Emergency Response

Emergency Care

Purpose:

To provide timely, quality care in the event of an emergency.

Policy:

All Staff will be familiar with emergency procedures in the event of a patient emergency to ensure quality care and a safe outcome. Patients requiring an emergency level of care will be transported by ambulance to the nearest medical facility

Procedure:

In the event of a medical/psychiatric emergency, the clinical staff will:

1. Assess the patient and perform appropriate intervention including calling a code blue or green and calling 911 as needed
2. Code carts or emergency medical kits and oxygen is available at all clinic sites. Kits will be labeled with contents, expiration date(s) noted, and will be readily accessible in the event of an emergency
3. When indicated, transport to the nearest medical facility will be arranged
4. BHCHP has a written agreement with Boston Medical Center to provide emergency services for the transfer of patients (see attached)
5. In the event of an emergency transport, a copy of pertinent patient medical information will be sent with them
6. All clinical staff will be certified in CPR. This includes certified nursing assistants, MAs, RNs, PAs, MDs, DMDs, dental assistants, hygienists, and mental health staff.

BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Boston University
School of Medicine

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June 10, 2008

Emergency Medicine

Barry Bock
Director of Clinical Operations
780 Albany Street
Boston, MA 02118

Dear Barry:

Boston Medical Center's Emergency Department agrees to accept patients in need of emergency care from the Boston Health Care for the Homeless Program, Jean Yawkey Place, McInnis House Clinic.

Sincerely,

Jonathan S. Olshaker, MD
Professor and Chair
Department of Emergency Medicine
Boston University School of Medicine

Inappropriate Behaviors

Policy:

Inappropriate behavior may lead to disruption of health care of other patients, may set up the potential for violence, or may disrespect staff or other patients. This type of behavior must be swiftly dealt with to minimize negative outcomes.

Procedure:

Any staff member observing inappropriate behavior (defined as inappropriate touching of other patients or staff, making threatening or harassing comments, or any actions which make staff or patients feel unsafe) should:

- Direct the patient or others to a safe location either by asking the patient to wait in the exam room (leaving the door open) or the waiting room.
- Notify the supervisor. If the supervisor is not available, then notify a coworker of the behavior immediately if a threat of violence exists.
- The Site Director of Nursing shall request other staff assistance for problem solving and reassure other patients who may have been witness to the inappropriate behavior that all necessary action is taking place.
- Do not pass the patient on to another staff member for additional care until the issue has been addressed and/or resolved.
- If the incident is deemed as a serious threat to the safety and security of patients, staff, and/or the functioning of our clinics then the Site Director of Nursing must:
    - Notify the Chief Operating Officer by pager.
    - Dependent upon the type of incident the Chief Operating Officer will notify the Director of Human Resources and the Medical Director.
- If the patient remains in the clinic area, the site supervisor or another designated member of the Team will notify the patient regarding the consequences of their behavior in the clinic.
- The incident will be documented in the EMR.

Psychiatric Emergencies

Purpose:

To clarify the management of all psychiatric emergencies at BHCHP.

Procedure:

1. Please immediately notify the Site Manager or designee. It is essential that he/she be aware of any emergency in progress.

2. Please utilize any onsite available member of the Behavioral Health Team in clinic to assist with behavioral problems. The Associate Medical Director for Psychiatry can be paged for assistance as well if needed. If the situation is deemed to be threatening the safety of staff and/or patients, please call a Code Green (see policy).

3. If it is deemed necessary to have the patient further evaluated for possible hospital admission, please call the BEST team to discuss next steps. The BEST team number is **1 800 981 4357 (HELP)**. These are the possible next steps based on patient and clinic safety concerns:

    a. If patient is not threatening to harm themselves or others but is requesting hospitalization and evaluating staff do not consider there to be an imminent threat, the patient can be evaluated in the Clinic by a BEST Clinician or at the BEST office at 85 East Newton Street. The decision as to which is appropriate should be based on the timeline for the patient to be seen and/or ability of the patient to walk to the BEST office (with an escort if available). It is preferable to send the patient to BEST as their clinician may take up to an hour to arrive. Please call BEST to inform them that you are referring a patient.

    b. If there is considered to be imminent risk of harm to self or others, the patient should be sent by ambulance for ER evaluation and BEST notified. The Site Manager or designee should decide if Eascare or EMS should be called and which Security and/or clinic staff should watch the patient until transport arrives. In this case, a Section 12a form (aka “pink paper”) must be filled out for transport by an authorized licensed clinician (MD, psychiatric clinical nurse specialist, psychologist or LICSW). If there is no authorized clinician available, the BEST team can issue on a request a pink paper and fax it to the site. If there are questions or concerns, the psychiatrist on call can be consulted.

Guidelines for Contacting the BEST Team

Please have the following information available when contacting the BEST team:

1. General Demographic information, e.g. Name, DOB, SSN, health insurance etc.
2. Medical history and current medical issues including whether patient is medically stable or not.
3. Relevant psychiatric and substance abuse history.
4. Current medications.
5. Reason for contacting them:
    a. Suicidal ideation
    b. Homicidal ideation or aggressive or threatening behavior
    c. Psychotic symptoms e.g. hearing voices, paranoia etc. that are leading to patient being at risk of harm to self or others.
    d. Any change in behavioral status that makes them at risk of harm to self or others e.g. delirium (this is a medical diagnosis, but if the patient refuses to go to the Emergency Room or is combative, a Section 12 will be issued for transfer).

Mock Codes/Jackson Drills

Purpose:

To prepare for potential codes

Mock Codes (also known as "Jackson Drills" in memorial of patient William Jackson) are used to:

- To strengthen staff code response skills
- To teach, reinforce, and evaluate patient management during code blue resuscitation
- To promote patient safety
- To improve patient outcomes
- To help identify specific areas that require further education and training

Frequency of Mock Codes

A series of mock codes will be conducted program-wide ten times per year with the goal of having each clinical staff member participate at least once at least once every two years. This will ensure that many staff members at each site have recent training and practice

Records of Mock Codes

- Scoring sheets, which evaluate the performance of the mock code team, will be completed during each mock code (see attached).
- The Clinical Care Committee will select educational topics relevant to mock codes

Facilitating the Mock Code Scenario

- A **facilitator** will read the mock code scenario and observe the response, answering questions as appropriate about the scenario. The scenario should be presented in a consistent and orderly fashion to allow team members the opportunity to demonstrate their knowledge and skills in a realistic setting. Teaching should be reserved for post-mock code debriefing.
- To maintain the reality of the scenario, the facilitator should allow the scenario to progress in the direction that the team is leading even if the flow of the scenario deviates from the original scenario (i.e., if the team doesn't but oxygen on a hypoxic patient, the facilitator should indicate the patient's saturation has dropped).
- A **score-person** will have a stop watch and record appropriate times/actions on the score card. See attached BHCHP Mock Code Score Card and instructions for scoring mock codes below.
- Other **mock code organizers**, in addition to the facilitator and the score-person, will take notes about the performance including examples of appropriate management and areas needing improvement.
- Debriefing/education sessions should involve all members of the team and will be led by the facilitator.
- Begin the debriefing/education by asking the team to critique the team leader's management and the group's overall performance as a team. Ask participants if they felt the communication was clear and concise. The team should determine areas of appropriate patient management and areas needing improvement in technical or critical thinking skills. Following the feedback from the team themselves, the mock code organizers will give brief feedback collected, and the score-person will explain the score.
- Mock codes should only take approximately 20 minutes: 10 for code and 10 for debriefing/education.

How to Score a Mock Code

- Start the timer once the mock code has been announced. The time the mock code is called becomes minute 0.
- Keep a running time of when things happen (usually jotted down on the side of the score sheet), including when an intervention is ordered by the code team leader and when the intervention actually occurs. Once the mock code is complete, the scorer will review their notes and complete the scoring

Example of Mock Code Scenarios

- A 40 year old man presented to the front desk with chest pain. Before making it up to clinic, the patient suddenly collapsed in cardiac arrest. After BLS, and then two shocks from the AED, the patient regained his output.

