Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Complete or place bar-coded patient label here

Health Record #: _____
Patient Name: (Last, First)_____
DOB: mm / dd / yy Age: _____ ☐ Male ☐ Female ☐ Other
OHIP #: _____ Version Code: _____
Admission Date: mm / dd / yy

Assessment of Adults for Fall Prevention and Injury Reduction

General Information

Instructions: This BPG Order Set™ is intended for nurses and the interprofessional team. It provides evidence-based interventions, a care pathway and resources to guide the assessment of adults for fall prevention and injury reduction. It is intended to be used in conjunction with the Order Set, *Prevention and Management of Falls in Adults.* Refer to the Decision Support Resources section for additional information to complete the assessments marked with ** and for an explanation of the 8-digit ICNP® code appended to each intervention statement.[1]

When completing this Order Set, engage adults at risk for falls and fall injuries using the following actions: (1) explore their knowledge and perceptions of their falls risk and their level of motivation to address their risk; (2) communicate sensitively about risk and use positive messaging; (3) discuss options for interventions and support self-management; (4) develop an individualized plan of care in collaboration with the person; and (5) engage family (as appropriate) and promote social support for interventions.[2]

Assessment

Screening

☐ Screen all adults for falls risk **(10017585)****[3]

Timing of screening:

☐ Admission/initial contact ☐ Change in health status ☐ Routinely as per organizational policy

1. In the past year, has the person had any falls, slips or near misses? ☐ Yes ☐ No
2. Has the person experienced unsteady gait, poor balance or impaired mobility? ☐ Yes ☐ No
3. Based on your observations and clinical judgment, is the person at risk for falls? ☐ Yes ☐ No

If the person is not at risk for falls, maintain universal fall precautions.[4] Rescreen after a change in health status and routinely as per organizational policy. For persons who screen positive, conduct a falls risk assessment.**

Alert: *Falls history is a significant risk factor and predictor of potential further falls.*

Fall Risk Assessment

☐ Conduct a comprehensive falls risk assessment for "at risk" adults **(10023520)****[5]

Falls risk factors (select all that apply):

☐ Previous fall in the past year ☐ Advanced age/frailty ☐ Fear of falling
☐ Blood sugar levels below 3.9 mmol/L ☐ Impaired balance ☐ Impaired mobility
☐ Recent surgery within the last 2 years ☐ Postural hypotension ☐ Dizziness/vertigo
☐ Visual impairment ☐ Cognitive impairment ☐ Socio-economic factors ☐ Polypharmacy
☐ Poor nutrition ☐ Bowel/bladder incontinence ☐ Chronic health condition ☐ Medication
☐ Other (specify): _____

Environmental Factors (select all that apply):

☐ Bed rail ☐ Slippery/uneven surface ☐ Home hazard ☐ Equipment
☐ Physical restraint ☐ Footwear ☐ Poor lighting
☐ Other (specify): _____

Risk for fall injury(select all that apply): ☐ Bleeding risk ☐ Skin integrity risk ☐ Fracture risk

The following applies to persons who have fallen in the past year.

Details of falls history:

Number of falls in the past year? _____ Number of falls with injuries? _____

In the space below, provide details for the three most recent falls.

Alert: *Use the term "at risk" (for falls) with caution as it is associated with stigma, frailty, and loss of independence. Phrase messaging about risk and injury positively.*

Fall#1:

Date of Fall: Time of Fall:

Injuries sustained (select all that apply):

☐ No Injuries ☐ Hematoma ☐ Laceration(s) ☐ Fracture(s)
☐ Concussion ☐ Other (specify): _____

General location:
☐ Outdoors ☐ Health care facility ☐ Home ☐ Other:_____
Specific location:
☐ Bathroom ☐ Shower/bathtub ☐ Bedroom/room ☐ Living room
☐ Dining room ☐ Kitchen ☐ Activity room ☐ Hallway
☐ Stairway ☐ Other (specify): _____
Contextual factors:
☐ Fainted ☐ Hurrying ☐ Inattentive ☐ Substance use
☐ Incorrect use of assistive device ☐ Wearing unsupportive footwear
☐ Other (specify): _____
Activity during fall:
☐ Taking risks (e.g., climbing on a chair) ☐ Fall from height (e.g., roof/ladder)
☐ Attempting transfer ☐ Multitasking
☐ Other (specify): _____

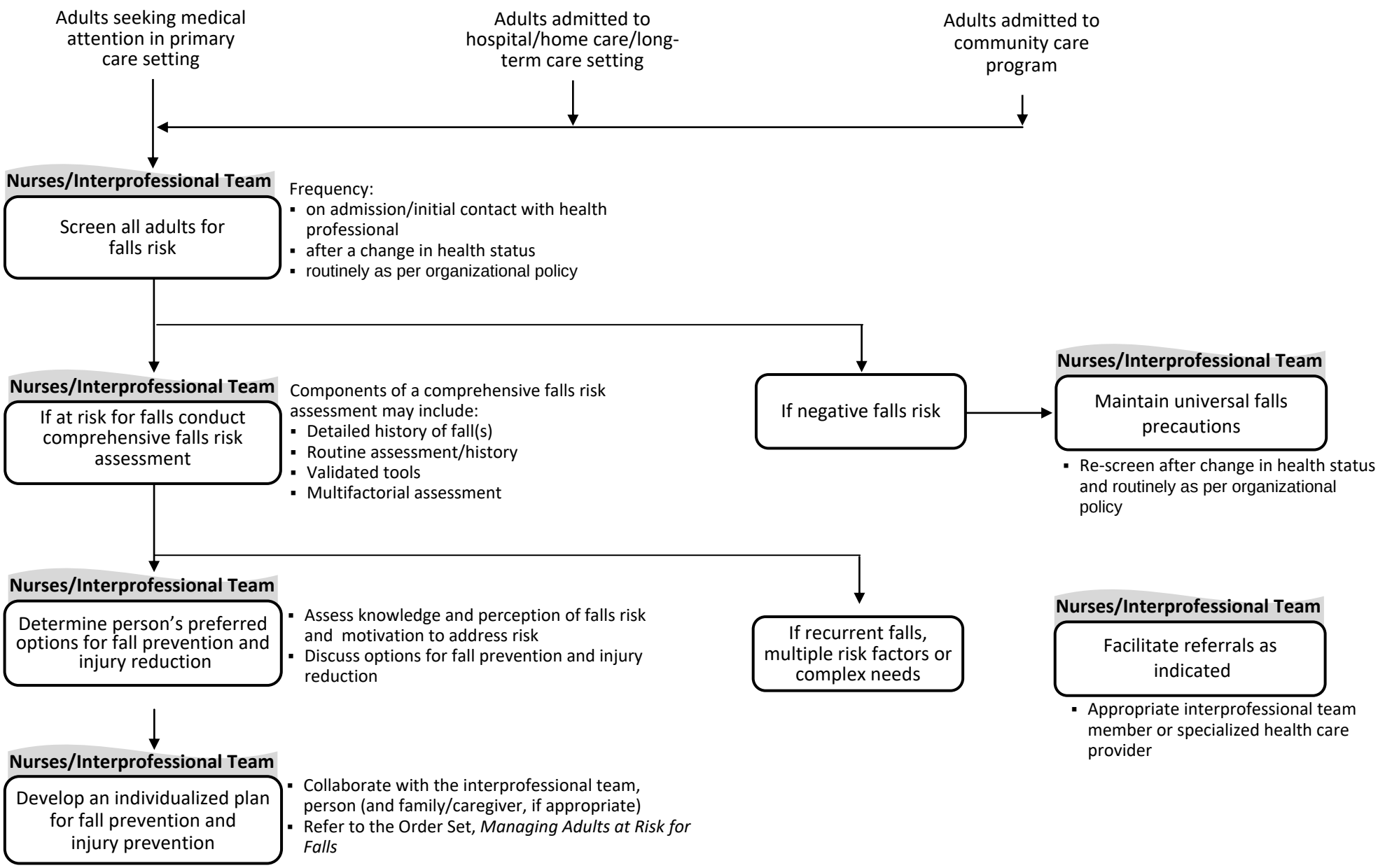
Fall#2:

Date of Fall: Time of Fall:
Injuries sustained (select all that apply):
☐ No Injuries ☐ Hematoma ☐ Laceration(s) ☐ Fracture(s)
☐ Concussion ☐ Other (specify): _____
General location:
☐ Outdoors ☐ Health care facility ☐ Home ☐ Other:_____
Specific location:
☐ Bathroom ☐ Shower/bathtub ☐ Bedroom/room ☐ Living room
☐ Dining room ☐ Kitchen ☐ Activity room ☐ Hallway
☐ Stairway ☐ Other (specify): _____
Contextual factors:
☐ Fainted ☐ Hurrying ☐ Inattentive ☐ Substance use
☐ Incorrect use of assistive device ☐ Wearing unsupportive footwear
☐ Other (specify): _____
Activity during fall:
☐ Taking risks (e.g., climbing on a chair) ☐ Fall from height (e.g., roof/ladder)
☐ Attempting transfer ☐ Multitasking
☐ Other (specify): _____

