Interprofessional Approach to Falls Prevention

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Share our falls prevention story

Share a unique approach to falls risk assessment

Provide a useful tool for preventing falls

Providence Healthcare

Mr. John Fallalot

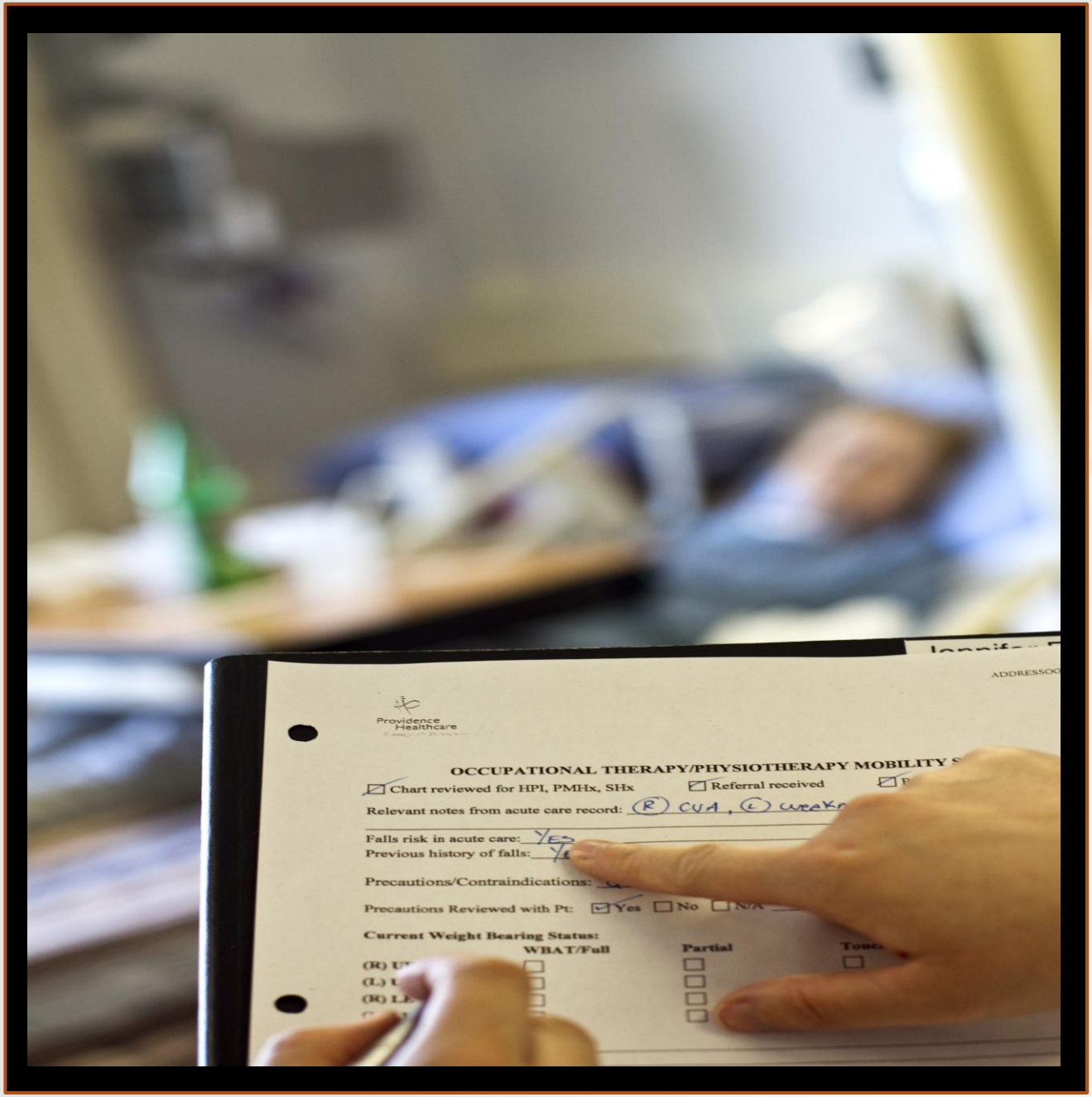
Admitted for Rehabilitation

Recent hip fracture due to fall at home

Falls risk screening assessment

Completed by OT and PT

Upon admission (within 1-3 hours)



All items required for falls prevention

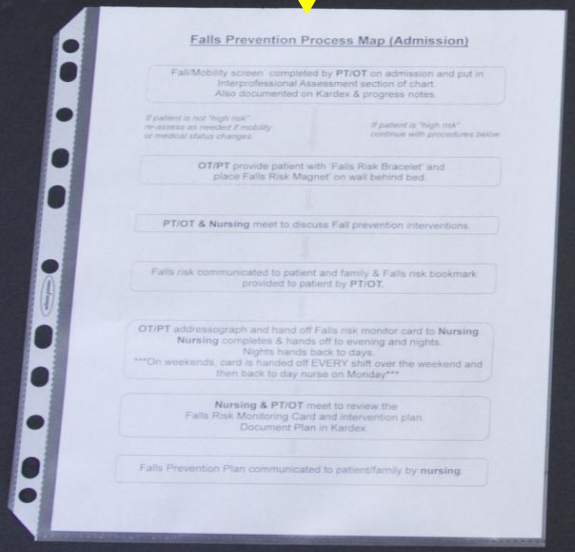
in

ONE

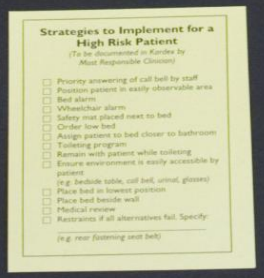
Toolkit

Inside the Toolkit

Process Map



Patient/caregiver education



Bracelet

Hand-off tool

Magnet

Falls risk bracelet

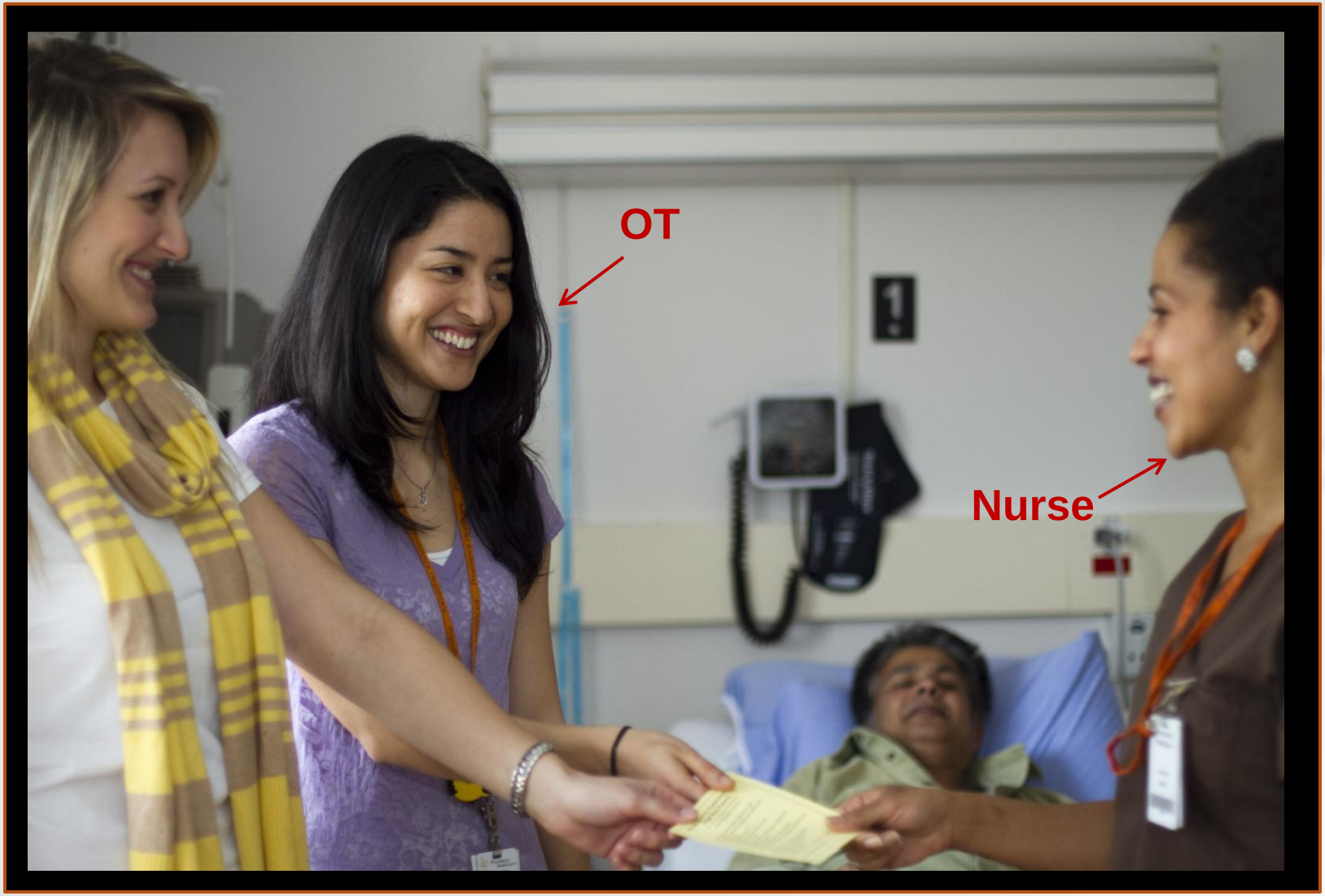
used to identify high risk patients

