Enhancing Life
Jersey City Medical Center

Department of Patient Care Services

POLICY: Falls Prevention & Management	**DEVELOPED BY: Patient Care Services**
POLICY COMMITTEE: _____ Janice Kozzi MSN, RN, CNL Policy Committee Chair ❑ N/A	**APPROVED BY:** _____ Rita Smith, DNP, RN CNO, Senior Vice President Patient Care Services _____ Name: Title: Dept: Chair/Designee of Developing Committee

Effective Date: June 2012 and as EMR is available to specific departments	**Revised Date:**	**Reviewed Date:**

Distribution: All nursing unit manuals

Reference: 2007 JCAHO National Patient Safety Goals

The John Hopkins Hospital Nursing Practice and Organization Manual Volume II Appendix A

An Evidence-based Approach to Fall Risk Assessment, Prevention, and Management
Poe, Stephanie, MScN, RN; Cvach, Maria MS, RN, CCRN; Gartrell, Denise, MS, RN; Radzik, MS, RN, CRNP Hoy, Tameria, BNS, RN

The John Hopkins Fall Risk Assessment Tool Postimplementation Evaluation
Poe, Stephanie, MScN, RN,; Cvach, MS, RN, CCRN; Dawson, Patricia, MSN, RN; Straus, Harriet, MAOM, RN, CRRN; Hill, Elizabeth, Phd, RN

Approvals:

Professional Practice	Y ☐	N/A ☐
Nursing Education	Y ☐	N/A ☐
Critical Care	Y ☐	N/A ☐
Emergency Dept	Y ☐	N/A ☐
Peri-Op	Y ☐	N/A ☐
Trauma	Y ☐	N/A ☐
Maternal Child Health	Y ☐	N/A ☐
Behavioral Health	Y ☐	N/A ☐
Cardiac Cath Lab	Y ☐	N/A ☐
Interventional Radiology	Y ☐	N/A ☐
Med Exec	Y ☐	N/A ☐
Pharmacy/ P&T	Y ☐	N/A ☐
Pathology/Blood Bank	Y ☐	N/A ☐
Other:	Y ☐	N/A ☐
Other:	Y ☐	N/A ☐

PURPOSE: To provide a mechanism for patient with potential for falls to be identified and placed on a fall prevention plan.

POLICY: All adult inpatients will be assessed by the registered nurse using The John Hopkins Hospital Assessment Tool upon admission and every shift to determine the potential risk for falls. Patients who have a change of condition will be reassessed for falls risk as seen necessary by registered nurse.

All adult Emergency Department patients will be evaluated by The John Hopkins Hospital Falls Assessment Tool.

All children admitted to Pediatrics are considered to be at increased risk for fall. These patient populations have their own risk for falls considered in their plan of care. These patients are not assessed by The John Hopkins Hospital Falls Tool.

Obstetrics patients who may be at an increased risk for falls have this considered into their plan of care, which is tailored to their individual needs; these patients are assessed by The John Hopkins Assessment Tool.

Behavioral Health population will be assessed by the John Hopkins Hospital Tool and then individual care plan will be implemented for their needs.

Procedure:

Environment for Fall Prevention:

Patients' environment would be observed for fall risk hazards on admission and PRN.
Environmental fall risk factors include:

Clutter/Obstacles
Lack of adequate lighting
Inoperable locks on bed/stretchers/wheelchairs
Remove excess equipment/supplies/furniture from rooms and hallways
Coil and secure excess electrical and telephone wires
Clean all spills inpatient rooms or in hallway immediately.
Place signage to indicate wet floor danger

Fall Risk Assessment:

- Any patient with a score 0-5 would be low risk
  Calculation of fall risk is not required for patients who are comatose, completely immobile, or completely paralyzed. Implement basic safety precautions as per low risk interventions.
- Any patient with a score of 6-13 total points would be identified as "Moderate Risk" will then have a yellow Star placed at patient's doorway
- Any patient with a score of >13 total points would be identified as "High Risk" will then have a red sign placed at patient's doorway

* Emergency Room will have a double sign which will be folded and tucked under mattress of the identified patient stretcher to show which fall precaution has been identified.

Patient Care management related to Falls:

- Registered nurse will report all patient falls and treatment of fall-related injuries to the licensed provider and clarify who will notify

family member of incident. Unlicensed staff will report to registered nurse any fall observed or notified of.

Patient Care management related to prevention of Falls:

- Registered nurse will communicate to team who is on falls risk and any changes during shift that would reflect a change in risk level; such as medication or conscious sedation; new admission. Suggestion is to utilize the appropriate white boards to assist in this communication.