Fall#3:

Date of Fall: Time of Fall:
Injuries sustained (select all that apply):
☐ No Injuries ☐ Hematoma ☐ Laceration(s) ☐ Fracture(s)
☐ Concussion ☐ Other (specify): _____
General location:
☐ Outdoors ☐ Health care facility ☐ Home ☐ Other:_____
Specific location:
☐ Bathroom ☐ Shower/bathtub ☐ Bedroom/room ☐ Living room
☐ Dining room ☐ Kitchen ☐ Activity room ☐ Hallway
☐ Stairway ☐ Other (specify): _____
Contextual factors:
☐ Fainted ☐ Hurrying ☐ Inattentive ☐ Substance use
☐ Incorrect use of assistive device ☐ Wearing unsupportive footwear
☐ Other (specify): _____
Activity during fall:
☐ Taking risks (e.g., climbing on a chair) ☐ Fall from height (e.g., roof/ladder)
☐ Attempting transfer ☐ Multitasking
☐ Other (specify): _____

Care Pathway



Decision Support Resources

- **International Classification for Nursing Practice (ICNP) Codes**[1]

  ICNP is a standardized language for describing nursing data that uses a numerical coding system. Standardized data is essential in electronic systems to facilitate outcome evaluation and ongoing quality improvement, seamless exchange of health information, comparative analysis and research. ICNP codes enable organizations to extract meaningful data from their systems. Email eHealth@RNAO.ca for information on embedding ICNP codes into electronic systems.

- **Screening For Falls Risk in Adults**[3]
  - Screening refers to a brief process that is used to identify individuals requiring assessment of risk factors and personalized interventions.
  - For adults living in the community, it is recommended that screening for falls risk be conducted at least annually.

  Risk prediction tools:
  - Risk prediction tools aim to calculate a person's risk of falling, either in terms of 'at risk/not at risk' or in terms of 'low/medium/high risk'.
  - No tool was identified in the literature that can be used to consistently or reliably predict fall risks in adults in hospital or community settings.
  - The literature does not currently support the use of risk prediction tools in hospitals as a stand-alone approach to screening.

- **Universal Fall Precautions**[4]

  Universal fall precautions apply to all patients regardless of fall risk. The goal is to keep the person's environment safe. The choice of precautions may vary by organization. Refer to the Order Set, *Prevention and Management of Falls in Adults* for interventions that are commonly implemented as part of the universal fall precautions.

- **Comprehensive Falls Risk Assessment**[5]
  - A comprehensive falls risk assessment is recommended for persons identified as being at risk for a fall.
  - Components of a comprehensive fall risk assessment may include:
    1. Details of falls history (frequency, context, contributing factors). This Order Set provides space to document the three most recent falls. If the person has fallen more than three times in the past year, review the falls history for each fall and identify possible patterns.
    2. Routine assessments/health histories
       - Identify factors associated with risk for falls or fall injury during admission/intake assessments, physical examinations, or health and social histories routinely conducted within health care settings.
       - For example, histories may detect biological, behavioural, psychological, and/or socio-economic risk factors and health conditions associated with an increased risk for falls.
    3. Validated tools
       - Validated or standardized tools may be used as one component of a comprehensive assessment for falls risk (e.g., to assess for impaired cognition, issues with gait or balance, fear of falling, and fracture risk)
       - Tools should be appropriate for the population and setting.
       - Refer to the RNAO Guideline, *Preventing Falls and Reducing Injury from Falls (3rd ed.)* (Appendix F - p. 92) for additional information on approaches and tools for assessing falls risk.
    4. Multifactorial assessments
       - Multifactorial assessments are one element of a comprehensive assessment. They include an in-depth exploration of the multiple factors or conditions contributing to risk for falls and involve members of an interprofessional team.
       - Multifactorial assessments are more commonly performed among persons who are at risk for falls in hospitals, long-term care homes and community dwellings for older adults.
       - Consider a multifactorial assessment for older adults (65 years and older) who:
         - present to a health care provider or organization because of a fall;
         - have experienced recurrent falls in the past year; and
         - have abnormalities of gait and/or balance.

       Other considerations:
         - In hospital settings, focus multifactorial assessments on factors that can be "treated, improved or managed during their expected stay".
         - In community settings, discuss with the person and/or family/caregiver (as appropriate) whether a multifactorial risk assessment is necessary taking into consideration the person's falls history, co-morbid medical conditions, and their personal values.