Jackson Drill Score Card Participants:	**Date:**	**Scorer:**	**Facilitator:**	**Site:**	**Scenario:**
Intervention (BLS)	**Yes/No**	**Record Times: Code starts at _____**	**Less than 1 min (2 pt)**	**Less than 2 min (1 pt)**	**Less than 3 min (0 pt)**
Team arrives					
Code team leader identified _____					
Circulation					
Assess for pulse not more than 10 sec	Y=2 N=0				
Start chest compressions Rate 100 per min >2 inches deep Minimize interruptions Board or floor used Ratio with ventilations 30:2	 Y=2 N=0 Y=2 N=0 Y=2 N=0 Y=2 N=0 Y=2 N=0				
Call for AED					
Call for 911					
AED pads in place and turned on					
Return to chest	Y=2				

compressions after AED	N=0				
Airway					
Open, ensure patency, head-tilt, chin-lift Use oral airway if indicated	Y=2 N=0 Y=2 N=0				
Breathing					
Ventilate with bag-mask, good seal	Y=2 N=0				
Ratio of 30:2 with compressions	Y=2 N=0				
Obtain code cart					
Recorder established	Y=2 N=0				
Universal precautions used	Y=2 N=0				
Consideration of causes of emergency	Y=2 N=0				
Code form completed	Y=2 N=0				

Total score out of 48 possible points: _____ /48_____ Percentage: _____%_____

Evaluation of Oversedation

Purpose:

BHCHP clinicians must often evaluate patients who appear sedated. Accurately determining the patient's level of sedation is important in deciding where the patient should be cared for and what the next steps in his or her care may be.

Procedure:

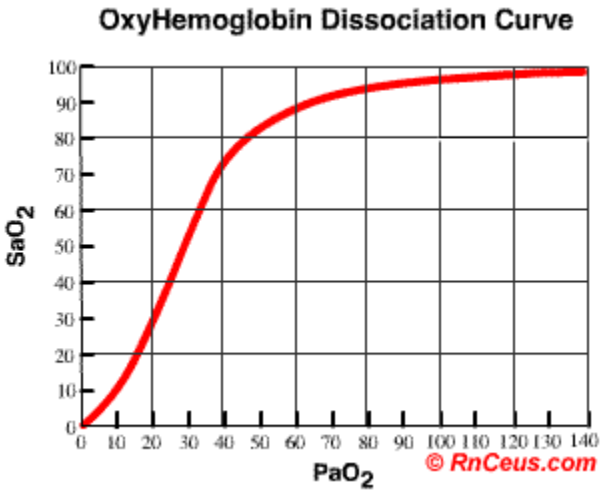
1. When a patient is thought to be over-sedated, initial assessment should include:
    - Assessment of sedation level. Sedation level can be graded using an S1 through S6 scale as detailed below:

i. S1 not sedated
ii. S2 calm and cooperative
iii. S3 drowsy, responds to verbal stimuli
iv. S4 sleeping, easy to arouse
v. S5 difficult to arouse (arouses to physical stimuli but does not communicate or follow commands, may move spontaneously)
vi. S6 unable to arouse (minimal or no response to noxious stimuli, does not communicate or follow commands)

- Vital signs. Once sedation level has been determined, the vital signs should be reviewed. For the purposes of this guideline ABNORMAL vital signs will be defined as:

i. Temperature >100.4 F, < 96.0 F
ii. RR less than 10, greater than 20
iii. HR less than 60, greater than 100
iv. Systolic BP less than 90, greater than 180
v. Diastolic BP less than 60, greater than 110
vi. Oxygen saturation less than 95%

Understanding the implications of abnormal oxygen saturation is important in this context. Please review the oxygen dissociation curve below:



This curve describes the relationship between the saturation of oxygen carried by hemoglobin (which we can measure), and the actual oxygen pressure which is available in the bloodstream.

- The horizontal axis is Pa02, or the amount of oxygen available.
- The vertical axis is SaO2, or the amount of hemoglobin saturated with oxygen.

- Note that large changes in available oxygen (PaO2) may only provoke small changes in the measured saturation in the flat part of the curve. By the time the measured oxygen saturation drops below 90, the available oxygen may already have dropped by half.

