NORTHWEST TERRITORIES
Health and Social Services Authority

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Appendix B - Individual Ambulatory Care Unit Template For Falls Prevention

Unit/Area: Laboratory at Stanton Territorial Hospital

Prevention: Falls prevention measures taken prior to patient visit (e.g. falls prevention handout and/or information given to patient with appointment details)

- Staff to participate in the information/training session organized by Stanton
- Ensure hallway and examination rooms are clean and clear of obstacles

Pre-examination:

- For emergency patient and inpatient, review the requisition for fall risk notification
- Upon arrival in the examination room, verify the inpatient bracelet (If yellow, this patient was assessed and classified at risk for fall)

During examination:

- Confirm stability with the patient
- Provide support when necessary
- Accompany patient that are using walking aids from and to the waiting room
- **Ensure their specific needs are met, for example: walker, wheelchair, rest period/waiting area, etc**
- Use mechanical lift or other means of transfer deemed appropriate for each situation
- Employ breaks on wheelchairs, stretcher, beds, etc
- Ensure table height is appropriate
- If patient is unstable, obtain assistance before proceeding with the exam
- If too unstable to stand, perform phlebotomy in the stretcher or wheelchair
- **Monitor closely for changes in the patient state**
- Once the exam is completed, ensure patient is not dizzy or feeling weak
- If the patient experiences dizziness, wait until the sensation subsides before releasing the patient from the collection area.
- If the patient is still experiencing dizziness even after several minutes, please consult with ER physician. Do not attempt to ambulate. Use other means of transportation if necessary.

Identification: Process of identifying patients at falls risk (e.g. stickers on charts, verbal communication from employees during handover, yellow bracelet given to patient, informing and engaging family members/ caregivers)

Patient at risk of fall include, but not limited to:

- Emergency Department Patients
- Inpatients
- Post-procedure patients
- Outpatients with visible disability
- Elderly
- Patients using assistive devices

For all patients:

Observe:

- gait
- footwear
- mental status (confused, disoriented, intoxicated, etc)
- use of mobility aid

For inpatient:

- Patient wearing a yellow bracelet
- Verbal communication by unit clerk or by nurse

For emergency department patient:

- Verbal communication by nurse
- Clinical history to suggest the patient is at risk of fall

For outpatient:

- Clinical history to suggest the patient is at risk of fall
- Patient fasting
- Elderly

Action Plan: Falls prevention measures taken once a falls risk is identified (e.g. verbal and written communication between staff members on new appointment and notification process on subsequent appointments, informing and engaging family members/ caregivers, one on one monitoring of patient, falls prevention handout and education given)

- Report all falls and near misses to your immediate supervisor and in the "Patient and Staff Incident Reporting System"
- Review the quarterly report on falls and near misses released by the OH&S nurse and look for an trends to take corrective action

Follow-up Plan- Process following a fall which may be unique to the area. (e.g. assessment by physician if there is one in the department)

Post All-Falls:

- Call for assistance by calling out or by pushing nearest emergency call button
- DO NOT ATTEMPT to mobilize the patient by yourself – always seek assistance after a fall
- Send patient to ER. If the patient refuses assessment by the ER physician, the reasons of his refusal must to be documented
- Report the incident in "Patient and Staff Incident Reporting System" (RiskPro)
- Discuss this incident at the following staff meeting for a group discussion regarding other prevention that can be implemented in the department

Post In-Patient or Emergency Patient fall:

- Review requisition for Falls-Risk notification
- If not completed, contact originating unit to see if a Fall-Risk assessment had been done and the outcome
- Notify originating unit of fall incident involving their patient. Follow the protocol in place for the originating unit
- Include the unit in the "Risk Pro" entry