FALLS PREVENTION

The New Program and Forms
The New Falls Prevention Program

As you know, there is a new Falls Prevention Program that is being implemented on April 1, 2013.

This brief inservice is to provide instruction on how to complete the 2 new forms associated with the new program, as well as the RN’s responsibility for falls assessment and response following a fall incident.
The new Fall Risk Assessment was developed specifically for psychiatric patients, and addresses the risks associated with certain psychiatric diagnoses.

As part of an ongoing patient fall risk assessment, these forms will be completed by the RN for patients:

- within 24 hours of admission
- once every week for the first month a patient is deemed to be a fall risk, and then monthly until the patient is no longer considered a fall risk
- whenever there is a fall incident
- annually
- whenever a patient’s level of consciousness/alertness or medical condition noticeably changes.
There are multiple opportunities to document a fall risk assessment on each form. Each column represents one assessment.

The falls assessment form should be filed under the “Assessments” tab in the chart.

Indicate the total score in each category in the first available column. **More than one item may be selected in each category if appropriate for the patient.**
Make sure to put a patient label at the top of the form.

Write the date, time, and your signature at the top of the first available column.

Indicate the patient’s score for his/her age.

Mental Status:
Patient may score for Agitation/Anxiety and the other categories including Fully alert, Intermittently confused or Confused/disorientation.
Elimination: 
*Elimination with assistance* is defined as follows: Patient calls for assistance with toileting on a regular basis.

Diagnosis:
Use the Physician’s diagnosis. Some patients may have more than one diagnosis. Patient may score for each diagnosis i.e. *Major Depressive Disorder* and *Alcohol Abuse*.

Ambulation/Balance:
Patient may score in more than one category, for example *Independent* and *Orthostatic Hypotension*.
Nutrition:
Use the Nurses Notes (24 hour summaries) or Admission Assessment to obtain this information.

A patient can be given a score of 12 based on any of the following:
- Caregiver or patient report of decreased appetite and intake of food and fluids over the last 24 hours.
- Documentation of patient meal/supplement intake of less than 50% over the last 24 hours.
- Documentation of “poor fluid intake” within the last 24 hours by nurses and/or attendants.
- Physical assessment reveals signs of dehydration or poor fluid intake (ie. Poor skin turgor, dry mucous membranes, abnormal labs).
Sleep Disturbance:
Use Nurses Notes (24 hour summaries) or Admission Assessment to obtain this information.

A patient can be given a score of 12 for *sleep disturbance* for any of the following:
- Patient, family or caregiver report of sleep disturbance (ie. “not sleeping,” “awake half the night”).
- Documentation of 4 hours of less of consecutive sleep the night prior to assessment.
History of Falls:
Use the progress notes or admission assessment to obtain this information.

Hint: Once we have these in all the charts, look back on the last one completed...if it is scored a “14” then you know they have a history of falls.
Medications That Increase Fall Risk

**Psychotropic Meds**
- Neuroleptics
- Antidepressants
- Benzodiazepines

**Cardiac Meds**
- Beta Blockers
- Antiarrythmics
- Calcium Channel Blockers
- Alpha Adrenergic Blockers
- ACE Inhibitors
- Vasodilators
Medications:
Circle all scores that apply in this category.

Score “10” if the patient is on any cardiac meds. Score an additional “8” points if the patient is on psychotropic meds OR “12” if the patient has had an increase in these meds or PRN psychotropic meds in the past 24 hours.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

- Indicate the fall risk on the patient Kardex program – a report will be generated on a monthly basis from the Kardex that will provide the list of patients at risk for falls to the Risk Manager.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

- Initiate a Nursing Care Plan outlining the interventions for fall prevention (unless the risk for falls is already included in the interdisciplinary treatment plan).
Choose only the interventions on the Nursing Care Plan that are appropriate for the particular patient being assessed.

The Nursing Care Plan template for a patient at risk for falls is located in the shared folder “Nursing Care Plans” and is in the “Non-psych NCPs” folder. It is entitled “Risk for Falls NCP Template 3-13.”

Remember...if the risk for falls is a chronic problem, include it in the Interdisciplinary Treatment Plan at the patient’s next review. As soon as the risk for falls is included in the treatment plan, the Nursing Care Plan can be discontinued.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

• Notify the attending physician (via the doctor’s book) so that he/she will review the patient’s medication to determine if any changes are warranted to decrease fall risk.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

- Pass along the falls assessment findings and nursing plan of care in shift report for the next 24 hours to assure that all nursing staff are informed.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

- Post a “Falling Star” sign outside the patient’s room and a “Falling Star” sticker on the spine of the patient’s chart to alert staff that the patient is a fall risk.

These are currently found in the Nursing Administration Office, but will eventually be located in Central Supply.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

• Suggest a referral for a consultation from the Occupational Therapist, if appropriate.
IF THE PATIENT IS A FALL RISK (score of 90 or above on the falls assessment):

Review all the possible interventions listed on the Nursing Care Plan, and implement the ones that make sense for the particular patient...then chart what was done and the associated assessments required by the care plan in the progress notes.
So what happens when a patient falls?
In the event of a fall, with or without apparent injuries:

• The staff member discovering the fall will evaluate for injuries, notify the nurse, and attend to the patient’s immediate needs.

• Vital signs will be taken immediately, including orthostatic blood pressures.

• If patient is diabetic, the blood glucose will be checked.
In the event of a fall, with or without apparent injuries:

• If the fall involved a possible head injury, initiate neurochecks per Nursing policy #130.06
In the event of a fall, with or without apparent injuries:

- RN will determine the circumstances leading to the fall and document in the patient’s medical record.
In the event of a fall, with or without apparent injuries:

• The RN will notify the Nurse Supervisor assigned to the unit so that the fall incident can be reported on the D.O.R.

• The RN will notify the physician of the fall incident.
In the event of a fall, with or without apparent injuries:

- The RN will complete a Post-Fall Investigation form.
- The fall incident is included in shift report for 24 hrs.
Be sure to affix a patient label at the top of the form.

Most of the information involves checkboxes and is self-explanatory.

For “Patient’s Response” – try to capture patient’s statements to the question. Indicate if patient is unable or unwilling to respond.
Consider all factors in the environment that might have contributed to the fall, i.e. “Peer pushed the patient,” or “Bed linens hanging off the bed onto the floor,” etc.

If no environmental factors present, indicate “none” next to “Other:”

<table>
<thead>
<tr>
<th>Mental Status of Patient: (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
</tr>
<tr>
<td>Able to follow verbal directions</td>
</tr>
<tr>
<td>Confused/Disoriented</td>
</tr>
<tr>
<td>Agitated/Anxious</td>
</tr>
<tr>
<td>Change in behaviors</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Status of Patient at time of fall: (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
</tr>
<tr>
<td>Recent weight loss/gain</td>
</tr>
<tr>
<td>Recent acute illness</td>
</tr>
<tr>
<td>Specify:</td>
</tr>
<tr>
<td>Recent cough/cold</td>
</tr>
<tr>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Other:</td>
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<th>Environment status at time of fall: (check all that apply)</th>
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<tbody>
<tr>
<td>Inadequate lighting</td>
</tr>
<tr>
<td>Floor wet or slick</td>
</tr>
<tr>
<td>Other:</td>
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</table>
List only new medications, or medications that have dosage and time changes that have occurred within the past 48 hours.

List any PRN medications administered to the patient within the past 48 hours.
Answer this question based on whether you feel the fall resulted in something that could be corrected with additional education ie. Proper use of assistive device, calling for help to toilet, correcting room clutter, etc.
Summarize the factors that contributed to the fall.

Indicate what you are implementing to prevent another fall for this patient.

Summary: Factors contributing to fall

Action Plan to prevent another fall incident:
<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall documented in progress notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident form completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Fall Investigation summary documented in progress notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Risk Assessment completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Prevention Nursing Care Plan completed/reviewed</td>
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Use this section as a “checklist” to assure that you complete all of the process of the Post Fall Investigation. Note that you will need to document your summary of the investigation of the fall in the progress notes.
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**Assessment completed by:**

Name (print): ________________________________

Signature: ________________________________

Date: _______________  Time: _______________

Submitted to Nursing Supervisor: ________________________________

Date: __________________  Time: __________________

Have the Nursing Supervisor sign the form when it is completed to verify that you notified him/her.

Make a copy of the form and send it to the Nurse Manager of the unit.
The Post-Fall Investigation Form is kept on the Shift Report clipboard until it is sent with the DWSR and any S&R pumpkin sheets to the timekeeping office on night shift.
Falls Data

The information captured on the Post-Fall Investigation Form is recorded by the Risk Manager for analysis and evaluation by the Interdisciplinary Falls Team, and is used to determine what changes in policy and procedure might be needed to reduce falls incidents.

It is important that the data on that form be accurate and as complete as possible.
Falls Incident packets are being compiled by the Unit Clerks (similar to the Seclusion and Restraint Packets) that will have all of the forms and instructions you will need in the event of a fall incident.
You have completed the inservice

“Falls Prevention: The New Program and Forms”

Name (printed): ________________________________

Signature: ____________________________________

Date: ___________________

Print and complete this slide, and send to Terry Slayback in the Nursing Administration Office to receive credit for this inservice.