Labrador-Grenfell Health

SUBJECT: **Falls Prevention (Client)**
APPROVED BY: Chief Executive Officer [redacted]
EFFECTIVE DATE: 2013 10
REVIEW/REVISED DATE:

Purpose:

- To provide a standardized approach to prevent client falls and injury from falls through the use of a standardized regional Falls Prevention Strategy.

Policy/Standard:

The Falls Prevention Strategy is comprised of four main components and involves all employees in preventing and reducing client falls. The four components are:

1. Risk assessment;
2. Implementation of standard interventions;
3. Customization of interventions for those at highest risk; and
4. Communication and education.

The Falls Prevention Strategy uses a multidisciplinary approach with roles and responsibilities across the continuum of care. Tools are provided to:

- Identify clients at risk for falls;
- Initiate preventative approaches;
- Provide appropriate strategies and interventions;
- Promote a safe environment for all clients;
- Provide learning opportunities for clients, their families and employees; and
- Monitor and evaluate outcomes.

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Materials Required:

- Falls Prevention Strategy Document (found at: http://lghealth/departments/htmlpage.cfm?MenuID=5128&NavID=2)
- High Risk for Falls Identifiers:
  - StepSafe logos *(Appendix A)*
  - Green Armbands
- Morse Fall Scale Risk Assessment for Acute and Long Term Care *(Appendix B)*
- Morse Fall Scale Risk Assessment for Home and Community Care *(Appendix C)*
- Fall Scale Risk Assessment Audit Tool *(Appendix D)*

- Environmental Check List *(Appendix E)*
- Post Fall Follow-up Form *(Appendix F)*
- Client Record and Care Plan
- Please Ask Us! Pamphlet (found at: http://www.lghealth.ca/index.php?pageid=190)
- Staying Safe at Home Booklet (found at: http://lghealth/departments/htmlpage.cfm?MenuID=5128&NavID=2)
- Falls Prevention Posters

Related Policies:

Culture of Safety	# PSQ-5-005
Continuous Quality Improvement	# PSQ-5-010
Occurrence Reporting and Management	# PSQ-5-020

Definitions:

Fall: is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury[1].

Procedure:

A. Acute Care, Long Term Care and Home Care Nursing Staff (RNs and LPNs)

1. Risk Assessment:

Complete a Morse Fall Scale Risk Assessment on all clients to determine if a client is at high, moderate or low risk for falls:

- Within 24 hours of admission to acute or long term care;
- At change of status;
- Following a fall;
- Every 3 months; and
- On all home and community care clients who receive home visits.

[1] Safer Heathcare Now! *Reducing Falls and Injuries From Falls Getting Started Kit.* Canadian Patient Safety Institute, 2010. Retrieved from: www.saferhealthcarenow.ca

2. Implementation of Interventions:

Implement a plan of care based on the level of risk within 24 hours of admission and update as necessary.
For acute care clients assessed as high risk for falling:

- Place StepSafe logo stickers on the client's chart and care plan and a StepSafe logo above the client's bed;
- Apply a green armband; and
- Implement appropriate standard safety measures as shown on the Morse Falls Scale Follow-up Interventions.

For long term care clients assessed as high risk for falling:

- Place StepSafe logo stickers on the client's chart and care plan and a StepSafe logo above the client's bed;
- Apply a green armband only when the client is transferred outside of the facility; and
- Implement appropriate standard safety measures as shown on the Morse Falls Scale Follow-up Interventions.

3. Customization of interventions for those at highest risk of falls-related injury:

- Identify those clients who are at greater risk for falls-related injury due to:
  - Age or frailty
  - Bone disorders
  - Coagulation disorders
  - Surgery
- Implement appropriate interventions as detailed in the Falls Prevention Strategy.
- Modify the environment to reduce the risk of fall-related injury.

4. In the event of a fall/near fall:

- Go immediately to the client, check for obvious injury and provide appropriate care.
- Ask for assistance as required.
- Repeat the Morse Fall Scale Risk Assessment.
- Determine whether the client's risk score has changed requiring additional interventions.
- Report the occurrence in the Clinical Safety Reporting System (*Occurrence Reporting and Management* PSQ-5-020).
- Complete a Post Fall Follow-up form for each client to determine contributing factors and the need for further preventative measures to decrease falls risk.
- Send completed Post Fall Follow-up form to the unit coordinator/manager.

- Review the occurrence with the multidisciplinary team and include risk factors, actual causes and practical solutions. Implement any physical or procedural changes to prevent future recurrences.

5. Communication and education:

- Communicate consistently and regularly with clients, family members and the healthcare team to reduce falls and injury from a fall.
- Provide clients and their families with falls prevention education.
- Communicate the results of the Falls Risk Assessment to the healthcare team, client and their family.
- Encourage clients/family to inform their healthcare provider if they are at risk of falling.

6. Auditing and evaluation:

Audits and evaluations will be completed at least annually using audit tools.

B. Ambulatory Care Staff

1. Risk Assessment:

Assess clients at risk of a fall through the following:

- Presence of approved StepSafe logo identifiers (green armbands, chart and care plan stickers).
- Client presentation:
    - Advanced age
    - Weakness or frailness
    - Requiring assistance
    - Assistive devices (walker, cane, crutches)
    - Accompanying equipment (IV pumps, oxygen)
    - Inappropriate footwear
- Clients/family who have self-identified to a health care provider that they require assistance with standing and/or walking.

2. Implementation of interventions:

To minimize the risk of client falls, employees should:

- Ask all clients prior to starting a procedure:
    - Do you need help standing?
    - Do you need help walking?

- Assist clients with standing and walking as required.

- Practice safe handling techniques when clients have to be transferred from stretchers, beds or wheelchairs.
- Identify and report any potential environmental hazards that could result in a fall such as wet floors, poor lighting, furniture at improper height, etc.
- Communicate to other members of the healthcare team that a client has been identified as being at risk for a fall.

3. <u>If a fall/near fall does occur:</u>

- Go immediately to the client, check for obvious injury and provide appropriate care.
- Ask for assistance as required.
- Report the occurrence in the Clinical Safety Reporting System (*Occurrence Reporting and Management,* PSQ-5-020).

4. <u>Communication and education:</u>

- Communicate consistently and regularly with clients, family members, and the healthcare team to reduce falls and injury from falls.
- Offer clients and their families falls prevention education
- Encourage clients/family to inform their healthcare provider if they are at risk of falling.
- Offer communication throughout the duration of the client's visit.

5. <u>Auditing and evaluation:</u>

Audits and evaluations will be completed at least annually using audit tools.

<u>References:</u>

Labrador-Grenfell Health Falls Prevention Strategy. Retrieved from: http://lghealth/departments/htmlpage.cfm?MenuID=5128&NavID=2, (September 2013).

Accreditation Canada. *Required Organizational Practices* Ottawa, ON: Accreditation Canada, 2012. Retrieved from: www.accreditation.ca

Morse, J. M., Morse, R., & Tylko, S. *Development of a Scale to Identify the Fall Prone Patient.* Canadian Journal on Aging, 8, 366-377. 1989.

Nova Scotia Department of Health. *Falls Assessment Framework.* Halifax, NS:Nova Scotia Health Promotion and Protection, 2006. Retrieved from: www.gov.ns.ca/health

Registered Nurses' Association of Ontario. *Prevention of Falls and Fall Injuries in the Older Adult. (revised).* Toronto, ON: Registered Nurses' Association of Ontario, 2005.

Safer Heathcare Now! *Reducing Falls and Injuries From Falls Getting Started Kit.* Canadian Patient Safety Institute, 2010. Retrieved from: www.saferhealthcarenow.ca

Appendix A

Appendix B: Morse Fall Scale Risk Assessment for Acute Care and Long Term Care

Labrador-Grenfell Health

Morse Fall Scale Risk Assessment for Acute Care and Long Term Care

Fall risk is based on fall risk factors and it is more than a total score. Determine fall risk factors and follow-up interventions to reduce risks. Complete on admission (within 24 hrs), at change of condition, transfer to a new unit, and after a fall. **Document completion of assessment, score, level of risk, and follow-up interventions in progress notes, Kardex and/or Care plan. Place completed assessment form on chart.**

Variables		Score	Admission Date_____	Review Date_____	Review Date_____
History of Falling (immediate or in the past 3 months)	No Yes	0 25			
Secondary Diagnosis	No Yes	0 15			
Ambulatory Aid	None/Bed rest/Nurse Assist	0			
	Crutches/cane/walker	15			
	Furniture	30			
IV or IV access	No Yes	0 20			
Gait	Normal/Bed rest/Wheelchair	0			
	Weak	10			
	Impaired	20			
Mental Status	Knows own limits	0			
	Overestimates or forgets limits	15			
To obtain the Morse Fall Score add the score from each category Total:					
Signature & Status:					

Morse Fall Scale Level of Risk	
High Risk	45 and higher
Moderate Risk	25 - 44
Low Risk	0 - 24

Definitions:

History of falling: **Yes** **score 25** if a fall has happened currently or if there is history of a fall within the last 3 months.

Secondary diagnosis: **Yes** **score 15** if more than one medical diagnosis is listed on the patient chart.

Ambulatory aids: **Score 0** if walks without a walking aid even if assisted or is on bed rest and does not get out of bed.
Score 15 if ambulatory with crutches, cane, or walker.
Score 30 if clutches furniture for support.

IV therapy: **Score 20** if has an IV apparatus or heparin lock.

Gait:
Normal: **Score 0** if is able to walk with head erect, arms swinging freely at sides, & strides unhesitantly.
Weak: **Score 10** if is stooped but able to lift head while walking without losing balance. Steps are short, and s/he may shuffle. Furniture support may be sought but is of feather-weight touch, almost for reassurance.
Impaired: **Score 20** if is stooped, may have difficulty rising from the chair, attempts to rise by pushing on the arms of the chair and/or by "bouncing". The head is down, and because balance is poor s/he grasps the furniture, a person, or walking aid for support and cannot walk without assistance. Steps are short and s/he shuffles. If wheelchair (WC)-bound, score gait used when transferring from the WC to the bed.

Mental Status: When using this scale, mental status is measured by checking the resident's self-assessment of his/her own ability to ambulate. Ask the resident, "Are you able to go to the bathroom alone, or do you need assistance?" **Score 15** if the resident's response is not consistent with the ambulatory orders on the plan of care. If the resident's response is unrealistic, then he/she is considered to overestimate his/her own abilities and to be forgetful of limitations. **Score 0** if the resident's reply judging his/her own ability is consistent with the ambulatory order on the plan of care. The resident is rated as "normal."

Morse Falls Scale Follow-up Interventions for Acute and Long Term Care

Morse Fall Scale Scores of:

- ☐ 0 - 24 (Low Risk) receive Standard Safety Measures
- ☐ ≥25 (Moderate and High Risk) receive Standard Safety Measures **+** Additional Safety Measures **+** Communication/Collaboration with multidisciplinary healthcare team and family is required.

Standard Safety Measures Acute and Long Term Care:

General:

- ☐ Frequent checks (q1h)
- ☐ Medication review by nurse
- ☐ Encourage regular toileting (examples may include: reducing fluid intake after dinner; assisting to toilet prior to sleep; providing bedpan/urinal/commode at bedside if appropriate)
- ☐ Provide educational materials to patient/resident and family (e.g. Please Ask Us!)

Personal:

- ☐ Wear well-fitting, non-slip footwear
- ☐ Walkers/canes/crutches are appropriately fitted and have correct tips
- ☐ Family or alternative attendant as required

Environment/Equipment:

- ☐ Call bell within reach
- ☐ If appropriate, toileting devices, personal items, phone, hand-held controls within reach
- ☐ Obstacles removed from key pathways and clutter-free bedside
- ☐ Oxygen and catheter tubing, IV pump electrical cords removed from pathway
- ☐ Use of side rails, according to clinical judgment within professional standards and scope of practice, for patients who are not bed-ridden
- ☐ Brakes on and bed in lowest position if / when patient is in bed
- ☐ Portable equipment pushed by patient/resident (i.e. IV pole) is sturdy and in good repair
- ☐ If appropriate, wheelchairs locked when stationary

Bathroom:

- ☐ Handrails in patient/resident bathroom are properly secured
- ☐ Assistive devices available as required (i.e. bath/shower chair)
- ☐ Emergency call button/cord in patient/resident bathroom present and working properly
- ☐ Non-slip surfaces provided in patient/resident shower/tub
- ☐ Door openings flush within the floor for ease of movement for patient/resident equipment

Additional Safety Measures:

- ☐ Increase frequency of checks
- ☐ Placement closer to nursing station
- ☐ More frequent toileting
- ☐ Bed, chair, and personal alarm
- ☐ Occupational Therapy referral **[ ]** Physiotherapy referral
- ☐ Refer to Dietitian for nutritional care if score **≥45** (High Risk) or if otherwise indicated
- ☐ Medication evaluation of patient profile for poly pharmacy (>5 meds) and falls risk by physician or pharmacist (upon availability)
- ☐ Hearing, speech, vision referral if required
- ☐ Consider physician assessment

Follow up interventions completed? [ ] Yes [ ] No Date: _____
Comments: _____
_____
_____

Appendix C: Morse Fall Scale Risk Assessment for Home and Community Care

Labrador-Grenfell Health

Client Name_____
DOB_____
MCP_____
CRMS#_____

Morse Fall Scale Risk Assessment for Home and Community Care

Fall risk is based on fall risk factors and it is more than a total score. Determine fall risk factors and follow-up interventions to reduce risks. Complete on admission (within 24 hrs), at change of condition, transfer to a new unit, and after a fall.

Document completion of assessment, score, level of risk, and follow-up interventions completed in progress notes and/or Care Plan. Place completed assessment form on chart.

Variables		Score	Admission Date_____	Review Date_____	Review Date_____
History of Falling (immediate or in the past 3 months)	No Yes	0 25			
Secondary Diagnosis	No Yes	0 15			
Ambulatory Aid	None/Bed rest/Nurse Assist	0			
	Crutches/cane/walker	15			
	Furniture	30			
IV or IV access	No Yes	0 20			
Gait	Normal/Bed rest/Wheelchair	0			
	Weak	10			
	Impaired	20			
Mental Status	Knows own limits	0			
	Overestimates or forgets limits	15			
To obtain the Morse Fall Score add the score from each category Total:					
Signature & Status:					

Morse Fall Scale Level of Risk	
High Risk	45 and higher
Moderate Risk	25 - 44
Low Risk	0 - 24

Definitions:

History of falling: **Yes score 25** if a fall has happened currently or if there is history of a fall within the last 3 months.

Secondary diagnosis: **Yes score 15** if more than one medical diagnosis is listed on the patient chart.

Ambulatory aids: **Score 0** if walks without a walking aid even if assisted or is on bed rest and does not get out of bed.
Score 15 if ambulatory with crutches, cane, or walker.
Score 30 if clutches furniture for support.

IV therapy: **Score 20** if has an IV apparatus or heparin lock.

Gait:
Normal: **Score 0** if is able to walk with head erect, arms swinging freely at sides, & strides unhesitantly.
Weak: **Score 10** if is stooped but able to lift head while walking without losing balance. Steps are short, and s/he may shuffle. Furniture support may be sought but is of feather-weight touch, almost for reassurance.
Impaired: **Score 20** if is stooped, may have difficulty rising from the chair, attempts to rise by pushing on the arms of the chair and/or by"bouncing". The head is down, and because balance is poor s/he grasps the furniture, a person, or walking aid for support and cannot walk without assistance. Steps are short and s/he shuffles. If wheelchair (WC)-bound, score gait used when transferring from the WC to bed.

Mental Status: When using this scale, mental status is measured by checking the resident's self-assessment of his/her own ability to ambulate. Ask the resident, "Are you able to go to the bathroom alone, or do you need assistance?" **Score 15** if the resident's response is not consistent with the ambulatory orders on the plan of care. If the resident's response is unrealistic, then he/she is considered to overestimate his/her own abilities and to be forgetful of limitations. **Score 0** if the resident's reply judging his/her own ability is consistent with the ambulatory order on the plan of care. The resident is rated as "normal."

Morse Scale Follow-up Interventions for Home and Community Care

Morse Fall Scale Scores of:

- ☐ 0 - 24 (Low Risk) receive Standard Safety Measures
- ☐ ≥25 (Moderate and High Risk) receive Standard Safety Measures + Additional Safety Measures + Communication/Collaboration with multidisciplinary healthcare team and family is required.

Standard Safety Measures:

General/Personal:

- ☐ Provide educational materials to client and family (e.g. Staying Safe at Home, Please Ask Us!)
- ☐ Medication review by nurse
- ☐ Wear proper and well fitting footwear with non-slip soles
- ☐ Walkers/canes/crutches are properly fitted and have appropriate tips
- ☐ Wear gripping winter footwear to prevent slipping on ice and snow
- ☐ Wear glasses and hearing aids
- ☐ Take time when first getting up (orthostatic hypotension)
- ☐ Long handled shoehorn to reduce the chance of falling when bent over
- ☐ Long handled reachers for reaching things in high places, instead of climbing
- ☐ A personal emergency response system if available (e.g. Emergency Alert)

Environment/Equipment:

- ☐ Remove dangerous scatter mats and replace with rubber-backed non-slip mats
- ☐ Remove clutter in rooms, hallways, and entrances
- ☐ Move extension cords out of walking paths
- ☐ Know where your pet is at all times
- ☐ Ensure proper lighting and use a night light
- ☐ Use battery operated emergency lights that will activate during a power outage
- ☐ Have flashlights at the bedside for power outages
- ☐ Ensure sturdy railing by all stairways inside and outside
- ☐ Use a sturdy step stool with handrail and rubber tipped feet
- ☐ Be aware of edges of steps, thresholds, and other potential trip areas both inside and outside the home. Consider contrasting color strips on edges of steps
- ☐ Keep walkways and steps clear of ice and snow

Bathroom:

- ☐ Have someone else in the home when a bath or shower is taken
- ☐ Grab bars for the bathtub, shower, toilet, etc.
- ☐ Have bath chair available if needed
- ☐ Have hand-held shower head for use with shower seat
- ☐ Non-slip mats for inside and outside the tub and shower area

Additional Safety Measures:

- ☐ Occupational Therapy referral [ ] Physiotherapy referral
- ☐ Hearing referral [ ] Speech referral [ ] Recommend vision referral, if required
- ☐ Consider physician assessment
- ☐ Recommend community pharmacist review for high risk medications
- ☐ Referral to Dietitian if score ≥45 (High Risk) or if otherwise indicated

Follow up interventions completed? [ ] Yes [ ] No Date: _____
Comments: _____
_____
_____

Appendix D

Labrador-Grenfell Health

Fall Scale Risk Assessment Audit Tool

Auditor Name: _____

Date of Audit: _____

Audit Location: _____

Next Audit Date: _____

Chart	Is a Fall Scale Risk Assessment Completed with Total Score Documented		Comment
	Yes	No	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Appendix E: Environmental Checklist

Labrador-Grenfell Health

Environmental Checklist For Acute Care and Long Term Care

Date:
Acute and/or LTC Room Assessed:
Individual(s) surveying:

Acute and Long Term Care

Client Room	**Yes**	**No**	**NA**
1. Is there adequate lighting in the client's room? (Bright light - no burned out bulbs?)	[ ]	[ ]	[ ]
2. Is the nightlight on the client's bed/wall functional/operating?	[ ]	[ ]	[ ]
3. Does the client have an unobstructed path to the bathroom?	[ ]	[ ]	[ ]
4. Where appropriate, are floors properly marked when wet to avoid slipping and are spills cleaned up immediately?	[ ]	[ ]	[ ]
5. Are client's room furnishings safely arranged?	[ ]	[ ]	[ ]
6. Is bedside furniture free of sharp edges?	[ ]	[ ]	[ ]
7. Is the bedside furniture sturdy?	[ ]	[ ]	[ ]
8. Are beds/stretchers kept at lowest possible setting whenever possible?	[ ]	[ ]	[ ]
9. Are beds/stretchers kept in locked position?	[ ]	[ ]	[ ]
10. If appropriate, are the side rails in the correct position as per the care plan for the client to reach the controls? (Use of side rails, according to clinical judgment within professional standards and scope of practice, for clients who are not bed-ridden)	[ ]	[ ]	[ ]
11. If appropriate, are the hand held controls within reach?	[ ]	[ ]	[ ]
12. Are the client's personal belongings/telephone/call bell/toileting devices within reach?	[ ]	[ ]	[ ]
13. Are handrails in client's bathroom properly secured?	[ ]	[ ]	[ ]
14. Emergency call button/cord in client bathroom present and working properly?	[ ]	[ ]	[ ]
15. Are non-slip surfaces provided in client shower/tub?	[ ]	[ ]	[ ]
16. Are the door openings into the client bathroom wide enough for an assistive device to fit through?	[ ]	[ ]	[ ]
17. Are door openings flush within the floor for ease of movement for client equipment?	[ ]	[ ]	[ ]
Equipment			
18. Is portable equipment pushed by client (i.e. IV pole) sturdy and in good repair?	[ ]	[ ]	[ ]
19. Are bedside commodes available on the unit, in good working order and have functioning brakes or rubber tips on the legs?	[ ]	[ ]	[ ]
20. Do walkers/canes/crutches have the appropriate tips?	[ ]	[ ]	[ ]

21. If appropriate, are wheelchairs locked when stationary?	[ ]	[ ]	[ ]
22. Is broken equipment properly tagged for non-use?	[ ]	[ ]	[ ]

Environmental Checklist Follow-Up

Acute and LTC Section

Item#	Corrective Action	Date Initiated	Responsible Individual	Anticipated Date of Completion	Actual Date of Completion

For additional corrective action:

Forwarded to: _____ Date: _____

Returned Date: _____ Signature: _____

Adapted from: Boushon, B. et al. (2008). Transforming Care at the Bedside. How to Guide: Reducing Patient Injuries from Falls, Institute for Healthcare Improvement. www.IHI.org

Appendix F:
Post Fall Follow-Up Form

Date & Time of fall: _____

Location of fall: _____

1. Physician notified: _____ **Date & Time**: _____

2. Family notified: _____ **Date & Time**: _____

3. Is there a need to re-educate the client, family and staff? [ ] Yes [ ] No

Documentation:	**Date/Time**	**Initial**
Fall documented in progress notes		
Post Fall Investigation Summary documented in progress notes		
Fall Risk Assessment Tool completed		
Individualized Fall Prevention Care Plan reviewed and revised as needed		
Occurrence Report completed		

Debriefing:	**Date/Time**	**Initial**
Completed within 72 hours of fall		
Incident, cause, and Action Plan reviewed		
Action Plan items initiated		

Completed by:

Name (print): _____ Signature: _____

Manager/Supervisor informed: _____ Date: _____

Labrador-Grenfell Health

Nursing – General
Policy and Procedure Manual

SUBJECT: **PRESSURE ULCER RISK ASSESSMENT - BRADEN RISK ASSESSMENT**
APPROVED BY: VP Acute Care Services
EFFECTIVE DATE: 2013 09
REVISED/REVIEW DATE:

Purpose:

To provide nursing staff with a tool for predicting pressure ulcer risk.

Policy/Standard:

The Braden Risk Assessment Scale is used to identify individuals at risk for development of pressure ulcers. This validated and reliable measurement tool has been used for adult populations in hospitals, nursing homes and the community to link a score and level of individual risk to nursing interventions that promote, maintain and/or restore skin integrity.

Risk Factors for Consideration:

- Over 80 years of age
- Diastolic blood pressure less than 60 mmHg
- Cardiovascular disease
- Increased temperature
- Decreased dietary protein intake
- Chair/bed bound
- Impaired ability to reposition
- Extracorporeal oxygenation (the use of a heart-lung machine to take over the work of the lungs and sometimes the heart).

Material Required:

Braden Scale – For Predicting Pressure Sore Risk Intervention Tool (Appendix I)

Procedure:

A registered nurse completes the Braden Scale as outlined below and whenever there is a significant change in an individual's health status.

Community Environment
Home/Personal Care Home
Complete on nursing admission for all clients who are chair/bed bound or who have limited ability to ambulate and for those clients who have two or more of the above risk factors for consideration. Repeat Braden Risk Assessment if score is less than or equal to 12, based on the stability/instability of the client and at a minimum of once per year.

Long Term Care Environment
Complete within 48 hours of admission, then weekly for four weeks, then quarterly.

Acute Care Environment
Complete on all adult inpatient admissions with the exception of mental health short stay and obstetrical patients.

If on initial assessment, the Braden Risk Score is 19 or above, the Braden Risk Assessment does not have to be repeated unless there is a change in the health status of the client.

