CROSS REFERENCES:

- Administrative Policy RI-20: Guidelines for Disclosure of Unanticipated Outcomes
- Administrative Policy TX-02: Restraint and Seclusion
- Administrative Policy EC-26: Occurrence and Medication Variance Reporting
- Department of Nursing Policy: Patient Sitters/Companions

PURPOSE:

- To identify patients at risk for a fall.
- To provide surveillance and timely interventions to prevent falls and their related injuries while promoting maximum independence and mobility of Shore Health System (SHS) patients / customers.
- To promote safety through a planned prevention program.

DEFINITIONS:

- **FALL**: A fall is defined as an unplanned descent to the floor (or extension of the floor, e.g., trash can, other equipment) with or without injury.

- **IMPULSIVITY**: Inclined to act on impulse rather than thought.

- **IMPULSIVE BEHAVIOR**: An action initiated without due consideration or thoughts as to costs, results, or consequences.

POLICY:

1.0 **FALL RISK SCREENING**

All adult patients admitted to SHS will be screened within 1 hour of arrival to the inpatient unit for fall risk utilizing the Hendrich II Fall Risk Assessment Tool. **NOTE**: This tool will not predict accidental falls or those falls resulting from a patient’s response to medical treatment.

1.1 All patients admitted to Shore Health System will be placed on Standard Fall Precautions.

1.2 Patients scoring 0-4 are considered at low risk and require at a minimum the implementation of Standard Fall Prevention Interventions. Additional precautions may be added based on nursing assessment.

1.3 Patients scoring 5-8 are considered at moderate risk and require at a minimum the activation of the Moderate Risk Fall Prevention Interventions. Additional precautions may be added based on nursing assessment.
1.4 Patients scoring 9 or greater are considered at high risk and require at a minimum the activation of the High Risk Fall Prevention Interventions. Additional precautions may be added based on nursing assessment.

2.0 FALL RISK RE-SCREENING FOR ADULT INPATIENTS

Fall Risk screening will be completed utilizing the Hendrich II Fall Risk Assessment Tool for adults.

2.1 Every 24 hours at a minimum.

2.2 Upon transfer to another unit or facility.

2.3 Following a fall.

2.4 When there is a change in patient condition. This may include but is not limited to:

   2.4.1 Post operative.
   2.4.2 Deterioration in condition.
   2.4.3 Changes in mental status.
   2.4.4 Increase in impulsivity.
   2.4.5 Addition of medications identified as high risk on the Hendrich II Fall Risk Assessment Tool.
   2.4.6 Addition of medical equipment.
   2.4.7 Change in mobility.

2.5 Report and discuss, with the physician, any changes in status (e.g., agitation, non-compliance) that may need further assessment of cause or the need for further interventions.

3.0 FALL PREVENTION INTERVENTIONS FOR ADULT INPATIENTS

3.1 Implement fall prevention interventions based on the risk score from the Hendrich II Fall Risk Assessment Tool and nursing assessment.

3.2 Standard Fall Prevention Interventions

   3.2.1 Actively engage patient and family in all aspects of the Fall Prevention Program

      3.2.1.1 Review the SHS Handbook “That’s Why I Chose Shore Health” with patient and family.

      3.2.1.2 Orient patient to surroundings.

      3.2.1.3 Encourage patients/families to call for assistance when needed.

      3.2.1.4 Teach patient use of grab bars and hand rails.
3.2.1.5 Instruct patient in all activities prior to initiating assistive devices.

3.2.1.6 Instruct patient in medication time/dose, side effects, and interactions with food/medications.

3.2.2 Bed Safety

3.2.2.1 Keep bed in lowest position as is practical and wheels locked.

3.2.2.2 Assure overlay mattress when in use is not over inflated.

3.2.3 Environment

3.2.3.1 Assure that locks on beds, stretchers, wheelchairs, and other moveable objects are on and functional.

3.2.3.2 Keep floors clutter/obstacle free (with special attention to path between bed and bathroom/commode).

3.2.3.3 Assure adequate lighting, especially at night.

3.2.3.4 Remove excess equipment/supplies/furniture from rooms and hallways.

3.2.3.5 Coil and secure excess electrical and telephone wires.

3.2.3.6 Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger.

3.2.4 Patient Care

3.2.4.1 Place call light and frequently needed objects within patient reach. Answer call bell promptly.

3.2.4.2 Approach patient towards unaffected side.

3.2.4.3 Transfer patient towards stronger side.

3.2.4.4 Use properly fitting nonskid footwear (slippers with rubber soles or treded socks).

3.2.4.5 Keep top two side rails up to assist with patient movement.
3.25 Clinical Communications

During shift to shift report and patient handoffs report patients fall risk score and the fall prevention plan.

3.3 Moderate Fall Prevention Interventions for fall risk score of 5-8.

3.3.1 Active engagement of patient and family. Instruct patient/family:

3.3.1.1 That the patient has been identified as at risk for falls.

3.3.1.2 That patient should only get up with the assistance of SHS staff.

3.3.1.3 To notify staff member when family is leaving the patient unattended.

3.3.1.4 About patient falls in hospital settings utilizing the FYI Fall Prevention Guidelines found on the SHS Intranet.

- Select Nursing
- Select Nursing Index
- Select Patient Education FYI
- Select Patient Education FYI on this page
- Select Fall Prevention Guidelines doc

3.3.2 In addition to standard fall prevention interventions, consider additional interventions to include but not limited to:

3.3.2.1 Move patient to room with best visual access to nursing station when possible.

3.3.2.2 Place patient in hi-lo bed.

3.3.2.3 Assure bed/Chair alarms are in use and activated.

3.3.2.4 Establish elimination schedule.

3.3.2.5 Round on patient every hour.

3.3.2.6 Reorient confused patients during each patient interaction.

3.3.2.7 Monitor and assist patient in following daily routines.

3.3.2.8 Supervise and/or assist bedside sitting, personal hygiene, etc.

3.3.2.9 Evaluate need for PT/OT consult if patient has a history of fall and/or mobility impairment.
3.4 Fall Prevention Interventions for a Fall Risk Score of 9 or Greater

In addition to standard and moderate fall prevention interventions, consider additional interventions to include but not limited to:

3.4.1 Encourage family to assist with 24 hour supervision.

3.4.2 Remain with patient while toileting.

3.4.3 Consult with pharmacy and physician for medication review to determine if any medications may be contributing to falls.

3.4.4 Consider restraints if other measures have not been successful.

3.4.5 Obtain physician order for least restrictive restraint.

4.0 THE HOSPITAL BASED ALERT SYSTEM PROVIDES A VISUAL CUE TO ALERT STAFF THAT A PATIENT IS AT MODERATE OR HIGH RISK OF FALLING

4.1. Apply fall risk bracelet to patient.

4.2 Any staff member observing a patient at risk for fall who is attempting to ambulate or transfer without assistance, will provide immediate assistance or intervene and call—for immediate assistance. The patient is not to be left unattended.

4.3 Shift to shift report will include the patients fall risk score and any prevention plan.

4.4 When a patient is transferred to another unit, the transferring nurse during patient handoff will make the accepting unit aware of the patient’s fall risk score upon transfer, the reason patient is at risk for fall, and current fall prevention measures/plan.

4.5 Bedrails contribute to patient fall risk by creating barriers to patient transfer in and out of beds.

4.5.1 **NOTE:** Full side rails are considered a restraint except during transport.

4.5.2 Use of bedrails must be assessed specific to individual patient needs.

4.5.3 Whenever possible, use alternative pillows and positioning devices to avoid the use of full bedrails.

5.0 STAFF EDUCATION

5.1 All employees, clinical and non-clinical are to receive education on Fall Prevention annually.
5.2 All staff nurses involved in direct patient care of the adult patient must complete the Hendrich II Fall Education Module or the Self Learning Module upon hire.

6.0 IF AN INPATIENT FALL OCCURS

6.1 Provide immediate supportive action for the patient.

6.2 Notify physician and nurse manager (or covering Administrative Supervisor).

6.3 Notify designated family member/emergency contact.

6.4 Record each occurrence in PCS utilizing the Fall Risk Assessment from the intervention list. This includes:

   6.4.1 Documentation of date, time and location of fall.

   6.4.2 Documentation of the event as an actual fall if the fall was witnessed, otherwise document as “found on floor”. If fall witnessed, document name of witness(s) and title(s).

   6.4.3 Documentation of any contributing factors, e.g., wet floors, cords, prior medication, etc.

   6.4.4 Notification of physician and designated family member / emergency contact.

   6.4.5 Outcome of post-fall patient assessment.

      6.4.5.1 Patient appearance at time of discovery.

      6.4.5.2 Patient response to event.

      6.4.5.3 Evidence of injury.

      6.4.5.4 Medical/nursing actions.

      If post fall neuro checks are indicated (signs of head trauma or complaints of headache post fall), perform post fall neuro checks at a minimum of every 15 minutes x 4, every 30 minutes x 2, every hour x 24.

   6.4.6 Follow-up diagnostic procedure or treatment.

   6.4.7 Protective measures and/or additional interventions instituted/changed after fall (e.g., moving closer to nursing station, more frequent observations).

   6.4.8 Complete on-line occurrence report.
7.0 MONITORING OF FALLS

7.1 All inpatient falls will be reviewed as soon after the fall event as possible but not to exceed 3 business days.

7.2 Inpatient fall occurrences data for nursing units is submitted quarterly to NDNQI.

7.3 Quarterly unit-based data is distributed to managers for review.

7.3.1 Managers will share the data with the unit staff and unit-based teams.

7.3.2 Unit-based teams will develop action plans in collaboration with other clinical disciplines as appropriate (Rehab, Pharmacy).

8.0 OUTPATIENTS AND VISITORS

8.1 Outpatients will be screened for fall risk by being asked the following questions at the time of registration:

8.1.1 If patient has experienced a fall in last 6 months.

8.1.2 If patient uses any assistance or equipment to aid in ambulating (i.e. staff escort, family escort, wheelchair, crutches, cane, walker). Offer assistance with mobility or transfer to transport patients to their destination (i.e. wheelchair).

8.2 Outpatients identified at risk for fall will have a fall precaution sticker placed on the face sheet centered between SHS logo and patient identification at the bottom of form.

8.3 If patient identified at risk for fall, take actions according to the following list of interventions:

8.3.1 Lock all moveable equipment that can be locked before transferring patients (bed, wheelchair, etc.).

8.3.2 Provide physically safe environment (eliminate spills, wet floors, clutter, electrical cords and unnecessary equipment).

8.3.3 Provide adequate lighting.

8.4 Outpatients and visitors to SHS that experience a fall will be offered Emergency Department (ED) Triage services to determine the level of injury that may have been sustained.

8.5 Patient falls in ancillary departments and outpatient/visitor falls are reported to Risk Management.
Nursing Policy

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SHS Administrative Policy

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REFERENCES:


