HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL
FALL PREVENTION AND MANAGEMENT PLAN

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SCOPE

All patient care areas within Hackettstown Regional Medical Center (HRMC).

PURPOSE

To outline and establish preventative measures to be implemented by staff to prevent and reduce the risk of harm from patient falls as well as manage patient fall incidents.

DEFINITIONS

Fall: An unplanned descent to the floor with or without injury to the patient
Assisted Fall: The attempt to minimize the impact of the fall by easing the patient's descent to the floor.
Fall with Harm: Any harm to the patient as a result of the fall (severity Level 3 or greater)

POLICY

1. All staff will implement standard measures to prevent patient falls and reduce the risk of harm from falls. Standard operating procedures will be followed according to the setting and services provided whenever a patient fall occurs.

2. The Fall Prevention and Management Program consists of the following:
   - Assessment of risk using a reliable, evidence-based risk assessment tool or screening criteria to identify patients at risk for falls
   - Implementation of fall prevention measures for all patients according to setting and services provided
   - Documentation of assessment and prevention measures according to setting and services provided
   - Education of staff on the fall prevention program and their role in patient fall reduction
   - Education of family/patient on all fall precautions
   - Conduction and documentation of a post fall huddle
   - Reporting of all falls using the online occurrence reporting system (HERCULES)
   - Evaluation of the Fall Prevention and Management Program to determine its effectiveness
   - Posting of fall prevention signage in patient rooms and bathrooms

3. Standard Fall Prevention Measures [all patients, regardless of risk level and setting and according to services provided]:
   - Provide a physically safe environment, control spills, clutter
   - Eliminate unnecessary equipment
   - Provide appropriate illumination i.e., night light left on (evening/night shift)
   - Provide clear access to commode or toilet
   - Assist with first ambulation: post-op patients, postpartum patients and patients on bed rest for more than 24 hours
   - Place assistive devices within patient's reach and on the side of the bed that the patient exits
   - Orient patients to the use of the call light and reinforce the importance of using the call light when assistance is needed to get out of bed/chair
   - Place patient articles, including bedpan, urinal and bedside table within easy reach
   - Maintain bed/stretcher in low position/brakes locked

- Lock all moveable furniture and equipment when transferring patients
- Raise and lock in position the upper rails [bed/stretcher] whenever treatment is not being rendered
- Provide treaded or non-skid footwear if appropriate
- Use safe patient transfer techniques
- Complete Ticket to Ride when transferring patient off the unit for diagnostic testing

PROCEDURE (Adult Inpatient Units)

1. Assessment:
   A. All patients will be assessed upon admission, at the beginning of each shift and upon transfer using the Morse Fall Risk Assessment tool.
   B. When using the risk assessment tool, select appropriate points related to the category /statements. The tool will self calculate provided all categories are answered.
   C. Each assessment will determine the patient's risk level. Update the plan of care accordingly.
   D. All patients received from the Surgical Services area after receiving any form of sedation are considered a fall risk until fully recovered from sedation.
   E. Certain patients are automatically at risk to fall. This includes a patient in restraints and the obstetrical patient with an epidural catheter.

2. Content/Interventions:
   A. Patients who are at NORMAL/**LOW RISK**: Total score 0-24, will have standard fall prevention measures implemented as applicable.
   B. Patients assessed at **MODERATE RISK** 25-44 score will have all the following implemented in addition the standard fall prevention measures:
      - Identify patient with yellow armband
      - Provide yellow socks for ambulatory patients
      - Consider supervised elimination (if assessment indicates) every 2 hours as necessary.
   C. Patients with **HIGH RISK** score 45 or above will have all the following interventions considered for implementation in addition to B and standard fall prevention measures:
      - Place patient on bed alarm and/or TABS monitor.
      - Assign patient a room close to the nurses' station if possible.
      - Consult Pharmacist for a medication review as appropriate.
      - Educate family regarding patient's risk level and what they can do to provide safety.
      - Place a self release belt on the patient when out of bed in a chair.
      - Place a chair pad alarm when patient out of bed.
      - Use a yellow blanket for the patient that has a bed alarm or TABS monitor in use when patient is off unit or out of bed.
      - Consider companionship at the bedside (family member, staff)
      - Conduct fall safety checks throughout the shift.
3. Inpatients Treated in Outpatient Areas:
   - All inpatients treated in outpatient areas are identified for fall risk by their primary nurse.
   - The staff in the outpatient areas will be cognizant of the fall protocol and follow inpatient

guidelines.

