

## Critical Care Falls and Treatment Interference Risk Reduction Strategies

All patients in Adult Critical Care are considered to be at increased risk for falls or harm due to treatment interference (e.g., self-extubation or dislodgement of medical devices). The following **Critical Care Falls and Treatment Interference Risk Reduction Strategies** incorporate the London Health Sciences Centre (LHSC) Standard and Enhanced fall risk prevention strategies and relevant critical care assessment and safety protocols into a population specific practice context.

These prevention strategies are implemented upon admission to the Critical Care Trauma Centre (CCTC), Cardiovascular Surgical Recovery Unit (CSRU) or Medical Surgical Intensive Care Unit (MSICU). The **Critical Care Falls and Treatment Interference Risk Reduction Strategies** remain a part of the patient’s care plan during their critical care admission. At the time of transfer from critical care, each patient will be screened using the LHSC electronic screening tool ([instructions for electronic screening](#)).

Nurses will determine which of the following **Critical Care Falls and Treatment Interference Risk Reduction Strategies** are appropriate at any given time (this will vary among individual patients and across the admission trajectory). The patient’s risk of falling or increases as the level of sedation is reduced, the patient’s motor strength improves and/or the patient is delirious.

<b>Critical Care Falls and Treatment Interference Risk Reduction Strategies (Include both LHSC and Critical Care Specific Interventions)</b>	
<b>LHSC Standard and Enhanced Precautions (Apply to all critical care patients if applicable)</b>	<b>Additional Critical Care Specific Interventions (Apply to all patients if applicable)</b>
<ul style="list-style-type: none"> <li>• Familiarize the patient with their environment including lines and tubes</li> <li>• Call bell system within patient reach and operational if available</li> <li>• Keep the patient’s personal possessions within safe patient reach including mobility devices</li> <li>• Have sturdy handrails in patient bathrooms, rooms and hallways</li> <li>• Place the hospital bed in the lowest position when a patient is resting in beds: raise to a comfortable height when the patient is transferring out of bed</li> <li>• Keep hospital bed brakes locked</li> <li>• Keep wheelchair wheel locks in the “locked” position when stationary</li> <li>• Provide patient and family with falls prevention education</li> <li>• Keep nonslip, comfortable, well fitting footwear on the patient</li> <li>• Use night lights or other supplemental lighting at night</li> <li>• Keep floor surfaces clean and dry and clean up all spills promptly</li> <li>• Keep patient care areas uncluttered</li> <li>• Complete and document mobility plan on</li> </ul>	<ul style="list-style-type: none"> <li>• ECG, invasive arterial line and SpO<sub>2</sub> alarms on and appropriately set</li> <li>• Pain assessment and agitation screening (VA-MAAS) and intervention upon admission/start of shift and Q4H and PRN</li> <li>• Screening, causation assessment and treatment of delirium per protocol</li> <li>• Implement bowel routine as soon as there is no contraindication</li> <li>• Implementation of <u>Critical Care Minimal Restraint protocol</u></li> <li>• All side rails up for sedated or neurologically altered patients; if lowered to facilitate family visit provide instruction to notify RN before leaving.</li> <li>• Frequent reorientation</li> <li>• Daily assessment of invasive lines and tubes, including Foley catheters</li> <li>• Activate bed exit alarm for patients with MAAS greater than 3 and documented Motor Strength of 3/5 or greater if available (able to overcome gravity).</li> <li>• Utilize chair alarms based on clinical judgment and availability.</li> </ul>

<p>Kardex and AI and assist with patient mobilization and transfers</p> <ul style="list-style-type: none"><li>• Assess for (and modify where possible) contributing factors e.g., vision , hearing, delirium)</li><li>• Evaluation of medication that may increase risk of falling</li><li>• Assess bowel and bladder elimination</li><li>• Follow safe patient handling <a href="#">practices</a></li></ul>	<ul style="list-style-type: none"><li>• Assess patient’s cognitive ability to utilize a call bell. When capable, ensure a suitable call bell (e.g., patients with spinal cord injury/motor weakness require assisted device) is within reach at all times.*</li></ul>
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\* If suitable technology is not available, document limitations and any alternative strategies that are in place (e.g., methods for communicating with nurse).

BM July 13, 2018

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