CH PATIENT FALL PREVENTION

Summary:
Every patient presenting to the hospital will be assessed in order to determine the patient’s potential for falls.

Effective Date: 6/27/2000
Revision History: 5/18/2011, 8/1/09, 11/01/07, 4/01/06, 1/02/06, 5/31/04, 6/27/00
Facilities: SJMC, SMMC
Approved By: SJMC CNO, SMMC CNO
Policy Impacts: All Employees

POLICY:

Every patient presenting to the hospital will be assessed in order to determine the patient’s potential for falls. For inpatients, the assessment will be performed by utilizing the Hendrich II Fall Risk Model and scorecard (See Addendum A). Outpatients will be assessed for fall risk by utilizing the Outpatient Fall Risk Assessment (Addendum B), or by utilizing a department specific Fall Assessment form.

Reasonable attempts will be made to safely support the patient’s rights for independence and self-determination by activating the least restrictive methods for fall prevention. Restraint (physical or chemical) use will be for the purpose of protection only and not for punishment or convenience.

FALL PREVENTION OBJECTIVES:

- To minimize the risk of patient falls without compromising the mobility and functional independence of patients.
- To delineate the characteristics that place patients at risk for falls.
- To promote proactive healthcare practices for patient care planning, which minimize the risk for fall.
- To identify the main components of an effective Fall Prevention Program which are:
  - thorough assessment
  - appropriate intervention
  - appropriate documentation
  - regular evaluation
DEFINITIONS:

- **Fall**: An unanticipated change in body position in a downward motion, or against an object, that may or may not result in physical injury.

- **Mechanical Restraint**: Any device applied to a patient for the purpose of limiting free movement (example: chest/limb/sheet restraint).

- **Chemical Restraint**: A drug used to inhibit a particular behavior or movement.

- **Fall Risk Factors**:
  - **Intrinsic Risks** – consist of factors as related to the patient; such as medication effects, medical or health issues (example: arthritis, dizziness, low blood pressure, generalized weakness), gender.
  - **Extrinsic Risks** – consist of conditions related to the environment; such as wet or slippery floors, equipment in the patient’s way, poor lighting.

**Hendrich II Fall Risk Model Patient Risk Factors**:

- Confusion/Disorientation/Impulsive Behavior
- Symptomatic Depression
- Altered Elimination
- Dizziness/Vertigo
- Gender (Male)
- Administered antiepileptic medications
- Administered benzodiazepine medications
- Difficulty in rising from a sitting position

Identification of patient problems such as impaired: eyesight, hearing, cognition, gait and balance, or fall within past six (6) months, are also conditions that need to be evaluated when considering the patient’s risk for falling.

PROCEDURE:

I. Inpatients

A registered nurse will assess the inpatient immediately upon admission, every shift, and anytime the patient has a change in condition or is transferred to another level of care, by utilizing the Hendrich II Fall Risk Model Scorecard (See Addendum A), in order to determine the inpatient’s potential risk for falls. This assessment will also indicate which patients require the initiation of an appropriate fall prevention program. Inpatients identified as being at high risk for falls, which is designated by a Hendrich II Fall Risk Score of five (5) or greater or has sustained a fall within the last six (6) months, will be placed on the "The Hendrich II Fall Prevention Program," which identifies inpatients by using the following indicators:

- Place yellow “Fall Risk” ID band on all inpatients that are identified to be at high risk for falls.
• Place yellow magnet on white board in patient room with inpatient at risk identified.
• Have inpatient utilize yellow “Fall Risk” safety slippers when out of bed or ambulatory.
• Implement appropriate fall precaution safety devices. (Examples: bed alarm activation, chair/w/c alarm, gait belt, Velcro belt).

If the inpatient is unable to perform the “Get Up and Go” test (comatose, debilitation, traction) the nurse should score all other risk factors. If the inpatient scores a five (5) or greater without using the “Get Up and Go” test, they should be considered “at high risk” for falls. If the inpatient cannot make attempts to get up, but they have risk points, they should be considered a “high risk patient” and be placed on the Fall Prevention Program as soon as they can attempt to get up.