If on initial assessment the Braden Risk Score is 18 or lower, the Braden Risk Assessment is repeated and interventions reviewed as per the following schedule:

Inpatient Unit	**Frequency of assessment/review of interventions**
Critical Care	Daily
Medical/Surgical	Monday/Wednesday/Friday
Extended Care (e.g. rehab, palliative care, comfort care, geriatric assessment, MH-Long stay)	Weekly for one month and every three months thereafter
Medically Discharged	On admission, weekly for one month, then every three months (as per LTC environment)

Criteria for Referral based on Braden Assessment Score

The Braden Risk Assessment Score should not be the sole criteria for determining appropriate clinical interventions. Nursing interventions are to be initiated based on professional judgment and with consideration to available resources. The goal is to develop a plan of care that will promote, maintain and/or restore skin integrity.

Mild – Moderate Risk (total score 13-18)
Individuals who have Braden Risk Assessment score of Low to Moderate Risk (13-18) the RN should consider a referral to appropriate clinical discipline (for example, referral to dietitian if score on 'nutrition component is 2 or less; referral

to physiotherapist and/or occupational therapy if score on mobility component is 2 or less).

High Risk (total score 12 or less)
Individuals who have Braden Risk Assessment score of high Risk (score 12 or less) the RN must send a referral to dietitian if score on “nutrition” component is 2 or less and a referral to physiotherapy and/or occupational therapy if score on “mobility” component is 2 or less.

References:

Newfoundland and Labrador Skin and Wound Care Manual – July 2008

SUBJECT: **Medication Reconciliation on Admission**
APPROVED BY: Chief Executive Officer
EFFECTIVE DATE: 2014 02
REVIEW/REVISED DATE:

Purpose:

- To provide a structured process (through medication reconciliation) in which healthcare professionals partner with clients, families and caregivers for accurate and complete transfer of medication information at transitions of care.
- To enhance client safety by reducing potential for medication discrepancies such as omission, duplications, and dosing errors.

Policy/Standard:

Medication Reconciliation will be completed within 24 hours for all clients admitted to an Acute or Long Term Care Facility.

Materials Required:

- Regional Medication History & Reconciliation Form (Appendix A)
- Medication Reconciliation on Admission Self-Study Package: located on the LG Health Intranet at: http://lghealth/apps/view_items.cfm?MenuID=6&CategoryID=476

Procedure:

1. Complete a Best Possible Medication History (BPMH) using a systematic process of interviewing the client/family/caregiver and a review of at least one other reliable source of information such as, but not limited to:

    - the patient medication list;
    - medication containers/bottles/vials;
    - a list from the family physician;
    - a list from the community pharmacy;
    - previous hospital records;
    - a Medication Administration Record (MAR) from another facility;
    - a listing of client's medications from inter-agency referral forms/letters;
    - a Meditech bulletin (generated by the Meditech system).

A BPMH must be completed by one of the following health care professionals:

- Physician,
- Registered Nurse, or
- Pharmacist.

*If it is not possible to interview the client/family/caregiver, at least two reliable sources of information must be obtained to complete a BPMH (see list above). The reason an interview was not possible must be documented on the Regional Medication History & Reconciliation Form (Appendix A).

2. A physician, registered nurse or pharmacist reconciles the BPMH with the medication orders and identifies any discrepancies.

3. If there are no discrepancies between the BPMH and the medication orders, it is recorded on the Regional Medication History & Reconciliation Form as “no discrepancy” and the client’s medications will be deemed reconciled.

4. Any discrepancies between the BPMH and the medication orders must be resolved with the responsible prescriber and documented on the Regional Medication History & Reconciliation Form.

5. Once all discrepancies between the BPMH and the medication orders have been resolved and noted on the Regional Medication History & Reconciliation Form, the client’s medications will be deemed reconciled.

References:

Accreditation Canada. *Required Organizational Practices* Ottawa, ON: Accreditation Canada, 2012. Retrieved from: www.accreditation.ca

Institute for Safe Medical Practices Canada. *Medication Reconciliation.* Retrieved from: http://www.ismp-canada.org/medrec/

Safer Healthcare Now! *Medication Reconciliation in Acute Care Getting Started Kit.* Canadian Patient Safety Institute, 2011. Retrieved from: www.saferhealthcarenow.ca

Safer Healthcare Now! *Medication Reconciliation in Home Care Getting Started Kit.* Canadian Patient Safety Institute, 2011. Retrieved from: www.saferhealthcarenow.ca

Safer Healthcare Now! *Medication Reconciliation in Long Term Care Getting Started Kit.* Canadian Patient Safety Institute, 2012. Retrieved from: www.saferhealthcarenow.ca

Medication Reconciliation on Admission Self-Study Package 2013, Labrador-Grenfell Health

Appendix A: Regional Medication History and Reconciliation Form

Labrador-Grenfell Health

Regional Medication History & Reconciliation

Site: ☐ LHD ☐ LTC Goose Bay ☐ GCMH ☐ JMG ☐ GNJ ☐ LBHC ☐ Homecare _____

Date & Time:

Allergies:
☐ NKA

☐ On No Medications at Home
☐ Unable to Obtain Medication History – Reason: _____

Source of Medication Information *(Check ALL that apply)*
☐ Patient recall ☐ Review of medication vials ☐ Review previous hospital records ☐ Family/caregiver recall
☐ Family Physician list ☐ MAR from another facility ☐ Review of patient medication list ☐ Electronic Bulletin
☐ Other _____ ☐ Community pharmacy list Pharmacy Name: Tel:

Nurse/Physician/Pharmacist to document home medication.

Best Possible Medication History (BPMH)
(Prescriptions and non-prescription – eg. OTC, herbals, etc.)

Physician to Complete (where applicable)

Height:
Weight: kg

Prescription Medication Name & Strength	Dose	Route	Dosing Interval	Last Dose	Continue	Change	Hold	Discontinue	Reason for Change	No Discrepancy	Discrepancy	Resolved - (DI - MM)
NON-PRESCRIPTION MEDICATIONS (eg OTCs, herbals, others)												

Are R_x Meds being taken as prescribed? ☐ Yes ☐ No
Explain:

Physician Signature:

Ordering Physician:

Date:

BPMH by: _____ Date/Time: _____

Pharmacy Consult: ☐ Yes ☐ No
Reason for Referral: _____

Reconciled by: _____

Date / Time: _____

2012 05 (Revised) Page ____ of ____

*** Note Clarification of Discrepancies in client chart.

SUBJECT: **VENOUS THROMBOEMBOLISM PROPHYLAXIS**
APPROVED BY: VP Nursing, Chief Nurse
EFFECTIVE DATE: 2014 03
REVISED/REVIEW DATE:

Purpose:

To provide guidelines for assessment and treatment of clients at risk of venous thromboembolism (VTE).

