FALLS PREVENTION

WOMEN'S HEALTH MISSION

Rosalie a 35 ans, a eu un accouchement vaginal il y a 2 heures. Son épidurale a été arrêtée depuis 1h30. Sa vessie est pleine et elle fait son premier lever. Elle se lève de la toilette pour se laver les mains et tombe.

Qu'est-ce que vous évaluez?

Algorithm for initial post-fall evaluation of adult patients

(This tool should not replace your clinical judgment)

(*see reverse side)

A. FIRST RESPONDER

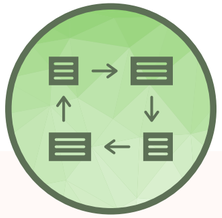
If the patient is or becomes unconscious at any point during this process, call a Code Blue (55555)

1. Stay with the patient at all times, reassure them, ask for help
2. Ensure the safety of the environment, make sure there are no immediate threats
3. Inform a nurse and await evaluation before moving the patient
4. Cover the patient with a blanket, if necessary (do not put a pillow under their head before the nurse's evaluation)

B. INITIAL EVALUATION PRIOR TO MOBILIZING THE PATIENT

Nurse:

- Evaluate the patient's level of consciousness
- Ask the patient and/or witnesses how the fall occurred
- Ask the patient about their symptoms before the fall
- Evaluate the possibility or presence of head and/or neck injury



Rosalie s'est cogné la tête sur le plancher.

Qu'est-ce que vous évaluez?

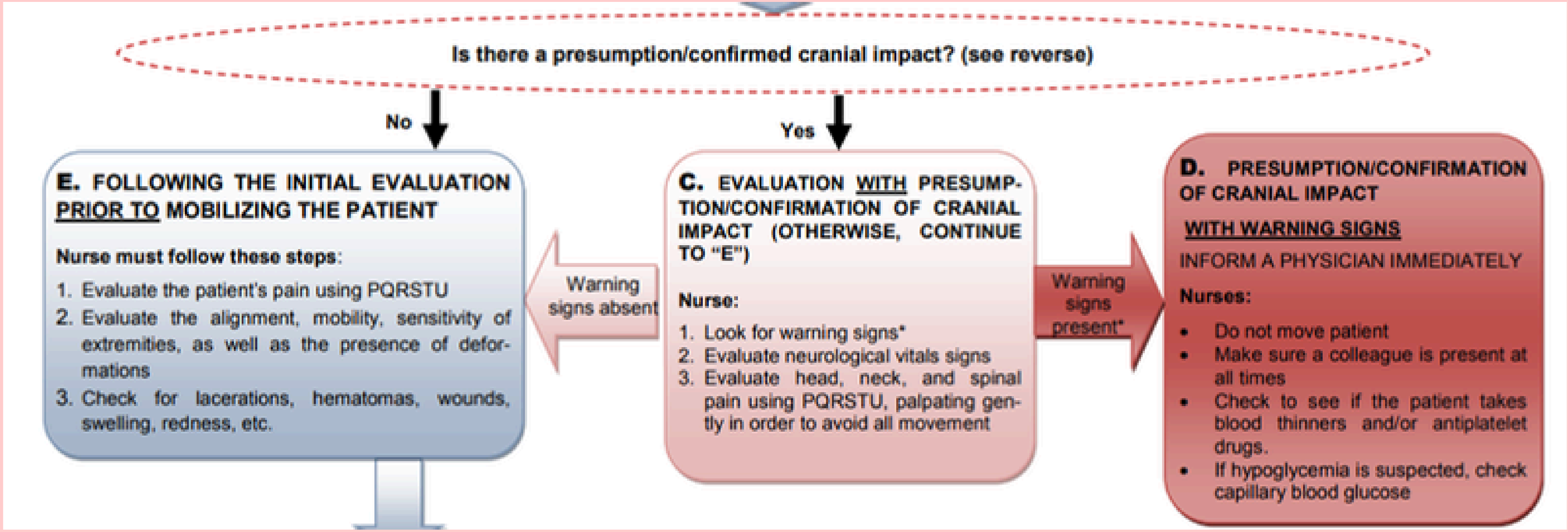
You must assess if there was
CRANIAL IMPACT
during the fall

Possible signs of head injury

- No witness to the fall
- Patient cannot confirm the absence of head impact
- Visible head injury*
- Change in level of consciousness*
- Cranial pain/ headache*
- Nausea and/or vomiting*
- Blood or clear fluid from either ears, nose, or mouth*

Rosalie est consciente, mais a mal à la tête, là où elle s'est cognée. Elle n'a pas de nausées ou vomissements.

Qu'est-ce que vous évaluez?


Is there a presumption/confirmed cranial impact? (see reverse)
No
Yes
E. FOLLOWING THE INITIAL EVALUATION PRIOR TO MOBILIZING THE PATIENT
Nurse must follow these steps:
1. Evaluate the patient's pain using PQRSTU
2. Evaluate the alignment, mobility, sensitivity of extremities, as well as the presence of deformations
3. Check for lacerations, hematomas, wounds, swelling, redness, etc.
Warning signs absent
C. EVALUATION WITH PRESUMPTION/CONFIRMATION OF CRANIAL IMPACT (OTHERWISE, CONTINUE TO "E")
Nurse:
1. Look for warning signs*
2. Evaluate neurological vitals signs
3. Evaluate head, neck, and spinal pain using PQRSTU, palpating gently in order to avoid all movement
Warning signs present*
D. PRESUMPTION/CONFIRMATION OF CRANIAL IMPACT
WITH WARNING SIGNS
INFORM A PHYSICIAN IMMEDIATELY
Nurses:
• Do not move patient
• Make sure a colleague is present at all times
• Check to see if the patient takes blood thinners and/or antiplatelet drugs.
• If hypoglycemia is suspected, check capillary blood glucose

Is there a presumption/confirmed fracture? (see reverse)

No

H. POST-FALL MOBILIZATION OF THE PATIENT

The nurse, nursing assistant, and/or patient attendant:

- Mobilize the patient in order to place them in a bed according to the required post-fall procedures
- When the patient can move themselves:
  - → Use a chair to help them progressively get up
- When the patient cannot move themselves:
  - → Mobilize them with a lift, transfer board, or sling