2. Using the sedation scale, vital signs assessment and keeping in mind the steep decline in PaO2 with SaO2 below 95% the following actions can be considered:*
    - S1 Usual clinical care
    - S2 with normal vital signs Usual clinical care
    - S2 with abnormal vital signs or S3 Usual clinical care + additional monitoring

i. Monitor
ii. Perform vital signs every 30 minutes at minimum, with sedation level reevaluation
iii. If vital signs improve may be released from clinic
iv. If vital signs decline or you are not able to continue monitoring patient due to clinic or shelter schedule then send to ER

- S4 and normal vital signs Usual clinical care + additional monitoring as above

i. Take into account setting, if transportation to hospital may not be available in a timely manner additional monitoring is not appropriate and patient should be transferred to the ER
ii. If monitoring can be use, follow guidelines detailed above

- S4 and abnormal vital signs Give Naloxone and send to ER
- S5 or S6 Give Naloxone and send to ER

	Vital Signs Stable	Abnormal Vital Signs
S1		
S2		
S3		
S4		
S5		
S6		

Close Monitoring

ER

*For patients with co-occurring medical conditions such as cardiac disease, pulmonary disease, cirrhosis and others, ED referral should be considered earlier.

Naloxone Use in the Oversedated Patient

Purpose:

When a patient is found to be over-sedated, critical assessment must be undertaken and several key actions must be performed. Patients can be sedated for multiple medical reasons including drug overdose (ie, benzodiazepines and opiates) and organic causes, including hypoxia or hypercarbia. The rapid administration of naloxone (Narcan) may be life-saving in patients with overdose due to opiate use.

Procedure:

1. When a patient is thought to be over-sedated, initial assessment should include:
    a. Level of consciousness/sedation level

i. S1 not sedated
ii. S2 calm and cooperative
iii. S3 drowsy, responds to verbal stimuli
iv. S4 sleeping, easy to arouse
v. S5 difficult to arouse (arouses to physical stimuli but does not communicate or follow commands, may move spontaneously)
vi. S6 unable to arouse (minimal or no response to noxious stimuli, does not communicate or follow commands)

    b. If S5 or S6, call a Code Blue and follow Code Blue procedures, including initiation of emergency response.
    c. Assess need for CPR or insertion of airway, provide oxygen, obtain vital signs with pulse oximetry and finger stick.
    d. Based on clinical scenario, senior most clinician on site will rapidly determine the need for naloxone administration (clues to opiate overdose include pinpoint pupils and track marks, although absence of these findings does not exclude opiate overdose).
    e. If Code Blue occurs at JYP and no NP/PA/MD is on site, initiate call to On Call provider. If time allows, include On Call provider in decision to use naloxone. If time does not permit and patient in stage S5 or S6 and EMS has not yet arrived, then Nurse Manager will initiate nalaxone use.
2. Naloxone use in the oversedated patient:
    a. Naloxone prefilled syringes (2mg/2 ml) are stored in clinic's emergency drug kits and on all BMH/JYP code carts along with two (2) safety needles, atomizer and diagram for atomizer use.
    b. Intranasal administration (preferred route)

i. Intranasal administration is the preferred method in oversedated patients because it provides an effective method for administration of the drug without a needle, which greatly reduces the risk of needlestick injury. In addition, naloxone is rapidly absorbed across mucous membranes and naloxone administered intranasally exhibits antagonist effects almost as rapidly as IV naloxone, with bioavailability approaching 100%.
ii. Confirm no exclusion criteria for intranasal route (nasal trauma, epistaxis).
iii. Remove protective caps from vial & injector. Thread vial into injector. DO NOT PUSH VIAL

INTO INJECTOR, remove cover & expel air before injection.

