APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
Lillian Perez-Posadas, RN, MN Hospital Administrator/CEO	Nursing, Pharmacy, Rehabilitative Services, Dietetic Services, Social Services	Interim Approved January 30, 2019	6301-I F-5	1 of 22
TITLE: FALL PREVENTION PROGRAM				
LAST REVIEWED/REVISED:				
ENDORSED:				

PURPOSE:

To provide a methodology for the Interdisciplinary Team to continuously assess a patient's fall risk;
To provide a protocol to reduce and/or prevent patient falls; and
To provide a procedure in the event of a patient fall.

POLICY:

It is the policy of the hospital to provide patients (in-patients and out-patients) the highest quality care in the safest environment. This program identifies the factors that place the patients at risk for falls, promotes proactive healthcare practices to keep the patient safe, and identifies the main component of an effective Fall Prevention Program. The program components include fall risk assessments, identifying risk factors, implementing interventions to prevent patient falls, documentation, evaluation, regular assessment and re-evaluation. In the event of a fall by visitors and guests, care and immediate actions have been identified.

DEFINITIONS:

Fall = is an unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient: All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Include assisted falls when a staff member attempts to minimize the impact of the fall.

Acute Change of Condition (ACOC) = is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. "Clinically important" means a deviation that, without intervention, may result in complications or death.

PROCEDURE:

I. NURSING ADMISSION, ASSESSMENT AND INTERVENTION

a. Upon admission, and every shift, or with any ACOC, every patient will be assessed for the potential for fall, using a Fall Risk Assessment Tool for Adult or the Pediatric Populations.

i. The Morse Fall Scale shall be used to assess all adults (18 years and older) (see Attachment A).

1. For adult patients, staff must complete the additional medication assessment in the Optimum iMed Electronic Health Record (EHR). This is to ensure that Licensed Nursing Staff assess and document medication usage in the adult population (see Attachment B).
2. Based on the findings of their assessment a plan of care may be initiated to ensure our patients are kept safe from falls.

ii. The Humpty Dumpty Falls Scale shall be used to assess infants and pediatric patients (age 3 months to 17 years) (see Attachment C).

b. A plan of care will be implemented based on the risk assessment score. A Fall Risk Care Plan will be initiated for patients indicated as High Risk. Each assessment tool is scored to determine the fall risk level of either low risk, moderate risk, or high risk. The following interventions are required for each patient population and risk level.

ADULT POPULATION = Morse Fall Scale (Adults 18 years and Older)

i. Low Risk (score of 0-24): Implement the Standard Fall Precautions:

1. Familiarize the patient with the environment (orient/re-orient to unit).
2. Have the patient demonstrate call light use.
3. Maintain call light within reach.
4. Keep the patient's personal possessions within patient safe reach.
5. Have sturdy handrails in patient bathrooms, room, and hallway.
6. Place the hospital bed in low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed.
7. Keep hospital bed brakes locked.
8. Keep wheelchair wheel locks in "locked" position when stationary.
9. Keep nonslip, comfortable, well-fitting footwear on the patient.
10. Use night lights or supplemental lighting.
11. Keep floor surfaces clean and dry. Clean up all spills promptly.
12. Keep care areas uncluttered.
13. Follow safe patient handling practices.
14. Place "Call Don't Fall" visual cues in patient rooms (see Attachment D).
15. If patient's condition permits, encourage daily exercise or ambulation to maintain strength and reduce risk of debilitation.

ii. Moderate Risk (score of 25-44): Implement the Standard Fall Precautions and the following:

1. Encourage a family member to stay with the patient if possible, and to inform the nurse if the patient will be unattended for a period of time.
2. An Alert clasp identifier for fall (YELLOW clasp, see Attachment E) will be placed on the patient's ID bracelet.
3. Place a "Caution: Fall Risk" sign in front of the patient's room (see Attachment F). This is to alert hospital staff to monitor the patient closely for falls, and do "spot-checks" if passing by.
4. Inform Rehabilitative Services via iMED application of patient's risk level for Balance Screening. A physician's order for Rehabilitative Services evaluation should be obtained, as necessary.
5. Emphasize on preventing falls during admission through patient education, elaborating more on obtaining assistance when getting out of bed (See Attachments G and H).

iii. High Risk (score of 45 and above): Implement the Standard Fall Precautions, Moderate Risk Interventions, and the following High Risk Preventative Measures:

1. Communicate High Risk Status during report and patient transfer. Notify the Physician of patient's high risk for fall status.
2. Include Fall Precaution in patient's indicator profile (iMed).
3. Re-educate patient and family on Fall Prevention Interventions. Instruct family to notify nurses if patient will be left alone in room.
4. If situation permits, relocate patient closer to nurses' station.
5. If available, a bed alarm shall be placed on the patient's bed.
6. Consider requesting for a Patient Sitter throught the House Supervisor if one is available.
7. Recommend initiation of referrals or consults to address individual assessed problems (rehabilitative, dietary, social services, and pharmacy).

8. An **Environmental checklist** (see Attachment I) shall be performed at every shift to ensure the safety of the patient. Any nursing staff can perform this checklist and inform the appropriate department of the deficiency for corrective action.

PEDIATRIC POPULATION = Humpty Dumpty Falls Scale (3 mos. – 17yrs.)

i. Low Risk (score of 7-11): Implement the Standard Fall Precautions:

1. Assess elimination needs and assist as needed.
2. Keep call light within reach and educate patient/family on its functionality.
3. Place "Call Don't Fall" visual cues in patient rooms (see Attachment D).
4. Keep environment clear of unused equipment and clear of hazards.
5. Orient/re-orient patient and family to room and unit.
6. Keep bed in low position with brakes on.
7. Place side rails X2, assess large gaps, use additional safety precautions.
8. Use of non-skid footwear for ambulating patients.
9. Use of appropriate size clothing to prevent risk of tripping.
10. Assess for adequate lighting, leave nightlights on.
11. Ensure patient and family education given to parents and patients.

ii. High Risk (score of 12 and above): Implement the Standard Fall Precautions and the following:

1. Place a "Caution: Fall Risk" sign in front of the patient's room (see Attachment F).
2. Accompany patient with ambulation.
3. Family members are encouraged to accompany patient throughout course of hospitalization.
4. Educate Patient/Family regarding falls prevention: fall risk factors, appropriate transfer/ambulation needs, appropriate use of side rails.
5. Remove all unused equipment out of room.
6. When possible, apply protective barriers to close off spaces or gaps in the bed.
7. Evaluate medication administration times. Optimize medication administration times around safe functional independence of patient (ie. toileting, ambulating, etc.)
8. Move patient closer to nurses' station, if possible.
9. If available, a bed alarm shall be placed on the patient's bed.
10. Consider requesting for a Patient Sitter throught the House Supervisor if one is available.
11. An **Environmental checklist** (see Attachment I) shall be performed at every shift to ensure the safety of the patient. Any nursing staff can perform this checklist and inform the appropriate department of the deficiency for corrective action.

c. Educate and allow for the patient and family to participate in the plan of care. The nurse shall review the environmental criteria that reduce the risk of falls.

d. Involve an Interdisciplinary Team (Pharmacy, Dietetic Services, Rehabilitative Services and Social Services) in the patient's plan of care, if necessary.

e. The patient's plan of care shall be modified based on changes in the patient's condition. Any significant changes in the patient's condition must be communicated to all staff members involved in the patient's care.

f. Refer to Case Manager for Discharge Planning, if necessary.

II. INTERDISCIPLINARY APPROACH

The causes of falls are multifaceted. An interdisciplinary approach ensures that falls are being prevented in our organization. The Interdisciplinary Team will actively meet to ensure there is an ongoing process to assess, monitor, identify outcomes, plan, implement and evaluate the fall prevention process. An automatic alert for screening will be given to the respective Professional Support Departments via the iMED application, or via telephone communication. The roles of the interdisciplinary team are as follows:

a. Nursing Services

The Nursing Services Department shall conduct assessments of all patients upon admission and every shift, or upon ACOC utilizing the respective Fall Risk Assessment Tool for the Adult or Pediatric Department. A plan of care shall be developed and will be implemented based on the patients risk assessment score as previously indicated.

b. Rehabilitative Services

The Rehabilitative Services will receive triggers of "High Risk for Fall" based on the Nursing Assessment. The physical therapist or occupational therapist will attempt to "screen" the patient and proceed to obtain formal Physician orders to "evaluate and/or treat" as deemed necessary.

c. Dietetic Services

Refer to Dietetic Services Policy 5.02: Nutritional Screening. All inpatients are screened for nutritional risk by a member of the health care team within 24-48 hours of admission. Based upon nutritional risk factors identified, a Nutrition Care Process note by a clinical dietitian I/II or dietetic technician I/II may be warranted.

d. Pharmacy Department

Refer to Pharmacy Department Policy 706: Review, Verification and Interpretation of Medication Orders. The pharmacist shall interpret all medication orders and resolve all questions or problems prior to dispensing medications. This review shall include any drug interactions, such as drug-disease interactions pertaining to a patient's fall risk.

e. Social Services

Refer to Social Services Policy 6431-6: Social Services Consultation and Referral Procedures.

i. Social evaluation of family or home situation for safe and secure placement at discharge.
ii. Discharge Planning: Durable medical equipment and home health care coordination.

f. Physicians

A Physician Champion shall be identified and participate in the Fall Prevention Team's initiatives. All physicians shall be aware of the fall prevention program and the efforts taken to keep patients safe from falls. Physicians shall also review orders, medications and make necessary referrals to respective professional support departments to ensure patient needs are met and they are kept safe from falls.

g. Hospital Wide Staff Responsibility

GMHA has adopted the No Pass Zone and is implementing the following measures: Staff must NOT Pass the patient's room or ignore the call light if a patient is calling for help. Any hospital staff must notify nursing staff of the patient's call if there is

no immediate response. Staff must knock on the patient's door, ensure privacy, and ask what the patient may need In Labor & Delivery or OB Ward, staff must not enter the patient's room and rather alert staff that the patient is calling.

