FALLS PREVENTION

Update 2014
RSH Falls Prevention Program

As you know, a Falls Prevention Program was implemented on April 1, 2013.

As part of that Falls program the Interdisciplinary Falls Team completed a review of the program, and considered input from nurses and physicians about the current forms and program.
We will continue to use the Edmonson Fall Risk Assessment

• The Edmonson instrument is being reviewed by the Falls Team to check the validity and reliability with our patient population (in response to feedback received from nurses and physicians).

• The next few slides will serve as a review of the Edmonson, and how to complete the assessment.
Edmonson Psychiatric Fall Risk Assessment

As part of an ongoing patient fall risk assessment, these assessments 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.

<table>
<thead>
<tr>
<th>Edmonson Psychiatric Fall Risk Assessment</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
</tbody>
</table>

**FALL RISK = Score of 92 or Greater**

Instructions:
1. Complete the assessment upon Admission, after a fall, on exacerbation for pts at risk for falls, and whenever mental status/medical condition changes.
2. Circle all the scores that apply. More than one item may be selected in each category if appropriate for the patient.

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td></td>
</tr>
<tr>
<td>2. Mental Status</td>
<td></td>
</tr>
<tr>
<td>3. Communication</td>
<td></td>
</tr>
<tr>
<td>4. Medications</td>
<td></td>
</tr>
<tr>
<td>5. Depression</td>
<td></td>
</tr>
<tr>
<td>6. Ambulation/Toilets</td>
<td></td>
</tr>
<tr>
<td>7. Nutrition</td>
<td></td>
</tr>
<tr>
<td>8. History of Falls</td>
<td></td>
</tr>
</tbody>
</table>

Assessment...

Total: Add all 0 sections
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.

<table>
<thead>
<tr>
<th>1. Age</th>
<th>8 Less than 50</th>
<th>10 50 to 79</th>
<th>26 80 and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Mental Status</td>
<td>4 Fully Alert/Oriented at all times</td>
<td>12 Agitation/Anxiety</td>
<td>13 Intermittently confused</td>
</tr>
<tr>
<td></td>
<td>14 Confusion/Disorientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Elimination</td>
<td>9 Independent with control of bow/ bladder</td>
<td>12 Catheter/ Ostomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 Elimination with Assist</td>
<td>11 Altered elimination (incontinence, recta, frequency)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 Incapable but Ambulates independently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Medications</td>
<td>10 No Medication</td>
<td>11 Substance Abuse/ Alcohol/ Abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 Psychotic Medications (Including: Benzodiazepines and Antidepressants) OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13 Increase in these medications and/or PAIN  (spasmyphen) in the last 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Diagnoses</td>
<td>10 Bipolar/Schizoaffective Disorder</td>
<td>12 Major Depressive Disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 Dementia/ Delirium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Ambulation/ Gait</td>
<td>7 Steady Gait Immobile</td>
<td>8 Proper Use of Assistive Devices (cane, walker, etc)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 Vertigo/Osloeholism/ Weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 Unsteady/ Requires Assist and Aware of Abilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 Unsteady but Forgets Limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Nutrition</td>
<td>12 Has had very little food or fluids in the past 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 No apparent abnormalities with appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Sleep Disturbance</td>
<td>8 No sleep disturbance</td>
<td>12 Report of Sleep Disturbance by patient or family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 History of Falls in the last 2 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FALL RISK = Score of 90 or Greater**

Instructions:
1. Complete the assessment upon admission, after a fall, once/week for pts at risk for falls, and whenever mental status/medical condition changes.
2. Circle all the scores that apply. More than one item may be selected in each category if appropriate for the patient.
3. File the assessment in the “Assessment” section of the patient record.
4. If pt. is a fall risk (score of at least 90), follow Falls Risk Protocol.
Special note on “Mental Status”....

If the patient is fully alert and oriented at all times, you need to subtract 4 points for this section.

If the patient is fully alert and oriented at all times and is agitated or anxious, the score for this section would be “8”

If the patient is fully alert and oriented at all times and is NOT agitated or anxious, the score for this section would “-4”
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* ie. 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 or less of consecutive sleep the night prior to assessment.
History of Falls:
Use the progress notes or admission assessment to obtain this information.

We will also be implementing a new “Falls Record” on which falls for individual patients will be tracked (similar to a seizure record).

Hint: Once we have Edmonson assessments 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.

#### Instructions:
1. Complete the assessment upon Admission, after a fall, once/week for pts at risk for falls, and whenever mental status/medical condition changes.
2. Circle all the scores that apply. More than one item may be selected in each category if appropriate for the patient.
3. File the assessment in the “Assessments” section of the patient record.
4. If pt. is a fall risk (score of at least 90), follow Falls Risk Protocol.
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.
Revised Post-Fall Investigation Report

• The Post-Fall Investigation Report has been revised to be an “addendum” to the Unusual Incident Report, so that information does not have to be duplicated on either form.

• The Post-Fall Investigation Report is to be stapled to the Unusual Incident Report and be put in the Doctor’s book to be signed by the physician, and then both forms will be sent to Quality Management department.
The Post-Fall Investigation Report is now a one-page form (front and back).

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**Post Fall Investigation Form**

**Patient:**

**Date of Fall:**

**Time of Fall:**

1. Was this fall observed? [ ] Yes [ ] No
2. Was the patient identified as a patient at risk for falls prior to this fall? [ ] Yes [ ] No
3. Most recent Edmonston's Fall Risk score prior to this fall: [ ] Date of assessment:

4. Resident's Vital Signs, immediate post-fall:
   - Patient unable to stand, get orthostatic pressures, lying and sitting.
   - **Temp.**  |  **Pulse**  |  **B/P**  |  **Resp**  |  **O2 Sat.**  |  **Blood Sugar**
   - Sitting:  |  Sitting:  |  |  |  |  
   - Standing: |  Standing: |  |  |  |  

5. Is there evidence (considering the above vital signs and circumstances of the fall) that the patient may be suffering from orthostatic hypotension? [ ] Yes [ ] No
   - Orthostatic Hypotension: drop of at least 10 mm Hg systolic pressure or 10 mm Hg diastolic pressure within 3 min of position change.
6. Does the patient have a history of falls? [ ] Yes [ ] No
7. Was the patient on precautions at the time of the fall? [ ] Yes [ ] No
   - No. 1:1 precautions  [ ] Suicide precautions  [ ] Eye/gait precautions  [ ] 0.15 m checks
8. Things to include in the narrative of the Unusual Incident Report:
   - Description of incident section should include:
     - What the patient was doing when the incident occurred.
     - Exact location of the fall.
     - Any environmental issues that may have contributed to the fall.
     - The patient's description of what happened.
     - Staff member's description of what happened (if observed).
   - Nursing Comments section should include:
     - A description of any injuries to the patient and any details of the physical assessment.
     - Mental Status of the patient.
9. Was a mechanical device in use at the time of the fall? [ ] Yes [ ] No
   - If yes, what device? [ ] Chair Alarm  [ ] Bed Alarm  [ ] Hospital Bed  [ ] Other:
10. Was a medical assistive device in use at the time of the fall? [ ] Yes [ ] No
    - If yes, what? [ ] Cane (straight)  [ ] Cane (Quad)  [ ] Walker  [ ] Crutches  [ ] Wheelchair  [ ] Gait Belt  
    - Other:  
11. Any physical impairments/problems with patient at time of fall? [ ] Yes (check all that apply) [ ] None Known
   - Incontinence  |  Recent change in B/P  |  Weakness/Fatigue
   - Recent weight loss/gain  |  Unsteady gait  |  Decrease in fluid intake
   - Recent acute illness  |  Recent change in lab values (e.g., B/P)  |  Pain
   - Recent medication  |  Vision impairment  |  Urinary incontinence
   - Hearing impairment  |  Hearing aid  |  Dysphagia/dysphonia
   - Other:  

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**Action Plan to prevent another fall incident:**

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**Post Fall Follow-up**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post documented in progress notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unusual 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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assessment completed by:**

Name (print):  
Signature:  
Date:  
Time:  

Staple this form to the Unusual Incident Report and place in doctor's book for physician review. After physician completes, resubmit immediately to the Risk Management in the Quality Management Department.
Be sure to affix a patient label at the top of the form.

