
TITLE: Fall Prevention Protocol

POLICY: To identify residents at risk for falls; to use appropriate interventions to prevent falls and promote safety; and to assure monitoring of fall interventions.

PROCEDURE:

1. All residents will have fall assessment completed on admission and quarterly thereafter and anytime a resident shows a significant change in status
2. Any resident that falls will have the Incident Occurrence form filled out and Potential for Falls added to care plan with appropriate interventions applied. This will be re-evaluated at care conferences to determine if interventions remain appropriate.
3. CNA Fall Follow-up assessment will be completed along with the incidence/occurrence form. Weekly analysis report will be updated by committee members and reviewed by a licensed nurse and/or to be evaluated by Physical Therapy if deemed appropriate.
4. All residents will have a Physical Therapy evaluation on admission and when resident falls into Level 3 on the Angel Program with recommendations to be added to the residents plan of care.
5. Staff training will be done as needed to assist staff in recognizing and eliminating environmental hazards and how to provide adequate supervision to prevent falls.
6. Angel pin will be checked daily; plastic angel to be placed on resident's door by nameplate and also on the residents chart with a written order.
7. Residents will wear Angel pin if decline in health, one or more falls in one month; and if unable to be left alone in wheelchair, commode, or toilet.
8. Angel committee to meet on an as needed basis to review any resident(s) that have fallen to determine if further interventions are necessary or need to be added to the care plan. Committee will consist of interdisciplinary team members.

FALL PREVENTION PROTOCOL to include but no limited to (see to Care Plan)

Level One:

Every new admit until PT evaluation completed with program for fall prevention if necessary and any resident having one – two falls.

Interventions:

1. Direct supervision of ADL's or ambulation as needed.
2. Personal items to be left within resident's reach i.e. call light, TV remote, tissues, water, etc.
3. Reorient resident to surroundings and remind resident to wait for assistance.
4. Check room for need for additional lighting.

5. Assure safety of the environment i.e. dry floor, uncluttered floor, bed in low position, wheelchair locked, use of lowered chair
6. Offer snacks and beverages.
7. Offer resident SBA (stand-by-assist) and use gait belt for transfers.

Level Two:

Any resident with more than two falls in one month; taking one fall related medication (i.e. diuretic); mild to moderate physical impairment; or occasional impaired mental status (i.e. at night).

Interventions:

1. Side rails up or down per facility policy and care plan.
2. Consider asking family to visit as assistance to monitor resident during resident more apt to fall if there is a pattern or trend.
3. TAB's monitor and monitor for effectiveness.
4. Offer resident activities of interest i.e. magazine, puzzles, memory books, etc.
5. Offer beverages and snacks.
6. Encourage frequent exercise, toileting, and stand aide.
7. Medications to be a lowest dose possible per physician order and monitored by licensed nurses, pharmacist, and MD.
8. Monitor labs ordered by physician and report abnormalities.

Level Three:

Any resident with three or more falls in one month; confused, disoriented, combative, unpredictable; unable to comprehend/recall instructions; unsteady gait/moderate to severe physical impairment; bladder or bowel urgency/incontinence.

1. Place resident in highly visible area for monitoring.
2. TABS monitor and monitor for effectiveness.
3. PT and/or OT evaluation.
4. Physician consult with mention in progress notes.
5. Do not leave resident alone on toilet, commode, or in room alone.
6. Constant supervision with transferring, ambulation, toileting, etc.
7. Use interventions from levels one and two and additional interventions as needed.

Approved By: _____ Date _____

Medical Director Approval _____ Date _____

Original Approval Date: Revision Dates:

Fall Follow-Up Assessment

Resident _____ Time _____ Date _____

Resident Environment:

(Location of fall, Floor Conditions, etc.)

Resident Situation:

(Describe Incident, How did fall occur?)

Decline in ambulation or transfer skills? _____ Yes _____ No

Steady gait? _____ Yes _____ No

Is/was the resident wearing shoes/slippers? _____ Yes _____ No

Was the resident using appliances correctly? _____ Yes _____ No

(Ex. Walker, w/c, cane)

Resident ambulation status: _____ independent _____ assist

Are/were the resident's familiar objects handy? _____ Yes _____ No

(Ex. Call light, remote, tissue)

Has the resident had other falls within the past 30 days? _____ Yes _____ No

Resident has S/S of restlessness? _____ Yes _____ No

Resident toileting privilege: _____ independent _____ assist

Resident in high visibility area? _____ Yes _____ No

Is there a pattern that can be identified? _____ Yes _____ No

If yes, describe the pattern: _____

Does the resident currently use tabs or baby monitor? _____ Yes _____ No

If yes, was the device in place? _____ Yes _____ No

If yes, was the device functioning properly? _____ Yes _____ No

CNA Intervention thoughts/ideas:

(What could be done to change the situation or prevent from happening again?)

CNA Signature: _____ Date _____

Reviewed by RN/LPN: _____ Date _____

RN/LPN Comments:
