



# NCAL PCS 2016 FALLS PREVENTION



Kaiser Permanente is committed to maintaining patient safety by identifying patients at risk for falls, and at high risk of injury from falls, and implementing evidence-based interventions to prevent falls and injury.

# Universal Interventions for ALL Patients to Prevent Falls

- Assess Fall Risk on admission. Reassess Fall Risk every shift, after a fall, a change in status, level of care, and PRN
- Purposefully Round on patients to proactively meet patient comfort, toileting, and personal needs
- Ensure call light, phone, assistive devices & personal items are within reach
- Use teach back to verify that patients knows when and how to use the call light system
- Promote mobility to prevent deconditioning
- Provide non-skid foot coverings for ambulation
- Eliminate potential trip hazards in the room; provide a clear path to the bathroom
- Ensure appropriate and adequate lighting at all times
- Address sensory deficits such as a the need for glasses, hearing aides, etc.



## Conduct a Fall Risk Assessment in KP HealthConnect utilizing the Schmid Fall Risk Assessment Tool.

# SCHMID Fall Risk

## Schmid Fall Risk

Mobility

Mentation

Elimination

Prior History of Falls

Current Medications

Total Score

### SCHMID FALL RISK ASSESSMENT\*

SCORE	MOBILITY
0	AMB W/NO GAIT DISTURBANCE
1	AMB OR TRANSFERS W/ASSISTIVE DEVICES OR ASSISTANCE
1	AMB W UNSTEADY GAIT AND NO ASSISTANCE
0	UNABLE TO AMBULATE OR TRANSFER
MENTATION **	
0	ALERT, ORIENTED X 3
1	PERIODIC CONFUSION OR DISORIENTATION X 1 OR 2
1	CONFUSION AT ALL TIMES
0	COMATOSE/UNRESPONSIVE
ELIMINATION	
0	INDEPENDENT IN ELIMINATION
1	INDEPENDENT, BUT W FREQUENCY OR DIARRHEA
1	NEEDS ASSISTANCE W TOILETING
1	INCONTINENCE
PRIOR FALL HISTORY	
1	YES – BEFORE ADMISSION
2	YES – DURING THIS ADMISSION
0	NO
1	UNKNOWN
CURRENT MEDICATIONS	
1	ANTICONSULSANTS, SEDATIVES, PSYCHOTROPICS, HYPNOTICS, NEW ANTIHYPERTENSIVES, OPIODS, DIURETICS AND/OR LAXATIVES
TOTAL SCORE	

\*\* Consider History of Dementia or Delirium or Current Delirium as a risk factor equivalent to Periodic Confusion, Disorientation or Confusion at all times when assessing Mentation.

**SCORE OF 3 OR ABOVE: PATIENT AT RISK FOR FALLS**

***SCORE OF  $\geq 3$ : Patient at risk for Falls***



*Utilize the ABCS (Age, Bones, Coagulation, and Surgery Recently) tool to assess for patients at high risk for injury from a fall.*

# SCHMID Plus ABCS

Patients at High Risk for Serious Injury From a Fall

Defined as at FALL RISK (Schmid score  $\geq$  3 or RN clinical judgment) and having one or more of the ABCS criteria


## 3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented


# SCHMID Plus ABCS

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A	Age	$\geq 75$ years old

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A	Age	$\geq 75$ years old
B	Bones	Any disease, condition, or medication that affects bone strength: osteoporosis, previous fracture, prolonged steroid use, or metastatic bone cancer

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<b>C</b>	<b>Coagulation</b>	Patients with impaired blood clotting, either through use of anticoagulants or underlying clinical conditions (i.e., chronic liver disease, bleeding/platelet disorders)

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## 3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

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<b>1</b>	<b>Provide ASSISTANCE and NEVER LEAVE PATIENT ALONE</b> with TOILETING or AMBULATING. These patients should not be allowed to dangle at the side of the bed other than during transfer.
<b>2</b>	<b>Provide TOILETING SCHEDULE</b> per patient needs of frequency and urgency.
<b>3</b>	<b>Provide EDUCATION TO PATIENT/FAMILY</b> regarding the high risk for injury if they fall, in the hospital and at home.



Implement fall prevention measures for all patients identified as at **Risk for Fall**.

# Utilize a comprehensive plan of care.



## Ensure that the patient is visibly identified as a Fall Risk.

- Place a Yellow Arm Band on patient.
- Accept BPA for Fall Risk and acknowledge banner in KP HealthConnect.
- Flag the patient as a Fall Risk using room signage.