Falls prevention equipment (alarms/mats) stored centrally

Standardized approach to obtaining equipment

PT

Equipment technician

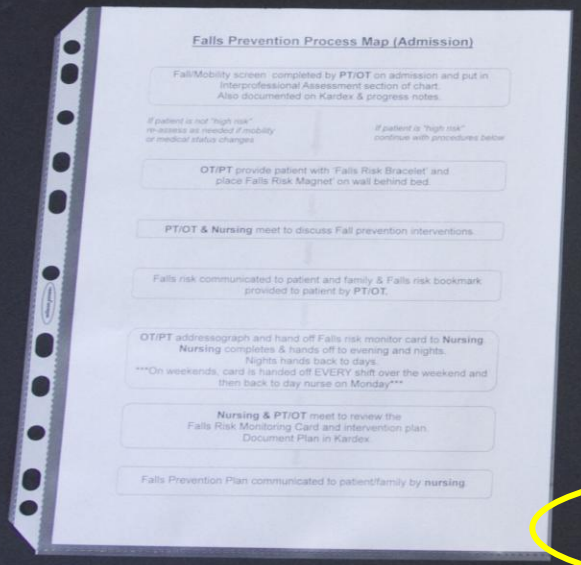


“Falls prevention hand-off tool”

Treatment plan is shared across professions and shifts

Inside the Toolkit

Process Map



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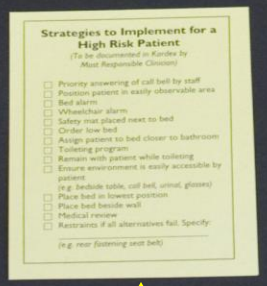


