PURPOSE: The fall prevention policy is intended to:
- objectively and systematically identify patients at risk for fall
- direct the creation of an individualized plan of care to reduce fall risk.

POLICY STATEMENT: All inpatients will be assessed for fall risk during the admission process. A plan of care based on identified risk factors and the following protocol will be implemented on admission. Fall risk will be reassessed and updated once daily, or with change in patient’s condition.

1) **Assessment of Fall Risk:** RN responsibilities:
   a) Using the Hendrich II Fall Risk Assessment Model (See Appendix A), assess adult inpatients for fall risk within 8 hours of admission to the hospital.
      i) The Hendrich tool is located in the Admission Data Base and on Nursing Flow Sheets.
   b) Document the score and check off either Level I or Level II indicating the appropriate level of risk. One box must be checked.
   c) The RN will enter Falls Risk Level into the Kardex.
   d) Reassess the patient’s risk for falls at least once daily, and whenever there is a significant change in the patient’s condition, which may include: cognition, mobility, a fall in a patient with no previous risk identified or any other situation in which the nurse determines an assessment to be indicated. Document the level of risk on the nursing flow sheet.
      i) Level of Fall Risk should reflect highest level of risk over 24 hours, acknowledging that risk may fluctuate over 24 hours due to delirium. For example, a patient who is confused on evenings but more oriented on days should still be a Level II fall risk. Interventions may be altered from shift to shift but risk remains.
      ii) As patient condition changes, improving mental status or physical ability may reduce risk, and the interventions targeted to risk factors can be modified.

2) **Interventions: (See Appendix B)**
   a) Risk Score determines level of fall prevention interventions warranted.
      i) Institute Level I Fall Prevention interventions (environmental) when Hendrich II Fall Risk score is 4 or below.
      ii) Institute Level II Fall Prevention interventions when the Hendrich II Fall Risk score is 5 or above as well as Level 1 Fall Prevention.
   b) **Level 1.** Fall prevention interventions for all patients--these include interventions aimed at reducing environmental hazards, compensating for some functional limitations and education to increase involvement of patients and families.
      i) Orient patient to the environment on admission, transfer and as needed.
      ii) Utilize appropriate lighting on evening/night shift to allow for safe access to bathroom
      iii) Wipe up spills immediately and teach patients to call for assistance with spills
      iv) Arrange furniture/objects safely. Remove unneeded furniture to assure an uncluttered path to the bathroom or doorway.
v) Assist with toileting/elimination as appropriate and in a timely manner.
vi) Evaluate effects of medications that predispose patient to falls in collaboration with Pharmacy and Medical Staff.

vii) Observe patients at least every 30 minutes and assess need for assistance.

c) **Level II.** Fall prevention interventions for patients at high risk: **score 5 or above.** Used in addition to Level I interventions. Level II interventions indicate staff awareness of fall risk factors and patient focused fall risk reduction strategies.

i) Identify patient as Level II fall risk with the following:
   (1) If on Level II Falls Risk, note this on the front of the chart binder.
   (2) Individualize Kardex by identifying the level of Falls Risk and, if on Level II, documenting patient-specific interventions.

ii) Inform patient about fall risk and provide written and verbal information to educate them about their participation in reducing fall risk.

**NOTE WELL:** Patient may not be able to retain education due to risk factors impacting cognition such as brain injury, delirium, dementia or depression.

iii) Level II Interventions for individual risk factors
   (1) Confusion/Disorientation/Impulsivity
      (a) Alert non clinical staff to patient risk so they may pay closer attention to these patients and more closely monitor their activities
      (b) Relocate patient to another room closer to the nurses station or other area that would offer better visibility/faster response time.
      (c) Assure close adherence to 30 minute rounds. Observation can be made more frequently if warranted.
      (d) See Strategy diagram for other suggestions-Appendix B.
      (e) If other interventions fail, consider more restrictive alternatives
   (2) Symptomatic Depression
      (a) Evaluate patient's ability to interpret information and respond appropriately.
      (b) Educate patient about effect of depression and medications on fall risk if indicated.
      (c) Reinforce safety precautions with the patient.
   (3) Altered elimination.
      (a) Observe and assess patient's ability to safely self-toilet. Educate patient on how to make the activity safer and document ability and successful techniques used by patient.
      (b) Plan individualized schedule for voiding using baseline elimination patterns. Assess impact of diuretics and other medications and devise a voiding schedule based on dosing times.
      (c) Obtain bedside commode if appropriate.
   (4) Dizziness / Vertigo
      (a) Assess for treatable medical problems such as anemia and dehydration that may contribute to dizziness.
      (b) Monitor orthostatic blood pressures.
      (c) Instruct patient to:
         (i) rise from lying to sitting position slowly.
         (ii) dangle before walking.
         (iii) perform ankle pumping in sitting position before walking.
         (iv) sit down immediately if feeling dizzy.
(d) Collaborate with Pharmacy to assess medications that may contribute to dizziness/vertigo.

(5) Any Prescribed Antiepileptic
   (a) Increased fall risk is based on whether or not adverse reactions to the drug (mobility, gait, cognition, mood, elimination changes) occur in the individual. Monitor for adverse reaction from the medications.
   (b) Explain to patient how these medications may impact fall risk and provide strategies for maintaining safety while on these meds
   (c) Review with Pharmacy and Medical Staff to assure dosage is appropriate and adverse reactions are minimized.
   (d) Consult physician regarding limiting dose or discontinuation when appropriate.

(6) Any Prescribed Benzodiazepine
   (a) Consider non pharmacologic interventions for benzodiazepine indications (nonpharm. sleep intervention, meditation, behavioral interventions)
   (b) Increased fall risk is based on whether or not adverse reactions to the drug (mobility, gait, cognition, mood, elimination changes) occur in the individual. Monitor for adverse reactions from the medications, document and communicate findings to treatment team.
   (c) Explain to patient how these medications may impact fall risk and provide strategies for maintaining safety while on these medications.
   (d) Review with Pharmacy and Medical Staff to assure dosage is appropriate and adverse reactions are minimized.
   (e) Consider other etiologies for behavior such as pain for agitation, etc.
   (f) Consider limiting dose or discontinuation when appropriate.
   (g) Note that some benzodiazepines have a long half life so that risk may extend for some time after last dose.

(7) Poor performance on Get Up & Go Test
   (a) Consider obtaining appropriate assistive devices and educate patient in their use. These may include non-skid mats, walkers, canes, raised seats, etc.
   (b) Request physical therapy consult.
   (c) If unable to perform the Get Up & Go Test (e.g.patient refusal), score all other risk factors that can be assessed.

3) Post Fall Evaluation and Care:
   a) Assess and treat patient for injury and move to a safe location/position if indicated.
   b) Notify the charge nurse of the fall occurrence as soon as possible.
   c) Notify attending or on-call physician of fall, pertinent circumstances, post fall patient assessment and request that they evaluate patient.
   d) Complete Patient Event Report as directed in event reporting policy. See SPLATTS guidelines (Appendix C) for information on key fall reporting points.
      i) Document whether Level II protocol was in use or not at the time of fall.
      ii) Identify immediate interventions needed to prevent another fall and document on Patient Event reporting system
   e) A fall in the hospital will almost always indicate the need to increase the patient's fall risk to Level II. If patient is not a Level II at this point, document rationale in Kardex.
   f) RN shall document the fall in a factual manner in the daily nursing flowsheet under “Unusual Events” (i.e., patient found on floor by P. Jones, PT).
   g) Identify immediate interventions needed to prevent another fall, document in the Kardex and assure that the interventions are implemented.
   h) Communicate the fall in shift-to-shift report as well as identified strategies to maintain the patient’s safety.
MONITORING PLAN:

A. Nurse Manager will follow up on all falls in event reporting system consistent with the \textit{VSH Comprehensive Event Reporting Protocol}, and will assure that Level II precautions are in place post fall, if indicated, and any applicable strategies are identified in the Kardex.

