SJ PATIENT FALL PREVENTION

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

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>6/26/2000</th>
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<tbody>
<tr>
<td>Revision History:</td>
<td>1/14/13, 8/08/29/11; 1/09; 11/01/2007; 4/01/2006; 1/02/2006; 5/31/04</td>
</tr>
<tr>
<td>Facilities:</td>
<td>SJMC</td>
</tr>
<tr>
<td>Approved By:</td>
<td>SJ CNO</td>
</tr>
<tr>
<td>Policy Impacts:</td>
<td>All Employees</td>
</tr>
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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
DEFINITIONS:

- **Fall**: A patient fall is an unplanned descent to the floor with or without injury to the patient. Include falls when a patient lands on a surface where you wouldn’t expect to find a patient. All unassisted and assisted (see definition below) falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Also report patients that roll off a low bed onto a mat as a fall. Falls that occur by students, staff members, and/or visitors should be documented as a “Fall-Related Other”.

- **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, or at the discretion of the nurse, will be placed on the "The Hendrich II Fall Prevention Program," which follows the below prevention techniques:

- 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
- Place yellow sticker on chart and have signage placed on head of bed.
- Place gait belt in visible area in patient room (associated with patient bed).
- 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)
- 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
- Verify easy access to personal belongings
- Provide assistance out of bed
- Remove any environmental obstacle from the patient’s walking pathway
- Provide assistance to the bathroom or commode and remain with the patient at all times
- Fall Preventions education completed and documented with patient/family
- Contract signed within 24 hours of admission
- Bed locked and in lowest position/chair brake on
- Call light and personal items within reach
- Adequate lighting utilized/obstacles removed from walkways.
- Hourly rounding to include the 4 Ps (Potty-Pain-Position-Possessions)
- Use assistive devices as indicated (Wheelchair/Cane/Walker/Hearing aids/Glasses)

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. General Knowledge
   a) Monitor the patient’s activities and mobility.
   b) Discuss fall prevention in the home prior to discharge
c) Use interdisciplinary team management: ** Every employee has an influence on patient safety and fall prevention

1. Interventions for the patient at high risk for falls are to be provided by all hospital personnel, as appropriate.
2. If the patient is transported, the staff member transporting the patient utilizes the Tick 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.
3. Non-clinical staff should immediately report a patient trying to get out of bed alone, standing alone, etc. to the nursing staff for assistance.
4. 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.
5. Any need for repairs of items/equipment/furniture etc., which are necessary for patient safety, will be requested and repaired as soon as possible.
6. 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.

III. 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 identification 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).

IV. 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.

V. 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. Additionally, patient or patient family will sign a “falls contract” (see Appendix D) to ensure compliance. Patient may refuse to sign contract, if patient is competent per RN assessment.

VI. 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.
VII. If the patient (or the guardian, patient family or durable power of attorney (DPOA) provided the patient is competent/cognitively intact) refuses to comply with suggested safety precautions as educated by a member of the care staff, the potential for injury due to a fall should be re-explained to the patient/patient family/guardian/DPOA. The re-education and/or refusal from the patient/patient family/guardian/DPOA will be documented as a patient note in the appropriate medical record.

VIII. 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.

IX. Patients needing assistance with ambulation/transfer, PT/OT will document on the patient whiteboard, if assistance is ordered by the PT/OT to communicate with nursing personnel.

X. If a patient experiences a fall, with or without an injury, during their hospitalization, the patient’s physician should be notified, an event 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, before the end of the shift, with the assistance of the manager, charge nurse, or nursing supervisor, regardless if the patient sustains an injury.

XI. The risk of a fall and/or fall with injury is the responsibility of both the competent patient/patient family (when patient is cognitively impaired) and the caregiver. The “Generally Accepted Performance Standards” (GAPS) accountability form is a requirement for each caregiver to sign upon employment and caregivers who have not previously signed this acknowledgement.

References:


APPROVAL SIGNATURES: SJMC 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>
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<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>
<tr>
<td>Get-Up-and-Go Test: “Rising from a Chair”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to rise in single movement-No loss of balance with steps</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pushes up, successful in one attempt</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Multiple attempts but successful</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Unable to rise without assistance during test</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><em>(OR if a medical order states the same and/or complete bed rest is ordered)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If unable to assess, document this on the patient chart with the date and time</em></td>
<td></td>
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(A score of 5 or greater = High Risk) (16=max 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 any of these questions, place a yellow “Fall Risk” I.D. band on the patient.

_________________________           _____________  __________
                        Hospital Representative                              Date      Time
**ADDENDUM C**

**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 any of these questions place a yellow “Fall Risk” I.D. 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