Hand-off tool

Bracelet

Magnet

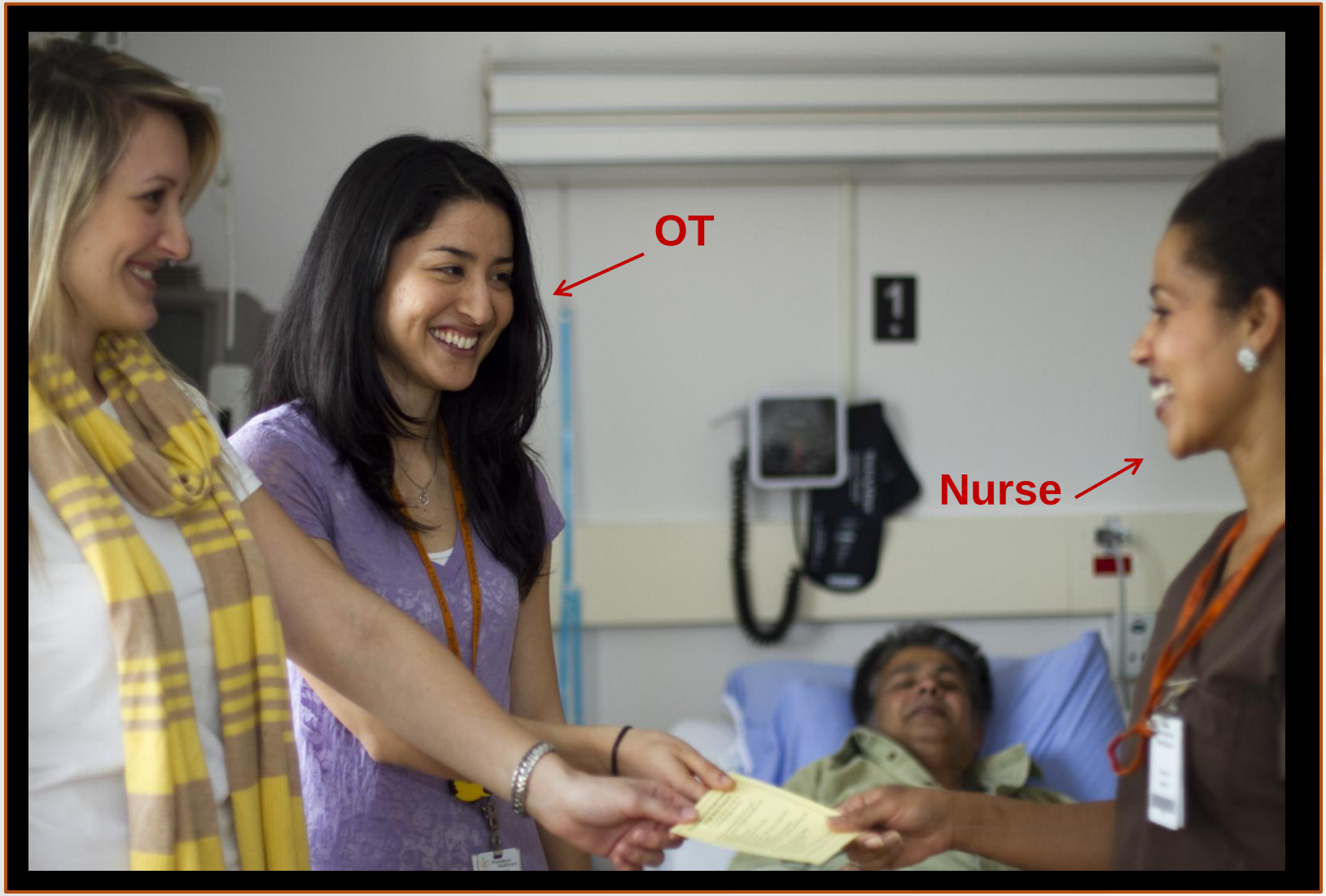
Day
Nurse
Night
Nurse

Protective fall mats

“LEAN” approach to equipment retrieval

Ensures quick access and availability

Night
Nurse
Day
Nurse



“Falls prevention hand-off tool”

Treatment plan is shared across professions and shifts

What is the best falls risk identification tool?

