# OREGON STATE HOSPITAL

PORTLAND – SALEM

## POLICIES AND PROCEDURES

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| **SECTION 6:** | Patient Care | **POLICY: 6.046** | |
| **SUBJECT:** | **Patient Fall Prevention<br>Fall Risk Screening, Assessment, and Management** | | |
| **POINT PERSON:** | **KATHY DEACON<br>CHIEF NURSING OFFICER** | | |
| **APPROVED:** | **GREGORY P. ROBERTS<br>SUPERINTENDENT** | **DATE: MAY 17, 2011** | |

## I. POLICY

A. It is Oregon State Hospital's (OSH) goal to provide an environment that promotes safety and prevents the adverse outcomes associated with falls. The Patient Fall Prevention Program focuses on early identification of patients at risk for falling, implementation of patient-specific strategies to manage associated risks, and establishing a systematic approach to post-fall assessment and management.

B. All patients shall be screened by a registered nurse (RN) for potential risk to fall on admission as part of the Initial Nursing Assessment.

C. Patients identified through the initial screening process as being at risk of falling, and all patients admitted to geropsychiatric services, shall be assessed by a RN utilizing the Oregon State Hospital Nursing Assessment-Fall Assessment & Guidelines form (#75063) (Attachment 1).

D. Reassessment of fall risk is required following a significant change in patient condition or treatment that holds the potential to increase the risk of falling.

E. Following consideration of all relevant factors, appropriate fall risk measures shall be identified and implemented for each patient assessed to be at risk for falling.

F. A patient who sustains a fall shall be appropriately evaluated and monitored.

## II. PURPOSE

Describes Oregon State Hospital's Fall Prevention Program, including staff responsibilities related to patient screening and assessment, implementation of fall prevention strategies, post-fall assessment, and documentation and reporting requirements.

## III. DEFINITIONS

A. "Fall"

1. In the context of fall screening/assessment, a fall is an independent act or unintentional loss of balance (i.e., not caused by interaction with another person) that results in an individual making unexpected contact with the ground/floor or other hard surface.

2. For purposes of post-fall assessment, an individual's unplanned, unexpected contact with the ground/floor or other hard surface, regardless of cause, and whether witnessed or unwitnessed, should be considered a fall.

## IV. PROCEDURES

A. Fall Risk Screening and Assessment

1. The RN is responsible for completion of the initial Fall Risk Screening located on Page 5 of the Oregon State Hospital Nursing Assessment admission form (OSH-STK 75094) (Attachment 2) for each patient admitted to OSH.

2. A "Yes" response to any of the screening questions indicates the need for the RN to complete the Oregon State Hospital Nursing Assessment-Fall Assessment & Guidelines form (#75063) and implement appropriate fall prevention measures.

3. The Oregon State Hospital Nursing Assessment-Fall Assessment & Guidelines form (#75063) is to be completed on all patients admitted or transferred to geropsychiatric services, with the exception that nursing judgment shall determine whether it is necessary to do so for a patient transferred to a medical bed for short-term care.

4. A patient should be reassessed following a significant change in his/her condition or Treatment Care Plan that holds the potential to increase his/her risk of falling. Geropsychiatric patients and those with open fall problems should be reassessed at least annually.

5. An assessment for fall risk shall include the patient's biographical data, history related to falls, overall cognitive level, muscle strength, postural instability, visual and auditory impairments, gait and balance issues, medical conditions, medications, and ability to perform activities of daily living. Identified risk factors shall be evaluated and addressed with the goal of minimizing the possibility of injuries from falls.

6. A score of ten (10) or more on the fall risk assessment is an indicator of increased risk and should be included in the initial nursing care plan, be brought to the attention of the patient's physician/nurse practitioner (NP), and be discussed at the interdisciplinary treatment care planning meeting. Those patients assessed as being a "Fall Risk" shall be so identified by placing a yellow "FALL RISK" label on the exterior spine of the patient's chart.