III. PATIENT/FAMILY EDUCATION

a. Upon admission, all patients including patient's family and friends shall be instructed on how to prevent falls (see Attachment G and H). Outcomes of this education shall be documented appropriately.
b. In the event of a fall, the patient's family shall be notified.
c. Upon discharge, patients identified as moderate or high risk for falls shall have discharge instructions provided to the patient and/or family regarding preventing falls at home. This discharge instruction(s) shall be shall be based on the patient's individualized needs and shall be included in the discharge planning process.

IV. IN THE EVENT OF A FALL

All falls will be documented and reported in the electronic health record as well as on the Post Fall Information Report and the electronic incident reporting system (i.e. Safety Learning System- SLS). The patient shall be assessed and care will be planned by the interdisciplinary care team to prevent repeat falls and/or falls resulting in an injury. All falls will be tracked and trended on a monthly basis by the Nursing Department's Performance Improvement Unit Representatives and will be included in the Performance Improvement report.

A. In-Patient and Out-Patient Falls

In the event a patient fall or if an assisted fall occurs, immediate actions shall occur:

a. The patient shall immediately be assessed by a registered nurse and receive necessary first aid and treatment. Follow the Guam Memorial Hospital Authority Post Fall Protocol (Attachment J). Assess the level of injury:
  i. No injuries
  ii. Minor Injury: Bruise, abrasion, minor laceration
  iii. Major Injury: Fracture(s), head trauma, loss of function
  iv. Death related to fall
b. The patient's vital signs and level of consciousness shall be monitored for the next 24 hours (or as long as possible for out-patients) as follows:
  First Hour: Every 15 minutes
  Next Four Hours: Every 2 hours
  Remaining Hours: Every 4 hours
c. The attending physician shall be notified immediately. Inform the physician of the extent of the injury (if any), the neurological status of the patient, and the current vital signs.
d. Complete the Patient Safety Form (refer to Patient Safety Program policy A-PS800) or the electronic Safety Learning System (SLS) AND the Post Fall Information Report (Attachment K).
  i. The reports should be completed as soon as possible and before the end of the shift.
  ii. In the Nursing Units, the completion of the Post-Fall Information Report shall involve the charge nurse, the patient's primary nurse and nurse assistant, and any other staff member who witnessed the fall.
  iii. In any other areas in the hospital, the Completion of the Post-Fall Information Report and/or the electronic incident reporting system shall be completed by all staff members who have witnessed/unwitnessed the fall.
  iv. The electronic reporting of the fall in the SLS must be completed by all staff who witnessed/unwitnessed the fall, either individually or the staff members may consolidate their findings and discussion into one report.

e. In the Nursing Units, a "Post-Fall Huddle" shall occur immediately, involving the Primary nurse, Charge nurse, Nurse assistant, Hospital Nurse Supervisor on-duty and any other staff who witnessed the fall. Outside of the Nursing Unit the Post-Fall Huddle shall involve all witnesses. **The Post-Fall Information Report shall be used to guide the team's discussion.**

f. The Fall Prevention Team including the Interdisciplinary members will be notified of the fall through the Post-Fall Information Report attached in the Nursing Supervisor's 24 hour report. The Fall Prevention Team will also be notified of falls electronically via the SLS.

g. The Fall Prevention Team will meet to discuss reported falls and determine corrective actions to improve patient outcomes.

h. Any death or major loss of function related to a fall shall be reported immediately to the Patient Safety Officer/Risk Manager, Associate Administrator of Nursing Services and the Hospital Administrator.

B. Falls Involving Patient Visitors and Guests

In the event of a fall by patient visitors and guests, immediate first aid shall be administered by the first responder on the scene. The patient visitor or guest shall be encouraged to seek care in the Emergency Room if warranted and the documentation of the fall shall be reported in the SLS. If the patient visitor or guests refuse care and treatment it must documented in the SLS.

V. DOCUMENTATION AND COMMUNICATION

Huddle boards shall be placed in front of or near all Nursing Stations to communicate and indicate patient room numbers for those with a high risk for fall so that all staff will be aware. Huddle boards shall be updated throughout the shift as needed. Staff huddles shall be conducted at each change of shift or as needed and shall include the patients identified as a high risk for fall.

Nursing documentation on patient's risk level for fall shall be stated in the iMED application, in the General Admission and on the RN-LPN Shift Assessment. Interventions will be built into the plan of care, and shall include patient and family education and fall precaution interventions employed to reduce the risk of fall.

Completion of patient education will be indicated in the RN/LPN Shift Assessment by the statement: Patient was educated on fall risk prevention: _ Verbal _ Handout given _ Return Demonstration

Communicate the patient's risk level for fall during each hand-off process. Include interventions aimed to reduce the risk factors.

In the event a fall has occurred, the following shall be documented in the patient's notes (iMED):

- **P**hysician notification
- Medical and nursing **A**ctions that were taken.
- **L**evel of injury with descriptions
- **L**ocation of the fall
- **O**bservations: Patient appearance at the time they were discovered
- Patient's **R**esponse to the fall, such as altered mental status, or presence of pain.
    - Recall the acronym PALLOR to ensure complete documentation of the fall in the patient's medical record.

In-patient or out-patient fall events are to be included in the "24-Hour Report" at the end of the shift.

VI. PERFORMANCE IMPROVEMENT

All fall occurrences will be monitored by the Patient Safety Officer/Risk Manager and reported to Nursing Management, Patient Safety Committee, and the Performance Improvement Committee. Nursing services shall identify opportunities to reduce the risk associated with falls through preventative strategies, alternatives and process improvements.

VII. ATTACHMENTS

- **a.** Attachment A: Morse Fall Scale
- **b.** Attachment B: Fall Medication Assessment in Optimum iMed Electronic Health Record
- **c.** Attachment C: The Humpty Dumpty Scale
- **d.** Attachment D: Call Don't Fall Poster
- **e.** Attachment E: Patient Alert Clasps
- **f.** Attachment F: Caution: Fall Risk sign
- **g.** Attachment G: "Call Don't Fall" Educational Material During Admission
- **h.** Attachment H: Fall Prevention Information for Family & Friends
- **i.** Attachment I: Environmental Checklist for Fall Risk Patients
- **j.** Attachment J: Guam Memorial Hospital Post Fall Protocol
- **k.** Attachment K: Post-Fall Information Report

VIII. RELATED POLICIES

- **a.** Administrative Policy A-PS800: Patient Safety Program
- **b.** Dietetic Services Policy 5.02: Nutritional Screening
- **c.** Pharmacy Policy 706: Reviewing, Verification, Interpretation of Medication Orders
- **d.** Social Services Policy 6431-6: Social Services Consultation and Referral Procedures
- **e.** Administrative Policy 6480-2: Reporting Malfunction and Failures

IX. RESCINDED POLICIES

Fall Prevention Program, GMHA Nursing Services Manual, effective 08/2009

IX. REFERENCES

- **a.** National Database of Nursing Quality Indicators (NDNQI). Guidelines for data collection on the American Nurses Association's National Quality Forum Endorsed Measures. http://www.k-hen.com/Portals/16/ANAs%20NQF%20specs.pdf. May, 2010. Accessed December 30, 2014.
- **b.** AMDA Clinical Practice Guideline: Acute Change of Condition
- **c.** Preventing falls in hospitals a toolkit for improving quality of care. Agency for Healthcare Research and Quality, Jan 2013 retrieved October 2015 from http:// www.ahrg.gov
- **d.** Harvey, K., Kramlich, D., Chapman, J., Parker, J. and Blades, E. (2010), Exploring and evaluating five paediatric falls assessment instruments and injury risk indicators: an ambispective study in a tertiary care setting. Journal of Nursing Management, 18: 531–541.
- **e.** The Lippincott. Manual of Nursing Practice (10th ed., pp. 187, 192). Philadelphia: Lippincott Williams & Wilkins.
- **f.** Quigley, P., & White, S. (2013, May 31). Hospital-Based Fall Program Measurement and Improvement in High Reliability Organizations. *OJIN: The Online Journal of Issues in Nursing, volume 18, no. 2*, manuscript 5. doi: 10.3912/OJIN.Vol18No02Man05
- **g.** ECRI Institute. (2009, March). Falls. *Healthcare Risk, Quality, & Safety Guidance.* Retrieved from https://www.ecri.org/components/HRC/Pages/SafSec2.aspx?tab=2
- **h.** Centers for Disease Control and Prevention. (2015, September 21). *Important Facts about Falls.* Retrieved from: http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html
- **i.** Campaign Zero – Families For Patient Safety. (n.d.). *Patient Safety Checklists.* Retrieved from: http://www.campaignzero.org/patient-safety-checklists/prevent-falls-and-fractures/

j. Maryland Patient Safety Center. (2012). *Call for Solutions*. Retrieved from: http://www.marylandpatientsafety.org/html/education/solutions/2012/documents/Call_Dont_Fall_Initiative.pdf

k. Miami Children's Hospital.(n.d.). *Implementing a Humpty Dumpty Pediatric Falls Assessment.* Retrieved from: https://ana.confex.com/ana/ndnqi07/recordingredirect.cgi/id/92

l. Primaris.(2006). *Falls: Morse Fall Scale*. Retrieved from: http://www.primaris.org/sites/default/files/resources/Restraints%20and%20Falls/falls_morse%20fall%20scale%20final.pdf

ATTACHMENT A:

MORSE FALL SCALE
(Adults 18 years and Older)

Risk Factor	Rating	Date: TIME:	TIME:	TIME
HISTORY OF FALLS				
Yes	(25)			
No	(0)			
SECONDARY DIAGNOSIS				
(Two more medical Diagnoses)				
Yes	(15)			
No	(0)			
AMBULATORY AID				
Furniture	(30)			
Crutches/Walker/Cane	(15)			
None/Bedrest/Wheelchair/Nurse	(0)			
IV/SALINE LOCK				
Yes	(20)			
No	(0)			
GAIT TRANSFERRING				
Impaired	(20)			
Weak	(10)			
Normal/Bed Rest/Immobile	(0)			
MENTAL STATUS				
Forgets Limitations	(15)			
Oriented to own ability	(0)			
	TOTAL SCORE			
Level of Risk: Score of 0-24 = Low Risk Score of 25-44 = Moderate Risk Score of > 45 = High Risk Implement appropriate fall prevention strategies based on patient's risk level	**FALL RISK LEVEL** (LOW, MODERATE, HIGH)			

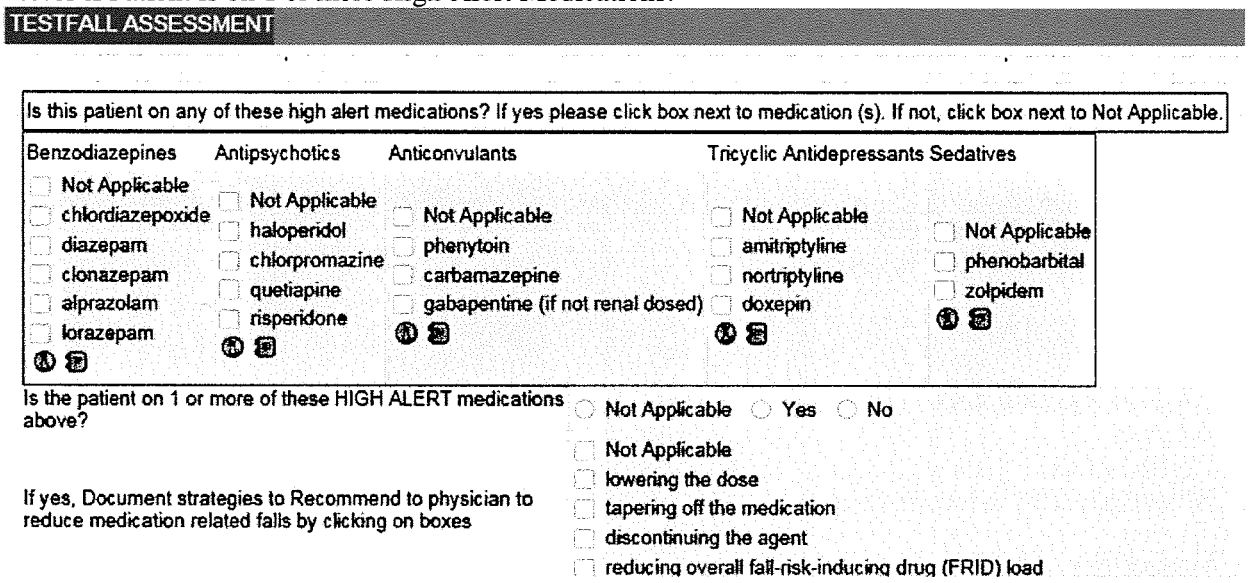
MORSE FALL SCALE
FALL RISK ASSESSMENT TOOL — ADULTS
Guam Memorial Hospital Authority
Form #
Stock #
Approved:

Patient ID

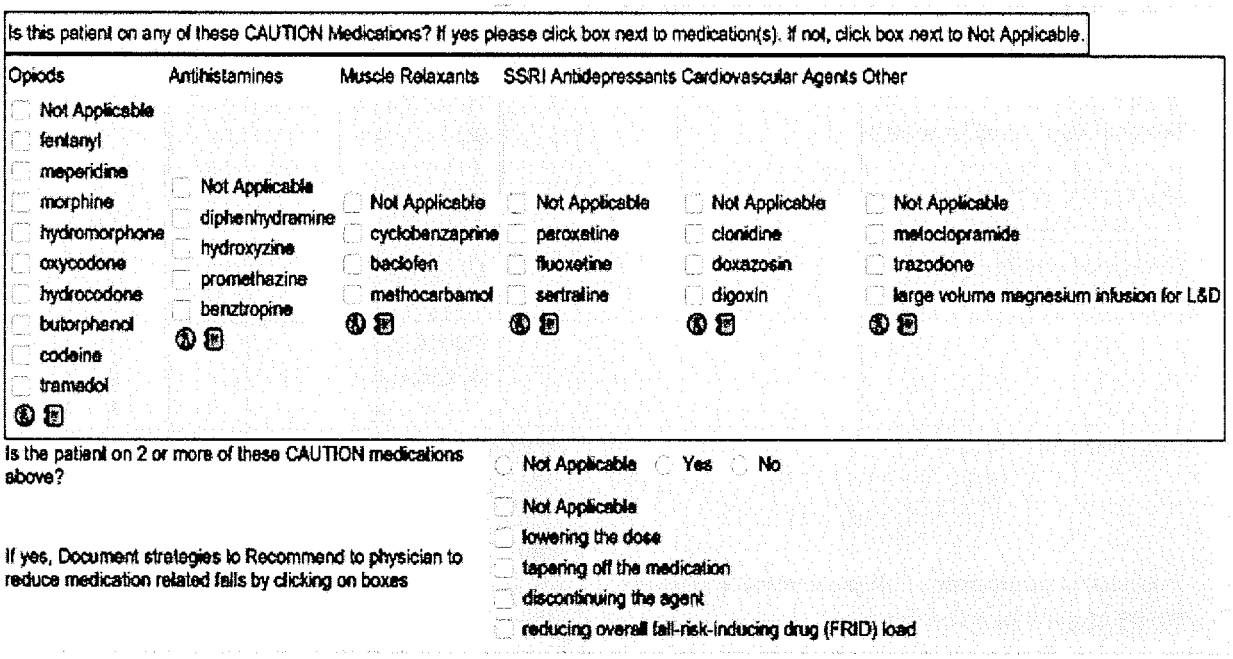
ATTACHMENT B:

New Fall Medication Assessment in Optimum iMed Electronic Health Record:

Assess if Patient is on 1 or more High-Alert Medications:



Assess if Patient is on 2 or more Caution Medications:



Note: A plan of care and specific nursing interventions (as per policy) are to be implemented if patient is found to be at "High Risk" for patient falls due to medication assessment findings.

ATTACHMENT C:

THE HUMPTY DUMPTY SCALE
(3 months – 17 years)

DATE:		TIME:			
Parameter	**Criteria**	**Score**	**SCORE**		
Age	Less than 3 years old	4			
	3 to less than 7 years old	3			
	7 to less than 13 years old	2			
	13 years old and above	1			
Gender	Male	2			
	Female	1			
Diagnosis	Neurological Diagnosis	4			
	Alterations in Oxygenation Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc)	3			
	Psych/Behavioral Disorders	2			
	Other Diagnosis	1			
Cognitive Impairments	Not aware of limitations	3			
	Forget Limitations	2			
	Oriented to Own Ability	1			
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4			
	Patient Uses assistive devices or Infant Toddler in Crib or Furniture/Lighting(Tripled Room)	3			
	Patient Placed in Bed	2			
	Outpatient Area	1			
Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3			
	Within 48 hours	2			
	More than 48 hours/None	1			
Medication Usage	Multiple Usage of: Sedatives (excluding ICU patients sedated or paralyzed) Hypnotics Barbituarates Phenothiazines Antidepressants Laxatives/Diuretics Narcotics	3			
	One of the Medications listed above	2			
	Other Medications/None	1			
		SCORE			
		RISK LEVEL			

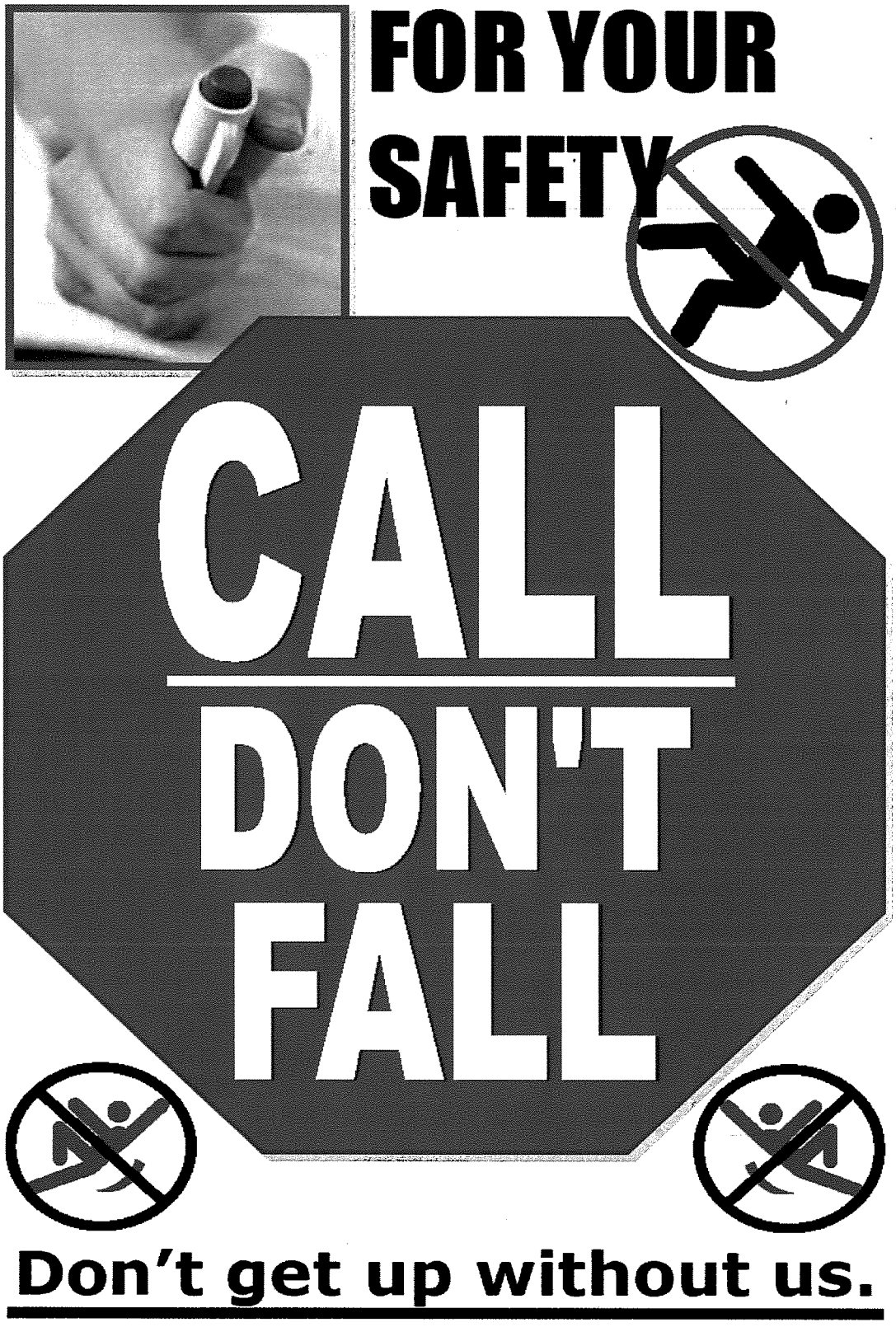
FALL RISK LEVEL:
7-11: LOW RISK
12 or ABOVE: HIGH RISK

THE HUMPTY DUMPTY SCALE
FALL RISK ASSESSMENT TOOL-PEDIATRIC POPULATION
Guam Memorial Hospital Authority
Form #
Stock #
Approved

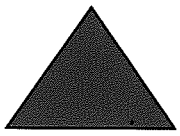
Patient ID

ATTACHMENT E:

ATTACHMENT D:

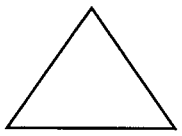


ATTACHMENT E: PATIENT ALERT CLASPS

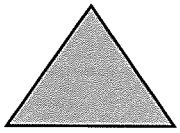


ALLERGY

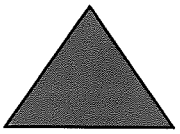
DNR STATUS



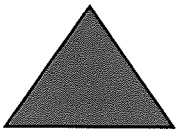
FALL RISK



LIMB ALERT



SUICIDE RISK



WOUND RISK

ATTACHMENT F: CAUTION - FALL RISK SIGN

ATTACHMENT G

"Call Don't Fall" Educational Material During Admission (page 1)

Did you know?

- Falls and fall injuries are more common than strokes and can be just as serious.
- Children are at the same risk for falls even in the presence of a family member.

Ask yourself these questions...

- Do you have a history of falling?
- Do you have problems balancing or walking? Are you using assistive devices, such as a cane or wheelchair?
- Do you have problems seeing or hearing?
- Are you taking more than two medications for chronic diseases such as hypertension, diabetes, and/or seizures or epilepsy?

- Do you experience occasional anxiety, depression, or disorientation/confusion?
- Do you feel dizzy, or light-headed?

If you answered "yes" to any of these questions, you may be at risk for falling.

FALL RISK

A Special Note for

FAMILY MEMBERS AND VISITORS

We appreciate your assistance in ensuring your loved one is cared for. During your loved one's stay in the hospital, please make sure that

- the strategies of preventing falls are maintained.
- You provide us any information or risk factors your loved one may have that might cause him/her to fall, such as a history of falling, the use of assistive devices, or has a hard time hearing or seeing.
- You inform your nurse that your loved one will be alone, as you exit the unit. Often times falls occur because our staff is not aware that the patient no longer has any visitors in the room.

GUAM MEMORIAL
HOSPITAL AUTHORITY

650 Governor Carlos Camacho Rd.

Phone: 671-647-2555

CALL. DON'T FALL.

FOR YOUR SAFETY

Don't get up without us.

How You can Prevent Falls During your Hospitalization

ATTACHMENT G

"Call Don't Fall" Educational Material During Admission (page 2)

Why do falls happen?

Falls may occur in the Hospital because:

- The Medications you take, such as pain relievers and blood pressure pills, may make you feel dizzy and disoriented
- Your illness and the ordered treatments, such as diagnostic tests and surgery, may leave you weak and unsteady.
- The unfamiliar surroundings of a hospital room, may leave you frightened and disoriented.

The staff and management of GMHA would like to prevent a fall occurrence while you are in our care. To do this, we have created this pamphlet to educate our patients and visitors of strategies on preventing falls. Your participation and cooperation with our Fall Prevention Program will help us in achieving our goal and prevent you from any unnecessary injuries.

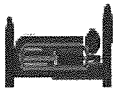
What will happen now?

Our nursing staff will do a general admission assessment which includes assessing for your risk of falling. It is important that you answer their questions truthfully, as your fall risk level determines the appropriate care to prevent falls.

There are different strategies that will be used to reduce your chances of falling. This brochure will highlight some strategies that you can do to assist us in

Some Strategies to Prevent Falls

- Follow your physician's activity order, such as bed rest. The activity your physician orders has its reason(s) related to your diagnosis.



- Remind your healthcare professional to keep the call button next to you.

- Use your call button to ask for assistance when needed. Never try to get out of bed on your own. Please wait patiently for our staff to respond to your call.
- Always place your bed in the lowest position
- Make sure the lighting is adequate enough for you.
- Familiarize yourself to your surroundings
- Use your glasses and/or hearing aid
- Use appropriate footwear, non-skid soles
- Place your personal items within your reach
- Reduce the clutter in your room. Do not bring unnecessary items from home.
- You may bring your assistive devices such as a cane or walker. However, make sure it is in good condition, and inform us that it is your personal belonging.
- When asked by us, take the opportunity to use the bathroom. We will assist you to the bathroom and back to your bed. Consider keeping a urinal or bedpan next to you if you frequently use the bathroom at night.

- Pay attention to caution signs, such as "wet floor"
- Inform us of any spills which may have occurred and we will work immediately to clean it up.