- Mode of transportation to the department from inpatient areas is based upon activity level, assessed risk level, gait and/or procedure to be done and is determined by the primary/charge nurse.
- Face to face handoff with the transporter to assure the patient is not left alone.

4. Post-Fall Management:
   A. Immediately Post Fall:
      1) Notify Hospitalist for medical post assessment.
      2) If fall is witnessed and no apparent injury, move patient back to bed.
      3) If fall is unwitnessed or there is apparent injury, do not move patient until evaluated by a physician.
      4) A patient assessment, including vital signs, level of consciousness, absence/presence of pain will be completed by the RN caring for the patient.

   B. Post Initial Assessment:
      1) Notify Manager and/or Shift Administrative Supervisor.
      2) Hospitalist to contact primary physician to consult on follow up care.
      3) Primary physician and/or Hospitalist to notify the family.
      4) Hospitalist or attending physician to order low risk post monitoring or high risk post monitoring.
      5) Fall risk to be reassessed at this time. If patient was not on fall precautions, implement appropriate interventions. If the patient was already identified as a fall risk, review the interventions for appropriateness and modify as necessary to prevent future fall and reduce risk of injury from fall. Update plan of care as indicated.
      6) The Administrative Supervisor is responsible for the conduction and documentation of the post fall huddle. A Post Fall Huddle is conducted to extract the patient care team's insight as to likely causes for the fall and identification of any additional prevention efforts which could be employed in the future for this patient and for others. Participants should include the primary RN, the Administrative Supervisor, the Hospitalist, and the CNA [Certified Nursing Assistant], a pharmacist [when available], the Charge RN and/or Nurse Manager, and other available staff as appropriate.
      7) Implement/schedule any follow up diagnostic testing if ordered.
      8) Complete an incident report [HERCULES] for all patients who fall, regardless of injury or harm by the end of the shift.
      9) Advise new caregiver of fall occurrence during hand-off.
      10) Document according to the guidelines indicated in this policy.

   C. Low Risk Monitoring

      The following assessment will be conducted and documented every 4 hours x 3:

      - Glasgow coma scale
      - New neurological deficits including loss of feeling or movement
      - Head/neck pain symptoms
      - Changes in behavior
      - Level of Consciousness

- Presence/Absence of headache and vomiting

******* Any change in assessment contact the physician immediately.***

D. High Risk Monitoring

The following assessments will be conducted and documented every 30 minutes x2, then hourly x4, then every 2 hours for complete 24 hours of observation:

- Glasgow coma scale
- New neurological deficits including loss of feeling or movement
- Head/neck pain symptoms
- Changes in behavior
- Level of Consciousness
- Presence/Absence of headache and vomiting

The assessments may not be deferred for any reason including patient sleep.

******* Any change in assessment contact the physician immediately.***

PROCEDURE (Outpatient Departments)

1. All outpatients are screened through monitoring for the following criteria:
   - Inability to follow directions
   - Unsteady gait
   - Presentation on a stretcher, wheelchair, with an assistive device for walking
   - Past history of falls
   - Present encounter is related to a fall
   - All patients who receive sedation or narcotics should be considered at risk for falling until fully recovered, transferred, or discharged.
2. All outpatients who meet screening criteria may have the following additional fall prevention measures implemented according to the setting and services provided:
   - Appropriate assistance to ensure safety
   - Accompany patient to the bathroom
   - Do not leave patient unattended in the bathroom
   - Instructing patient not to get out of chair/stretcher without calling for assistance;
   - Provide most direct access to bathroom;
   - Provide non-skid footwear, if appropriate.

3. Standard Fall Prevention Measures:

- As detailed in this policy on page one in section #3
- All patients who receive sedation or narcotics should be considered at risk for falling until fully recovered, transferred, or discharged.
- The Diagnostic Imaging Department requires all patients who are imaged on the x-ray table have Velcro straps/similar safety devices used to secure the patient, prevent an injury and minimize motion, unless clinically contraindicated. In most cases where Velcro straps/similar safety devices are clinically contraindicated, a designee must remain immediately next to the patient while on the

table to ensure patient safety throughout the completion of the test and transfer to the stretcher. A safety device may be utilized in accordance with manufacturer's guidelines for young children undergoing fluoroscopy exams to reduce motion and thereby reduce radiation exposure.

