NCAL PCS 2016
FALLS PREVENTION

KAISER PERMANENTE®

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.

 |

KAISER PERMANENTE®

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	ANTICONVULSANTS, 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 ≥ 3: Patient at risk for Falls

KAISER PERMANENTE®

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

 |

KAISER PERMANENTE®

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

3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented

 |

KAISER PERMANENTE®

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

A	Age	≥ 75 years old

3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented

 |

KAISER PERMANENTE®

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

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

3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented

 |

KAISER PERMANENTE®

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

A	Age	≥ 75 years old
B	Bones	Any disease, condition, or medication that affects bone strength: osteoporosis, previous fracture, prolonged steroid use, or metastatic bone cancer
C	Coagulation	Patients with impaired blood clotting, either through use of anticoagulants or underlying clinical conditions (i.e., chronic liver disease, bleeding/platelet disorders)

3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented

 |

KAISER PERMANENTE®

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

A	Age	≥ 75 years old
B	Bones	Any disease, condition, or medication that affects bone strength: osteoporosis, previous fracture, prolonged steroid use, or metastatic bone cancer
C	Coagulation	Patients with impaired blood clotting, either through use of anticoagulants or underlying clinical conditions (i.e., chronic liver disease, bleeding/platelet disorders)
S	Surgery Recently	First 48 hours post-surgery, especially patients who have orthopedic surgery or a lower limb amputation

3 Vital Behaviors

To Reduce Falls for Patients at High Risk for Serious Injury

All three must be implemented

 |

KAISER PERMANENTE®

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

A	Age	≥ 75 years old
B	Bones	Any disease, condition, or medication that affects bone strength: osteoporosis, previous fracture, prolonged steroid use, or metastatic bone cancer
C	Coagulation	Patients with impaired blood clotting, either through use of anticoagulants or underlying clinical conditions (i.e., chronic liver disease, bleeding/platelet disorders)
S	Surgery Recently	First 48 hours post-surgery, especially patients who have orthopedic surgery or a lower limb amputation

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.

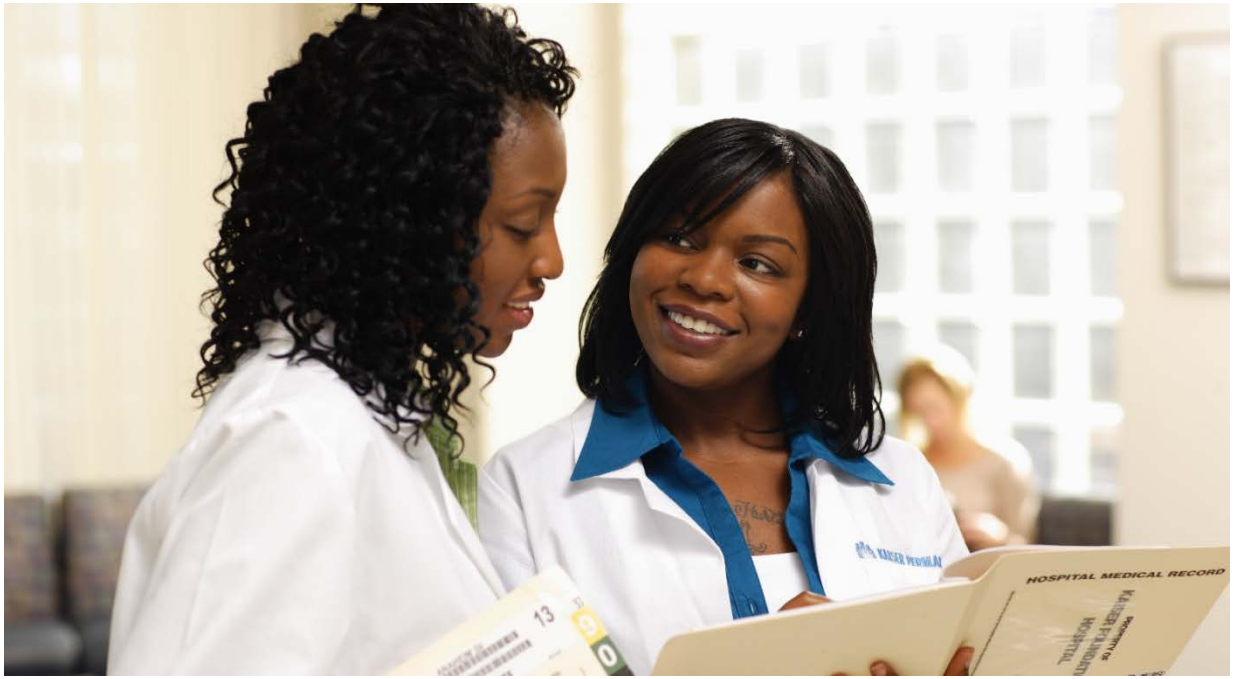
KAISER PERMANENTE®

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

 |

KAISER PERMANENTE®

Utilize a comprehensive plan of care.

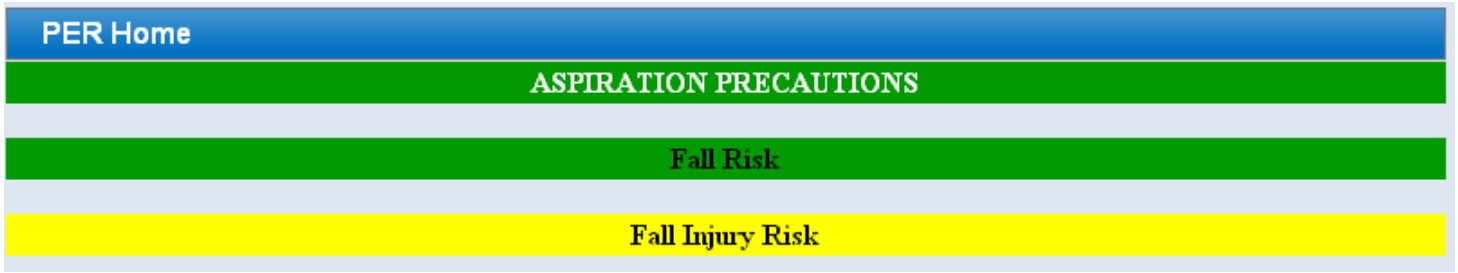


 |

KAISER PERMANENTE®

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.



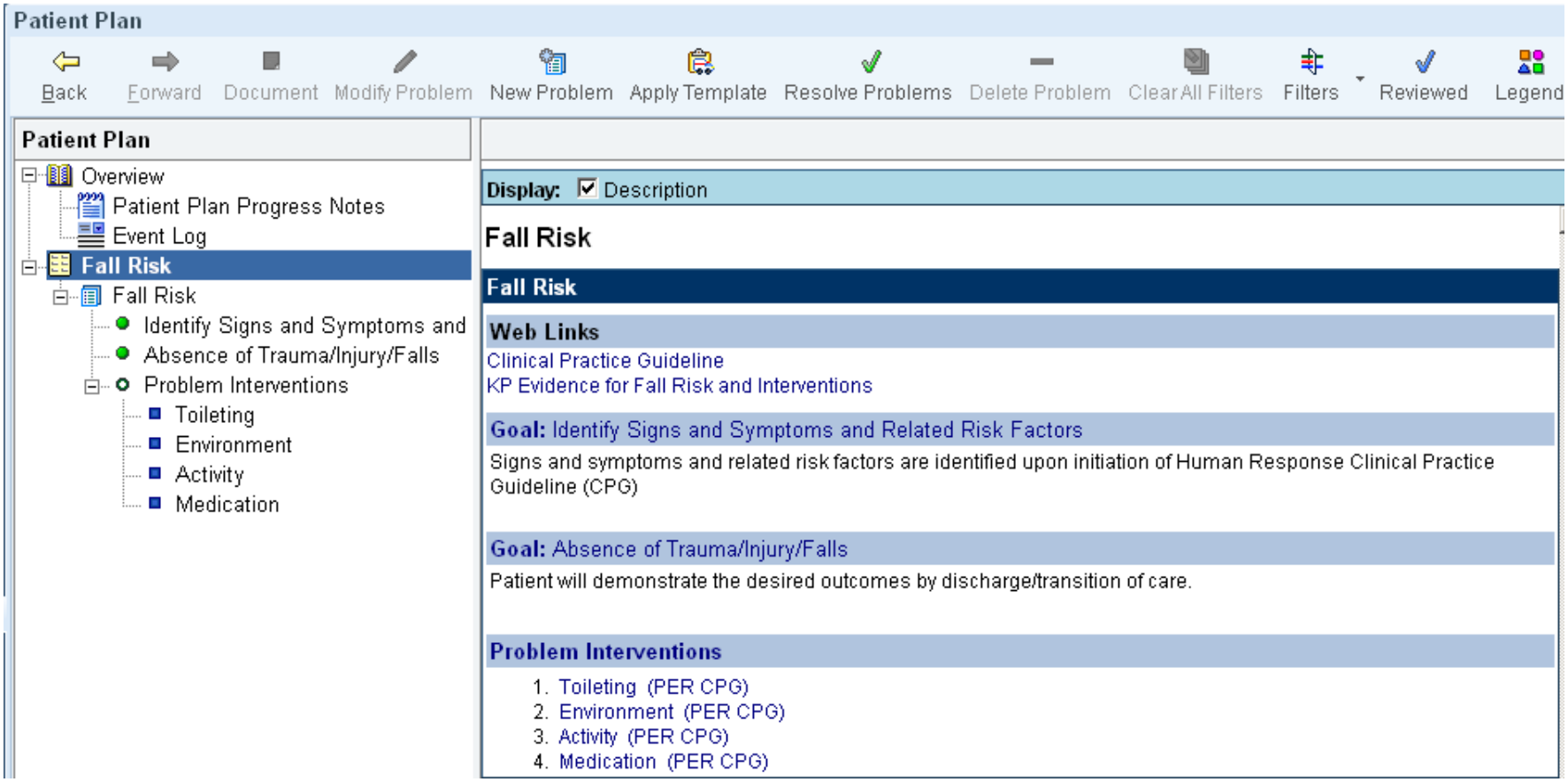
 |

KAISER PERMANENTE®

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.

 |

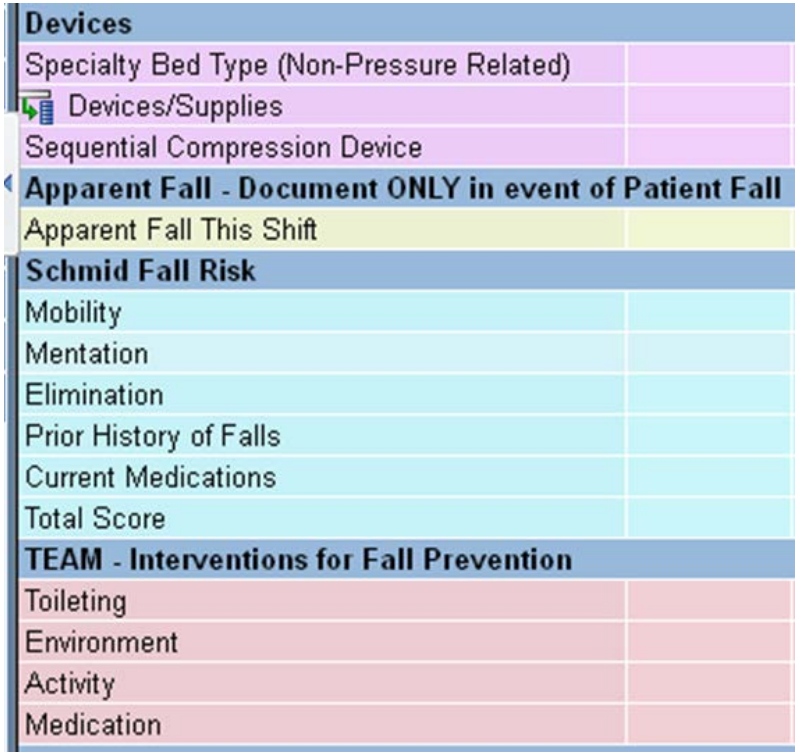
KAISER PERMANENTE®



 |

KAISER PERMANENTE®

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.



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

KAISER PERMANENTE®

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

 |

KAISER PERMANENTE®

Selection options for individualized interventions for TEAM bundle

Toileting	Environment	Activity	Medication
Check off all that apply ☐ Assist to toilet ☐ Assist to bedside commode ☐ Urinal accessible ☐ Remains with patient	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	Check off all that apply ☐ Progressive mobility ☐ Muscle strengthening exercises ☐ Equipment for mobility support ☐ Mobility aids within reach ☐ PT consult as appropriate	Check off all that apply ☐ Identify side effects ☐ Review high risk medications ☐ Adjust timing ☐ Pharmacy consult ☐ MD consult

 |

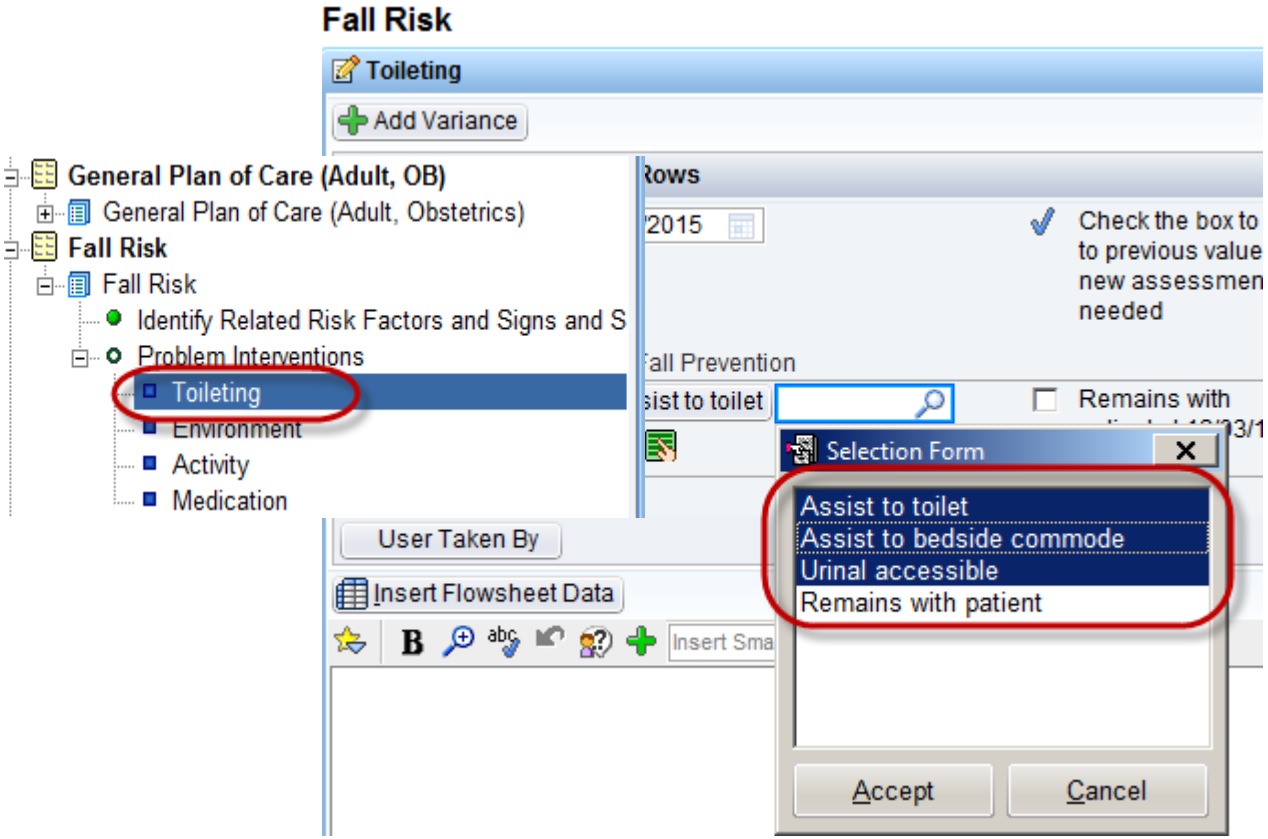
KAISER PERMANENTE®

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



 |

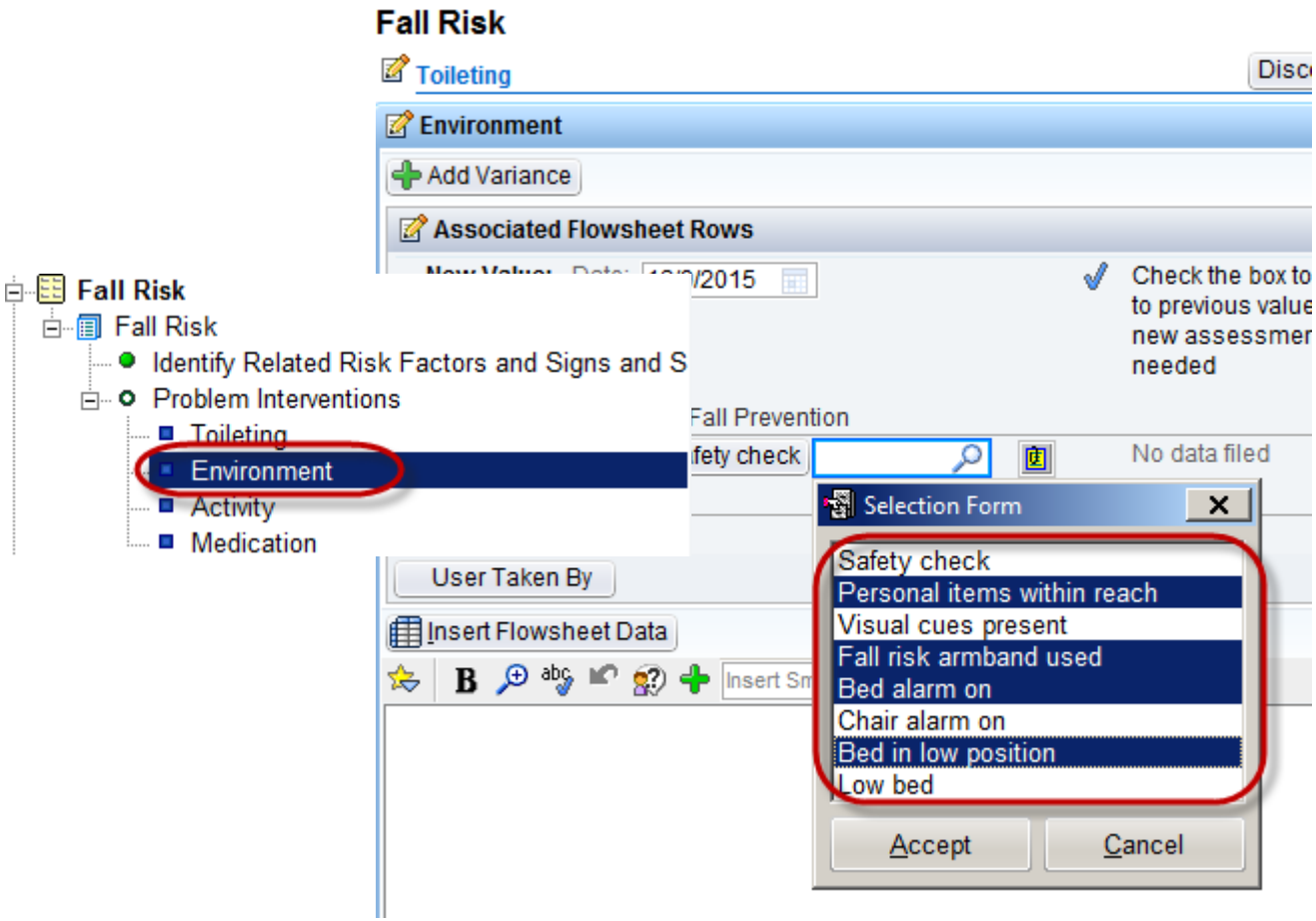
KAISER PERMANENTE®

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



 |

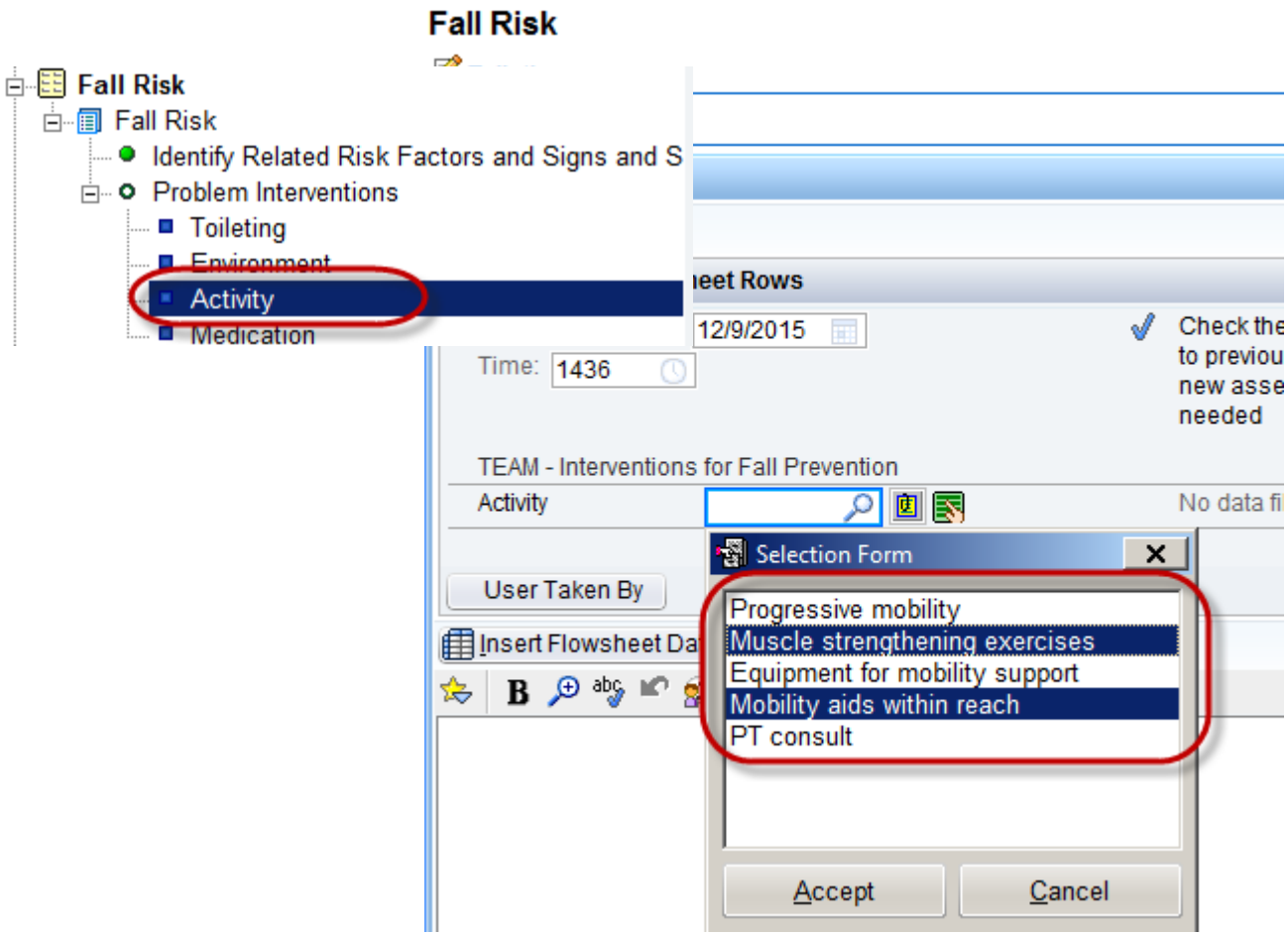
KAISER PERMANENTE®

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



 |

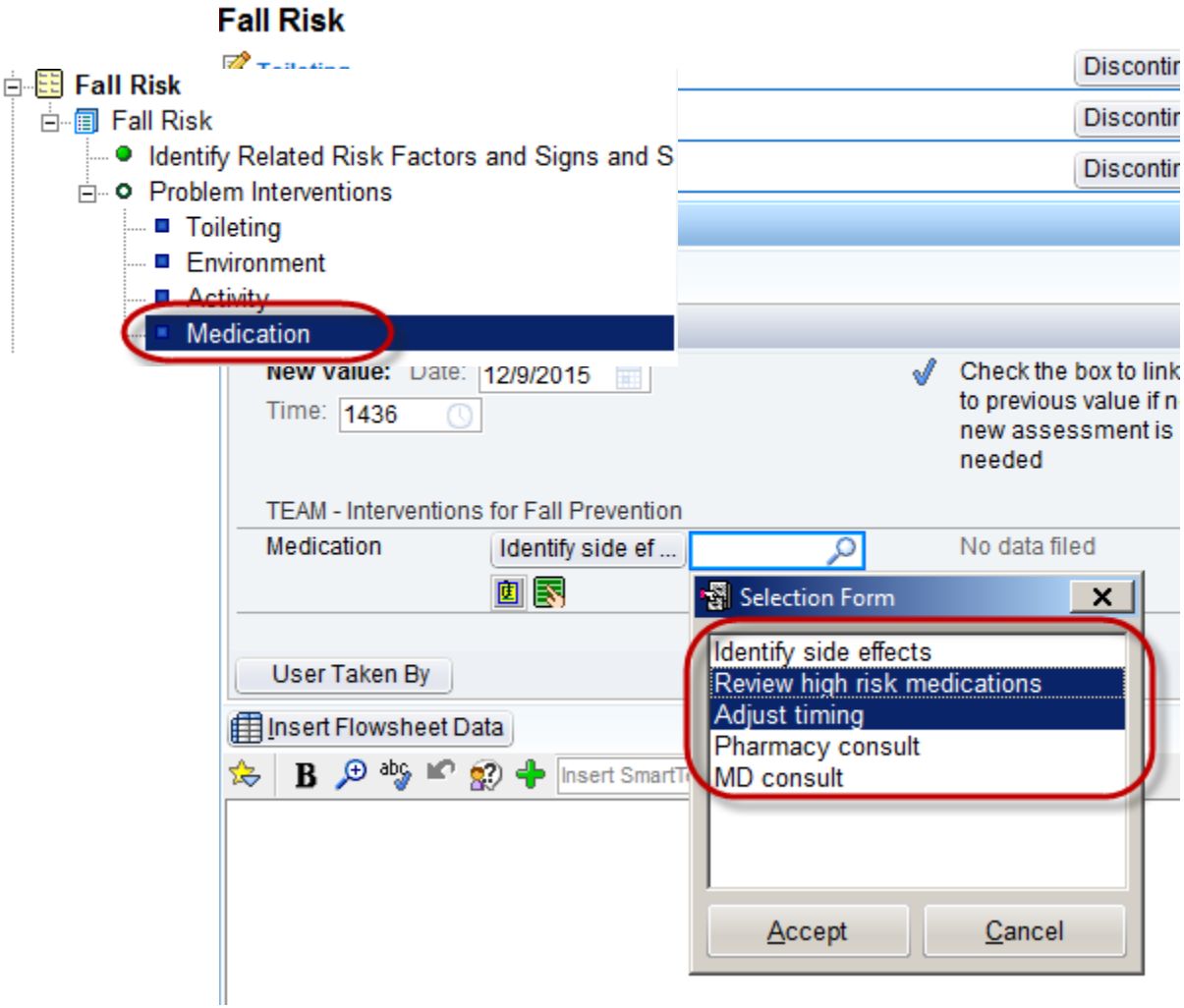
KAISER PERMANENTE®

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



 |

KAISER PERMANENTE®

Special Populations

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

 |

KAISER PERMANENTE®

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.

 |

KAISER PERMANENTE®

Perinatal Populations

All patients will be assessed for fall risk:

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

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

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

KAISER PERMANENTE®

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.*

 |

KAISER PERMANENTE®

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.

 |

KAISER PERMANENTE®

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.

 |

KAISER PERMANENTE®

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

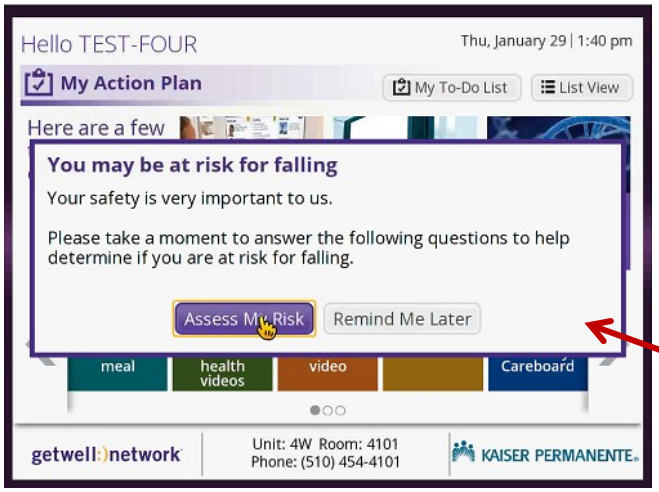
3 Vital Behaviors

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.

KAISER PERMANENTE®

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

KAISER PERMANENTE®

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

 |

KAISER PERMANENTE®

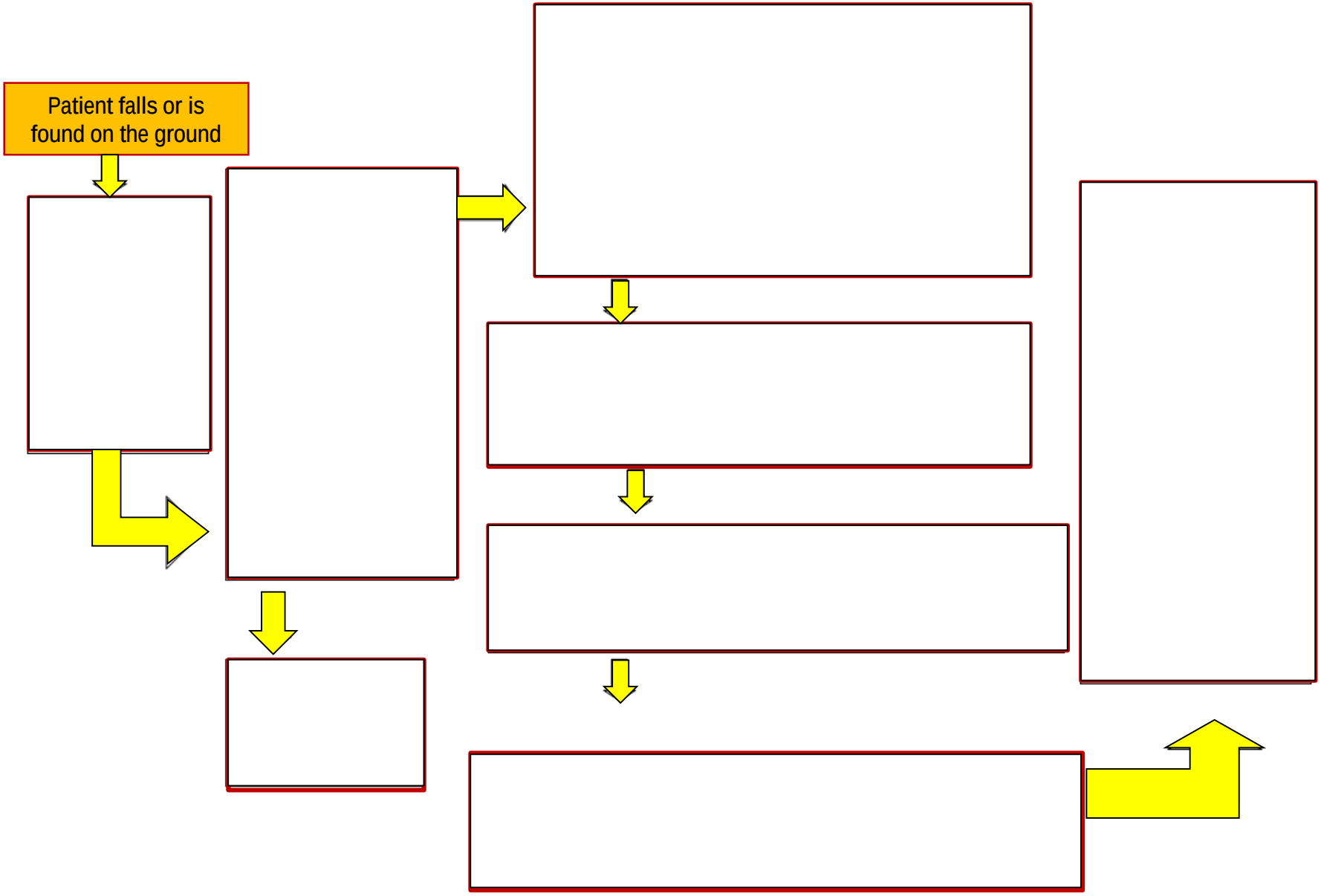
Activate your local notification process to get resources to the patient.

- 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.

 |

KAISER PERMANENTE®

Assessment of Adult Patients After a Fall



 |

KAISER PERMANENTE®

For more information, refer to
Your Medical Center Fall Policy

 |

KAISER PERMANENTE®

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