Never mobilize a patient by holding them under the arms

Yes

F. ET G. TRANSFERRING PATIENT TO BED/STRETCHER, WITH POSSIBLE/CONFIRMED FRACTURE

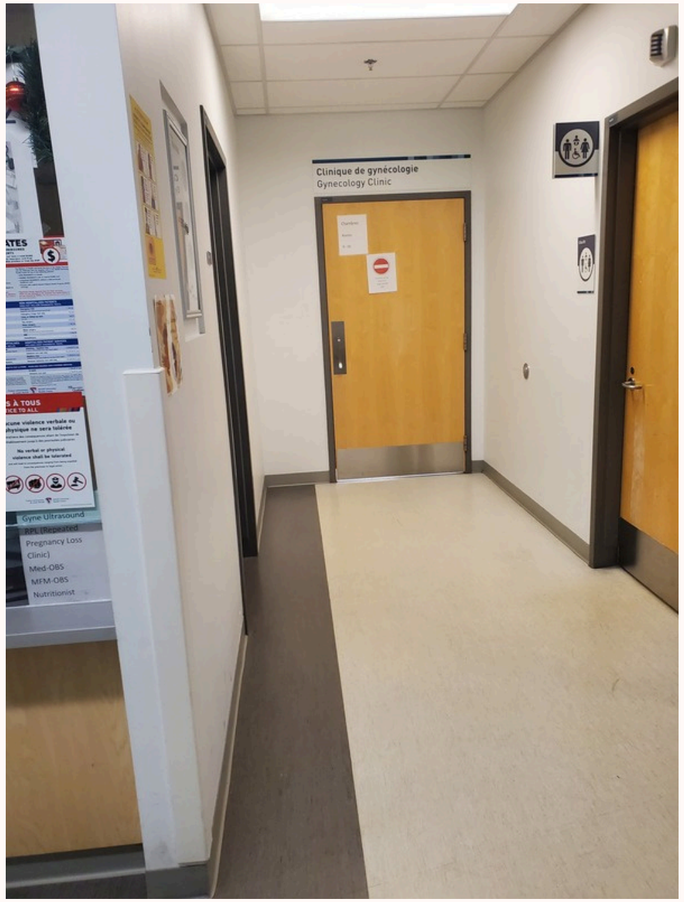
INFORM PHYSICIAN IMMEDIATELY

Nurse, nursing assistant, and/or patient attendant:

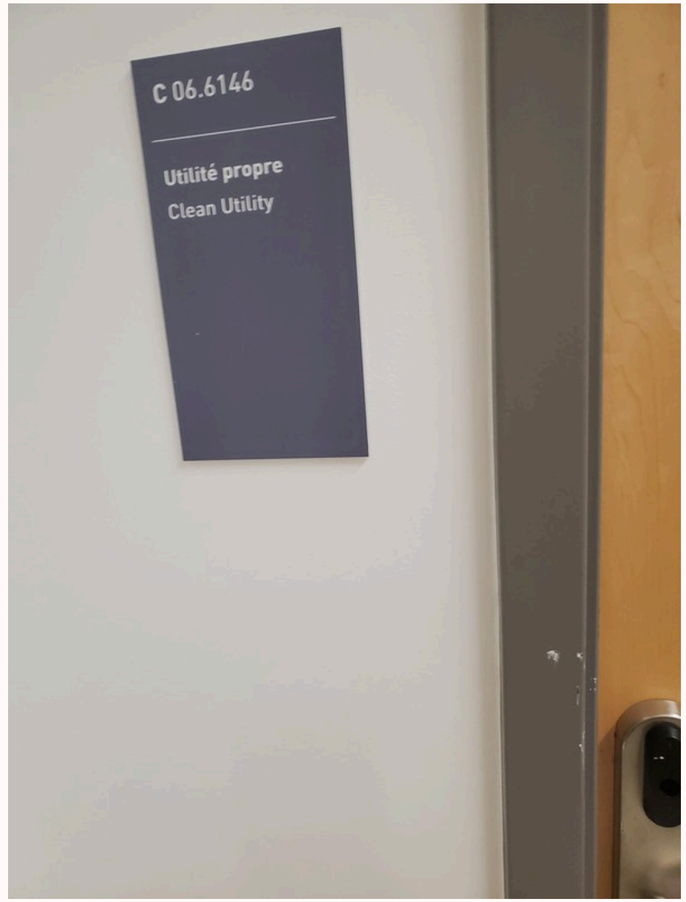
- Manually immobilize the potentially fractured extremities
- Transfer the patient to a bed or stretcher using a mobilization/transfer board or sling
  - → It is not possible to immobilize arms, forearms, ribs, or the neck when using the lift; however, it can be used in cases of a fractured wrist or hand (see reverse)
- In the event of a possible fracture to the hip (see reverse):
  - → Place the patient in lateral decubitus position with the affected side down

Never mobilize a patient by holding them under the arms

Where is the patient lift????



Gynecology clinic



First door to your left

De quel suivi Rosalie a-t-elle besoin et pendant combien de temps?

J. 48 HOURS POST-FALL EVALUATION WITHOUT CRANIAL IMPACT

Nurse or nursing assistant:

1. Check all vital signs at least once every eight-hour shift
2. Check for orthostatic hypotension as soon as the patient's condition permits

Nurse:

3. Check the following elements once every eight-hour shift:
   - Level of consciousness
   - Pain, using PQRSTU (use an approved tool such as the PAINAD scale, as needed)
   - Mobility of the extremities
   - The presence or absence of a hematoma
   - The presence or absence of a deformation
   - The presence or absence of headache, using the PQRSTU where applicable
   - The presence or absence of nausea and/or vomiting
4. Inform physician of all changes in the patient's condition
5. Document in chart complete evaluation

K. 48 HOUR POST-FALL EVALUATION WITH PRESUMPTION/CONFIRMATION OF CRANIAL IMPACT

Nurse or nursing assistant must:

1. Check all vital signs at least once every eight-hour shift.
2. Check neurological signs in the following sequence:
   - Every 15 minutes the first hour
   - One hour later
   - Every two hours for four hours
   - Every four hours for 24 hours
   - Once 24 hours later
3. Check orthostatic hypotension as soon as the patient's condition permits

Nurse:

4. Check the following elements once every eight-hour shift:
   - Level of consciousness
   - Pain, using PQRSTU (use an approved tool such as the PAINAD scale, as needed)
   - Extremities mobility
   - The presence or absence of a hematoma
   - The presence or absence of a deformation
   - The presence or absence of headache, using the PQRSTU where applicable
   - The presence or absence of nausea and/or vomiting
5. Inform physician of all changes in the patient's condition
6. Document in chart complete evaluation

Département des soins infirmiers
FORMULAIRE D'ÉVALUATION POST-CHUTE (ADULTE)
Department of Nursing
POST-FALL EVALUATION FORM (ADULT)

►ÉVALUATION INITIALE POST-CHUTE / INITIAL POST-FALL EVALUATION◄

Lieu / Location : **Date** (YYAAMMDD) ____/___/___ **Heure**/Time ___ :___

Explication du patient (et/ou témoin) de la chute/ Explanation from patient (and/or witness) about the fall:

Symptômes ressentis par le patient avant la chute/ Symptoms felt by patient prior to the fall:

Patient sans déficit cognitif OU témoin est capable de confirmer que le patient ne s'est pas cogné la tête/ Patient without cognitive impairment OR witness can confirm the patient did not hit their head	☐ **Oui**/Yes ☐ **Non**/No→ **Si non, présumer impact crânien et compléter les SECTIONS 1 ET 2/** If no, suspect cranial impact and complete SECTIONS 1 AND 2
Hypoglycémie soupçonnée/ Hypoglycemia suspected	☐ **Oui**/Yes → **Vérifier et documenter la glycémie/** Check and document blood glucose ☐ **Non**/No
Prise d'anticoagulants ou antiplaquettaires Taking anticoagulants or antiplatelet drugs	☐ **Oui**/Yes→ **Risque de saignement accru/** Consider increased risk of bleeding ☐ **Non**/No

♦*Si résultats anormaux ou pour toute évaluation complémentaire → inscrire une note DARP au dossier* ♦*If abnormal findings or for further evaluation → write DARP note in patient's chart*	**Initiales**/Initials
NEUROLOGIQUE **1. Calme 2. Alerte 3. Orienté aux personnes, lieu, temps 4. Pupilles symétriques ; réaction bilatérale égale et rapide 5. Force motrice égale et normale dans les membres supérieurs et inférieurs 6. Obéit aux consignes 7. CAM négatif** NEUROLOGICAL 1. Calm 2. Alert 3. Oriented to person, place, time, 4. Pupils symmetrical; react equally and briskly 5. Motor strength equal and normal in upper and lower limbs 6. Follows commands 7. CAM negative	
COLONNE CERVICALE + EXTREMITÉS **1. Absence de douleur 2. Symétrie des membres inférieurs et supérieurs 3. Membres alignés/absence de déformation 4. Absence de paresthésie** CERVICAL SPINE + EXTREMITIES 1. No pain 2. Lower and upper limbs symmetrical 3. Alignment of extremities/no deformities 4. No paresthesia	
VÉRIFICATION DES SIGNAUX D'ALERTE POST CHUTE **1. Aucun changement d'état de conscience 2. Absence de douleur crânienne ou céphalée 3. Absence de nausées et vomissements 4. Absence de sang ou liquide clair des oreilles, nez ou bouche** POST FALL WARNING SIGNS VERIFICATION 1. No change in level of consciousness 2. No cranial pain or headache 3. No nausea and vomiting 4. No blood or clear fluid from ears, nose or mouth	
INTÉGRITÉ DE LA PEAU **1. Absence d'hématome 2. Absence de plaie 3. Absence d'œdème**	

♦*Si non complété, justifier au dossier du patient*♦ ♦*If not completed, justify in progress note*♦	**Initiales**/ Initials
☐ **Vérifier et inscrire les signes vitaux x1** Check and document vital signs x1	
☐ **Médecin avisé (STAT si fracture ou impact crânien avec signaux d'alerte soupçonné)** Physician notified (STAT if suspected fracture or cranial impact with warning signs)	
☐ **L'assistante infirmière-chef ou en charge avisée** Assistant nurse manager or the nurse in charge notified	
☐ **Divulgation : famille avisée *** Disclosure: family notified *	
☐ **Rapport d'incident-accident (AH-223) complété** Incident report (AH-223) completed	
☐ **Nouveau MORSE et TACC complétés** New MORSE and CATT completed	
☐ **PTI (Plan Thérapeutique Infirmier) mis à jour** PTI updated	

►ACTIONS REQUISES / REQUIRED ACTIONS◄

►**TOUTE chute/** All falls	☐ **Compléter SECTION 1 du formulaire 48h post-chute/** Complete SECTION 1 of 48h post-fall form ☐ **Mobiliser selon l'algorithme/** Mobilize according to algorithm ☐ **Débreffage post-chute (voir guide de débreffage post-chute)/** Hold post-fall debriefing (refer to Post-Fall Debriefing Guide)
►**Présomption d'impact crânien/** Cranial impact suspected	☐ **Compléter SECTION 2 du formulaire 48h post-chute/** Complete SECTION 2 48h post-fall form
►**Présence de signaux d'alerte post-chute/** Post-fall warning signs present	☐ **Aviser médecin STAT** / Notify physician STAT

► * DIRECTIVES RELATIVES À LA DIVULGATION/ * DISCLOSURE GUIDELINES ◄

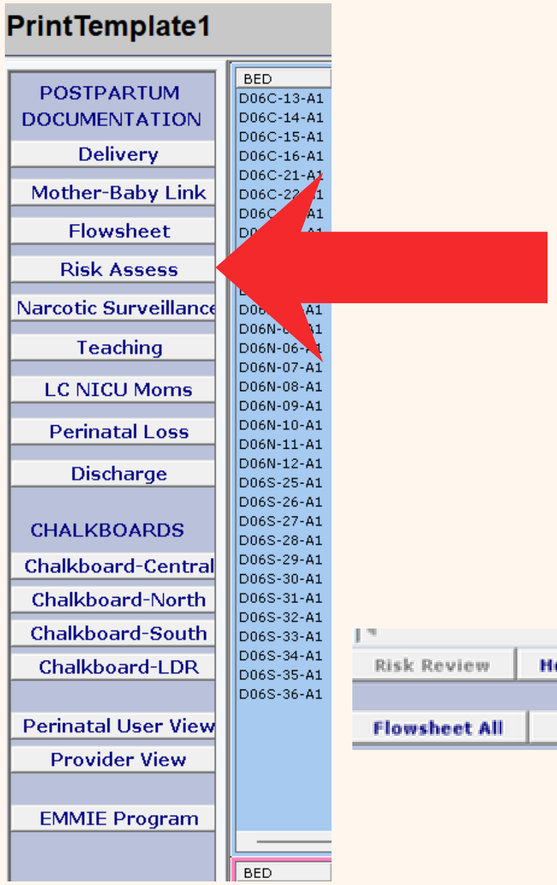
Toute chute de sévérité D à I (voir formulaire AH-223) doit être divulguée.
La divulgation doit se faire aux personnes suivantes :
Si le patient est apte à consentir :
- *Divulguer au patient lui-même ;*
- *Si le patient consent : divulguer au partenaire/conjoint de fait/conjoint, à un parent proche, ou à une personne qui fait preuve de sollicitude ou qui a l'intérêt supérieur du patient à l'esprit.*

All falls of severity D through I (see AH-223 form) must be disclosed.
Disclosure must be made to the following individuals:
***If apt to consent**:*
- *Disclose to patient himself/herself;*
- *If patient consents: disclose to partner/common-law/spouse, to a close parent, or to a person who demonstrates care for or has the best interest of the patient in mind.*

