 48hrs including
  - Delirium/Concussion/Subdural Haematoma - level of consciousness, change of speech, dizziness, headache, amnesia, vomiting
  - Musculoskeletal injury - change in pain, stiffness, walking, or balance
- **Falls and does not hit head or witnessed fall:**
  Observe for changes from baseline hourly for 2 hours for and, if no new deficit, then occasional checks for 24 hours.
  - Observe for same changes as above
- **Falls with person who is coagulopathic** [On anticoagulants, anti-platelet therapy and with a known coagulopathy (disorder where blood is too slow to clot)]. ***Current alcohol misuse is considered coagulopathy.***
  Observe for changes from baseline every 2 hours for 12 hours and, if no new deficits, then occasional checks for 24 hours
  - Include above changes plus marked bruising or swelling or any lacerations that do not stop bleeding.
  - Family should be encouraged to inform the GP/NP and follow directions for follow up.

Follow up and debrief

Notify:

- Family if not present during encounter
- Other team members involved in care. Complete Post-Fall Safety Huddle with team to review what led to fall, person's status, reassess risks, and change interventions as needed.
- GP/NP as appropriate (person may follow up independently)

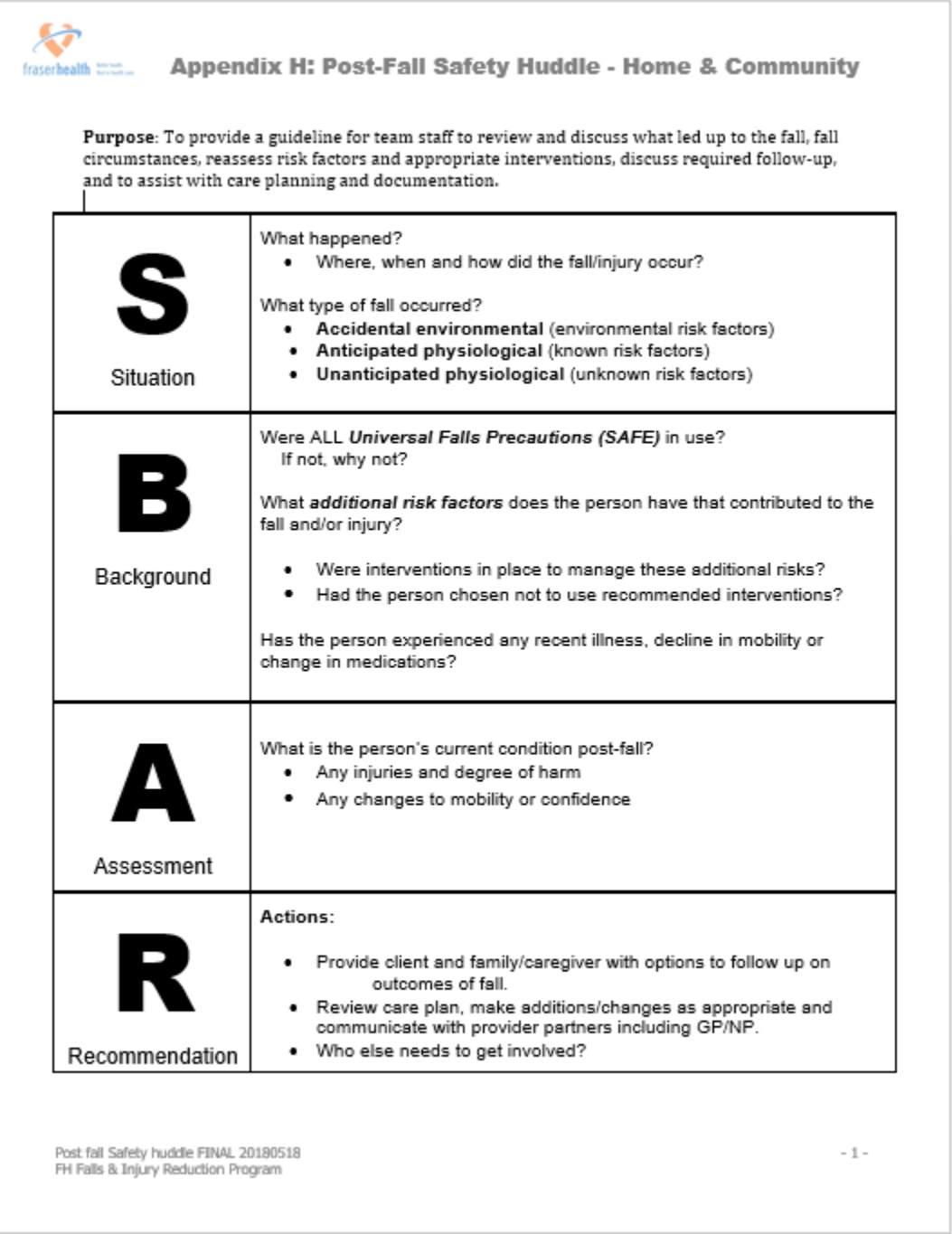
Document assessment, interventions, and follow-up as per Fraser Health documentation policies.

Debrief

- Discuss event with team leader/supervisor
- Arrange for critical incident debriefing if needed.

Post fall management algorithm (Home and Community) 20180509 1

Appendix H: Post – Fall Safety Huddle – Home & Community



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Appendix H: Post-Fall Safety Huddle - Home & Community

Purpose: To provide a guideline for team staff to review and discuss what led up to the fall, fall circumstances, reassess risk factors and appropriate interventions, discuss required follow-up, and to assist with care planning and documentation.

S Situation	What happened? • Where, when and how did the fall/injury occur? What type of fall occurred? • **Accidental environmental** (environmental risk factors) • **Anticipated physiological** (known risk factors) • **Unanticipated physiological** (unknown risk factors)
B Background	Were ALL ***Universal Falls Precautions (SAFE)*** in use? If not, why not? What ***additional risk factors*** does the person have that contributed to the fall and/or injury? • Were interventions in place to manage these additional risks? • Had the person chosen not to use recommended interventions? Has the person experienced any recent illness, decline in mobility or change in medications?
A Assessment	What is the person's current condition post-fall? • Any injuries and degree of harm • Any changes to mobility or confidence
R Recommendation	**Actions**: • Provide client and family/caregiver with options to follow up on outcomes of fall. • Review care plan, make additions/changes as appropriate and communicate with provider partners including GP/NP. • Who else needs to get involved?

Post fall Safety huddle FINAL 20180518
FH Falls & Injury Reduction Program

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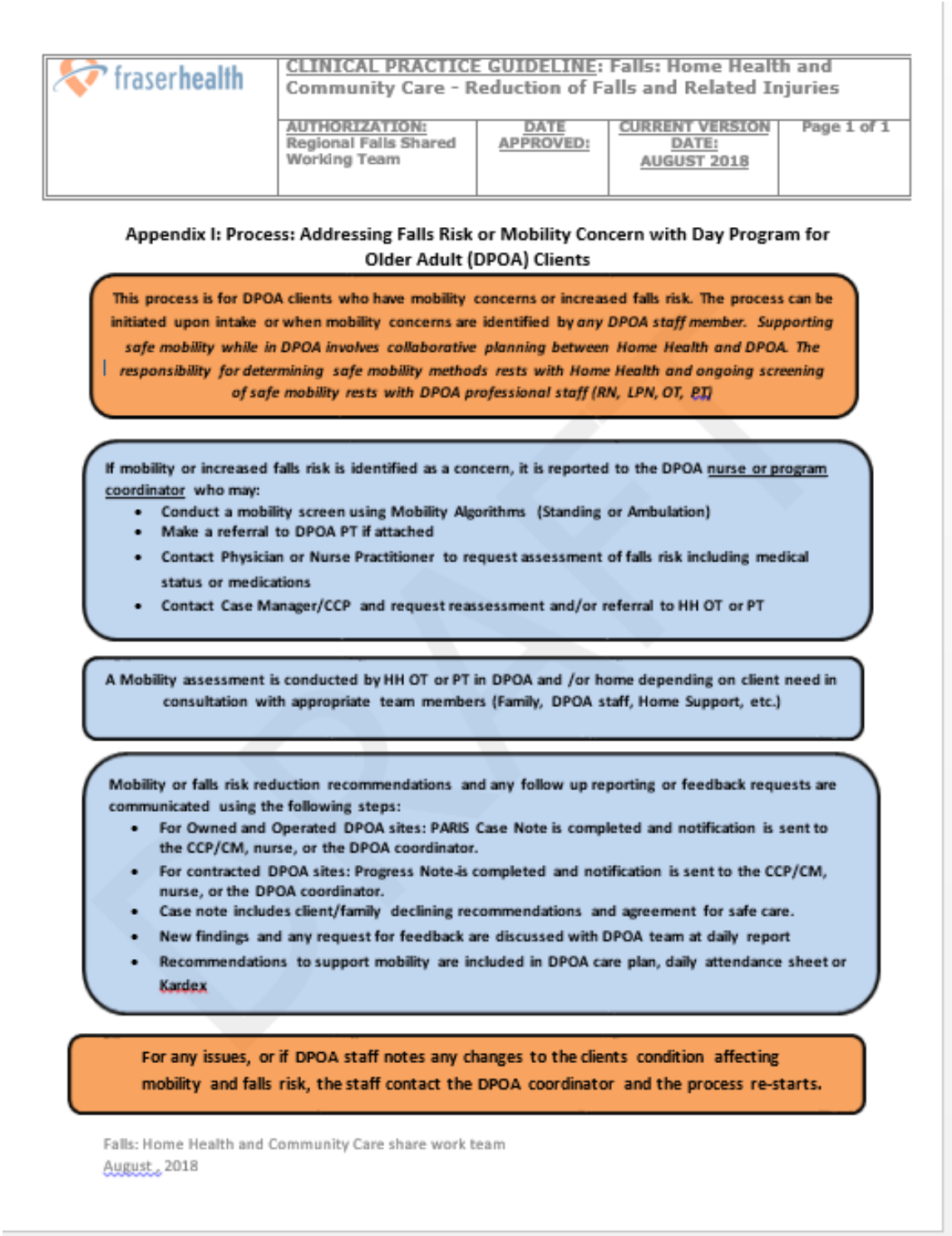
Appendix I: Process: Addressing falls risk and mobility concerns with DPOA clients



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CLINICAL PRACTICE GUIDELINE: Falls: Home Health and Community Care – Reduction of Falls and Related Injuries

AUTHORIZATION:	DATE APPROVED:	CURRENT VERSION DATE:	Page 1 of 1
Regional Falls Shared Working Team		AUGUST 2018	

Appendix I: Process: Addressing Falls Risk or Mobility Concern with Day Program for Older Adult (DPOA) Clients

This process is for DPOA clients who have mobility concerns or increased falls risk. The process can be initiated upon intake or when mobility concerns are identified by *any DPOA staff member. Supporting safe mobility while in DPOA involves collaborative planning between Home Health and DPOA. The responsibility for determining safe mobility methods rests with Home Health and ongoing screening of safe mobility rests with DPOA professional staff (RN, LPN, OT, PT)*

If mobility or increased falls risk is identified as a concern, it is reported to the DPOA nurse or program coordinator who may:

- Conduct a mobility screen using Mobility Algorithms (Standing or Ambulation)
- Make a referral to DPOA PT if attached
- Contact Physician or Nurse Practitioner to request assessment of falls risk including medical status or medications
- Contact Case Manager/CCP and request reassessment and/or referral to HH OT or PT

A Mobility assessment is conducted by HH OT or PT in DPOA and /or home depending on client need in consultation with appropriate team members (Family, DPOA staff, Home Support, etc.)

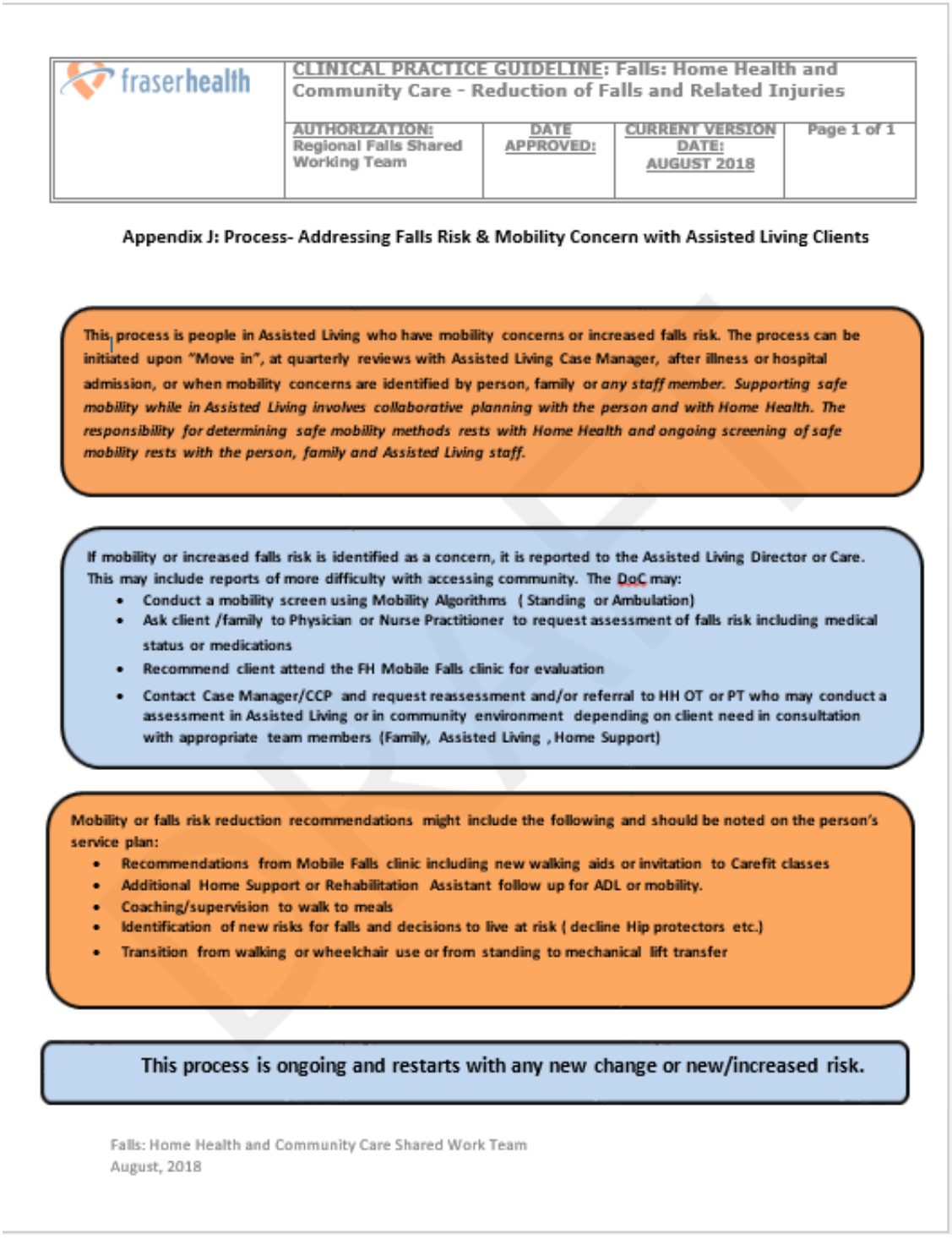
Mobility or falls risk reduction recommendations and any follow up reporting or feedback requests are communicated using the following steps:

- For Owned and Operated DPOA sites: PARIS Case Note is completed and notification is sent to the CCP/CM, nurse, or the DPOA coordinator.
- For contracted DPOA sites: Progress Note is completed and notification is sent to the CCP/CM, nurse, or the DPOA coordinator.
- Case note includes client/family declining recommendations and agreement for safe care.
- New findings and any request for feedback are discussed with DPOA team at daily report
- Recommendations to support mobility are included in DPOA care plan, daily attendance sheet or Kardex

For any issues, or if DPOA staff notes any changes to the clients condition affecting mobility and falls risk, the staff contact the DPOA coordinator and the process re-starts.

Falls: Home Health and Community Care share work team
August , 2018

Appendix J: Process: Addressing falls risk and mobility concerns with Assisted Living



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CLINICAL PRACTICE GUIDELINE: Falls: Home Health and Community Care - Reduction of Falls and Related Injuries

AUTHORIZATION:	DATE APPROVED:	CURRENT VERSION DATE:	Page 1 of 1
Regional Falls Shared Working Team		AUGUST 2018	

Appendix J: Process- Addressing Falls Risk & Mobility Concern with Assisted Living Clients

This process is people in Assisted Living who have mobility concerns or increased falls risk. The process can be initiated upon "Move in", at quarterly reviews with Assisted Living Case Manager, after illness or hospital admission, or when mobility concerns are identified by person, family or *any staff member. Supporting safe mobility while in Assisted Living involves collaborative planning with the person and with Home Health. The responsibility for determining safe mobility methods rests with Home Health and ongoing screening of safe mobility rests with the person, family and Assisted Living staff.*

If mobility or increased falls risk is identified as a concern, it is reported to the Assisted Living Director or Care. This may include reports of more difficulty with accessing community. The DoC may:

- Conduct a mobility screen using Mobility Algorithms (Standing or Ambulation)
- Ask client /family to Physician or Nurse Practitioner to request assessment of falls risk including medical status or medications
- Recommend client attend the FH Mobile Falls clinic for evaluation
- Contact Case Manager/CCP and request reassessment and/or referral to HH OT or PT who may conduct a assessment in Assisted Living or in community environment depending on client need in consultation with appropriate team members (Family, Assisted Living , Home Support)

Mobility or falls risk reduction recommendations might include the following and should be noted on the person's service plan:

- Recommendations from Mobile Falls clinic including new walking aids or invitation to Carefit classes
- Additional Home Support or Rehabilitation Assistant follow up for ADL or mobility.
- Coaching/supervision to walk to meals
- Identification of new risks for falls and decisions to live at risk (decline Hip protectors etc.)
- Transition from walking or wheelchair use or from standing to mechanical lift transfer

This process is ongoing and restarts with any new change or new/increased risk.

Falls: Home Health and Community Care Shared Work Team
August, 2018