Policy/Standard:

Every hospitalized client (with exception of excluded groups) is to be assessed for VTE risk at the following times:

- Upon admission to hospital
- Changes in client's clinical condition
- Postoperatively
- At transitions of care and time of discharge

All hospitalized clients at risk for VTE will receive venous thromboprophylaxis.

Thromboprophylaxis is to be administered to every hospitalized client in whom it is indicated based on their risk of thrombosis and their risk of bleeding.

Due to limited evidence, the following client groups are currently not included for VTE prophylaxis in this policy:

- Pediatrics
- Obstetrics
- Mental Health
- Long Term Care

Materials Required:

List of Contraindications – Appendix A
VTE Risk Assessment & Prophylaxis Order Sheet – Appendix B
VTE Audit Tool – Appendix C
VTE Assessment Process Flowchart– Appendix D

Related Policies: Not Applicable

Definitions:

Venous Thromboprophylaxis	A collective term for a clot that develops within the venous system including deep vein thrombosis (DVT) and pulmonary embolism (PE).
Deep Vein Thrombosis (DVT)	A blood clot occurring in one or more deep veins, especially the lower limbs. The clot may cause partial or complete blocking of the circulation in the vein.
Pulmonary Embolism (PE)	A blood clot that originates in the deep veins and travels through the bloodstream where it can be partially or completely blocking a pulmonary artery.
Fully Mobile	Refers to clients who are ambulating without assistance or are mobilizing to the same capacity as they were prior to their admission to hospital.
Nurse	Refers to the LPN or RN.

Procedure:

1. Physician must determine eligibility for VTE prophylaxis by:
   a. Assessing the client's risk for VTE.

   b. Assessing for possible contraindications to thromboprophylaxis - Appendix A.

   c. Weighing the risk of bleeding against risk for VTE.

2. Physician will order appropriate thromboprophylaxis if necessary. If thromboprophylaxis is not ordered, a rationale must be documented by physician. VTE Risk Assessment & Prophylaxis Order Sheet must be used for these purposes – Appendix B. (CSCMH – physicians will write med orders on MAR).

3. If mechanical prophylaxis is ordered due to client's bleeding risk, client must be reassessed daily. When bleeding risk decreases, low molecular weight heparin (LMWH) should be considered by the physician.

4. Nursing staff will educate the client regarding VTE prevention and administration of thromboprophylaxis.

5. Nursing staff will provide thromboprophylaxis treatment to the client as ordered by the physician.

6. Nursing staff will properly fit and apply thromboembolic stockings (TEDs) when prescribed and will monitor the client for correct usage and complications.

Thromboprophylaxis Principles

General Principles

Thromboprophylaxis is not indicated in clients who are mobile and expected to have a hospital length of stay less than 72 hours.

For all clients in whom it is possible and appropriate, early and frequent ambulation is essential.

Anticoagulant thromboprophylaxis is contraindicated in clients who are actively bleeding or have a high risk of bleeding. In these situations, either properly measured and fitted bilateral, knee length TEDs or intermittent pneumatic compression devices (IPCD) are to be used (in stroke patients IPCD's are more appropriate). The physician will reassess risk of bleeding daily. If bleeding risk decreases and VTE risk persists, anticoagulant thromboprophylaxis is to be considered. Refer to Appendix A for a List of Contraindications.

Optimal thromboprophylaxis is defined by an appropriate:

a. Modality for the client's risks of VTE and bleeding,
b. Dose (if an anticoagulant is the method used),
c. Timing – upon admission, post operatively, or after transfer from another health care facility.

A low molecular weight Heparin (LMWH) is recommended. (eg. Enoxaparin)

a. For clients with heparin-induced thrombocytopenia (HIT), either currently or in the past, LMWH is contraindicated. In this event, the attending physician must choose a more appropriate drug.
b. LMWH should be continued unless there is evidence of active bleeding or the client has developed a significant increase in bleeding risk.
c. LMWH should NOT be held the evening before an invasive procedure planned for the next day.

TEDs or IPCD's will be used in clients where anticoagulants are contraindicated and may also be used as an adjunct to pharmacologic prophylaxis in clients who are considered very high risk for VTE.

LMWH Times for Administration and Dosing

- Prophylaxis should be started within 24 hours after surgery end time or within 24 hours of hospital admission for general medicine clients.

- Anticoagulant prophylaxis generally will continue until discharge.

Weight

- Dosage must be calculated according to guidelines as outlined in the CPS.

- If the client has renal impairment, dosage LMWH must be adjusted according to CPS.

Orthopedic Clients

Although there are exceptions for orthopedic clients, the following is generally recommended for this high risk group:

- If anticoagulants are contraindicated, intermittent pneumatic compression devices (IPCD) may be used when appropriate, if available.

- Extension of Prophylaxis treatment recommended for outpatients is a minimum of 14 days. Clients undergoing Total Hip Replacement (THR) or Hip Fracture Surgery (HFS) from the day of surgery require up to 35 days.

- Clients undergoing Total Knee Replacement (TKR), Total Hip Replacement (THR) and Hip Fracture Surgery (HFS) will receive a LMWH. It is recommended that 12 hours preoperatively or 12 hours or more postoperatively.

- The following methods of thromboprophylaxis have proven to be effective for Total Hip or Knee Arthroplasty:
  a. A low molecular weight Heparin (LMWH); once or twice daily SC dosing.
  b. The pentasaccharide, Fondaparinux; once daily SC dosing.
  c. A direct thrombin inhibitor, Dabigatran Etexilate; once daily oral dosing.
  d. A direct Xa inhibitor, Rivaroxaban; once daily oral dosing.
  e. Warfarin in doses to prolong the INR to 2.0 - 3.0.

References:

Bonner, L., Coker, E., & Wood, L. (2008). Preventing venous thromboembolism through risk assessment approaches. British Journal of Nursing.

Geerts, W. (2011). Venous thromboembolism prevention getting started kit. Retrieved from: https://www.saferhealthcarenow.ca/EN/Interventions/vte?Documents/VTE%20Getting%20Started%20Kit.pdf.

Guyatt, G.H., Akl, E.A., Crowther, M., Cutterman, D.D., Schuunemann, H.J. (2012). Executive summary: antithrombotic therapy and prevention of thrombosis, 9th ed. American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. DOI: 10.1378/chest.1412S3.