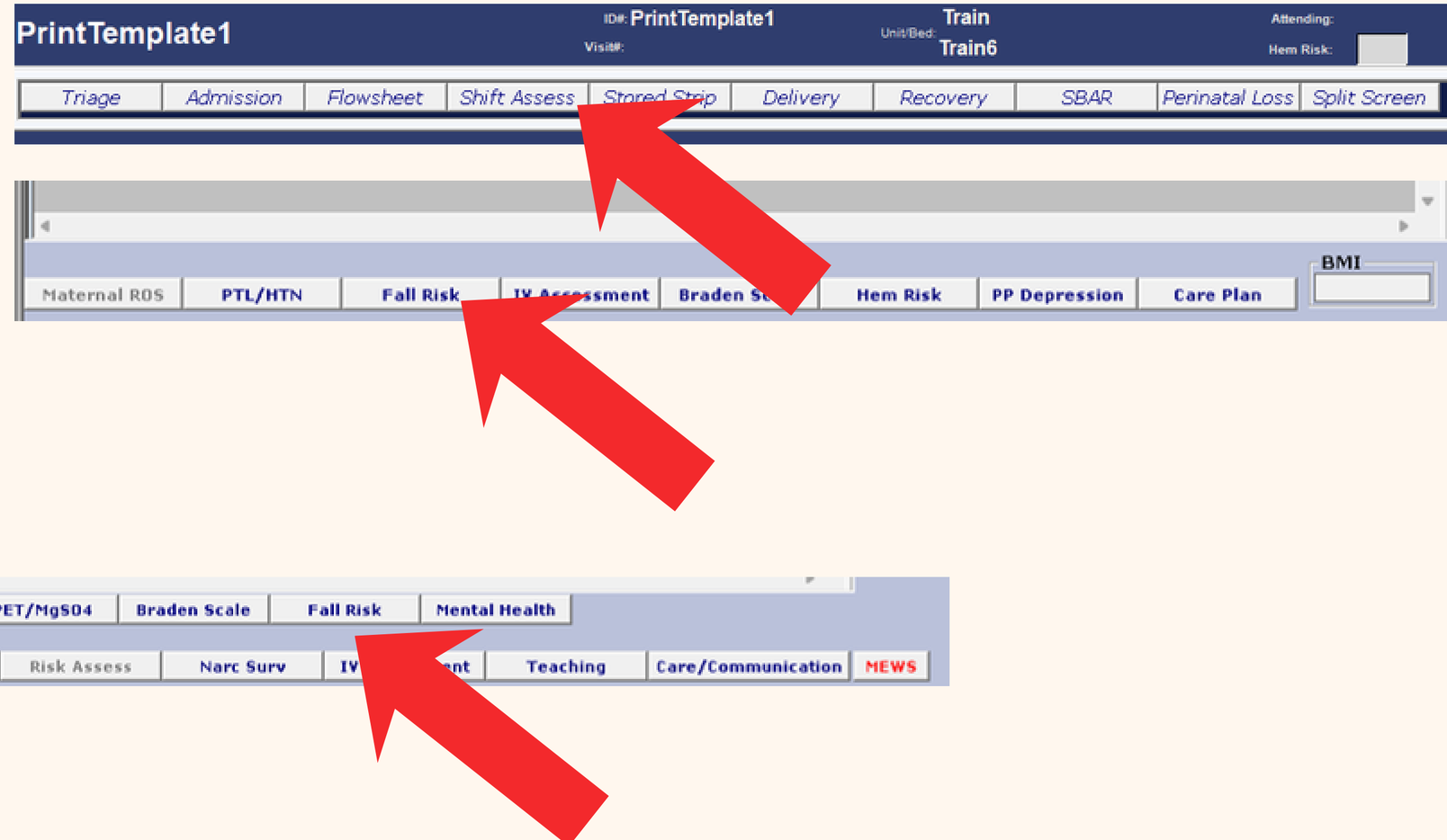
***If inapt to consent**:*

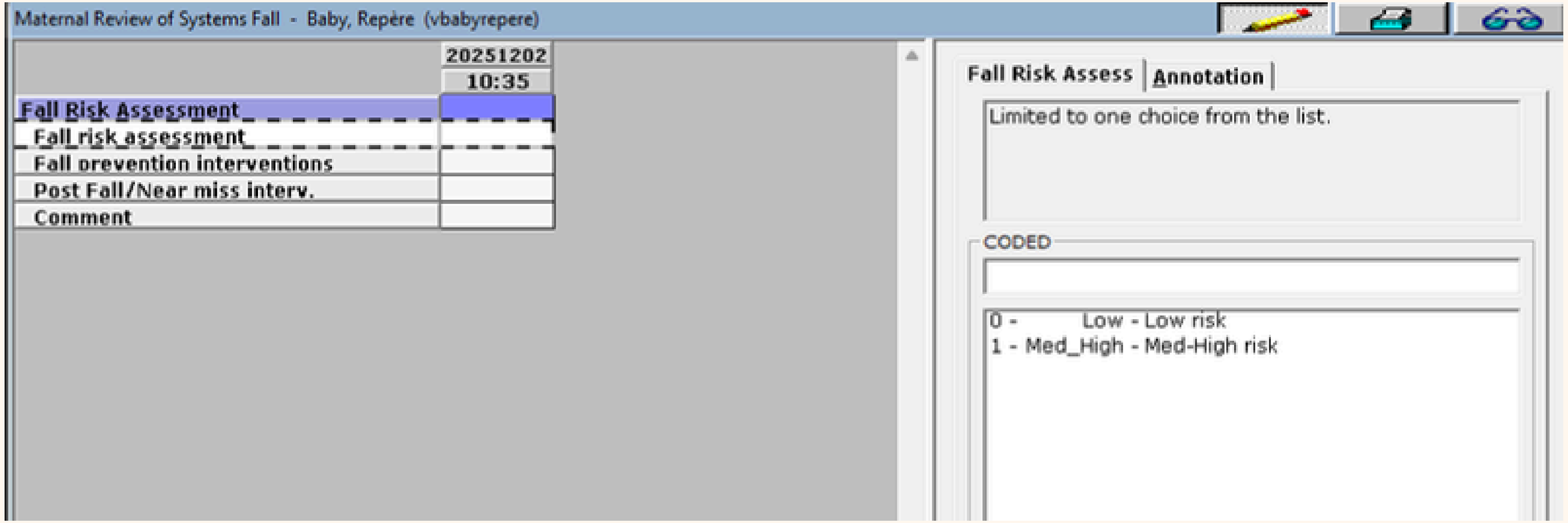
DOCUMENTATION CENTRICITY

Postpartum view



Birthing Centre / Antepartum view





Low Risk: Healthy patient, without comorbidities and without risk factors

Medium-High risk: ... all the rest!

An Assessment is needed:

- **On Admission**
- **When status changes**
- **When transferred**

Please complete an Incident/Accident report for:

- an ***actual*** fall
- a ***near*** fall

INTRINSIC RISK FACTORS

Prior history

- Fall during pregnancy
- Comorbidities (diabetes, MSK or neuro disorders)
- Visual Impairment

Cardiovascular considerations

- Orthostatic hypotension
- Dizziness
- Anemia
- Pre-eclampsia

Medication Use

- Narcotic analgesics
- Tocolytics, antihypertensives, sedatives
- Magnesium sulfate within 24h

