1. Policy: FALL

On admission, all traumatic brain injury and spinal cord injury patients are considered high risk for falls secondary to their diagnosis and injury level. Risk factors exhibited by patients may include: cognitive impairment including confusion/disorientation, impulsivity, and poor judgment, poor mobility/generalized weakness, medications, dizziness/vertigo, depression, and altered elimination. The Interdisciplinary Clinical Team will use their initial assessment to determine how to provide the safest environment for each patient. Safety interventions will be initiated as needed for each patient. Continued assessment and monitoring will occur until the patient is no longer considered at increased risk for falls.

Safety education is provided to patients, family and staff.

Purpose:

Staff will incorporate appropriate safety interventions, in the least restrictive environment, to help reduce the incidence of falls, pressure ulcers, DVT's.

2. Definition: FALL:

Any unplanned descent to the floor or next lower surface.

Assisted Fall: when a staff member minimizes the impact of the fall by easing the patient's descent, or in some manner attempts to break the patient's fall.

Near miss - a patient is in a situation at risk for fall, but fall did not occur, such as a bed rail left down, patient without safety belt, anti-tipper bars left up, safe keeper bed left unlocked. Patient transferring or ambulating without required assistance.

3. Responsibilities:

Nursing Staff and Doctors, Physiotherapist.

5.PROCEDURE:

I.Fall Prevention Assessment

A. Nursing, Physical Therapy, Occupational Therapy, complete their portion of the Interdisciplinary assessment on admission.

1. Nursing assessment is completed within 24 hours of admission and then every shift.
2. Physical Therapy, Occupational Therapy, Interdisciplinary assessment is completed within 72 hours of admission.

B. Physical Therapy assesses each patient for mobility/safety and completes the individualized transfer/mobility sheet within 72 hours of admission and updates weekly, or as needed. This transfer sheet is displayed in a prominent position in the patient's room and bathroom.

C. Brain injured patients are at risk for falls based on assessment of motor impairment, sensory impairment, cognitive status, history of falls, and/or use of ambulatory devices. Nursing assesses the need for safety devices/restraints per policy.

D. All newly admitted patients utilize safety belts unless deemed safe for ambulation by initial physical therapy mobility/safety assessment. Staff or families should not remove the safety belt unless approved by the team and documented on the restraint form.

E. All newly admitted patients using wheelchairs must have their anti-tip bars in the down position until cleared by their physical therapist.

F. Patient ambulation is not permitted until cleared by the physical therapist.

G. Ongoing assessments by nursing and therapies document changes in patient condition that could increase Modified Morse fall risk. Physical therapy updates the transfer status as needed.

II. Fall risk interventions include:

A. Educate staff, patient, and family to increase awareness of patients at risk for falling during hospitalization and provide possible strategies to minimize the risks.

B. Nurse and techs will include specific information regarding patient safety for mobility and transfers in shift to shift handoff communication.

C. For all patients, staff will be trained to prepare the environment prior to a transfer or mobility activity, and specifically, prior to removing a safety device/restraint from a wheelchair or a bed. Thus, staff will not need to take their hands or eyes from the patient to locate a needed item.

D. If a restraint is ordered, nursing staff will have 2 people present for transfers.

E. On any shift, if the caregiver finds the patient needs more assistance than the transfer sheet indicates; the caregiver has the authority to alter the type of transfer to maintain safety and communicate this information on shift to shift report, document in Case sheet under transfers, and communicate with the therapists.

F. Reduce environmental hazards.

1. Beds shall be left in the low position, with side rails ups, call light and bedside table within reach. After the bed is raised for nursing care or change of linens, it is returned to the low position/side rails up, unless patient status indicates otherwise.

G. Implement patient targeted interventions to reduce risk.

III. Immediate Post-Fall Actions

A. After a fall, the RN should assess the patient.

B. If the fall was un witnessed or patient hit their head, a scoop board and collar should be used to transfer the patient to a stretcher.

C. A call to the Consultant should always be made, regardless of whether the Nurse feels as though an consultant assessment is warranted.

D. Documentation related to assessment and monitoring that occurs after the fall should be completed in case sheet by the Nurse.

IV. Quality Improvement

A. Any fall within the hospital is reported on the event report form per policy/procedure Each fall incident is followed up with an action plan determined by the details of the fall.

B. Falls and near falls are monitored on a continuous basis and tracked monthly as number of falls per thousand patient days. Inpatient fall data is submitted to quality dept.

C. All falls and near miss falls are reviewed monthly by the Patient safety committee

Committee to monitor fall rate and determine any trends requiring an action plan.

PRESUURE ULCERS

POLICY:

• Nursing, in collaboration with the health care team, will assess and manage skin integrity for all patients throughout the hospital stay. Patients and families are to be encouraged by care providers to participate to the extent possible in the care and prevention of skin breakdown.

• Risk for pressure ulcer development will be evaluated upon admission to a nursing unit and on a routine basis for all adult and pediatric patients using the Braden Scale (adult) or the Braden Q (pediatric) Scales. Risk assessments (Braden scores) will be done more often when the patient condition warrants more frequent assessment.

• Skin inspections will be completed on admission and daily for all hospital patients.

• Any patient with a Braden score < 12 or when nursing assessments indicate a patient need, skin inspections will be done every 8 hours.

PURPOSE:

• To maintain the integrity of patients' skin, a significant factor in health.

• To minimize the risks and prevent the occurrence of skin breakdown.

• To provide for early detection and intervention of all breakdown evident upon admission to the hospital.

• To promote prompt evaluation and intervention of any changes in skin integrity during the hospital stay.

SCOPE: All wards & ICUs

DEFINITIONS

• Risk assessment: identification of the potential risk that a patient will develop skin breakdown as the result of pressure to a bony prominence or body part impacted by equipment.

• Skin Inspection: the head to toe evaluation of bony prominences and skin folds / creases when prolonged pressure may result in skin breakdown.

• Interventions: the steps taken by care providers to increase monitoring, reduce or alleviate pressure, redistribute weight, and / or eliminate friction and sheer to mitigate or eliminate the risk of skin breakdown.

PROCEDURE:

I. Risk Assessment A. Admission to the nursing unit:

Findings will be documented on the Fall risk form. Pressure reduction interventions, based on the patient's Braden assessment, will be implemented by nursing and documented in the patient's medical record.

1. The Nurse completing the baseline admission assessment will perform a pressure ulcer risk assessment on all adults and pediatric patients for the risk for pressure ulcer development by using the:

2. Braden Scale for Predicting Pressure Sore Risk tool for adults

3. Braden Q for the pediatric population

II. Skin Inspection A.

On Admission and daily:

• The nurse completing the admission of a patient to the hospital will inspect all of the skin on the patient.

A. The focus of the examination will be on the skin over the bony prominences and in skin fold/creases. Findings will be documented in the patient medical record (paper or electronic). Skin care interventions will be implemented when appropriate and documented on the appropriate form.

B. Communication to the provider and other caregivers of a skin breakdown is essential. The nurse will be consulted as needed based on patient's skin condition and provider order.

C. If a patient refuses a full skin inspection, the patient's refusal must be documented along with the skin areas not examined.

D. High risk patients (patients with a Braden < 12) will have skin inspections completed every shift.

B. Re-evaluation:

• **Acute Care** Medical/Surgical and ICU Population: Daily, every 2nd hourly position changing

• Ward Units Daily, only if admission Braden is less than 19 Deterioration of medical status, every 4th hourly position changing.

• **Maternity Care Units:** o Daily, only if admission Braden is less than 19 o Deterioration of medical status

C. Role of the Nurse:

• While providing routine care, the Nurse is to monitor the skin condition of a patient.

("Monitoring the skin" means "keeping track" or "watching".)

• When observing an abnormal condition, the Nurse will notify the to the incharge and consultant, They can perform a thorough assessment of the condition

• The Nurse will follow-through with the skin care interventions implemented for prevention and treatment of skin breakdown.

III Interventions

A. Plan of Care

• In developing a plan of care the following will be considered: o Patient History (previous incidence of pressure ulcer?)

o Cognitive changes or impairment of the patient

o Current state of skin integrity and personal hygiene practices of the patient that Impact skin health

o Any cultural practices that impact the health or integrity of the skin

o Risk for pressure ulcer development

• Plans for the maintenance of skin integrity will include the patient and family

Whenever possible and may include, but are not limited to the following:

- ✓ Daily inspections, cleansing, and moisture management as needed
- ✓ Patient movement and activity focused on pressure redistribution of bony prominences that may result in skin breakdown
- ✓ Recognition of early signs of skin breakdown with prompt interventions to minimize tissue damage Identification of risk factors present or acquired that compromise skin integrity, i.e. medication, nutritional status, age, cultural practices, traumatic wounds, surgical wounds, etc.
- ✓ Communication of skin care concerns so the entire healthcare team can implement interventions
- ✓ Physical agents that may improve the overall integrity of the skin such as protective creams, barriers, coverings, pressure reduction devices, etc.

B. Care and interventions

• The care and intervention for any identified skin breakdown or wound will be aimed at: o Prevention of any further advancement of the wound, or additional skin breakdown

- ✓ Implementation of appropriate evidence-based care indicated for the problem identified – Note: See Tissue Integrity Resources.
- ✓ Collaboration with the interdependent and interdisciplinary health care teams regarding the presence of breakdown and the intervention plan
- ✓ Close monitoring of the response to treatment
- ✓ Referral to additional resources when indicated – Wound Care Specialist, Registered Dietician , Physical Therapist, Occupational Therapist.

C. Evaluation of the plan of care will include:

- ✓ Provisions for changes in the plan if progress toward expected outcomes are not evident
- ✓ Patient ability/willingness to maintain compliance with the plan
- ✓ Review during care management rounds if indicated
- ✓ Clear communication of progress to the rest of the health care team

D. Documentation

- ✓ Skin Integrity and/or conditions affecting the patient's skin must be documented
- ✓ according to established procedures.
- ✓ The presence of skin breakdown/abnormal skin appearance, i.e. abrasion, blister, bruising - due to pressure, burn, denuded, erythema, hematoma, laceration, rash, skin tear and wound, will be documented upon admission and daily.
- ✓ Upon identification of a wound, a full wound assessment, including its location, size, and description of the tissue involved, will be completed.
- ✓ Interventions and progress toward outcome focused goals need regular documentation according to established procedures.
- ✓ Specific documentation that must be complete include: o Admission Data Base.

DEEP VEIN THROMBOSIS

POLICY:

This policy aims to ensure that all adult patients seen by Inodaya Hospital staff are offered appropriate assessment, protection and advice relating to an increased risk of venous thromboembolism.

PURPOSE:

The purpose of this policy is to ensure that the appropriate level of prophylaxis for the prevention of Thromboembolism is offered to all adult patients who are at risk of embolism taking into account the patient's individual clinical situation.

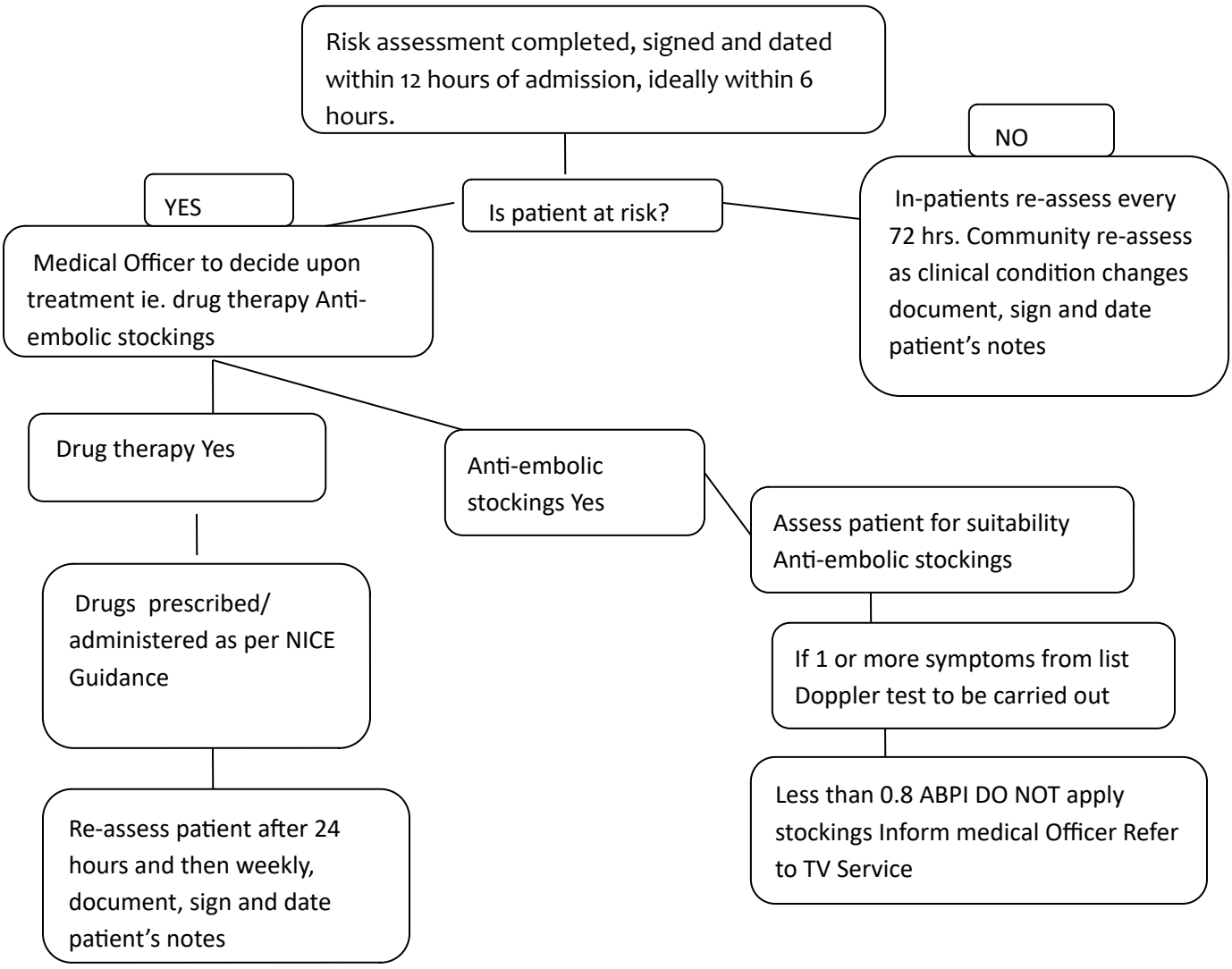
SCOPE:

To provide guidance for all clinical staff working in the hospital who have responsibility to give accurate advice to patients. This policy applies across in-patients settings, like ICUS and wards and minor injuries units, and excludes maternity services who have their own separate policy.

DEFINITION:

Deep vein thrombosis (DVT) is a medical condition that occurs when a blood clot forms in a deep vein. These clots usually develop in the lower leg, thigh, or pelvis, but they can also occur in the arm.

THROMOBOEMBOLISM PROPHYLAXIS FLOW CHART



KEY POINTS:

To deliver best practice with the intention of prevention of venous thromboembolism (VTE).

- ✓ All patients will have a risk assessment, completed, signed and dated within 12 hours of admission, ideally within 6 hours, on admission to case loads and wards to identify patients who are at potential risk of VTE.
    - Application of this policy will reduce the adverse clinical impact to patients.
    - Ensure provision of appropriate advice and support regarding the risk of
- ✓ VTE to patients and their relatives during their stay and prior to discharge.
    - Ensure all incidences of VTE are recorded via the Trust risk management
- ✓ process and are subject to a root cause analysis investigation. Patient deaths as a result of embolism will be reported as Serious Untoward Incidents.

JOB RESPONSIBILITIES:

- ✓ Patients have a holistic assessment on admission, which is documented, dated and signed.
- ✓ Patients have a specific risk assessment for Venous Thromboembolism (VTE completed, signed and dated within 12 hours of admission, ideally within 6 hours.
- ✓ The responsible Medical Officer is informed of results of the VTE risk assessment

- ✓ Safe administration of prescribed treatment as per Medicines Management Policy Patients are assessed correctly for suitability for anti-embolic stockings and if suitable can be measured and have stockings applied, if arterial impairment is
- ✓ suspected a Doppler assessment must be completed and medical advice sought.
- ✓ Competency in Doppler assessment is maintained.
- ✓ In-patients and community patients commenced on prophylaxis must be reassessed after 24 hours.
- ✓ Patients on prophylaxis must have their VTE risk re-assessed weekly.
- ✓ For in-patients deemed not at risk of developing VTE risk must be reassessed every 72 hours.
- ✓ Community patients deemed not at risk of VTE must be reassessed as their clinical condition changes.
- ✓ Infection Prevention and Control procedures are followed
- ✓ Any cases of VTE are reported immediately via the Trust's risk management system using RM1 form.
- ✓ All deaths attributed to VTE to be reported as a Serious Untoward Incident