<b>PER Home</b>
<b>ASPIRATION PRECAUTIONS</b>
<b>Fall Risk</b>
<b>Fall Injury Risk</b>

When a patient's Schmid scale is 3 or above and a Fall Risk Care Plan template has never been applied, the nurse is alerted that the Fall Risk Care Plan template will be automatically added to the patient plan.

BestPractice Advisory - Xncggxsrtwlv,Kd Ww

**ALERT: The patient Schmid score is 3 or greater. ACTION: Fall Risk Care Plan will be applied automatically.**

The following actions were applied automatically:

✓ Added to Care Plan: FALL RISK IP NATL



## Patient Plan

Back Forward Document Modify Problem New Problem Apply Template Resolve Problems Delete Problem Clear All Filters Filters Reviewed Legend

### Patient Plan

- Overview
  - Patient Plan Progress Notes
  - Event Log
- Fall Risk**
  - Fall Risk
    - Identify Signs and Symptoms and
    - Absence of Trauma/Injury/Falls
    - Problem Interventions
      - Toileting
      - Environment
      - Activity
      - Medication

Display:  Description

### Fall Risk

#### Fall Risk

#### Web Links

[Clinical Practice Guideline](#)  
[KP Evidence for Fall Risk and Interventions](#)

#### Goal: Identify Signs and Symptoms and Related Risk Factors

Signs and symptoms and related risk factors are identified upon initiation of Human Response Clinical Practice Guideline (CPG)


#### Goal: Absence of Trauma/Injury/Falls

Patient will demonstrate the desired outcomes by discharge/transition of care.

#### Problem Interventions

1. Toileting (PER CPG)
2. Environment (PER CPG)
3. Activity (PER CPG)
4. Medication (PER CPG)

When this Fall Risk Care Plan is added, the TEAM Bundle interventions will also be added to the shift doc flow sheet below the Schmid Fall Risk group.

<b>Devices</b>	
Specialty Bed Type (Non-Pressure Related)	
 Devices/Supplies	
Sequential Compression Device	
<b>Apparent Fall - Document ONLY in event of Patient Fall</b>	
Apparent Fall This Shift	
<b>Schmid Fall Risk</b>	
Mobility	
Mentation	
Elimination	
Prior History of Falls	
Current Medications	
Total Score	
<b>TEAM - Interventions for Fall Prevention</b>	
Toileting	
Environment	
Activity	
Medication	

Identify individualized interventions based on risk factors. These include Toileting, Environment, Activity, and Medication in KP HealthConnect.



# Selection options for individualized interventions for TEAM bundle

T oileting	E nvironment	A ctivity	M edication
<p>Check off all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Assist to toilet</li> <li><input type="checkbox"/> Assist to bedside commode</li> <li><input type="checkbox"/> Urinal accessible</li> <li><input type="checkbox"/> Remains with patient</li> </ul>	<p>Check off all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Safety check</li> <li><input type="checkbox"/> Personal items within reach</li> <li><input type="checkbox"/> Visual cues present</li> <li><input type="checkbox"/> Fall risk armband used</li> <li><input type="checkbox"/> Bed alarm on</li> <li><input type="checkbox"/> Chair alarm on</li> <li><input type="checkbox"/> Bed in low position</li> <li><input type="checkbox"/> Low bed</li> </ul>	<p>Check off all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Progressive mobility</li> <li><input type="checkbox"/> Muscle strengthening exercises</li> <li><input type="checkbox"/> Equipment for mobility support</li> <li><input type="checkbox"/> Mobility aids within reach</li> <li><input type="checkbox"/> PT consult as appropriate</li> </ul>	<p>Check off all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Identify side effects</li> <li><input type="checkbox"/> Review high risk medications</li> <li><input type="checkbox"/> Adjust timing</li> <li><input type="checkbox"/> Pharmacy consult</li> <li><input type="checkbox"/> MD consult</li> </ul>

# Selection options for individualized interventions for Toileting from TEAM Bundle

## Toileting

Check off all that apply

- Assist to toilet
- Assist to bedside commode
- Urinal accessible
- Remains with patient

The screenshot displays a software interface for managing patient care. The main window is titled "Fall Risk" and contains a tree view on the left. Under "Fall Risk", the "Problem Interventions" section is expanded, and "Toileting" is selected and highlighted with a red circle. Below the tree view, there are fields for "User Taken By" and "Insert Flowsheet Data". A "Selection Form" dialog box is open in the foreground, also with a red circle around it. This dialog box contains a list of four options: "Assist to toilet", "Assist to bedside commode", "Urinal accessible", and "Remains with patient". The "Assist to toilet" option is currently selected in the list. At the bottom of the dialog box are "Accept" and "Cancel" buttons. In the background, a table with columns for "Rows" and "2015" is visible, along with a checkbox labeled "Check the box to to previous value new assessment needed".

# Selection options for individualized interventions for Environment from TEAM Bundle

## Environment

Check off all that apply

- Safety check
- Personal items within reach
- Visual cues present
- Fall risk armband used
- Bed alarm on
- Chair alarm on
- Bed in low position
- Low bed

The screenshot displays the 'Fall Risk' section of the TEAM Bundle software. The 'Environment' option is highlighted in the 'Problem Interventions' list. A 'Selection Form' dialog box is open, showing a list of selection options: Safety check, Personal items within reach, Visual cues present, Fall risk armband used, Bed alarm on, Chair alarm on, Bed in low position, and Low bed. The 'Personal items within reach' and 'Bed in low position' options are highlighted in the dialog box. The background interface includes a 'Toileting' section, an 'Add Variance' button, and a table for 'Associated Flowsheet Rows'.

# Selection options for individualized interventions for Activity from TEAM Bundle

## Activity

Check off all that apply

- Progressive mobility
- Muscle strengthening exercises
- Equipment for mobility support
- Mobility aids within reach
- PT consult as appropriate

**Fall Risk**

- Fall Risk
  - Identify Related Risk Factors and Signs and S
  - Problem Interventions
    - Toileting
    - Environment
    - Activity**
    - Medication

Time: 1436

TEAM - Interventions for Fall Prevention

Activity

User Taken By

Insert Flowsheet Data

Selection Form

- Progressive mobility
- Muscle strengthening exercises**
- Equipment for mobility support
- Mobility aids within reach
- PT consult

Accept Cancel

# Selection options for individualized interventions for Medication from TEAM Bundle

## Medication

Check off all that apply

- Identify side effects
- Review high risk medications
- Adjust timing
- Pharmacy consult
- MD consult

The screenshot shows a clinical software interface for a 'Fall Risk' assessment. The left sidebar contains a tree view with 'Medication' selected and highlighted with a red circle. The main area displays a form with fields for 'new value', 'Date' (12/9/2015), and 'Time' (1436). Below these fields is a section titled 'TEAM - Interventions for Fall Prevention' with a search bar and a 'No data filed' message. A 'Selection Form' dialog box is open in the foreground, also with a red circle around it, listing the following options: 'Identify side effects', 'Review high risk medications', 'Adjust timing', 'Pharmacy consult', and 'MD consult'. The 'Accept' and 'Cancel' buttons are at the bottom of the dialog. A checkbox on the right side of the main form is checked, with the text 'Check the box to link to previous value if new assessment is needed'.



# Special Populations

- Use of Low Beds
- Perinatal
- Perioperative Areas
- Emergency Department

# Low Beds

- Consider deploying a specialty **Low Bed** for patients of short stature, inadequate quad strength, and difficulty accessing the call light, or requiring assistance to get out of bed.
- Patients with cognitive impairment (confusion, dementia, delirium), or agitation are also good candidates.
  - Notify appropriate staff at your medical center to obtain a low bed.
  - Utilize the Devices section for Specialty Bed documentation in KP HealthConnect.

# Perinatal Populations

## All patients will be assessed for fall risk:

- Implement fall precautions as appropriate for the patient.
- Yellow armbands are not used.

## Patients receiving epidural analgesia:

- Reassess for fall risk after epidural analgesia has been initiated
- Instruct on when and how to get out of bed
- Assess for return of sensation and motor function using the Modified Bromage Scale, after discontinuation of epidural analgesia, prior to being assisted out of bed.

*Perinatal patients receiving magnesium sulfate and postpartum patients will be instructed to call for assistance when getting out of bed until the nurse identifies that the patient is able to ambulate independently.*

## Discontinuing Fall Precautions:

Fall precautions may be discontinued for perinatal patients when all of the following criteria have been met:

- Ambulates twice without assistance while nurse present.
- No complaints of dizziness or leg weakness.
- Patient verbalizes confidence in ability to ambulate without assistance

*Key concept: Perinatal patients receiving magnesium sulfate or epidural anesthesia are at an increased risk for a fall.*

# Perioperative/Procedural Sedation Areas

- All patients in the PeriOperative and Procedural Sedation departments are considered at risk for falls related to sedation and anesthesia and universal fall precautions will be routinely instituted.
- • Schmid Fall Score and Yellow armbands are **not** utilized. *It is the responsibility of the Inpatient Nursing staff to place the yellow arm band upon arrival to the inpatient unit, if applicable.*

# Emergency Department

- Fall Risk Assessed using the Schmid Scale
- Universal fall precautions
- Family or friends in attendance should be informed of the fall risk and encouraged to stay at bedside with the patient
- Yellow armbands may be used.

*If the Fall Risk Care Plan is resolved or inactivated and the patient becomes a fall risk again, a BPA will fire again reminding the nurse to reactivate the Fall Risk Care Plan.*

BestPractice Advisory - Xncggxsrtwlv,Kd Ww

▼ Patient is at risk for falls. Please remember to apply or reactivate the Fall Risk Care Plan.

↗ [Click here to go to the Patient Plan Activity](#)

# Implement the Vital Behaviors to reduce falls for patients at high risk for injury (Schmid Plus ABCS)

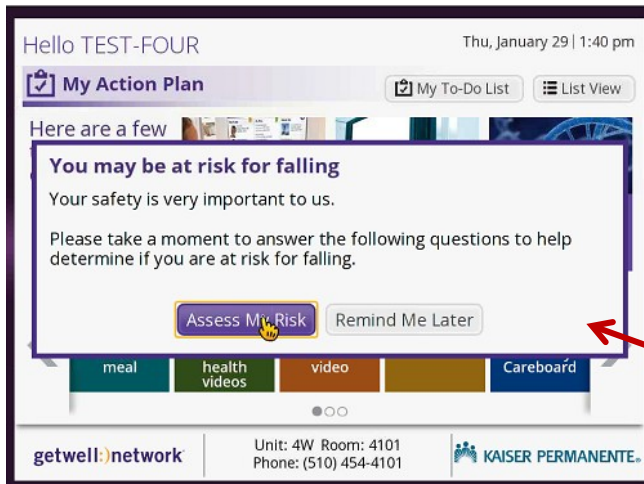
## 3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

**\*\*All three must be implemented\*\***

- 1 Provide **ASSISTANCE** and **NEVER LEAVE PATIENT ALONE** with **TOILETING** or **AMBULATING**. These patients should not be allowed to dangle at the side of the bed other than during transfer.
- 2 Provide **TOILETING SCHEDULE** per patient needs of frequency and urgency.
- 3 Provide **EDUCATION TO PATIENT/FAMILY** regarding the high risk for injury if they fall, in the hospital and at home.

# Interactive Patient Care (GetWell) for New Hospitals only



Upon admission, the **Preventing Falls** video is one of the four mandatory videos a patient will need to watch.

Four hours after a patient's admission, the **Fall Prevention Patient Self Assessment** will trigger automatically.

*Based on the answers to these questions, the patient will be asked to watch the **Preventing Falls** video again.*





Provide, reinforce, and document education to your patient, significant other, and/or family members on fall risk and prevention measures.