Hemorrhage

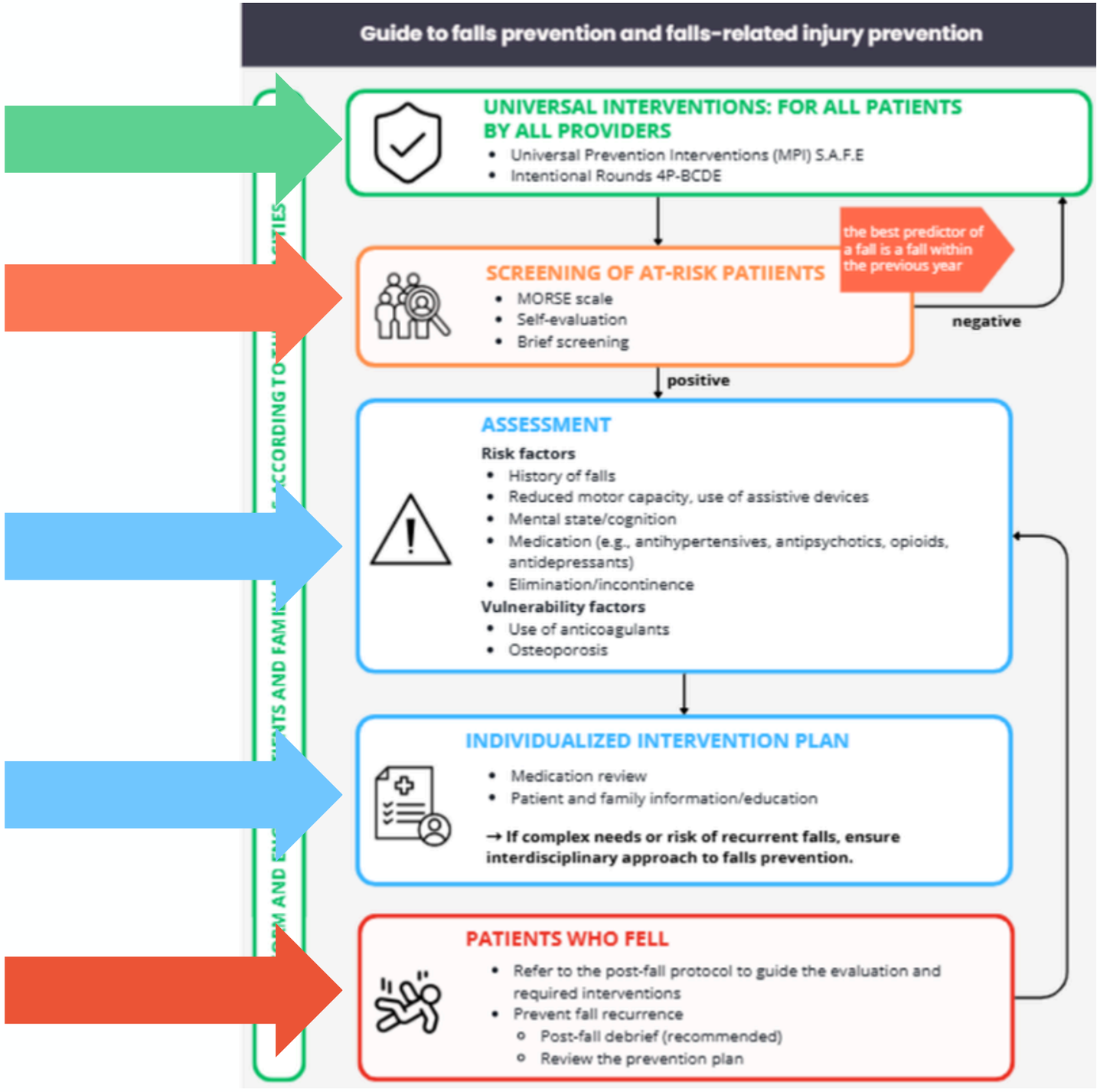
- Antepartum bleeding in current hospitalization
- EBL 1000-1500 ml (mod risk)
- EBL >1500 ml (high risk)

Neurological Function

- Sensory deficits during neuraxial anesthesia
- Sensory deficits within 3h after neuraxial anesthesia

Motor Activity

- History of bedrest
- Motor deficits post neuraxial anesthesia



FALL AND INJURY PREVENTION PRINCIPLES

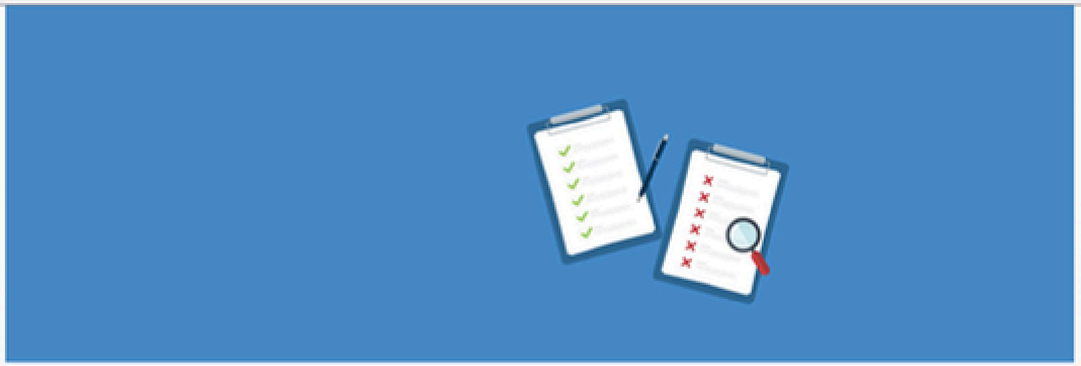
FALLS PREVENTION

S.A.F.E.

- S. Safety of the environment
- A. Mobility assistance
- F. Reduced risk factors
- E. Engage the user and their loved ones

MyMUHC

News | Employee Toolbox | Manager Toolbox | Team Resources | Policy and Procedures



/ Team Resources / Nursing / Clinical Practice / Clinical Adult Policies

☆ Favorite

Clinical Policies and Procedures – Adult

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

F

Falls

- Prevention of Falls and Fall Injuries in the Adult Population - NEW 30 oct 2025
- Universal Interventions to Prevent Falls Poster
- Environmental Scan for Room
- Stratégies de mini-implantation avec intégration au Plan thérapeutique infirmier (PTI) - Chutes
- Environmental/Equipment Rounds Worksheet for Falls Prevention

Post Fall

- Post-Fall evaluation and clinical monitoring of adult patients: Interprofessional Procedure (MSI Expertise Santé)

NEWBORN FALLS

TRANSFERRING A NEWBORN

Skin-to-skin *with their parent on a wheelchair or stretcher, always accompanied by a HCP or transport attendant*

If not possible, use a cot *or incubator with side rails up*

On PP, newborns must be transported outside the room in their bassinettes/cots, car seat, or stroller

+

Never carry a newborn in ones' arms

PREVENTING INFANT FALLS IN THE OR

- One hand on baby at all times
- Pat baby to remove fluids
- Dry hands with same towel
- Hold and lift baby with 2 hands at all times
- Loudly state ‘ALL CLEAR’
- Place baby onto a stable surface
- HCP takes baby from surface while another person opens door (transfer to resus room)

Post-fall interventions for neonate

- Ensure newborn safety
- Provide immediate supportive care as needed
- Call pediatric team
- Complete incident report
- Document in centricity

RECAP FALLS PREVENTION

PREVENTING A FALL IS BETTER THAN TREATING ONE!