Maynard, G., & Stein, J. (2010). Designing and implementing effective venous thromboembolism prevention protocols: lessons from collaborative efforts. Journal of Thrombosis and Thrombolysis, 29: 159-166. DOI: 10.1007/s11239-009-0405-4.

Sunnybrook Health Sciences Centre. (2010). Venous thromboembolism policy and guidelines.

APPENDIX A

LIST OF CONTRAINDICATIONS

Contraindications to TEDs include, but may not be limited to, the following:

- Severe peripheral arterial disease
- Severe peripheral neuropathy
- Severe leg deformity
- Recent skin graft
- Severe dermatitis, leg ulcers, gangrene
- Sever leg edema
- Stroke clients

Contraindication to anticoagulant prophylaxis include, but may not be limited to, the following:

- Platelets less than 50 x 10^9 /L
- Active bleeding
- Hemorrhagic stroke
- Coagulopathy: INR greater than 1.5 or PTT greater than 40 seconds
- Heparin Induced Thrombocytopenia (HIT)
- Inherited bleeding disorders (i.e. von Willebrand's Disease or hemophilia)
- Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours or expected within the next 12 hours
- Acquired bleeding disorders (acute liver failure)
- Concurrent use of anticoagulants

Appendix B

Labrador-Grenfell Health

Physician's Order Sheet
Venous Thromboembolism (VTE)
Risk Assessment & Prophylaxis
Order Sheet

Allergies: _____

PHYSICIAN MUST SELECT APPROPRIATE ORDER:
(CSCMH must be written on MAR).
Complete assessment at admission, changes in client's clinical condition, post op & upon discharge:

VTE RISK LEVEL & PROPHYLAXIS ORDERS (Not intended for Patients less than 18 years of age)	Please note: If a patient requires a different regimen, use blank "Doctor's Order Sheet"
☐ **Low Risk** Expected length of stay less than 72 hrs. minor ambulatory surgery, fully mobile, NO other risk factors or already on therapeutic anticoagulation.	☐ Early ambulation, education about VTE and its prevention.
☐ **Moderate Risk** Medical/surgical patients; ie. CHF, pneumonia, acute infection, active inflammation, less than fully ambulatory, nephrotic symptoms, those not in the low or high risk category.	Choose ONE pharmacologic option: Heparin 5000 units subcut ☐Q12H (Moderate Risk) ☐Q8H (High Risk) ☐Enoxaparin 40 mg subcut once daily ☐For patients with *CrCl less than 30ml/min.: Enoxaparin 30 mg subcut once daily ☐For weight greater than 100kgs Enoxaparin 40 mg SC **BID** And/Or ☐TEDS (May be used as an adjunct to anticoagulant or when anticoagulant contraindicated- not to be used in stroke patients)
☐ **Highest Risk** Major general surgery (intra-abdominal or pelvic surgery, surgeries greater than 45 min), ischemic stroke, history of VTE, active cancer, major trauma, acute spinal cord injury with paresis, hypercoaguable states, etc.	☐ No Prophylaxis Comment: _____
ORTHOPEDIC PATIENTS – TO BE USED BY ORTHOPEDIC SURGEONS ONLY	
☐ Dalteparin Sodium 5000 IU subcutaneously daily **OR** ☐ Rivaroxaban 10 mg po daily Anticoagulant to be continued on discharge as per recommendations.	

*CrCl calculated by Cockcroft-Gault formula not eGFR

Physician's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

Original – Chart Copy Duplicate – Pharmacy Copy
O – January 2014
LGH-240

Appendix C

Labrador-Grenfell Health

Venous Thromboembolism (VTE)
AUDIT TOOL

Site:		Month / Year	
Unit:		# of completed Prophylaxis Assessments	

Sample Size: 20 Admissions/Month

Exclusions: - *Paediatrics (18 years of age) - Obstetrics - Psychiatry/mental health – Rehabilitation - Long-term care*

Appropriate VTE Prophylaxis: Evidence based prophylaxis **AND** started within 24hrs after admission or surgery end-time - **Safer HealthCare Now**

Assessments of Prophylaxis Use (Acute Care Only)

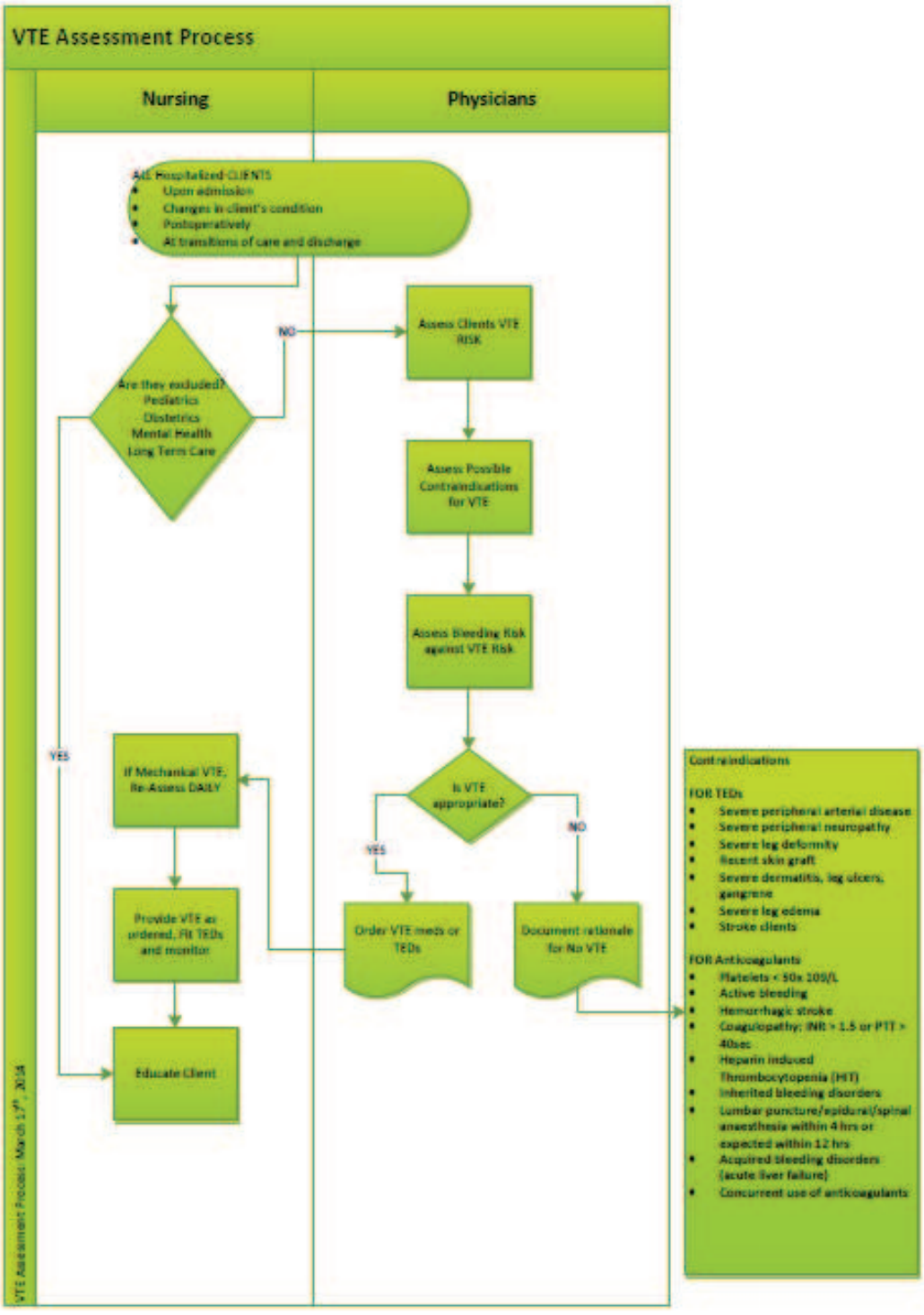
Date	Chart #	Risk Assessment Completed		Patient Prophylaxis Indicated		Appropriate Prophylaxis Given			Comments
		YES	NO	YES	NO	YES	NO	N/A	
TOTAL # of Assessments:		**TOTAL:**		**TOTAL:**		**TOTAL:**			