7. Interventions designed to maintain the patient's safety should be included in his/her Treatment Care Plan and be implemented by unit staff. Interventions that may be considered include but are not limited to:

    a. Environmental Adjustments

        1) Remove obstacles, reduce clutter.
        2) Strategic furniture placement.
        3) Proximity of necessary equipment to patient.
        4) Adequate lighting.
        5) Non-skid floor surfacing.
        6) Handrails, grab bars.
        7) Mitigation of uneven floor surfaces.
        8) Motion sensors/alarms, noise monitors.
        9) Low bed position, anti-roll mattress.

    b. Patient-specific Assistive and Protective Devices

        1) Ambulatory aids (canes, walkers, etc.).
        2) Visual and/or auditory assistive devices as needed.

3) Appropriate footwear, properly fitted clothing.
4) Protective devices (helmet, mat, hip protector, etc.).

c. Other

1) Patient education/training (gait training, transfer techniques, etc.).
2) Exercise programs to strengthen specific muscle groups.
3) Medication review/adjustment.
4) Medication administration schedule adjustment.

B. Post-Fall Assessment and Management

1. When a patient fall occurs in the course of an off-grounds recreational activity at which no RN/LPN is present, assigned staff shall implement any necessary immediate first aid measures within their position description and/or call for appropriate clinical backup and/or transport assistance. The incident shall be reported to the RN on the patient's unit.

2. When a patient is found on the ground/floor, staff should investigate in an effort to determine what happened. In the absence of evidence suggesting otherwise, it is logical to conclude that a fall has occurred.

3. Following a fall in which the patient struck his/her head, or in the case of an unwitnessed fall, the patient should not be moved until after having been assessed for injuries. Call for assistance.

If the patient is a reliable reporter and states that he/she did not hit his/her head, the nurse's clinical judgment shall guide decisions regarding movement and the need for neurologic status assessment.

a. RN/LPN Responsibilities

1) Examine the patient for injuries.
2) Assess vital signs, O2 saturation, and capillary blood glucose (CBG) if patient is diabetic.
3) Assess neurologic status (loss of consciousness, confusion, ability to speak).
4) Clean and dress any wounds.

5) Contact physician, NP, or physician on duty (OD), ensuring that any relevant information regarding patient's platelet count, anticoagulation, and/or anti-platelet therapy is communicated.
6) Evaluate and note any factors that may have contributed to the fall, including but not limited to environmental issues and staffing levels.
7) Notify immediate supervisor and the patient's family or guardian as appropriate based on severity of injury and/or patient/family/guardian request.
8) Complete and file an incident report.
9) Document fall in Nursing Progress Notes.
10) Flag the patient's chart as "Fall Risk" as appropriate.
11) Assess neurological status and vital signs q 1hr X 4hrs then q 4hrs X 24hrs.
12) Place on Alert Charting for a minimum of 24 hours.
13) Notify physician, NP, or OD of any change in patient status.

b. Physician/NP/OD

1) Assess for injuries.
2) Determine if emergency department (ED) referral is necessary.
3) Consideration should be given to obtaining a CT scan if abnormal neurologic signs, neck pain, numbness of extremities, or if patient at high risk for bleeding (low platelet count, on anticoagulants or anti-platelet therapy).
4) Consider need for analgesia.
5) Continue observations as appropriate.

4. Following observed falls in which the patient did not strike his/her head, he/she should not be moved until after being assessed for injuries. Call for assistance.

a. RN/LPN Responsibilities

1) Examine the patient for injuries.
2) Assess vital signs, O2 saturation, and CBG if patient is diabetic.
3) Clean and dress any wounds.
4) Contact physician, NP, or OD if injury sustained.

5) Notify immediate supervisor and the patient's family or guardian as appropriate based on severity of injury and/or patient/family/guardian request.
6) Complete and file an incident report.
7) Document fall in Nursing Progress Notes.
8) Flag the patient's chart as "Fall Risk" as appropriate.
9) Assess vital signs q shift X 24hrs.

b. Physician/NP/OD

1) Assess any injuries.
2) Determine whether ED referral or x-ray is required.
3) Consider need for analgesia.