Control external factors

Monitor internal factors

MATERNAL FALLS PREVENTION

Rapid assessment and Document

Repeat assessment as situation evolves

INFANT FALLS PREVENTION

Assess parents' capacity

Teaching is key

IF FALL OCCURS

Make required assessments

Monitor accordingly

Fill incident report

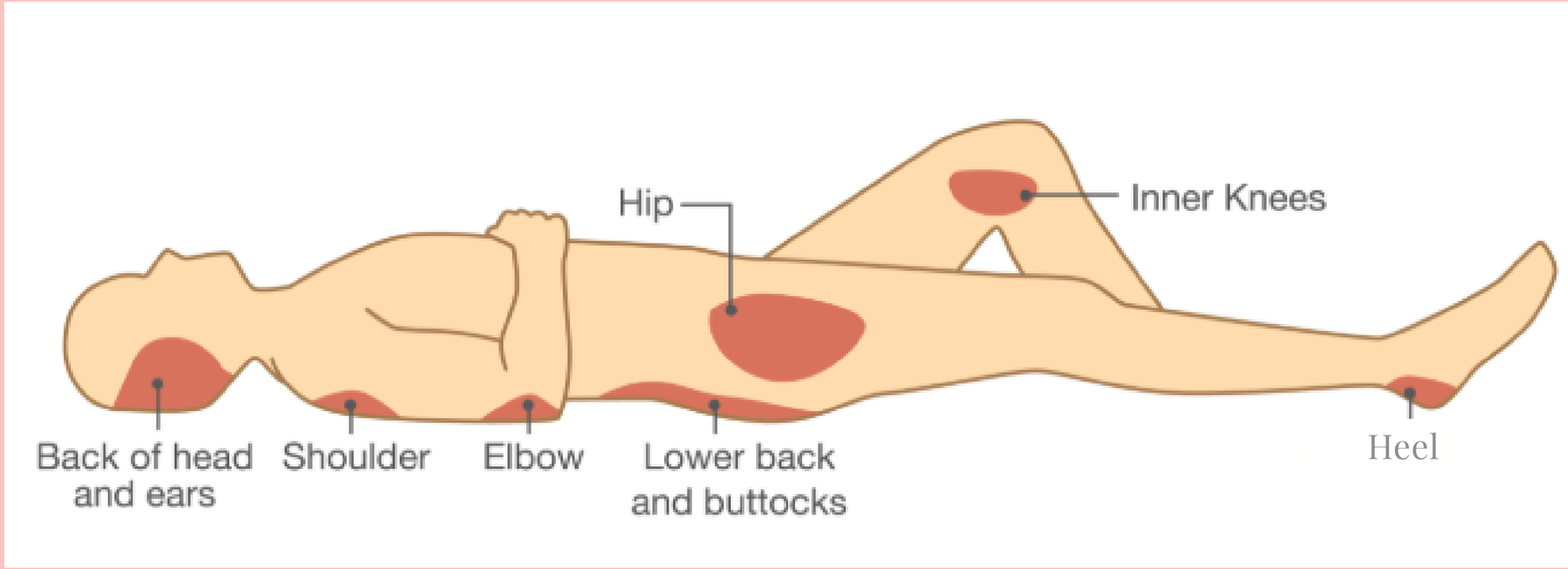
DOCUMENT in Centricity

What about the partner?????

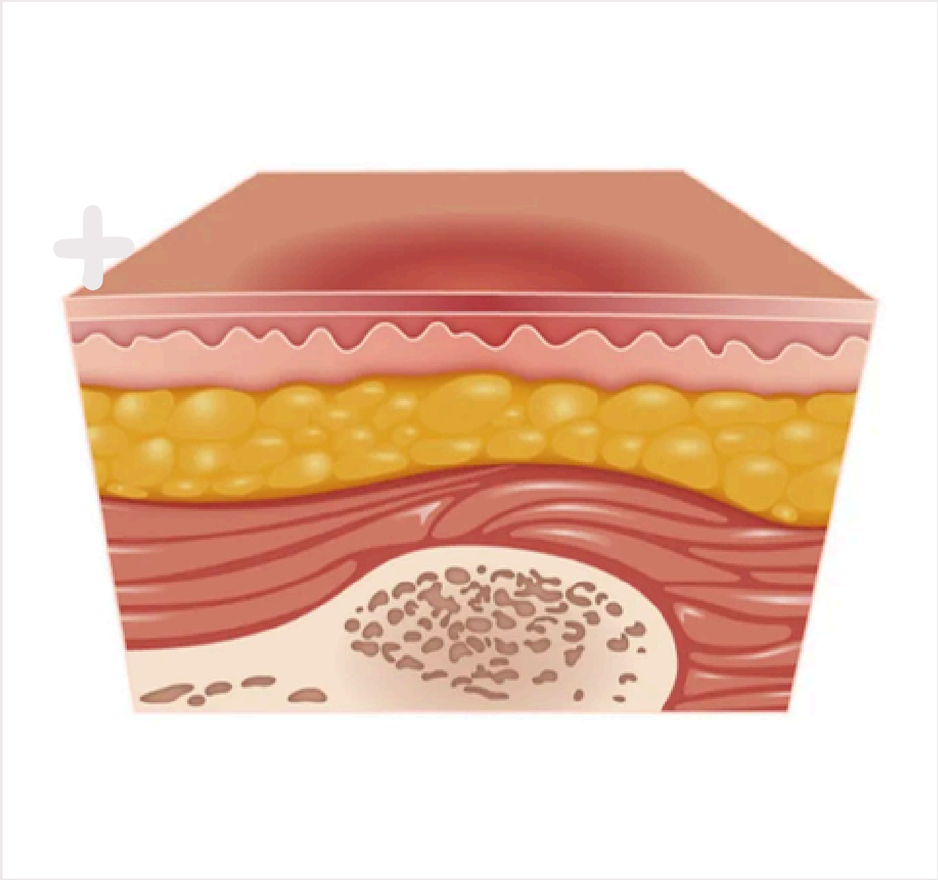
CHANGE OF TOPIC!

RISK ASSESSMENT AND PREVENTION OF PRESSURE INJURIES

High risk areas for pressure ulcers



EARLY SIGNS OF PRESSURE INJURY



Spot of skin becoming discoloured (may appear red, purple or blue).

A patch of skin that feels warm, spongy or hard, painful or itchy.

A spot that does not blanch when touched (for people with dark skin, the pigmentation will be different from the rest of the skin).

What risk factors should we consider for our patient population?

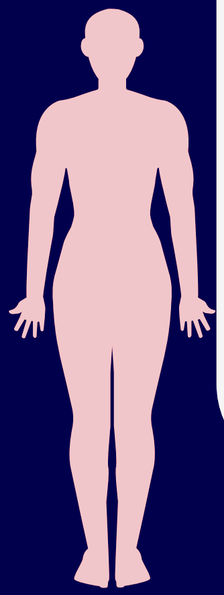
- Increased blood volume
- Nutritional deficiencies
- Increased moisture
- Decreased activity/mobility
- Increased weight
- Comorbidities like HTN, PET and GDM
- Hormonal changes
- Analgesics/substance use

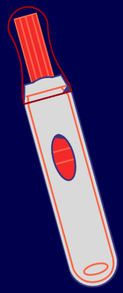
DOCUMENTATION FOR ANTEPARTUM PATIENTS

Braden scale:

- *on admission*
- *if status changes*
- *q week if score >15*
- *twice a week if <14.*

