

PROTOCOL FOR: Falls: Risk Identification, Prevention Management, and Treatment

- PURPOSE: 1. To effectively identify patients who are a risk for falls, to protect patients from injury and to promote patient safety.
- POLICY: 1. The nurse will identify patients' fall risk utilizing the John Dempsey Hospital Fall Risk Identification Tool located on the inpatient nursing database (HCH #1282) and/or the unit-specific nursing flowsheet as follows:
- All in-patients upon admission
 - Every shift for 24 hours following sedation procedures, then per protocol
 - When patient's clinical presentation changes, developing new risk factors
 - For unit transfers, receiving unit will identify patient's fall risk
 - Prior to patient discharge
 - After a fall
 - High risk patients are assessed every shift
 - Low risk patients are assessed every day
 - Excluded from protocol are patients who are comatose or incapable of independent movement.
2. Patients on admission with an assigned risk score of 0-2 are classified into the universal fall risk and universal falls strategies are to be instituted. No further assessment is warranted until the time of discharge unless there is a change in patient condition or treatment, a fall, or the patient is transferred.
3. An individual fall prevention treatment plan will be developed for each patient based on the patient's risk for falls. The plan will be implemented by the nurse utilizing appropriate safety measures.
4. The organization will monitor patient falls to identify trends and enhance patient care and safety.
5. FALL DEFINITION:
- a. A person unintentionally and abruptly goes from a standing, sitting or lying position to a lower level. Excluded from this definition are such position changes caused by overwhelming force (e.g. being pushed)
 - b. Patients who are assisted to the floor by staff (and would have fallen without staff's assistance) will also be identified as a fall.

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DESIRED PATIENT

- OUTCOME: 1. Optimal safety of patients will be maintained during hospitalization.

CLINICAL
ASSESSMENT

AND CARE:

1. All patients at the time of admission will be assessed for fall risk utilizing the John Dempsey Hospital Fall Risk Identification Tool, which is incorporated into the Inpatient Database (HCH# 1282).
2. The Admission Assessment for risk of falls for all inpatients will include an assessment of the following:
 - a. History of falling: (total score can equal up to 4 points)
 - in the last three months or during hospitalization (2 points)
 - fall was the reason for patient admission (2 points)
 - b. Confusion/Disorientation: (4 points) unable to follow instructions, poor safety awareness, unaware of own ability, attempts to get out of bed, restless, impulsive (4 points)
 - c. Mobility, impaired: (2 points)
Change of Position-observe the patient for the following:
 1. Can patient stand without assistance?
 2. Once standing, can patient maintain balance?
 3. Can patient move forward and walk without assistance?

If patient is unable to complete any one of the above, then he/she has a positive (+)change of position and must be scored according to the fall risk scale (2 points)

***If patient is unable to safely stand up from a chair and ambulate based on LIP orders for strict bedrest and/or the patient's inability to do so, then the nurse should document "unable to assess at this time" under the mobility, impaired section of the screening tool. As soon as the patient condition improves making mobility a possibility, then the mobility assessment should be implemented and scored accordingly.

- d. Elimination, altered: (2 points) Frequency, urgency, nocturia, diarrhea, incontinence
- e. Medications: (2 points) Patient is receiving any one medication from any one or more of the following categories - anticoagulants, diuretics, hypnotics, neuroleptics, anticonvulsants, narcotics, antihypertensives, sedatives, psychotropics.

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3. Patients will be classified for falls according to the John Dempsey Hospital Fall Risk Identification Scale as follows:
 - a. Universal Fall Risk: 0-2
 - b. Low Risk Fall Precaution: 4-8
 - c. High Risk Fall Precaution: 10-14
4. All patients will be minimally assigned Universal Fall Risk.
5. For patient's determined to be at low risk for falls, a fall risk score will be documented on the unit Flowsheet by the nurse daily.
6. For patient's determined to be at high risk for falls, a fall risk score will be documented on the unit Flowsheet by the nurse every shift.
7. The nurse will implement an individualized fall prevention treatment plan determined by the fall risk identification score and document interventions on the patient's care plan.
8. Patient's determined to be at a high risk for falls will have NO independent activity until their fall score decreases to less than 10. A progress note documenting a patient's noncompliance (i.e. patient independently performs activity without calling for assistance) should be entered into the medical record whenever necessary.
9. The individualized fall prevention treatment plan may incorporate (but is not limited to) the following interventions and guidelines.
 - a. Universal Fall Prevention Strategies:
 - Orient patient to surroundings and staff
 - Provide adequate lighting to promote safe ambulation; night light
 - Call bell within reach, visible and patient informed of the location and use
 - Instruct to call for help before getting out of bed
 - Non-slip footwear
 - Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords and unnecessary equipment)
 - Personal care items and telephone within arms length
 - Bed in lowest position with wheels locked; 2-3 side rails up
 - Relaxation tapes/music
 - Actively educate and engage patient and family in fall prevention strategies