C. Post-Fall Review

1. At the next Kardex/morning meeting, the Interdisciplinary Treatment Team shall review and MD/NP shall document recommendations for changes in care or give rationale for continuing current plan of care.

2. It is nursing management's responsibility to review the documentation, evaluate, and take action as needed on any issues determined to be contributing factors (environmental factors, staffing, etc.), ensure that the incident is communicated to the Interdisciplinary Treatment Team and that any required interventions are included in the patient's Treatment Care Plan. This shall be documented by a nursing progress note in the chart.

3. All staff involved in the patient's care must be informed of and implement planned interventions.

4. The patient should be reassessed for risk of falls and the assessment tool updated as appropriate.

## V. ATTACHMENTS

Attachment 1 – Oregon State Hospital Nursing Assessment-Fall Assessment & Guidelines form (#75063)

Attachment 2 – Fall Risk Screening (page 5 of the Oregon State Hospital Nursing Assessment admission form) (OSH-STK 75094)

## VI. REFERENCES

Scott, Vicky, Votova, Kristine, Scanlan, Andria, Close, Jacqueline Multifactorial and functional mobility assessment tools for fall risk among older adults in community, home-support, long-term and acute care settings, Age and Ageing 2007;36:130-139

New Oregon State Hospital Policy.

Attachment 1

Department of Human Services

# OREGON STATE HOSPITAL
## Nursing Assessment – Fall Assessment & Guidelines

**FALL ASSESSMENT: PREDISPOSITION FOR FALLING (Guidelines for Use)**

| INSTRUCTIONS: This assessment is completed on all patients if a fall occurs and on all newly admitted Geropsychiatric Treatment Services patients. | 1. Check applicable items, indicate points at right. | 2. Add points and note total score below. |
|---|---|---|

**I. AGE:** ☐ (1 pt.) 80 or more years old ☐ (2 pts.) 70-79 years old ▶ _____ pts.

**II. MENTAL STATUS:** ☐ (0 pt.) Oriented at all times or comatose ☐ (2 pts.) Confusion at all times ☐ (4 ...mittent ▶ _____ pts.

**III. ELIMINATION:**
☐ (0 pts.) Independent and continent ☐ (1 pt.) Catheter and/or ostomy ☐ (3 pts.) Eliminatio... with assista... ...ident ▶ _____ pts.

**IV. HISTORY OF FALLING WITHIN THE PAST SIX MONTHS:**
☐ (0 pts.) No history ☐ (2 pts.) Has fallen 1 or 2 times before ☐ (5 pts.) M... ▶ _____ pts.

**V. VISUAL IMPAIRMENT:** ☐ (1 pt.) ▶ _____ pts.

**VI. CONFINED TO CHAIR:** ☐ (3 pts.) ▶ _____ pts.

**VII. DROP IN SYSTOLIC BLOOD PRESSURE** of ... ...ween laying and standing:
☐ (2 pts.) ▶ _____ pts.

**VIII. GAIT AND BALANCE:**

Assess patient's gait while: 1) Standing ir... ...et on the ground for 30 seconds without holding on to something; 2) Walking straight forward: ... doorway; 4) Walking while making a turn. *NOTE: Check for any Yes answer.*

☐ (1 pt.) Wide base of support.
☐ (1 pt.) Loss of balance while ...
☐ (1 pt.) Balance problems ...
☐ (1 pt.) Decrease in mu...
☐ (1 pt.) Use of assisti... ...er, furniture etc.).
☐ (1 pt.) Unable to balance on 1 foot 5 seconds or more.
☐ (1 pt.) Lurching, swaying, or slapping gait.
☐ (1 pt.) Gait pattern changes when walking through doorway.
☐ (1 pt.) Jerking or instability when making turns.

▶ _____ pts.