Skin assessment should be performed daily

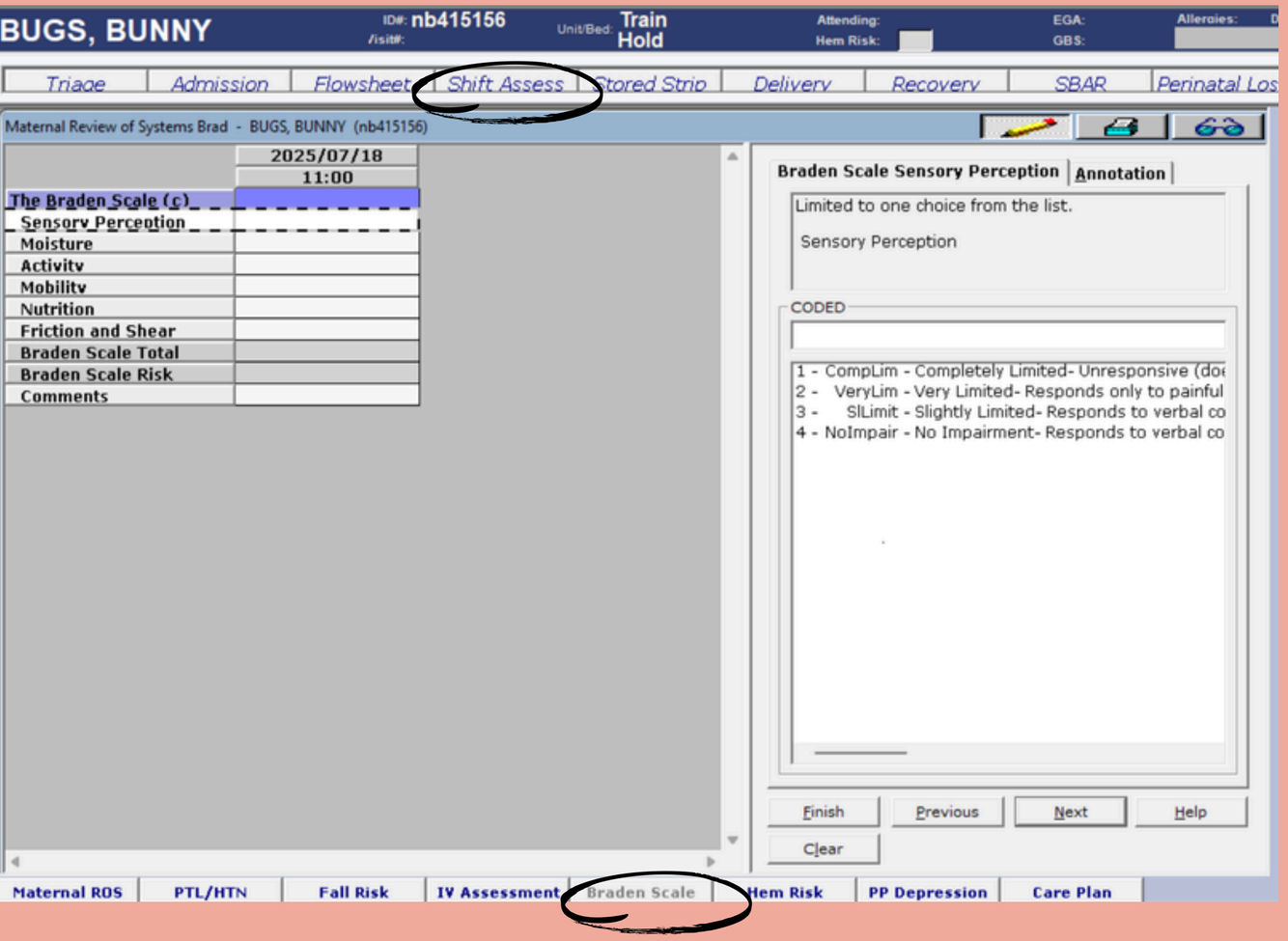




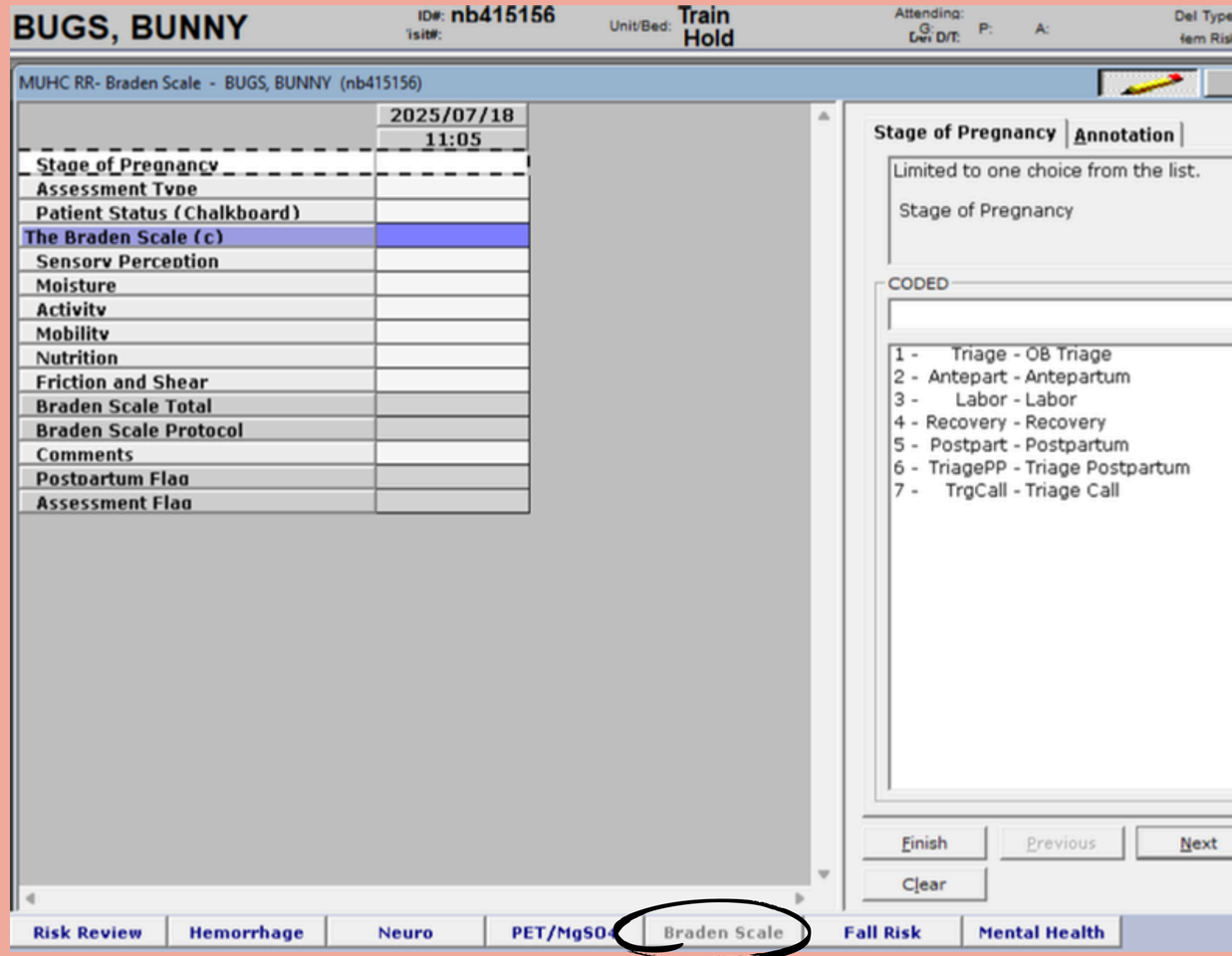
*Use clinical judgment for all other patients (i.e. PP patient with extended LOS, labouring pt with epidural for an extended period of time)

Where to document in centricity

Under shift assessment in perinatal view



Under PP documentaiton- risk assessment in PP/Nsy view



PLUTUS EDUCATION

Braden Risk Assessment Scale

Braden Risk Assessment Scale
(abridged version)

Sensory Perception	1. Completely limited	2. Very limited	3. Slightly limited	4. No impairment
Moisture	1. Constantly moist	2. Very moist	3. Occasionally moist	4. No impairment
Activity	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks frequently
Mobility	1. Completely immobile	2. Very limited	3. Slightly limited	4. No limitation
Nutrition	1. Very poor	2. Probably inadequate	3. Adequate	4. Excellent
Friction and Shear	1. Problem	2. Potential problem	3. No apparent problem	

- Mild risk: 15-18
- Moderate risk: 13-14
- High risk: 10-12
- Severe risk: less than 9

RISK REDUCTION

Encourage hourly position changes (pt/family teaching)

Encourage PO hydration

Ensure pt is not lying on any medical equipment or hard surface

Assess need for specialized mattress

Assess need for nutrition/OT/PT consults

Encourage pt to maintain dry skin

Centre universitaire de santé McGill | McGill University Health Centre

Algorithm for the Prevention and Management of Pressure Injuries
November 2022

Intact skin (no pressure injury)

ASSESSMENT
Braden Scale, Pain Scale

PRESSURE INJURIES
Stage 1,2,3,4, Deep Tissue Pressure Injury (DTPI), Unstageable

ADDRESS PATIENT CENTERED CONCERNS
Regarding Treatment Plan
(e.g. Pain, Quality of Life, Social Activity, Cost, etc.)

PROVIDE LOCAL WOUND CARE

STAGE 1
- Mepilex border sacrum/heel
- Thin hydrocolloid
- Barrier cream – Perianal skin
- No rince cleanser

STAGE 2

Non-infected

NIL to S/A exudate
- Thin hydrocolloid (nil)
- Hydrocolloid (S/A)
- Hydrophilic cream dressing (Triad)

M/A to L/A exudate
- Hydrophilic cream dressing (Triad)
- Hypertonic dressing
- Calcium alginate
- Hydrofiber foam
- Hydrofiber
- Mepilex border sacrum/heel

Challenging Location
- Hydrophilic cream dressing (Triad)

Infected

Consult Wound care/ET Nurse/Infectious Disease MD

Non-Occlusive dressing
- Hypertonic dressing
- Calcium alginate
- Hydrofiber foam
- Hydrofiber
- Mepilex border sacrum/heel

Short term topical antimicrobial
- Silver dressing
- Cadexomer Iodine
- PHMB dressing

STAGE 3/4/DTPI/UNSTAGEABLE
- Consult Wound care/ET nurse
- Consult wound care algorithm while waiting for woundcare team

PREVENTION

TREAT THE CAUSE

Sensory Perception
- Assess for neuropathy
- T & P Q 2hrs

Moisture
- Keep skin clean and hydrated
- Prevent excess moisture, use barrier creams (see stage 1)
- Consult Therapeutic Surface Decision Tree

Activity
- Consult PT/OT
- Maintain ROM
- Gradual Ambulation

Mobility
- Consult PT/OT : transfer seating/footwear assessment
- Mepilex sacrum/heel
- Consult Therapeutic Surface Decision Tree

Nutrition
- Promote adequate nutrition
- Consult nutritionist/dietitian

Friction and Shear
- Offload heels (waffles boots, mepilex border heel dressing
- HOBs: 30 degree
- Caution with transfers
- Mepilex border sacrum
- Consult Therapeutic Surface Decision Tree

BPG: Risk Assessment and Prevention of Pressure injuries/BRADEN SCALE; Interventions by Level of Risks

MILD-MODERATE RISK (+17)
- Turning schedule with 30 degree rule
- Maximal remobilization
- Protect heels (i.e. Keep heel from resting on any surface)
- Manage moisture, nutrition, friction and shear
- ***If other major risk factors are present, advance to next level of risk

HIGH RISK (10-16)
- All previous (Mild-moderate risk)
- Consult Therapeutic Surface Decision Tree
- Increase frequency of turning and facilitate 30 degree lateral turns with foam wedges
- Supplemental turning with small shift changes

VERY HIGH RISK (≤ 9)
- All previous (Mild-High risk) AND OR stage 3,4,DTPI, unstageable (excluding heels)
- Consult Therapeutic Surface Decision Tree
- Air overlay (waffle) should be applied while waiting for therapeutic surface

IMPORTANT: Use of a therapeutic surface does not substitute for an appropriate turning schedule
If a patient scores 3 or less in a subscale, apply the preventive interventions for that subscale as outlined above.

Developed by the MUHC Wound and Ostomy Care team

When a pressure injury is identified, we need to fill out an **Incident/Accident report**!

RECAP SKIN INTEGRITY ASSESSMENT

PREVENTING SKIN BREAKDOWN IS BETTER THAN TREATING IT!

HIGH RISK PATIENTS
On bedrest
Prolonged stay

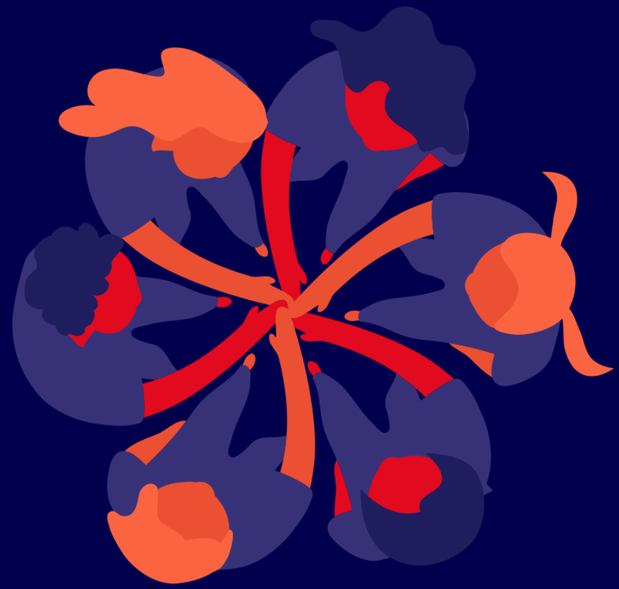
ASSESSMENT EVERY DAY!

BRADEN SCALE:
On admission then q week or 2x/week

MOBILIZE OFTEN
In or out of bed

DOCUMENT in Centricity

THANK YOU



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