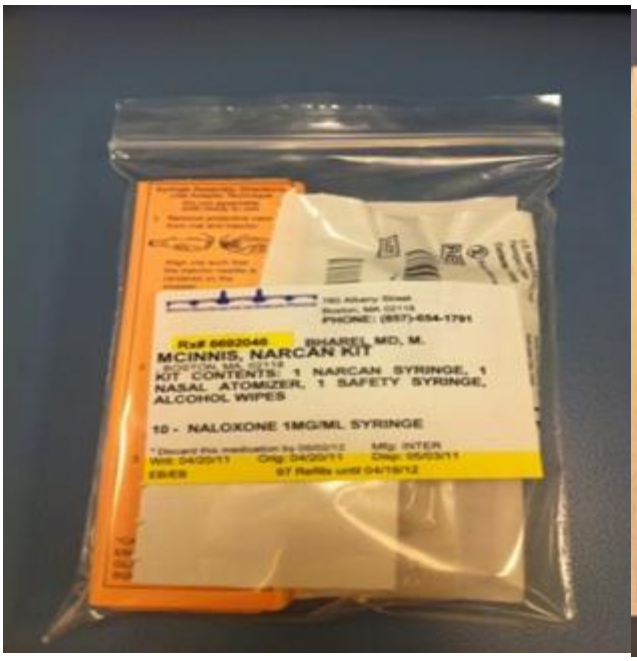
iv. Connect atomizer to syringe.
v. Administer 1mg (half of syringe) into each nostril, for a total dose of 2mg.
vi. If no response, repeat in 2-3 minutes.

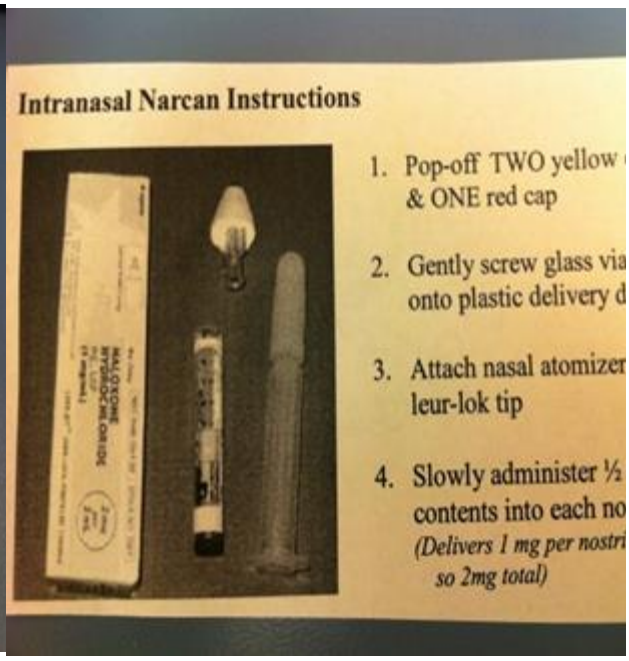
c. IM or SQ administration

i. Attach safety needle to pre-filled naloxone syringe
ii. Waste 1mg (1ml)
iii. Inject 1mg (1ml) IM or SQ
iv. If no response, repeat after 2-3 minutes

3. Naloxone use in the patient with respiratory or cardiac arrest:
    a. Prioritize BLS protocol, including circulation, airway, breathing, defibrillation if indicated.
    b. Attach safety needle to pre-filled naloxone syringe.
    c. Inject 2mg (2mL) IM or SQ.
    d. If no response, repeat in 2-3 minutes.
4. If naloxone is given:
    a. At earliest possible time notify, On Call provider
    b. Pharmacokinetics

i. Onset of reversal: 2-5 minutes. Onset of action is slightly delayed when delivered intranasally (ACLS, 2010; Kelly, 2005; Robertson, 2009).
ii. Peak effect: 6-10 minutes





JYP Code Blue

Purpose:

To establish guidelines for response for a person found in acute distress

Procedures:

Note: Procedures for Code Blue differ from Code Green

1. An employee who discovers a patient unresponsive or in acute distress will IMMEDIATELY: Call for clinical assistance and remain with patient. Activate the IGEACOM system if in a patient bedroom at the Barbara McInnis House.
    a. Request or activate a code on the overhead paging system by pressing the CODE button on any phone in the building and announcing: "Attention All Staff: CODE BLUE and state the exact location". The message will then be repeated twice automatically on the overhead system.
    b. In all patient bedrooms of the Barbara McInnis House press the Igeacom button that will connect you to the Unit Secretary, who will then announce the code on the overhead paging system once. It will be repeated once again automatically. **The person announcing the code has to hang up the phone handset for the page to be announced on the overhead system.**
    c. To announce a code blue at the BMC Clinic, follow 1a) procedure. The overhead system can be also activated from any Spectralink phone by pressing 4444 and announcing code blue and the exact location loudly and clearly.
    d. Code blues are never cancelled by staff. The clinician in charge, may however, direct excess staff to leave the scene.