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- Assure sensory/ambulatory prosthesis are utilized and are in safe working condition
 - Instruct patient in use of grab bars
- b. Low Risk Fall Prevention Strategies (in addition to universal fall prevention strategies):
- Medication teaching and review
 - Reassess fall potential every 24 hours
 - Assess need for bedside commode
 - Utilize patient walker (psychiatry only)
 - Utilize hip protector and/or bedside mat (psychiatry only)
 - Diversional activities
 - Elevated toilet seat
 - Consult with the psychiatric nurse consultant
 - Comfort rounds including positioning; offering fluids and snacks when appropriate and ensuring patient is warm and dry at least every 2-4 hours
 - Toilet minimally every 2 hours
 - PT consult is suggested
 - Identify fall risk on chart, Kardex, doorway and wristband
 - Bed and/or chair alarm
 - Restraints (MD order necessary)
 - Reassess fall potential daily
- c. High Risk Fall Prevention Strategies (in addition to universal and low risk fall prevention strategies):
- Consider Psychiatric consultation
 - Consider patient supervision (constant observation); MD order necessary every 24 hours
 - Room placement closer to nurses' station
 - Reassess fall potential every shift
 - Patient's determined to be at a high risk for falls will have NO independent activity until their fall score decreases to less than 10. A progress note documenting a patient's noncompliance (i.e. patient independently performs activity without calling for assistance) should be entered into the medical record whenever necessary.
10. Patients identified as low to high risk for falls will have their fall risk status communicated to other disciplines by identifiable safety alerts:
- a. Yellow wrist band applied to patient
 - b. Fall Risk magnet placed on outside door frame of patient's room

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- c. Yellow circle sticker placed on patient chart and on the nursing kardex
11. The "Falls: Risk Identification and Prevention Management" protocol, for low and/or high risk for falls, remains in effect for as long as the patient is at risk for falls.
12. For patient's whose risk level decreases to a score of 0-2 (universal fall precautions) for more than 24 hours, nursing will remove patient alerts from all designated areas.
13. Document in the patient's medical record that patient and/or family is educated about fall risk identification and prevention management.
14. IN THE EVENT OF A FALL (either pre- or post-admission), the following will occur:
 - a. RN/LPN will implement protocol after an assessment of the patient
 - b. Document specific facts in clinical medical record
 - c. Notify Licensed Independent Practitioner (LIP)
 - d. Document a physical assessment at the time of the fall and/or at the time of admission if a fall was the reason for admission; at a minimum, assess:
 - Blood pressure and heart rate
 - Level of consciousness
 - Observable injuries
 - e. If head trauma is suspected or injury is apparent, document on your unit flowsheet the neurological assessment that was completed at the time of the fall including:
 - Glasgow Coma Scale (eye opening, verbal response, motor response)
 - Pupillary light reflex (pupil size and reactivity to light)
 - Blood pressure, heart rate, respiratory rate, and pulse oximetry
 - f. Document preventive measures initiated
 - g. The frequency of neurological assessments and vital signs will be determined based on patient need and orders from the LIP responsible for the patient's care
 - h. Update fall treatment plan accordingly
 - i. Notify immediate family for any patient fall, if Possible
 - j. Notify Nurse Manager/Administrative Supervisor for falls resulting in moderate to major injury

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DISCHARGE PLANNING: If patient demonstrates gait problems, has fallen while in the hospital, or had a fall within the past 6 months, suggest physician consider a consult for outpatient gait-training program and/or home care referral.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 10/04

REVISION DATES: 8/06, 10/06, 8/07, 9/07, 4/09