B. Any patients with multiple falls should be identified and communicated to members of the Treatment Team by Quality, so that alterations in the treatment plan may be considered.

C. Data will be collected from Patient Event reports to identify trends in falls. This data will be shared with nurse managers to allow for unit based assessment of protocol effectiveness and identification of unit based strategies.

D. Quality Department will review all inpatient fall reports monthly for trends and patterns and will follow up with Clinical Leaders as appropriate.

E. Monthly safety rounds will include questions for staff on knowledge of fall prevention strategies.

DEFINITIONS:
Falls: A fall is defined as an event which results in the patient or any part of the patient's body coming to rest inadvertently on the floor, or other surface lower than the patient.

Included in this definition are patients found lying on the floor unable to account for their situation-unwitnessed falls.

Appendix A: Hendrich II Fall Risk Model
Appendix B: Inventory of Approved Fall Prevention Strategies
Appendix C: "SPLATTS" Fall Documentation to Enhance SAFE Reporting

REFERENCES: JCAHO 2008 Accreditation Participation Requirements, National Patient Safety Goal 9A
Reduce the risk of patient harm resulting from fall. Assess and periodically reassess each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen and take action to address any identified risks
JCAHO PC.2.150 Patients are reassessed as needed.
JCAHO PC.2.130 Initial assessments are performed as defined by the hospital.


Appendix A: Hendrich II Fall Risk Model

Hendrich II Fall Risk Model
| Confusion Disorientation Impulsivity | Patient is disoriented to time, place, and/or person. Patient is unable to retain or receive instructions or displays impaired judgment. This may be a progressive neurological state, drug induced, or behavioral in origin. Stroke patients (left hemi) may exhibit impulsive, unpredictable behavior as a result of the cerebral insult. | 4 |
| Symptomatic Depression | Medical diagnosis or nursing assessment finds the patient appears depressed, is not interacting appropriately, is tearful, withdrawn, or the patient states they are depressed. If the depression is managed with drugs and/or therapies in need NOT be scored if the depression is therapeutically in control. | 2 |
| Altered Elimination | Altered elimination from the clinical norm, such as incontinence, nocturia, frequency, urgency or stress incontinence, diarrhea, or related to use of cathartics. This does NOT include a Foley or indwelling catheter UNLESS it causes symptoms referenced above while in use with the patient. When the catheter is removed, it can be a high-risk time until normal elimination is established. | 1 |
| Dizziness Vertigo | Medical diagnosis of vertigo or the patient reports they feel like they are spinning or the room is spinning. Sway path may be present when the patient stands (circular motion upon arising). This is often seen in the aging adult with poor gait and balance and can occur as a result of some drug side effects. | 1 |
| Gender | Male | 1 |
| Any Prescribed Antiepileptics | Carbamazepine, Divalproex Sodium, Ethotoin, Ethosuximide, Felbamate, Fosphenytoin, Gabapentin, Lamotrigine, Mephenytoin, Methsuximide, Phenytoin, Primidone, Topiramate, Trimethadione, Valproic Acid, Levitracetam | 2 |
| Any Prescribed Benzodiazepines | Alprazolam, Buspirone, Chlordiazepoxide, Clonazepam, Clorazepate Dipotassium, Diazepam, Flurazepam, Halazepam, Lorazepam, Midazolam, Oxazepam, Temazepam, Triazolam, Zolpidem, Zaleplon, Eszopiclone, Rameitone, Trazodone | 1 |

**Get Up & Go Test**

With patient sitting in a chair (preferred) or on the side of the bed, place palm of hands flat on thighs and ask the patient to stand without assistance. Score the patient according to the guidelines below. * If the patient is unable to perform the test (unconscious, drug-induced coma, traction, debilitation/atrophy, and/or bed rest order) score all other risk factors that can be assessed. If the patient scores a 5 or greater (without the Get Up and Go) and can ATTEMPT to get up they should be considered "high risk for falls" if they cannot attempt to get up at all, but have risk points, they should be considered "pending high risk" and placed on the fall prevention guidelines as soon as they can ATTEMPT to get up.

| Ability to rise in a single movement | 0 |
| Pushes up, successful in one attempt | 1 |
| Multiple attempts, but successful | 3 |
| Unable to rise without assistance during test (OR if a medical order states the same and/or complete bed rest is ordered) | 4 |

**TOTAL SCORE**

- Complete Fall Risk assessment on admission for all patients.
- Re-assess for fall risk once daily and with change in patient condition and/or after a fall or when otherwise clinically indicated.
- Fall risk score ≥ 5 indicates Level II fall risk. Implement interventions based on identified risk factors.

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## APPENDIX B: Inventory of Adult Fall Prevention Strategies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>LEVEL</strong></td>
<td><strong>STRATEGY</strong></td>
</tr>
<tr>
<td>I</td>
<td>Orient patient to the environment on admission, transfer and as needed.</td>
</tr>
<tr>
<td>I</td>
<td>If applicable place bed in low position with brakes locked</td>
</tr>
<tr>
<td>I</td>
<td>Ensure footwear are fitted, non-skid, low heeled and secured properly</td>
</tr>
<tr>
<td>I</td>
<td>Utilize appropriate lighting on evening/night shift to allow for safe access to bathroom</td>
</tr>
<tr>
<td>I</td>
<td>Wipe up spills immediately and teach patients to call for assistance with spills</td>
</tr>
<tr>
<td>I</td>
<td>Arrange furniture/objects safely. Remove unneeded furniture to assure an uncluttered path to the bathroom or doorway.</td>
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<tr>
<td>I</td>
<td>Arrange furniture/objects safely. Remove unneeded furniture to assure an uncluttered path to the bathroom or doorway.</td>
</tr>
<tr>
<td>I</td>
<td>Ensure patient use of handrails in bathroom.</td>
</tr>
<tr>
<td>I</td>
<td>Assist with elimination as appropriate and in a timely fashion (i.e. Use bedside commode; toileting schedules; frequent toileting with assistance).</td>
</tr>
<tr>
<td>I</td>
<td>Evaluate effects of medications that predispose patient to falls in collaboration with Pharm. and Medical Staff.</td>
</tr>
<tr>
<td>I</td>
<td>Observe patients at least every 30 minutes. and assess need for assistance.</td>
</tr>
<tr>
<td>I- II</td>
<td>Educate patient and family regarding fall prevention strategies and their role. Document in Kardex.</td>
</tr>
<tr>
<td>II</td>
<td>Fall Risk notification applied to front of chart</td>
</tr>
<tr>
<td>II</td>
<td>Add Level II Fall Risk to Kardex</td>
</tr>
<tr>
<td>II</td>
<td>Assess for presence of delirium, treat reversible causes and use medication when appropriate to decrease patient distress</td>
</tr>
<tr>
<td>II</td>
<td>Move to room closer to nurse's station for better observation</td>
</tr>
<tr>
<td>II</td>
<td>Non-Skid mat next to bed</td>
</tr>
<tr>
<td>II</td>
<td>Frequent checks; 15 minute checks</td>
</tr>
<tr>
<td>II</td>
<td>Consider use of Geri-Chair</td>
</tr>
<tr>
<td>II</td>
<td>Consider a frequent toileting schedule</td>
</tr>
<tr>
<td>II</td>
<td>Provide constant observation</td>
</tr>
<tr>
<td>II</td>
<td>Restraints; soft limb restraints if warranted</td>
</tr>
</tbody>
</table>
"SPLATTS"

Fall Documentation to Enhance ROSIE Reporting

Symptoms experienced at the time of fall(s).

Previous number of falls or near falls

Location of fall(s)

Activity engaged in at time of fall(s)

Time (hour of day) of fall(s)

Trauma (physical and psychological) associated with fall(s)

Strategy to prevent next fall


Stone, Wyman and Salisbury: Clinical Gerontological Nursing: A guide to advanced practice.