2. NP/PAs, and RNs *in the location* of the code should respond, defined as follows:
    a. If code is in the Basement / 1st Floor / Lobby: BMC NP/PAs and RNs respond
    b. If code is on the 2nd floor: All BMH clinical staff respond
    c. If code is on the 3rd floor: BMH 3rd floor clinical staff respond
    d. If code is on the 4th floor: BMH 4th floor clinical staff respond
3. All MDs should respond to all code blue calls
4. Other staff who should respond to every Code Blue, provided they are in the building, include:
    a. BHCHP Director of Operations
    b. BHCHP Medical Director
    c. BHCHP Associate Medical Director
    d. BHCHP Director of Nursing
    e. BMH Medical Director
    f. BMH Director of Nursing
    g. BMH Nursing Supervisor
5. Staff access emergency equipment (AED, code cart, oxygen tank, patient chart) while en route.
    a. The first responding clinical staff member will assess patient's status and will initiate emergency measures to include, if indicated, BLS and 911 activation.
    b. The most senior clinical responder will assume leadership of the code response, which includes:

i. State "I am in charge"
ii. Confirm EMS activation (911 Response)
iii. Determine need to call for additional medical staff
iv. Acquisition of additional EQUIPMENT as needed
v. Designate person responsible as RECORDER of code to complete "Emergency Response Record"
NOTE: The Emergency Response Record will be forwarded to the BMH Nursing Supervisor (if code occurs on 2nd/3rd/4th floors) or BMC Nurse Manager (if code occurs in the basement or 1st floor).
vi. Designation of person responsible for TRAFFIC CONTROL to ensure elevator control, direction of EMT to location and removal of other patients from area
vii. Code leader must document note in patient's medical record after the Code Blue as a Medical Note or Respite Providers note or chart review if appropriate.

6. The MCINNIS HOUSE Nursing Supervisor responds to all codes on all shifts. He/she assumes the role of code leader unless an NP/PA is present; who then assumes the role of code leader unless an MD is present; who then assumes the role of code leader.
7. Between the hours of 5pm – 9am and weekends/holidays, all JYP staff respond to code blue.
8. Code blue may occur with staff or visitor. In this case the incident will be documented on the code blue form.
9. Jackson Drills will be conducted periodically in all BHCHP sites.

Roles: Code leader (code leader determines whether a 911 call is necessary), Recorder, Runners

JYP Use of IM Benzodiazepines for Seizures

Purpose:

In certain clinical situations, such as a prolonged seizure, it may be clinically necessary to use IM benzodiazepines to abort seizure or treat urgently while awaiting EMS support. The need for benzodiazepine IM is determined clinically by the NP/PA/MD. Some common indications include (but are not limited to) prolonged seizure or ETOH withdrawal in a patient who is unable to take medications by mouth.

Procedure:

- The BMH pharmacy keeps a stock of lorazepam IM.
- In the event of emergency, the NP/PA/MD who is assessing the clinical situation can order a stat dose of lorazepam IM.
- The routine dose ordered will be 0.5-1 mg IM (0.05mg/kg). This dose can be repeated at 30-60 minutes.
- During hours when the pharmacy is closed follow the standard code blue procedure.
- Lorazepam IM will be available during pharmacy hours AND when there is an NP/PA/MD available on site.

JYP Code Green

Purpose:

To clarify the management of all behavioral emergencies

Definition:

A Code Green applies to any situation in which the safety of staff and patients is immediately jeopardized by the behavior of a person who is acting out verbally or physically and/or where a person threatens harm to self or others in an acting out manner.

Procedure:

Note: Procedures for Code Green differ from Code Blue

1. Activate the **IGEACOM system where available/necessary or the** panic button by doing the following:
    a. In all clinics, both at BMH and BMC Clinic press a panic button or Igeacom that will activate a pre-recorded message, announcing a Code Green with room number, floor and location. The message will be repeated until canceled manually by pressing the RED cancel button on the Igeacom.
    b. In all patient bedrooms press the Igeacom button that will connect you to the Unit Secretary, who will then announce the code on the overhead paging system once. It will be repeated once again automatically**. The person announcing the code has to hang up the handset for the page to be announced on the overhead system.**

c. The overhead system can be also activated from any Spectralink phone by pressing 4444 and announcing code blue and the exact location loudly and clearly.

2. Safety comes first and all are to remember that no one should approach a person who is being violent or threatening.
3. In an effort to minimize the number of respondents, only the following assigned staff should respond to Code Greens that occur Monday through Friday from 9am – 5pm, provided they are in the building:

   All psychiatrists and psychiatric clinical nurse specialists
   All security personnel
   - **will respond to ALL codes**

   All psychiatrists and psychiatric clinical nurse specialists
   All security personnel
   Food service supervisors
   BHCHP Director of Operations
   BHCHP Medical Director
   BHCHP Associate Medical Director
   BHCHP Program Director of Nursing
   BMC Medical Director
   BMC Clinic Director
   - **will respond to ALL BMC Clinic, lobby and dental area codes**

   BMH Director
   BMH Supervisor of Case Management Services
   BMH Medical Director
   BMH Director of Nursing
   BMH Nursing Supervisor
   - **will respond to ALL BMH codes** Between the hours of 5pm – 9am and weekends/holidays, all staff respond to code green.

4. If appropriate, the first senior staff member on the scene should identify themselves verbally as the code leader by stating, "I am in charge," then determine what steps to take: options include calling 911, requesting a psychiatric evaluation if available, isolating the situation.
5. Patients and visitors are to be asked to clear the area.
6. Staff who are at the scene should be present but non-confrontational and act in a way to de-escalate the situation, consistent with training.
7. Mock code greens will be run periodically in all BHCHP sites.

After the Event

1. Reassure staff and patients
2. For code green on the basement or first floor the code leader pages the director of clinical operations (or his designee) and for code green on floors 2-4, the code leader pages the McInnis House BMH director.
3. Code leader writes an incident report

4. For the floors 2-4, inform Admissions, if the incident resulted in a patient being administratively discharged, of readmission criteria.
5. For the basement and first floor, the Director of Clinical Operations and the Medical Director will review the incidents.

FALL PREVENTION

Policy Statement: The staff at the Barbara McInnis House is charged with providing a safe environment for all patients. This Falls Prevention Program will provide guidelines to attempt to decrease the number of falls which patients may experience.

Purpose: The purpose of this program is to prevent patient falls during their stay at Barbara McInnis House by assessing each patients risk for falling and identifying the patient-specific strategies and interventions to prevent patients from falling. Also this policy will ensure proper care and documentation in the event of a fall.

Procedure:

1. Prevention

The Risk Assessment Tool (RAT) will be completed on every patient at BMH by the team RN on admission. If a patient scores 10 or higher, they will be put on our fall precaution protocol and remain on protocol until removed by team RN or team provider, or discharged from BMH.

2. Identify Patient to Staff at Respite

The color orange will indicate a patient in our fall prevention program. When a patient has been assessed to be at risk for falls, they will be identified by using orange stickers and wearing orange no slip socks. An orange sticker will be placed on the name plate outside the patient's room. A list of all fall precaution patients will be kept at all times.

3. When a Patient Falls

- The patient will be initially assessed for injury by a RN. If the fall is unwitnessed or the patient hit his or her head a Neurological assessment will be done. Neurological assessments will consist of assessment of the pts level of alertness, level of consciousness, pupillary response and ability to move all extremities.
- A provider will be notified if one is available, or as RN deems necessary, the patient will be sent to the ER or the on call provider will be consulted.
- Patient Fall Worksheet will be completely filled out. A copy must be sent or given to Nursing Supervisor and Nurse Educator.
- Description of event and patient's condition will be documented in EMR by the RN caring for patient.

The team RN will IMMEDIATELY put a new intervention in place and communicate this intervention to the whole team. Be sure to look at "NEW Suggested Interventions for a Patient Who Has Fallen".