- **Emergency Department:** All ED Patients will be assessed using the ED fall assessment available in the Emergency Department Electronic Documentation System. All interventions and preventative measures will be documented in the ED Electronic Documentation System

4. **Documentation:**
   - There must be documentation in the medical record noting that the patient is a fall risk and what interventions are in place to prevent the patient from falling.
5. **Post-Fall Management**
   - When a fall occurs and the patient is in need of immediate medical attention that exceeds the scope of practice in the outpatient area, call a Rapid Response for assistance.
   - Complete an incident report [HERCULES] for all patients who fall, regardless of injury or harm.
   - A patient who has experienced a fall will have the following documented in the Medical Record:
     a) Circumstances, time and location of fall
     b) Physician and time notified
     c) Physical assessment
     d) Patient complaints
     e) Nursing Manager/Administrative Supervisor and time notified
     f) Interventions and/or tests performed
     g) Family notification and by whom

PEDIATRIC PATIENTS

PROCEDURE

1. Assessment:
   A. All patients will be assessed upon admission, at the beginning of each shift and upon transfer using the Humpty Dumpty Assessment tool.
   B. When using the risk assessment tool, select appropriate points related to the category /statements. The tool will self calculate provided all categories are answered.
   C. Though all Pediatric patients are at risk to fall, each assessment will determine the level of patient's risk. Update the plan of care accordingly.
   D. High risk level patients are twice the risk of low risk.
   E. All patients received from the Surgical Services area after receiving any form of sedation are considered a fall risk until fully recovered from sedation.
2. Content/Interventions:
   A. Patients who are at **LOW RISK**: Total score 7-11, will have the standard fall prevention measures implemented as applicable and outlined per policy statement #3. In addition the pediatric patient will have the following:

- Side rails assessed for large gaps such that a patient could get extremity or other body part entrapped, use additional safety precautions
- Use of no skid footwear for ambulating patients and use of appropriate size clothing to prevent risk of tripping
- Assess eliminations need and assist as needed.

B. Patients with **HIGH RISK** score 12 or above will have all the following interventions considered for implementation in addition to A and standard fall prevention measures:
- Identify patient with yellow wrist band and sticker on the chart.
- Check the patient a minimum of every 1 hour to assure parent is remaining at the bedside
- Accompany patient with ambulation
- Developmentally place patient in appropriate bed
- Assign patient a room close to the nurses' station if possible.
- Consult Pharmacist for a medication review as appropriate.
- Educate family regarding patient's risk level and what they can do to provide safety.
- Keep door open at all times unless specified isolation precautions are in use

C. Post Fall Management should patient fall during hospital stay:
Immediately Post Fall:
- Notify Provider
- A patient assessment, including vital signs, level of consciousness, and absence/presence of pain will be completed by the RN caring for the patient.

Post Initial Assessment:
- Notify Manager and/or Shift Administrative Supervisor.
- Primary physician to provide any necessary orders or consult on follow up care.
- Fall risk to be reassessed at this time. If patient was not on high risk fall precautions, categorize them as such and implement appropriate interventions. If the patient was already identified as a high fall risk, review the interventions for appropriateness and modify as necessary to prevent future fall and reduce risk of injury from fall. Update plan of care as indicated.
- Advise new caregiver of fall occurrence during hand-off.
- Document according to the guidelines indicated in this policy.

D. All areas are inspected daily by their appropriate department staff to ensure a safe environment.

E. Weekly Environment of Care inspections are performed by the Facilities Department to ensure a safe environment.

PATIENT/FAMILY EDUCATION

Upon admission, the Fall Prevention Program is discussed and a copy of the Patient Guide containing fall prevention education is provided to the patient and/or family, regardless of the patient's risk level.

EVALUATION

Monthly monitoring for effectiveness of the program is done through Risk Management. Total number of falls as well as severity of fall related injury is reported to department/unit managers where fall occurred. A root cause analysis [RCA] will be done if trending is noted or there is a fall that results with an injury.

REFERENCES

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