Reviewed By:		**Date**	

Responsible: Auditing Committee
Accountability: Site Manager
Deadline for Submission: 15th of each month for month prior
Submit to: Andre Myers, PS&Q – FAX: 456-2562

Appendix D

VTE Assessment Flowchart



Labrador-Grenfell Health

SUBJECT: **Dangerous Medication Abbreviations, Symbols, and Dose Designations: "Do Not Use"**

APPROVED BY: Chief Executive Officer _____
EFFECTIVE DATE: 2014 02
REVIEW/REVISED DATE:

Purpose:

To provide documentation guidelines to prevent and eliminate misinterpretation of medication abbreviations, symbols and dose designations.

Policy/Standard:

- Health care providers **must not use** the abbreviations, symbols and dose designations found in Appendix A, **"Do Not Use"** Abbreviations**.**
- Health care providers must not abbreviate medication names when documenting medications.
- Employees must report the identified use of abbreviations on the "Do No Use" list through the Clinical Safety Reporting System (CSRS) as per policy PSQ-5-020.

Materials Required:

- ISMP "Do Not Use" Abbreviation list, Appendix A

Related Policies:

- Occurrence Reporting and Management #PSQ-5-020

Responsibilities:

All health care providers must:

- Refer to the abbreviations listed in Appendix A when documenting medications.
- Follow-up immediately with the appropriate health care provider when they identify the use of an abbreviation on the "Do Not Use" list.

Managers/supervisors must:

- Check their department/unit's pre-printed forms and standing orders for policy compliance;

- Eliminate abbreviations and dose designations identified on the "Do not use" list from all documentation, including, but not limited to:

  i) Labeling and packaging
  ii) Preprinted orders or standing orders
  iii) Computer order entry screens.
  iv) Medication administration records.

- Educate employees about the policy during orientation and when changes and/or updates are made.
- Place the "*Do Not Use*" poster (Appendix A) in areas where medications are documented (e.g. clinical areas, pharmacy, medical transcription areas, clinics, etc.).

References:

Institute for Safe Medication Practices Canada. *Dangerous Abbreviations, Symbols, and Dose Designations*. Retrieved from www.ismp-canada.org/dangerousabbreviations.htm

Institute for Safe Medication Practices Canada. (2006). *Eliminate the Use of Dangerous Abbreviations, Symbols, and Dose Designations.* ISMP Canada Safety Bulletin (Volume 6, issue 4).

Appendix A
ISMP "Do Not Use"

Do Not Use

Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

Abbreviation	Intended Meaning	Problem	Correction
U	unit	Mistaken for "0" (zero), "4" (four), or cc.	Use "unit".
IU	international unit	Mistaken for "IV" (intravenous) or "10" (ten).	Use "unit".
Abbreviations for drug names		Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO_4 (morphine sulphate), $MgSO_4$ (magnesium sulphate) may be confused for one another.	Do not abbreviate drug names.
QD QOD	Every day Every other day	QD and QOD have been mistaken for each other, or as 'qid'. The Q has also been misinterpreted as "2" (two).	Use "daily" and "every other day".
OD	Every day	Mistaken for "right eye" (OD = oculus dexter).	Use "daily".
OS, OD, OU	Left eye, right eye, both eyes	May be confused with one another.	Use "left eye", "right eye" or "both eyes".
D/C	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications).	Use "discharge".
cc	cubic centimetre	Mistaken for "u" (units).	Use "mL" or "millilitre".
mcg	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose.	Use "mcg".
Symbol	**Intended Meaning**	**Potential Problem**	**Correction**
@	at	Mistaken for "2" (two) or "5" (five).	Use "at".
> <	Greater than Less than	Mistaken for "7"(seven) or the letter "L". Confused with each other.	Use "greater than"/"more than" or "less than"/"lower than".
Dose Designation	**Intended Meaning**	**Potential Problem**	**Correction**
Trailing zero	X.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use "**X mg**".
Lack of leading zero	.X mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use "**0.X** mg".

ISMP Canada July 2006

Adapted from ISMP's List of *Error-Prone Abbreviations, Symbols, and Dose Designations 2006*

Report actual and potential medication errors to ISMP Canada via the web at https://www.ismp-canada.org/err_report.htm or by calling 1-866-54-ISMPC. ISMP Canada guarantees confidentiality of information received and respects the reporter's wishes as to the level of detail included in publications.

ismp CANADA
Institute for Safe Medication Practices Canada
Institut pour l'utilisation sécuritaire des médicaments du Canada