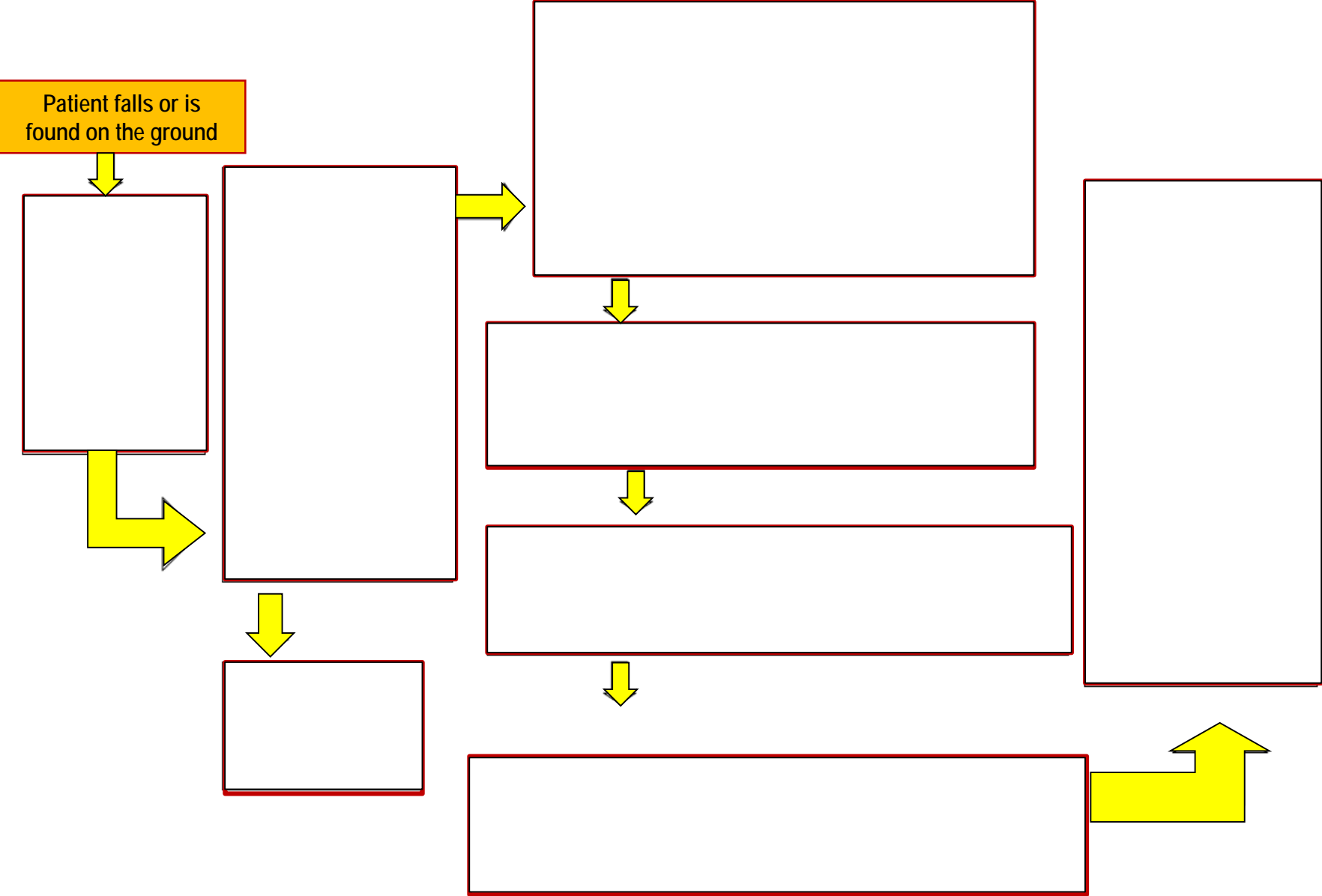


What do you do in the event of a patient fall?

## Activate your local notification process to get resources to the patient.

- Perform initial post fall assessment prior to moving patient.
- Conduct a thorough assessment of your adult patient and notify the MD after a fall to assess complications, order necessary test/procedures.
- Ensure that fall risk interventions are in place.
- Notify family immediately for falls with injury or altered level of consciousness. In other instances, notify family as soon as reasonably possible. Document family notification in KP HealthConnect.
- Reassess Fall Risk and document using the Schmid Fall Risk Assessment Tool every 4 hours X 24 hours.
- Implement and document individualized interventions to maintain patient safety.
- Review and revise the Plan of Care to add preventative measures to ensure another fall does not occur.
- Complete the “Apparent Fall This Shift” row on the shift flow sheet of KP HealthConnect. Include a narrative note using the **.fall** smart phrase, and complete an eRRF.
- Involve your patient’s treatment team.

# Assessment of Adult Patients After a Fall



# For more information, refer to Your Medical Center Fall Policy



Name: \_\_\_\_\_

Date: \_\_\_\_\_

Score: \_\_\_\_\_

### **RN Falls (True or False)**

1. If my patient falls or is found on the floor, I need to reassess for fall risk, document fall risk score in narrative, Evaluate the Care Plan and initiate new interventions as indicated. T F
2. Being comatose places the patient at high risk for falls T F.
3. Assessment for fall risk should be performed on admission, at least daily, after a fall, after change in level of care, and as needed. T F
4. During the assessment of the Adult Patient for falls, a nurse must use his/her Nursing judgment if a patient is a fall risk –regardless of the Schmid or ABCS scores. T F
5. If a patient has a Schmid score <3, but meets ABCS criteria, it would be appropriate to document "ABCS" in the Care Plan, and update with interventions reflecting the 3 vital behaviors. T F