- Registered nurse will direct the unlicensed staff to implement the basic safety interventions such as:

Low Risk:

- Environment as listed above
- Low bed
- Secure locked bed
- Offer nonskid footwear
- Place call bell within reach of patient & respond immediately

Moderate Risk: Score of 6- 13

- Environment as listed above
- Low risk intervention as listed above
- Rounding on patients according to the risk score hourly or more frequently when advised by registered nurse
- Yellow arm band
- Identify with yellow star on doorway / (ED on Stretcher)
- Consider location of at risk patients when able such as near doorway &/or near nurses station
- Offer assistance for toileting every 2 hours while awake

High Risk: Score of >13

- Environment as listed above
- Low risk & Moderate risk intervention as listed above
- Leave curtains open for high risk patients
- Identify room appropriate to risk score Red sign (high) on doorway or (ED Stretcher)
- Yellow arm band

- Consider sitter if appropriate
- Consider self-releasing belts
- Consider restraints as per facility's policy
- Consider medication regimen
- Increase communication with staff when transporting or transferring patient, have a staff member with patient during transport till next staff member is aware of patients arrival
- Consider bed side testing when appropriate.

Red sign will read as follows':

FALL RISK

- **Offer hourly toileting**
- **Stay with patient while in bathroom**
- **Room check for clutter & lighting**
- **Bed low & locked**
- **Call Bell answer promptly & personal items within reach**
- **Curtains open (consider bed best viewed)**
- **Check patient when passing by**
- **Communicate needs to team**

Consider: Room Location, Medication Regimen, Self Releasing Belt, Sitter when appropriate, Restraints according to the facility's Policy

Definitions to assist nursing:

Patient Fall - is an unplanned descent to the floor, with or without injury to the patients

Injury – a disruption of structure or function of some part of the body as a result of an unplanned event (e.g., fracture, sprains, abrasions, ecchymotic area, aggravation of pre-existing complaints)

Copy of tool in its entirety:

The Johns Hopkins Hospital Fall Assessment Tool

FALL RISK ASSESMENT, PREVENTION AND MANAGEMENT, ADULT

THE JOHNS HOPKINS HOSPITAL FALL ASSESSMENT TOOL

Fall Risk Factor Category

Scoring not completed for the following reason(s) (check any that apply). Enter risk category (i.e. Low/High) based on box selected.

☐☐ Complete paralysis, or completely immobilized. Implement basic safety **(low fall risk)** interventions.

☐☐ Patient has a history of more than one fall within 6 months before admission. Implement **high fall risk** interventions throughout hospitalization.

☐☐ Patient has experienced a fall during this hospitalization. Implement **high fall risk** interventions throughout hospitalization.

☐☐ Patient is deemed **high fall-risk** per protocol (e.g. seizure precautions). Implement **high fall-risk** interventions per protocol.

COMPLETE THE FOLLOWING AND CALCULATE FALL RISK SCORE. IF NO BOX IS CHECKED, SCORE FOR CATEGORY IS 0.

POINTS

AGE (**SINGLE**-SELECT)

☐☐ 60 – 69 years **(1 point)**

☐☐ 70 – 79 years **(2 points)**

☐☐ ≥ 80 years **(3 points)**

FALL HISTORY (**SINGLE**-SELECT)

☐☐ One fall within 6 months before admission **(5 points)**

ELIMINATION, BOWEL AND URINE (**SINGLE**-SELECT)

☐☐ Incontinence **(2 points)**

☐☐ Urgency or frequency **(2 points)**

☐☐ Urgency/frequency and incontinence **(4 points)**

MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (**SINGLE**-SELECT)

☐☐ On 1 high fall risk drug **(3 point)**

☐☐ On 2 or more high fall risk drugs **(5 points)**

☐☐ Sedated procedure within past 24 hours **(7 points)**

PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDS, ETC) (**SINGLE**-SELECT)

☐☐ One present **(1 point)**

☐☐ Two present **(2 points)**

☐☐ 3 or more present **(3 points)**

MOBILITY (**MULTI**-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)

☐☐ Requires assistance or supervision for mobility, transfer, or ambulation (2 points)

☐☐ Unsteady gait **(2 points)**

☐☐ Visual or auditory impairment affecting mobility **(2 points)**

COGNITION (**MULTI**-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)

☐☐ Altered awareness of immediate physical environment (1 point)

☐☐ Impulsive (2 points)

☐☐ Lack of understanding of one's physical and cognitive limitations (4 points)

***Moderate risk = 6-13 Total Points, High risk > 13 Total Points Total Points**

Electronic Medical Records will have the ability to add the score and place the number on the last line. Then the nurse will apply the appropriate interventions as directed in this Policy. Be aware that the first few questions on the assessment tool will indicate either low or high risk on the merit of that answer alone, the need to specifically answer the remaining questions on the Electronic Medical Record will not be necessary.