Table 2 - Expert panel recommendations for reducing the risk of harm related to falls and medications events

	FALLS EVENTS
#	Item
1	Obtain risk assessment for falls and recommend regional standardization of policy and guidelines for use
2	Improve equipment adaptation and availability of technology
3	Identify why the user equipment needs not being met including: market gaps, existing design not 'user-centred', Case Managers require education regarding the "Human Factors Approach" to help improve their procurement decisions, issues related to user needs i.e. physical, mental, social, cosmetic , environmental and users not consulted or needs assessment not completed
4	Recognize the limitations of access to innovations due to cost and knowledge
5	Provide a true 'inter-disciplinary team' with training and role definitions. Including RN, MD, RD, OT, PT, SW, Rec Therapist, Pharmacy, Case Manager, PSW, HCA, HSW, EMS, etc.
6	Improve consistency of service providers, team messaging, client assessment and provider education.
7	Understand risks and their mitigation in home care including multiple specialists, polypharmacy, over-the-counter herbals contribution to falls
8	Decrease fragmentation of communication between team members and across the care continuum - consider implementing a common chart across the care continuum.
9	Define criteria for a review
10	Improve equity of access to resources regardless of geography
11	Offer flexibility in provider service to meet client specific needs
12	Standardize operating procedures including for data collection, time frames, criteria for triggering reviews, standardized tools, follow up / case conference / case review (q3-6 months), transition processes and consults with specialists e.g. geriatrician
13	Provide expanded access to Case Manager – 24/7
14	Increase medical input into risk assessment and plan
15	Plan for how to support the client/family as independent decision makers
16	Care worker interaction with client/family to ensure a culture of respect and professionalism
17	Evaluate and address issues related to nutrition and depression
18	Provide the client tips on how to fall, how to get up and have a cell phone or a telephone in every room
19	Recognize that the client may limit the information they share due to anticipated repercussions
20	Identify and overcome barriers to timely access and cost of necessary tools/supports for clients and family
21	Advocate for environmental improvements
22	Ensure client assessments contain key and accurate information including a fall history that is collected before the next fall has occurred. Include family members in the initial assessment
23	Care for complex clients needs to include a frank and open dialogue with client and most influential family members about the risks e.g. self management, and what can be accomplished in the home, realistic expectations, the importance of advanced planning rather than reacting balanced with the client's right to live at risk. Refer to "How to support and participate in difficult conversations" from Toronto Central CCAC. Recognize that some clients do better in an environment with others e.g. lodge, seniors residence, LTC.
24	Montreal Cognitive Assessment (MOCA) is recommended as the most sensitive tool for assessing dementia at the earliest stage and is available in the public domain.

	MEDICATION-RELATED EVENTS
1	Standardize medication delivery processes, medication packaging - considering client needs, cost, and consistency, management of high risk medications, use of drug nomenclature, limit the number of approved pharmacies and protocols for at risk patient populations
2	Integrate between acute care and community a standardized discharge planning process emphasizing closing feedback loops
3	Have a single point of contact for the client emphasizing the importance of human contact over technology i.e. Case Manager as the case quarterback and 24/7 Hotline for support
4	Define the process for escalation of care
5	Ensure patients and families have a clear role in medication management and are empowered and informed
6	Assessment of capability in home setting with regular reassessment.
7	Require understanding of difference between Medication management vs medication reconciliation
8	Clear identification of appropriate translator with contact information
9	Continuity of providers can increase safety whereas changing providers can lead to catching errors
10	Provide tools to assist client in being autonomous
11	Provide visual tools to prevent tampering (i.e. a photo of how an intact PICC line should appear)
12	Improve integration with Community Pharmacist
13	Improve use of technology to support communication
14	Investigate professional accountability for PSW giving meds
15	Evaluate the client's cognitive level, language preference and health and technology literacy
16	Changes to medications to be described to client in clear language by pharmacist
17	Encourage health ministries to provide financial support for pharmacy to be reimbursed for medication counseling / home visit
18	Encourage health ministries to support involvement of independent practitioners (i.e. physicians, community pharmacist) and integration with Home Care etc.
19	Clearly define the accountability and responsibility of caregivers for client outcomes
20	Improve documentation of information related to issues and action taken
21	Caregivers to improve their method for closing the communication loop
22	Minimize handoffs to reduce the risk for miscommunication and error
23	Develop a method for accessing resources or experts to respond to questions and escalate concerns
24	Provide medications in ready to administer form
25	Prepare and have available timelines for medication dispensing and dose changes
26	Develop a checklist for medication reconciliation and accountability for completion
27	Tool to post medication information for client to easily see and access