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

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

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

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RN Signature____
DON or Nurse Educator Signature
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	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		