UPDATE ON THE FALLS PREVENTION PROGRAM
SEPTEMBER 2013

REMINDERS ABOUT FALLS PREVENTION
Falls prevention is an integral part of a “Culture of Safety” in an organization. Falls Prevention is EVERYONE’S responsibility.
Since the implementation of our Falls Prevention Program in April, our falls incidents have decreased, thanks to staff and patients being aware and responsible for falls prevention efforts.
Always trying to improve........

During a recent evaluation of the Falls program, it was discovered that we needed to clarify the definition of a fall.
DEFINITION OF A FALL

The National Database of Nursing Quality Indicators (NDNQI) defines a fall as any unplanned descent to the floor or some lower level, with or without injury to the patient.

Any staff assistance of patients to the floor is considered an assisted fall, and protocol should be followed as for all fall incidents.
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Any staff assistance of patients to the floor is considered an assisted fall, and protocol should be followed as for all fall incidents.
According to the definition, if a patient intentionally throws him/herself onto the floor, or drops to the floor or a lower level intentionally, it is not considered a fall, even if injury results.

If the patient was injured while intentionally going to the floor or a lower level, you must complete an unusual incident report, but you do not need to complete a Post-Fall Investigation Report, and it should not be listed as a fall on the D.O.R.
If you need to complete an unusual incident report for a patient who dropped intentionally to the floor and was injured or potentially injured, do not mark “Fall” as the Incident Type. You need to mark “Other” as the Incident Type on the report.
There are a variety of things that staff and patients can do to prevent falls. These are simple and common-sense prevention measures that everyone should be able to remember.
Intervention protocols for prevention of falls for all patients, regardless of risk level include

- Orient patient to environment. Make sure patients know the locations of bathrooms, light switches and other needed areas on the unit. Orient the patient to schedules and routines on the unit. Make sure they know who they can ask for help when needed.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Keep walkways free from obstructions and spills.

Make sure that patients’ rooms are free from clutter on the floors that might trip patients.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Promptly clean up any spills or wet spots on the floors.
- Use caution signs when floors are wet from cleaning or spills.
- Housekeeping staff should clean high traffic areas during times of low use to minimize patient contact with wet floors.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Patients should wear non-skid footwear whenever out of bed.
Intervention protocols for prevention of falls for all patients, regardless of risk level include

- Assure that nightlights are on and in working order in patients’ rooms during evening and night rounds.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Place patient’s items of need within easy reach.
Intervention protocols for prevention of falls for all patients, regardless of risk level include

- Assist patients with toileting as appropriate.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Evaluate efficacy and side effects of medication that predispose patients to falls:
  - sedatives/hypnotics
  - antihypertensives
  - diuretics
  - antiarrhythmics
  - laxatives
  - benzodiazepines
  - neuroleptics
  - antidepressants
  - other cardiac medications
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- **Reassess patients for fall risk**
  - with an increase in medications that pose an increased risk for falls
  - with any significant changes in the patient’s medical or psychiatric status
  - following a fall incident
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Monitor for orthostatic hypotension (drop in blood pressure with change in position) if the patient complains of dizziness, lightheadedness, or vertigo.

- Teach patient to rise slowly when getting in and out of bed.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Encourage use of assistive devices (walkers, canes, etc.) as prescribed or recommended by OT.
Intervention protocols for prevention of falls for all patients, regardless of risk level include:

- Educate patients regarding fall prevention techniques.
Possible additional fall prevention interventions for patients at risk for falls

- A Nursing Care Plan will be initiated for patients at risk for falls outlining the interventions for fall prevention.
- The Falls Prevention interventions included in the Nursing Care Plan will be selected based on the falls assessment findings.
- If the fall risk is a chronic condition, the Nursing Care Plan will be incorporated into the Interdisciplinary Treatment Plan at the next treatment plan review.
In the event of a fall...........

A Post-Fall Investigation must be completed by the RN.

It is the responsibility of the RN to assure that all information about the fall is obtained and included in the report.

### Post-Fall Investigation Form

#### Patient Information

- **Name:**
- **Date of Fall:**
- **Time of Fall:**

#### 1. Was this fall observed? [ ] Yes [ ] No
- Yes: [ ] by whom?
- No: [ ]

#### 2. Was the patient identified as a patient at risk for falls prior to this fall? [ ] Yes [ ] No

#### 3. Resident’s Vital Signs immediate post-fall:

<table>
<thead>
<tr>
<th>Temp.</th>
<th>Pulse</th>
<th>B/P</th>
<th>Resp.</th>
<th>O2 Sat.</th>
<th>Blood Sugar (diabetes only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4. Does the patient have a history of falls? [ ] Yes [ ] No

#### 5. Was the patient on precautions at the time of the fall? [ ] Yes [ ] No
- Yes: [ ]
  - 1:1 precautions
  - Suicide precautions
  - Ongoing precautions
- No: [ ] Q 15 min. checks

#### 6. Patient’s response to “Why do you think you fell?”

- [ ]

#### 7. What footwear was the patient wearing?

<table>
<thead>
<tr>
<th>Barefoot</th>
<th>Shoes</th>
<th>Socks</th>
<th>Slippers</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other: [ ]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 8. Patient activity/need at time of the fall (check all that apply):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting in or out of bed?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Getting up from chair?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Looking for something?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Walking on unit?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Walking on grounds?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other:</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

#### 9. Location of fall:

<table>
<thead>
<tr>
<th>Location of fall</th>
<th>Patient’s bedroom</th>
<th>Bathroom on the unit</th>
<th>Bathroom off the unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main diningroom</td>
<td>Unit diningroom</td>
<td>Shower</td>
<td></td>
</tr>
<tr>
<td>Hallway on the unit</td>
<td>Hallway in the building</td>
<td>Activity/DAY Room</td>
<td></td>
</tr>
<tr>
<td>Classroom</td>
<td>Courtyard</td>
<td>Grounds</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
POST FALL RESPONSE AND INVESTIGATION

In the event of a fall, with or without apparent injuries

- The staff member discovering the fall will evaluate for injuries, immediately notify the nurse, and attend to the patient’s immediate needs.
Vital signs will be taken immediately, **including orthostatic blood pressures** (if patient is able/willing to comply)
Why Orthostatic Blood Pressure?

Orthostatic blood pressure is extremely important to evaluate because

- A significant drop in blood pressure (20 mmHg or more) accompanying a change in body position may be responsible for the patient’s fall.
- We administer many medications to patients that can result in orthostatic blood pressure drops. The patient’s medication may need to be adjusted to prevent further falls.
What if a patient’s orthostatic blood pressure cannot be checked immediately after a fall?

If the patient cannot stand, or is uncooperative, immediately following a fall, indicate on the Post-Fall Investigation Report that the orthostatic BP could not be obtained.

Be sure to check the orthostatic BP as soon as the patient is able to cooperate, and record the results in the chart.
If the patient is experiencing a significant drop in orthostatic blood pressure.....

- Initiate appropriate falls prevention strategies related to that issue until the patient’s medication can be adjusted by the physician.

- Make sure to put the blood pressure readings and the fall incident in the doctor’s book to alert the physician to the need to address the patient’s medication regimen.
If patient is diabetic, the blood glucose will be checked.
POST FALL RESPONSE AND INVESTIGATION

- RN will assess for injury, initiate appropriate interventions and monitoring based on patient condition, and notify the physician and Nurse Supervisor of the incident.
RN will determine the circumstances leading to the fall and document in the patient’s medical record.
The RN will assure that an unusual incident report is completed.
The fall incident is to be reported in shift report for 24 hours following the incident, and is also to be reported on the D.O.R.
The 3-page Post-Fall Investigation Form records important information about the fall incident, including both environmental and patient factors, that will be used by the Interdisciplinary Falls Team to evaluate individual and aggregate data about fall incidents.

The Post-Fall Investigation Form is kept with shift report until it is sent by night shift to timekeeping where the Quality Management staff will collect them.

A copy of the Post-Fall Investigation Form is also sent to the Nurse Manager for the unit.
REMEMBER!

Falls prevention is EVERYONE’S responsibility!

We ALL play a part in keeping our patients and our staff members safe!
You have completed the inservice

“UPDATE ON THE FALLS PREVENTION PROGRAM – SEPT 2013”

Printed Name: _____________________________________

Signature: ______________________________________

Date:  _____________________

Print and complete this slide and send it to Staff Development to get credit for this inservice.