Home Care Falls Prevention and Management Algorithm

- Upon initial assessment HCCC or designated professional completes HC Fall Risk Assessment Tool.

CC will:

- Review/discuss with client/family:
  - ➢ Universal fall prevention fact sheets: "You Can Prevent Falls" & "12 Steps to Stair Safety at Home";
  - ➢ Individual fall risk assessment score including identified risk factors and recommended client specific interventions/referrals as per the required Home Care Falls Prevention and Management Interventions Checklist.
- Develop with client/family care plan incorporating targeted client specific risk factors identified in the Fall Risk Assessment.
- Initiate & forward referrals as per agreed upon client specific care plan.
- Document fall risk score, assessment outcomes, client/family discussions and agreed upon client specific intervention/referrals as indicated on:
  - ➢ Required Intervention Checklist;
  - ➢ Procura Home Care Assessment Form section 5.39 & 5.40, Care Plan and Nursing Service Request Form.

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Client is reassessed for fall risk at annual reassessments, after a witnessed or reported fall, when a safety concern has been identified, and/or when a client's health and/or functioning status has changed.

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Falls Risk Score

High Risk
- Fall risk score 21 and over
- Recent client fall.

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- Review pamphlet "Falls Prevention: A Checklist for You and Your Family".
- Flag client's Procura Care Plan and/or Nursing Service Request (top right corner) with falling leaf symbol.
- Recommend to client/family high risk interventions/ referrals as identified in the Falls Prevention Checklist.
- Initiate referrals as appropriate.

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- Revise and document care plan to incorporate recommended high risk interventions/referrals.
- Complete documentation on Required HC Fall Prevention and Management Interventions Checklist.
- Document assessment outcomes, client/family discussions and recommend interventions/referrals in interdisciplinary progress notes.
- Share assessments and care plan with health partners/facility when/if client care is transferred.

Low to Medium Risk
- Fall risk score below 21

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- Document assessment outcomes, client/family discussions and recommended interventions/ referrals in interdisciplinary progress.
- Share assessments and care plan with health partners/facility when/if client care is transferred.