Mobility

Insight

Impulsivity

Vision

Balance

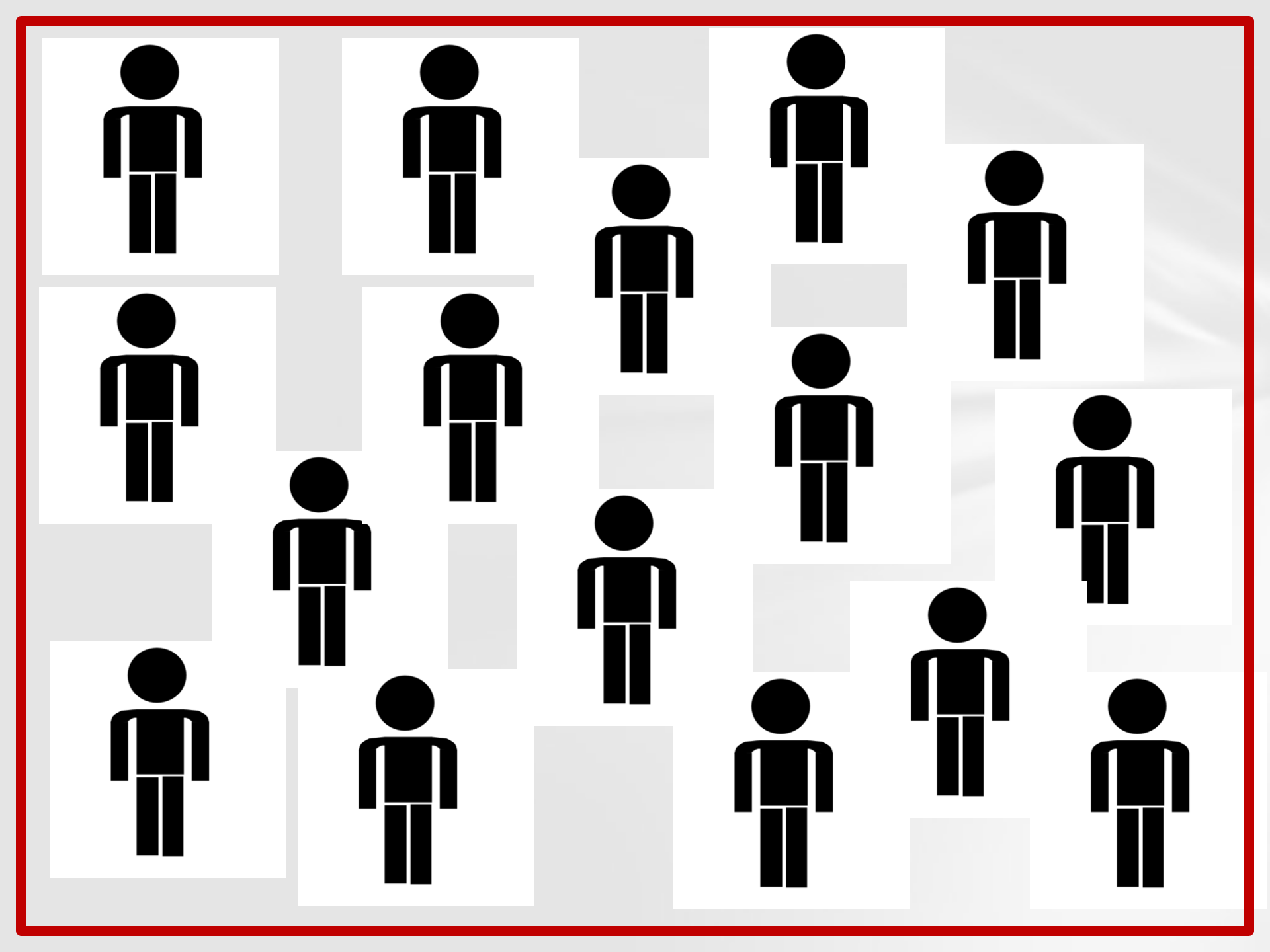
IV lines/ equipment

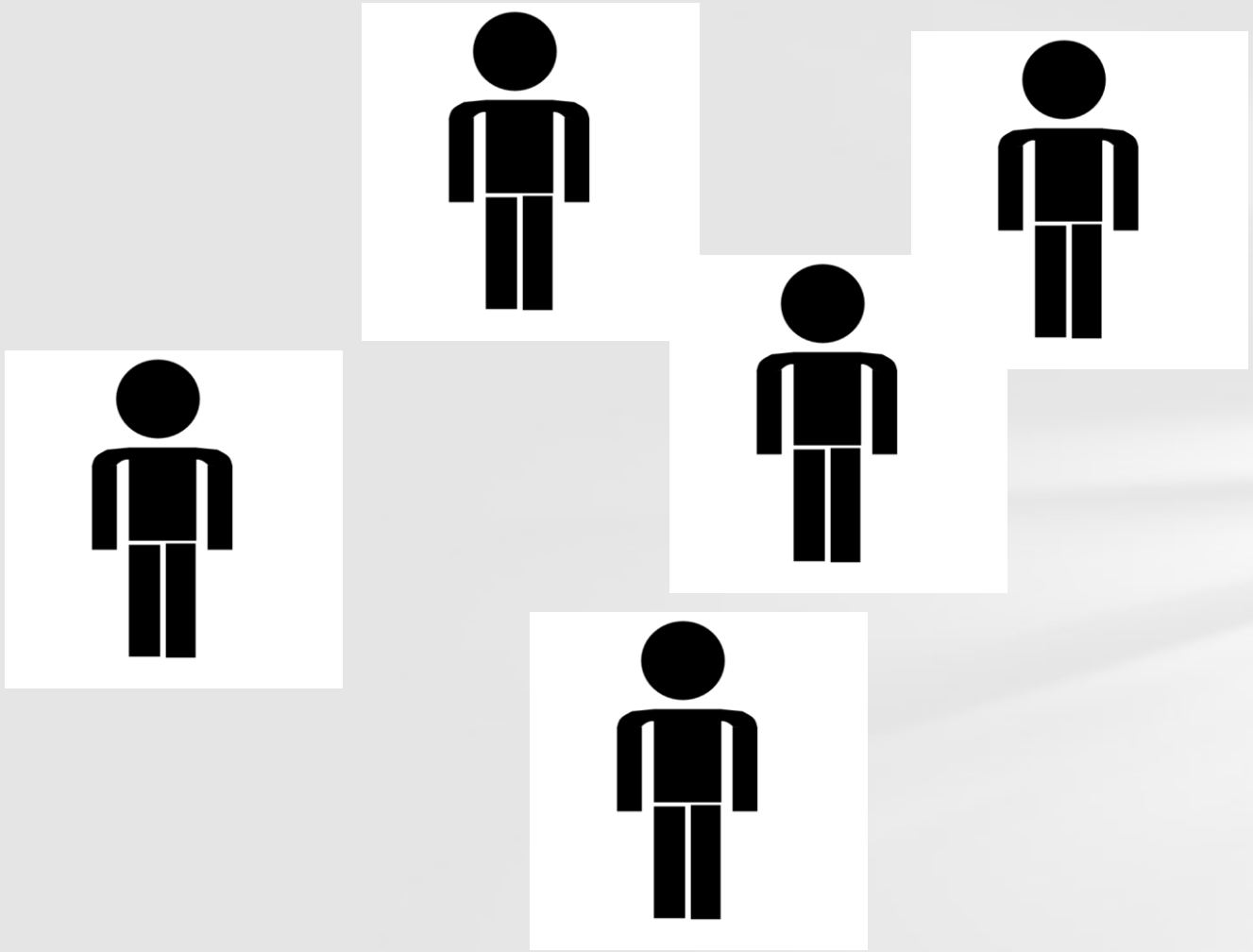
Strength

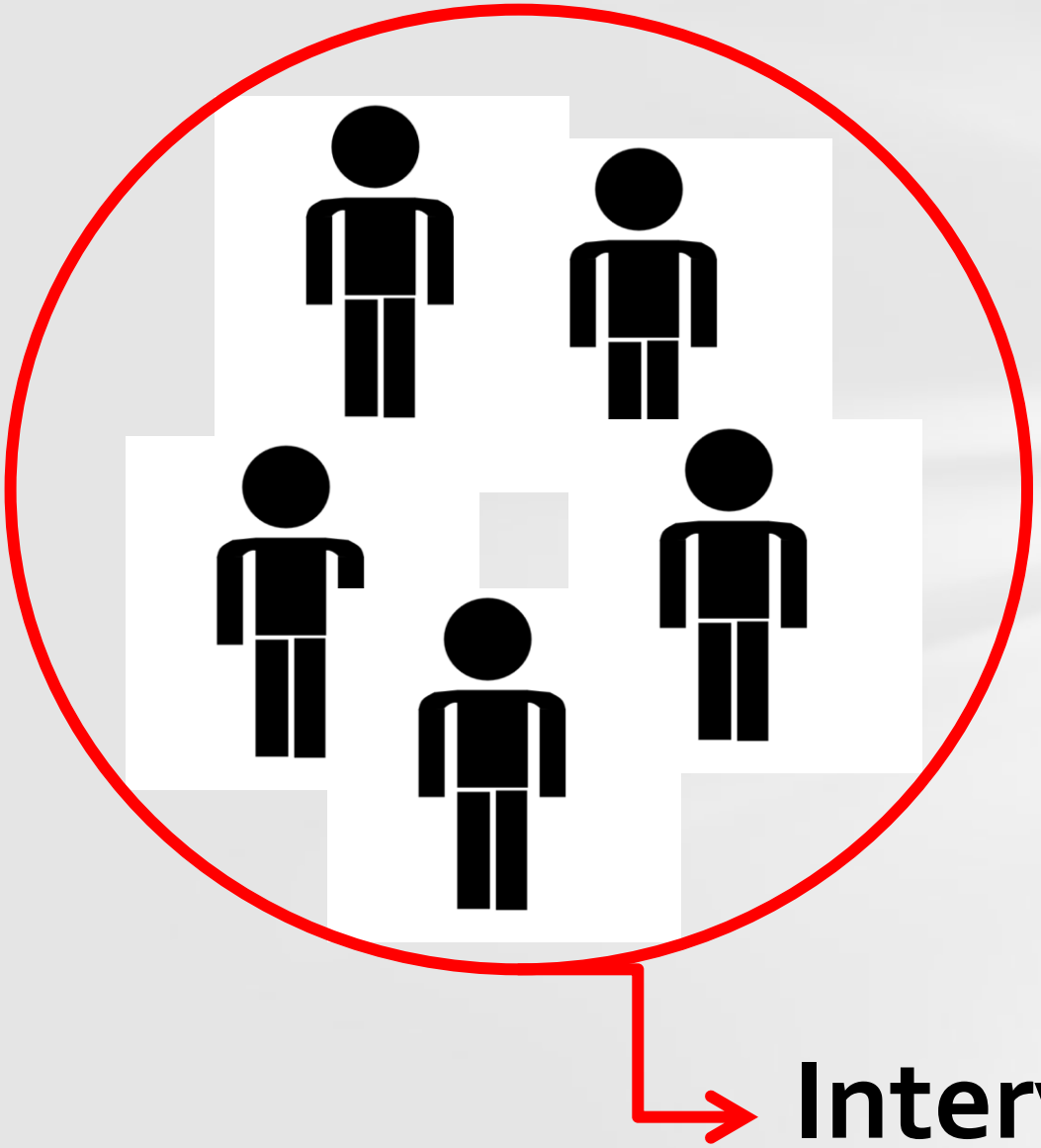
ROM

Medications

Continence







Interventions

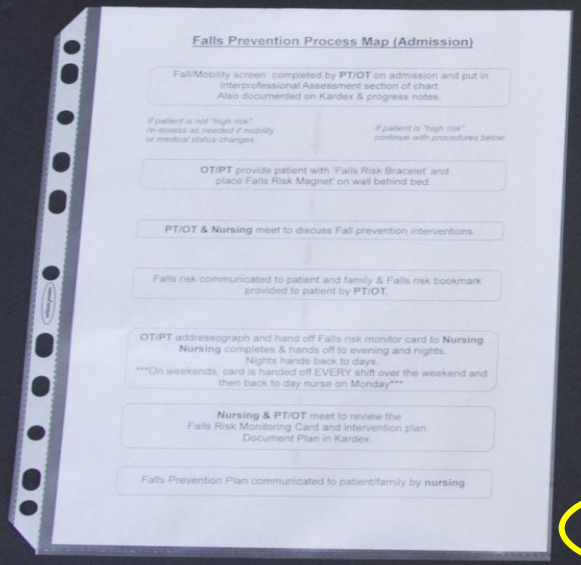
OT/PT Mobility Screen

- Day One
- Interprofessional
- Clinical reasoning
- Easy to add to
- Level of risk
- Early trigger of strategies

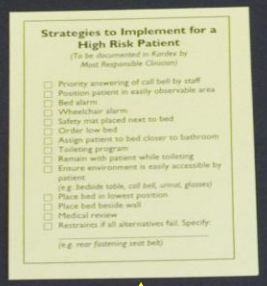
Interprofessional Communication

Inside the Toolkit

Process Map



Patient/caregiver education



Bracelet

Hand-off tool

Magnet

RAQUEL
BESSIE
ROCKY
STUDENT
STUDENT
ViewSonic

“Falls prevention hand-off tool”

Treatment plan is shared across professions and shifts

Hand – off tool

Addressograph

Date:_____

24 hr Monitor of Falls Risk Patient

** On admission and when required*
*** Remember to hand off to the next shift*

Patient demonstrates:

- ☐ ↓ awareness/safety judgement
- ☐ ↓ memory
- ☐ ↓ comprehension
- ☐ agitation
- ☐ confusion
- ☐ impulsivity
- ☐ difficulty following instructions
- ☐ urgency with bowel/bladder
- ☐ change in medical status
- ☐ change in medication
- ☐ cluttered environment

Initials:

Day 1
OT/PT_____
Nurse (D) _____
Nurse (E) _____
Nurse (N) _____

Saturday
Nurse (D) _____
Nurse (E) _____
Nurse (N) _____

Sunday
Nurse (D) _____
Nurse (E) _____
Nurse (N) _____

Strategies to Implement for a High Risk Patient

(To be documented in Kardex by Most Responsible Clinician)

- ☐ Priority answering of call bell by staff
- ☐ Position patient in easily observable area
- ☐ Bed alarm
- ☐ Wheelchair alarm
- ☐ Safety mat placed next to bed
- ☐ Order low bed
- ☐ Assign patient to bed closer to bathroom
- ☐ Toileting program
- ☐ Remain with patient while toileting
- ☐ Ensure environment is easily accessible by patient
  (e.g. bedside table, call bell, urinal, glasses)
- ☐ Place bed in lowest position
- ☐ Place bed beside wall
- ☐ Medical review
- ☐ Restraints if all alternatives fail. Specify:
  _____
  (e.g. rear fastening seat belt)

Metrics

24% Reduction in number of Falls

2010/2011 **2011/2012**

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