4. Evaluation of fall at Respite

- Each fall report will be reviewed by the Director of Nursing, Medical Director and Nurse Educator.
- Staff response will be evaluated to determine if response was appropriate and adequate interventions were implemented.
- Medical Director will determine the need to notify DPH.

- Falls will be reviewed every month at Clinical Care Committee.

STAFF RESPONSIBILITIES IN **FALL PREVENTION** PROGRAM

RN Responsibility

1. Initial assessment to determine whether patient needs to be on fall precautions.
2. Develop individualized plan of care for patient.
3. Alert RA staff of patient's needs.

RA Responsibility

1. Ensure that patient's environment is safe: bed positioning, area in room, etc.
2. Update and review Patient Fall List and communicate the changes to unit secretary each shift.
3. Follow individualized plan of care as developed by team RN.

Provider Responsibility

1. Identify predisposing condition that places patient at risk for fall and determine if it is reversible or not.
2. Identify steps to reverse or decrease factors that put patient at risk to fall: BP parameters, PT for gait training, etc.

Security and Kitchen Staff

1. Have an increased awareness of these patients and be alert to their risk. Contact nursing staff if there is any concern.

Housekeeper

1. Communicate to team RN and RA and patient when cleaning floor or room. Alert them to wet floors, crowded areas or moved furniture.

Unit Secretary

1. Update the Patient Fall List as directed by the team RA or RN and put a copy in the provider box and give a copy to each team RN and RA.

Patient Fall Worksheet

Patients Name _____ DOB_____
Date of Fall _____ Time of Fall_____
Fall risk score on admission_____
Did anyone witness the fall? YES NO IF yes, who? _____
When was the patient admitted? _____ Is the patient detoxing? YES NO

Medicine List- Please attach med list

Medical Problems – Please attach problem list.

Evaluation After Fall

_____
_____
_____
_____
_____

Contributing Factors (ie Was the floor wet, Was the patient wearing shoes, Medicines?)

_____
_____
_____
_____
_____

Additional Interventions Added to Care Plan:
Make sure to look at the NEW "Suggested Interventions for a Patient Who Has Fallen"

_____
_____
_____
_____
_____

RN Signature_____
DON or Nurse Educator Signature
_____

	RISK ASSESMENT TOOL	
RISK FACTOR	**DETAILS**	**POINTS**
Age	0-50 = 0 Over 50 = 2	
History of Fall In Past 30 Days	No Falls = 0 1-2 Falls = 2 3 Falls = 3 4 or More Falls = 4	
	All That Apply = 2	
Predisposing Diagnosis	**A.** Mobility Impairment Requiring Assistive Device: Crutch, Cane, Walker, Wheelchair, Boot, Arm Sling, Splint, Dressing on Foot **B.** Detox Requiring Sedative Meds: Benzos, Librium, Ativan, Clonodine, Opiates **C**. Methadone **D.** Pain Medication **E.** One Medication That May Be Sedating: Seroquel, Benzos, Neurontin, Psychiatric Meds **F.** Recent Sedation or Anesthesia **G.** Sensory Deficit: Visual or Auditory Impairment **H.** Cognitive Impairments or Impulse Control Issues **I.** Medical Conditions Thats May Alter Balance, Sensorium or Mobility: Hypertension, Hypogylcemic, Vertigo, Orthostatic Hypotension Mobility Impairment: Lower Back Pain, Paralsis, Fracture Neurological Conditions: Peripheral Neuropathy, Subdural Hemotoma, Subarachnoid Hematoma, Cerebellar Ataxia, Stroke, History of Head Injury, Seizure Disorder, Amputation, Lower Extremity Edema, Lower Extremity Cast, Walking Boot, Splint, Dressing	
Elimination Patters	Continent = 0 Frequent Stools/Urination = 1 Incontinent = 2	
LOC	Fully Alert = 0 Sedated, Easily Aroused = 2 Sedated, Defficult to Arouse = 4	
Equipment Needs	02 Tubing or Tank = 2 IV Tubing or Pole = 2 Assistive Device = 2	
TOTAL		