Indicate whether the fall was observed by anyone.

Indicate whether the patient was identified as a fall risk prior to the fall.

Enter the most recent Edmonson Fall Risk Assessment score and the date of the assessment.
Enter the patient’s Vital Signs immediately post-fall, including the orthostatic blood pressures. This should be done with a manual blood pressure cuff (not the automatic cuff).

***If the patient cannot stand safely, get the orthostatic blood pressure lying and then sitting.

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

Indicate if there is evidence that the patient may be suffering from orthostatic hypotension. If there is, put a note in the doctor’s book for the physician to evaluate.

Orthostatic hypotension is defined as a drop of at least 20 mm Hg in systolic pressure or 10 mm Hg in diastolic pressure within 3 min. of position change.
Indicate whether the patient has a history of falls, and whether the patient was on precautions at the time of the fall.

The #8 item outlines what the nurse should include in the narrative on the Unusual Incident form.
Indicate whether there was a mechanical device (chair alarm, bed alarm, etc.) or a medical assistive device (ie. Cane, walker, etc.) in use at the time of the fall.

Indicate any physical impairments or problems with the patient at the time of the fall.

9. Was a mechanical device in use at the time of the fall? □ Yes □ No
   If yes, what device? □ Chair Alarm □ Bed Alarm □ Hospital Bed □ Other: __________________________

10. Was a medical assistive device in use at the time of the fall? □ Yes □ No
    If yes, what? □ Cane (straight) □ Cane (Quad) □ Walker □ Crutches □ Wheelchair □ Geri-Chair
    □ Other: __________________________

11. Any physical impairments/problems with patient at time of fall? □ Yes (check all that apply) □ None Known

<table>
<thead>
<tr>
<th>Incontinence</th>
<th>Recent change in B/P</th>
<th>Weakness/Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent weight loss/gain</td>
<td>Unsteady gait</td>
<td>Decrease in fluid intake</td>
</tr>
<tr>
<td>Recent acute illness</td>
<td>Recent change in lab values (Hol, BG)</td>
<td>Pain</td>
</tr>
<tr>
<td>Specify:</td>
<td>Visual impairment</td>
<td>Glasses on</td>
</tr>
<tr>
<td>Recent cough/cold</td>
<td>Hearing Aid on &amp; working</td>
<td>Dizziness/lightheadedness</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>


Indicate whether there were any medication changes in the past week, and whether the patient has received any PRN medication within the past 24 hours.
Indicate the date and time the physician was notified, and whether or not the patient’s family was notified of the fall.

Summarize the plan of care that is being implemented to decrease the risk of another fall for the patient.

The “Post Fall Follow-up” should be used as a check list or “to do” list so that you know when all the appropriate documentation has been completed.

Print and then sign your name, and the date and time of the report. Staple this form to the Unusual Incident Report and place it in the doctor’s book for physician review. After the physician signs Unusual Incident report, send both reports to the Risk Manager (Judy Cole) in Quality Management.
The information captured on the Post-Fall Investigation Form and the Unusual Incident Report 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 these forms 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.

The revised Post-Fall Investigation forms will be used beginning Monday, March 17, 2014.
You have completed the inservice

“Falls Prevention: Update 2014”

Name (printed): __________________________________________

Signature: ________________________________________________

Date: ______________________

Print and complete this slide, and send to your supervisor and to Diane Mustard in Staff Development to receive credit for this inservice.