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 ASSESSMENT

<table>
<thead>
<tr>
<th>SCORE</th>
<th>MOBILITY</th>
<th>MENTATION</th>
<th>ELIMINATION</th>
<th>PRIOR FALL HISTORY</th>
<th>CURRENT MEDICATIONS</th>
<th>TOTAL SCORE</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>AMB W/NO GAIT DISTURBANCE</td>
<td>ALERT, ORIENTED X 3</td>
<td>INDEPENDENT IN ELIMINATION</td>
<td>YES – BEFORE ADMISSION</td>
<td>ANTICONVULSANTS, SEDATIVES, PSYCHOTROPICS, HYPNOTICS, NEW ANTIHYPERTENSIVES, OPIOIDS, DIURETICS AND/OR LAXATIVES</td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>1</td>
<td>AMB OR TRANSFERS W/ASSISTIVE DEVICES OR ASSISTANCE</td>
<td>PERIODIC CONFUSION OR DISORIENTATION X 1 OR 2</td>
<td>INDEPENDENT, BUT W FREQUENCY OR DIARRHEA</td>
<td>YES – DURING THIS ADMISSION</td>
<td><strong>3</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>AMB W UNSTEADY GAIT AND NO ASSISTANCE</td>
<td>CONFUSION AT ALL TIMES</td>
<td>NEEDS ASSISTANCE W TOILETING</td>
<td>NO</td>
<td><strong>3</strong></td>
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<tr>
<td>0</td>
<td>UNABLE TO AMBULATE OR TRANSFER</td>
<td>COMATOSE/UNRESPONSIVE</td>
<td>INCONTINENCE</td>
<td>UNKNOWN</td>
<td><strong>3</strong></td>
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**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 ≥ 3 or RN clinical judgment) **and** having one or more of the ABCS criteria

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### 3 Vital Behaviors

- To Reduce Falls for Patients at High Risk for Serious Injury
- All three must be implemented

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<td>Any disease, condition, or medication that affects bone strength: osteoporosis, previous fracture, prolonged steroid use, or metastatic bone cancer</td>
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To Reduce Falls for Patients at High Risk for Serious Injury
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SCHMID Plus ABCS

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</tr>
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<td><strong>Provide TOILETING SCHEDULE</strong> per patient needs of frequency and urgency.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Provide EDUCATION TO PATIENT/FAMILY</strong> regarding the high risk for injury if they fall, in the hospital and at home.</td>
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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.

<table>
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<tr>
<th>PER Home</th>
<th>ASPIRATION PRECAUTIONS</th>
</tr>
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<tr>
<td>Fall Risk</td>
<td>Fall Injury Risk</td>
</tr>
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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.
**Patient Plan**

**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.
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

<table>
<thead>
<tr>
<th><strong>Toileting</strong></th>
<th><strong>Environment</strong></th>
<th><strong>Activity</strong></th>
<th><strong>Medication</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check off all that apply</td>
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</tr>
<tr>
<td>□ Assist to toilet</td>
<td>□ Safety check</td>
<td>□ Progressive mobility</td>
<td>□ Identify side effects</td>
</tr>
<tr>
<td>□ Assist to bedside commode</td>
<td>□ Personal items within reach</td>
<td>□ Muscle strengthening exercises</td>
<td>□ Review high risk medications</td>
</tr>
<tr>
<td>□ Urinal accessible</td>
<td>□ Visual cues present</td>
<td>□ Equipment for mobility support</td>
<td>□ Adjust timing</td>
</tr>
<tr>
<td>□ Remains with patient</td>
<td>□ Fall risk armband used</td>
<td>□ Mobility aids within reach</td>
<td>□ Pharmacy consult</td>
</tr>
<tr>
<td></td>
<td>□ Bed alarm on</td>
<td>□ PT consult as appropriate</td>
<td>□ MD consult</td>
</tr>
<tr>
<td></td>
<td>□ Chair alarm on</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Bed in low position</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Low bed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Selection options for individualized interventions for Toileting from TEAM Bundle

- Assist to toilet
- Assist to bedside commode
- Urinal accessible
- Remains with patient
Selection options for individualized interventions for Environment from TEAM Bundle

Environment

- 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
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
Selection options for individualized interventions for Medication from TEAM Bundle

- Check off all that apply:
  - Identify side effects
  - Review high risk medications
  - Adjust timing
  - Pharmacy consult
  - MD consult

Diagram showing the TEAM - Interventions for Fall Prevention screen with selected options for Medication.
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 armband 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.
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.
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

Patient falls or is found on the ground
For more information, refer to Your Medical Center Fall Policy
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