II. Outpatients

• At the time of registration, patients having outpatient procedures will be assessed and documentation will occur on the outpatients identified at risk for falling by utilizing the following three (3) questions: 1) Do you have dizziness or vertigo? 2) Do you need help standing or walking? 3) Have you fallen within the last six (6) months? If the patient, guardian or durable power of attorney answers “yes” to any of these questions the patient is considered to be at high risk for falling. This process may be department specific. A yellow id band and chart identifier will be placed on any outpatient who is identified to be at high risk for falling.

• Two Outpatient Risk Assessment Forms are available; one is an individual form to be used for a single outpatient visit (See Addendum B), and the other is to be used for sequential outpatient visits for the same treatment or procedure (See Addendum C).

III. Six Elements of the Hendrich II Fall Prevention Program

1) Assess and reassess fall risk:
   a) Using the Hendrich II Fall Risk Model Scorecard (inpatients) or the Outpatient Fall Risk Assessment (outpatients), reassess the patient’s risk for falls at the intervals previously described in this policy.

2) Maintain a safe environment:
   a) Keep the patient’s bed in lowest position with brake and bed alarm on.
   b) Secure the call light within easy reach.
   c) Move the patient closer to the nurse’s desk, if possible.
   d) Verify easy access to personal belongings.
   e) Provide assistance out of bed.
   f) Remove any environmental obstacle from the patient's walking pathway.
   g) Provide adequate lighting for good visibility.
3) Monitor gait and mobility:
   a) Monitor the patient’s activities and mobility.
   b) Assist and/or stand by the patient during ambulation.
   c) Use canes and walkers as needed and keep them available.
   d) Use gait belts to assist in patient transfers and during ambulation.

4) Meet elimination needs:
   a) Provide assistance to the bathroom or commode and remain with the patient at all times.
   b) Make sure the call light is within easy reach of the patient and answer the patient’s call light promptly.
   c) Implement a toileting schedule based upon the patient’s needs, to be addressed during hourly rounding.

5) Provide patient and family education:
   a) Educate the patient and family on falls protocol.
   b) Discuss fall prevention in the home prior to discharge.
   c) Encourage patient’s family members and friends to participate in the patient’s fall prevention program.

6) Use interdisciplinary team management:
   a) Interventions for the patient at high risk for falls are to be provided by all hospital personnel, as appropriate.
   b) If the patient is transported, the staff member transporting the patient utilizes the Ticket to Ride to determine the patient's fall risk status and places the patient where he/she can be observed and monitored closely by the receiving department staff.
   c) Non-clinical staff should immediately report a patient trying to get out of bed alone, standing alone, etc. to the nursing staff for assistance.
   d) Staff members will immediately report any environmental hazards to housekeeping, such as slick floors or spills. The staff member finding the hazard will mark the area accordingly.
   e) Any need for repairs of items/equipment/furniture etc., which are necessary for patient safety, will be requested and repaired as soon as possible.
   f) If the patient is being transferred to another facility, the nurse should advise the other facility of the patient's fall risk by documenting on the transfer form.

IV. “Get Up and Go” Test: Rising from a Chair

The patient “test” is completed by using the Hendrich II Fall Risk Scorecard and has a score which ranges from 0 to 4 (See Addendum A).
**Scoring:**

0 – The patient is able to rise in a single movement and is then able to walk with no loss of balance.
1 – The patient is able to push themselves up into a standing position in one attempt.
2 – This score is not used.
3 – The patient must push up multiple times before they are able to rise.
4 – The patient is unable to rise without help.

V. Any patient may be placed on the Hendrich II Fall Risk Prevention Program based on the clinical judgment and decision of the nurse and/or physician.

VI. Patients identified as being at risk for falls will receive information/education regarding methods for prevention of falls. The nurse performing the initial assessment will provide the appropriate education at the time of admission and review with the patient and/or the spouse, family member or significant other.

VII. Utilizing the nursing process, the “Fall Prevention Program,” intervention will be initiated by the nurse performing the falls risk assessment. These interventions will be added to the patient's plan of care upon identification of the fall risk patient.

VIII. If the patient (or the guardian or durable power of attorney (DPOA), if the patient is incompetent) refuses the use of a side rail, protective device, or safety advice, the potential for injury due to a fall should be re-explained to the patient/guardian/DPOA. The conversation and/or refusal with the patient/guardian/DPOA will be documented as a patient note in the appropriate medical record.

IX. Inpatients, whose risk level decreases, will be monitored for the following 24 hours. If the degree of risk for fall stays below high risk level, the patient will be removed from the fall risk protocol and all insignia removed (bracelet, name card, magnet).

X. Patients identified to be at risk for fall will have falls protocol in place until identified to be no longer at risk for fall per completed fall risk assessment or upon exit from facility at time of discharge only.

XI. If a patient experiences a fall, with or without an injury, during their hospitalization, the patient’s physician should be notified, an incident report should be completed, the immediate supervisor should be notified, and the family or guardian should be notified. A “Fall Debriefing Form” must be completed after every patient fall, with the assistance of the manager or nursing supervisor, whether or not the patient sustains an injury.

References:


**APPROVAL SIGNATURES: CH Standard Policy Signatures**
## ADDENDUM A

### Hendrich II Fall Risk Model® © 2006

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Risk</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion/Disorientation/Impulsivity</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Symptomatic Depression</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Altered Elimination</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dizziness/Vertigo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Any Administered Antiepileptics (anticonvulsants)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Any Administered Benzodiazepines</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Get-Up-and-Go Test: “Rising from a Chair”**

<table>
<thead>
<tr>
<th>Ability to rise in single movement-No loss of balance with steps</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pushes up, successful in one attempt</td>
<td>1</td>
</tr>
<tr>
<td>Multiple attempts but successful</td>
<td>3</td>
</tr>
</tbody>
</table>
| Unable to rise without assistance during test  
  (OR if a medical order states the same and/or complete bed rest is ordered)  
  *If unable to assess, document this on the patient chart with the date and time* | 4 |

*A score of 5 or greater = High Risk*

**SCORE**

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ADDENDUM B

Outpatient Fall Risk Assessment

This document is to be completed at the time of admission to the Outpatient Department.

Date of Service: _______________ Outpatient Department: ________________

1) Do you have dizziness or vertigo? _____ Yes _____ No

2) Do you need help standing or walking? _____ Yes _____ No

3) Have you fallen within the last 6 months? _____ Yes _____ No

If the patient/DPOA/Guardian answers “Yes” to either of these questions, place a yellow “Fall Risk” id band on the patient.

______________________________           _____________  __________
Hospital Representative                              Date       Time
Outpatient Fall Risk Assessment Summary

This document is to be completed at the time of admission to the Outpatient Department. If the patient/DPOA/Guardian answers “Yes” to either of these questions place a yellow “Fall Risk” id band on the patient.

Date of Service: _________ Department _______________________

1) Do you have dizziness or vertigo? _____ Yes _____ No
2) Do you need help standing or walking? _____ Yes _____ No
3) Have you fallen within the last 6 months? _____ Yes _____ No

______________________________  _________________  ________________
Hospital Representative                     Date                     Time

1) Do you have dizziness or vertigo? _____ Yes _____ No
2) Do you need help standing or walking? _____ Yes _____ No
3) Have you fallen within the last 6 months? _____ Yes _____ No

______________________________  _________________  ________________
Hospital Representative                     Date                     Time

1) Do you have dizziness or vertigo? _____ Yes _____ No
2) Do you need help standing or walking? _____ Yes _____ No
3) Have you fallen within the last 6 months? _____ Yes _____ No

______________________________  _________________  ________________
Hospital Representative                     Date                     Time