**IX. MEDICATIONS...**

☐ Alcohol ☐ Antihistamine ☐ Antihypertensives ☐ Antiseizure/Antiepileptic
☐ Benzodiazepin... ☐ Diuretics ☐ Hypoglycemic agents ☐ Narcotics
☐ Psychotropics ...es/Hypnotics ☐ Other (specify) _____

From the above m... ...groups, indicate how many the patient is currently taking, or took prior to admission.

☐ (0 pts.) No medications ☐ (1 pt.) 1 medication ☐ (2 pts.) 2 or more medications
☐ With a change of medication and/or dosage in the past five days, add 1 point to the medication score: ▶ _____ pts.

**A score of ten (10) or above indicates a risk of falling.** **TOTAL SCORE** _____ pts.

RN Signature: _____ Date: ___/___/_____ Time: _____





ADDRESSOGRAPH

File: Nursing Assessment Section
Thin: Do Not Thin
Form #: 75063-MR 2 9/2006
MR #: 50-04-0137-00

Department of Human Services

OREGON STATE HOSPITAL
NURSING ASSESSMENT

## RISK AND SAFETY ASSESSMENT

**(Any identified risk must be addressed on Significant Findings: Treatment and Care Recommendations)**

| RISK AREA(s) | No Known Risk | Previous History | Current Risk | RISK AREA(s) | No Known Risk | Previous History | Current Risk |
|---|---|---|---|---|---|---|---|
| Danger to self related to Suicidal Acts | ☐ | ☐ | ☐ | Smoking | ☐ | ☐ | ☐ |
| Danger to others related to Aggressive/Homicidal Behavior | ☐ | ☐ | ☐ | Choking/Dysphagia | ☐ | ☐ | ☐ |
| Potential for Injury related to Poor Judgement/Insight | ☐ | ☐ | ☐ | PICA | ☐ | | ☐ |
| | | | | Self-Mutilation | ☐ | | ☐ |
| Risk for Elopement | ☐ | ☐ | ☐ | Substance Abuse | ☐ | | ☐ |
| Fire Setting | ☐ | ☐ | ☐ | Physical Limitations | ☐ | | ☐ |
| Sexual Acting Out | ☐ | ☐ | ☐ | Tuberculosis | ☐ | | ☐ |
| Wandering | ☐ | ☐ | ☐ | Medication – Related Movement Disorder(s) | | | ☐ |

Other:

## FALL RISK SCREENING

History of falling within last 6 months? ☐ Yes ☐ No Comments:
Balance or gait problems noted? ☐ Yes ☐ No Comments:
History of neurological impairments? ☐ Yes ☐ No Comments:
Use of assistive devices? ☐ Yes ☐ No
Comments:
Current visual impairments? ☐ Yes ☐ No
Comments:
**(If Yes to any of the above, complete Fall Assessment – Form #75063)**
*** All Geropsychiatric patients require a Fall Assessment on admission.**

## FUNCTIONAL ASSESSM

Check independent or type of assistance needed:

| | Level of Assistance | | | Comments |
|---|---|---|---|---|
| | Independent | Cues | Partial | |
| Bathing | ☐ | ☐ | ☐ | |
| Oral Hygiene | ☐ | ☐ | ☐ | |
| Hair/Shaving | ☐ | ☐ | ☐ | |
| Dressing | ☐ | ☐ | ☐ | |
| Toileting | ☐ | ☐ | ☐ | |
| Eating | ☐ | ☐ | | |
| Transferring | ☐ | ☐ | ☐ | |
| Mobility | ☐ | ☐ | ☐ | |
| Stair Climbing | ☐ | ☐ | ☐ | |
| Communication due to functional problem | ☐ | ☐ | ☐ | |

Possible environmental adaptations or equipment ar… … to maintain safety and promote optimal functioning.
Describe:





ADDRESSOGRAPH

File: Nursing Assessment Section
Thin: Do Not Thin
Form #: OSH-STK 75094 –MR-1 – 9/2006
MR #: 50-05-0139-00