- We encourage your family to watch over you. However, please inform us when you are going to be alone.
- Good nutrition, keeping your fluid level up and suitable exercise are important to maintain your health and reduce your chances of having a fall.
- If the patient is a child (less than 3 years of age), please ensure that the side rails are up when the child is in the crib.

- Never leave a child unattended, as an unfamiliar surrounding may cause injury.

Useful points to consider...

When you are moving from lying down to a standing position

- Sit on the bed for a minute before you stand up.
- If you become dizzy, do not try to get up. Use your call button to notify your nurse of your symptoms.
- Push off the bed, or chair, do not pull toward other furniture near by.

When you are walking

- Take your time. Pace yourself and take caution when you are turning.
- Wear suitable non-skid footwear.
- Use assistive devices appropriately, and ensure that it is in good condition before use.

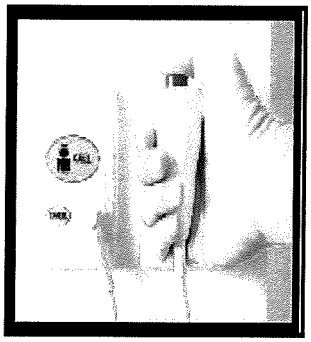
- Never lean or support yourself on rolling objects such as IV poles or your bedside table.

ATTACHMENT H

Fall Prevention Information for Family & Friends (page 1)

SLIPS, TRIPS AND FALLS CAN HAPPEN TO ANYONE

- One-third of people age 65 years and older fall each year.
- Every 29 minutes an older adult dies from a fall.
- 1 out of 5 falls causes serious injury such as a head trauma or fracture.



PLEASE CALL!

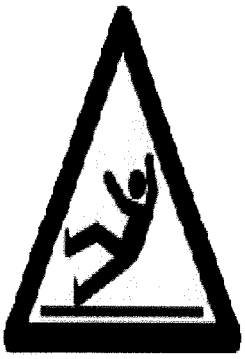
DON'T FALL!

GUAM MEMORIAL HOSPITAL AUTHORITY

850 Governor Carlos Camacho Rd.
Tamuning, Guam 96913

Phone: 671-647-2555
Fax: 671-649-0145

FALL PREVENTION



INFORMATION FOR FAMILY & FRIENDS

ATTACHMENT H:

Fall Prevention Information for Family & Friends (page 2)

GMHA WOULD LIKE TO ASK YOU TO HELP YOUR RELATIVE OR FRIEND.

The risk of a person falling increases while they are in the hospital. One of the worst outcomes is that a fall slows the recovery process or leads to other complications with a loss in mobility and independence.

Together, we can ensure they

- Do not fall or the risk of falling is reduced
- Maintain or regain their independence and mobility
- Don't stay in the hospital any longer than expected

For more information on Fall Prevention, please visit:

http://www.cdc.gov/HomeandRecreationalSafety/Falls/pubs.html

WWW.

WE ENCOURAGE YOU TO STAY AT THE BEDSIDE AND HELP US MAINTAIN SAFETY.

GMHA staff will frequently assess for the risk of falling. The risk level determines the level of assistance provided by staff. This is indicated by the falls risk symbol outside the room.

YOU can HELP keep your relative or friend SAFE:

- Understand the level of risk and what assistance they require.
- Always ask staff prior to mobilizing your relative or friend, in case there are specific orders from the doctor or physical therapist.
- Provide reassurance for your relative or friend, especially if they are confused and trying to get out of bed.
- Ensure they use walking aids if prescribed
- Walk with your relative—DON'T LEAVE THEM ALONE when they are walking or out of bed.
- Ensure their clothing is safe—flat shoes, not walking in socks, dressing gown or pajamas are not dragging on the ground.
- Assist them to the toilet, or seek our assistance, but DON'T LEAVE THEM ALONE.
- Encourage them to do as much as they can for themselves, within their limitations.
- Leave the bed rails the way you found them. With the bed rails down, NEVER LEAVE THEM UNATTENDED.
- Ensure the nurse call light is within easy reach.
- Alert the nursing staff if you notice new episodes of confusion or unsteadiness.
- Please stop at the nurses' station when you have finished your visit or must leave the bedside. This enables nursing staff to know your relative or friend is now alone.
- Provide these items for safe walking—non-slip footwear (flat and well fitting), glasses, hearing aid, walking aid if used at home.

ATTACHMENT I

Fall Prevention Program Environmental Checklist

Date:

Patient's Room	7-3 Shift TIME YES	NO	N/A	3-11 Shift TIME YES	NO	N/A	11-7 Shift TIME YES	NO	N/A
Is the bed at its lowest position?									
Is the call button within reach of the patient, and functional?									
Is there adequate lighting in the room?									
Is the room free of clutter, electrical cords in pathway and free of hazards on the floor?									
Are the brakes of the bed working properly?									
Is the bedside table or personal items within reach of the patient?									
Floors are not wet or slippery.									

Furniture	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
Are all furniture (beside table, recliners, chairs, etc) and medical equipment (particularly IV poles) functional? Furnitures are secured enough to support the patient?									

Mobility Aid	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
Are all assistive devices/mobility aids functional and appropriate for the patient?									
Is the patient wearing appropriate footwear? (rubber sole socks)									

Siderails	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
Are the siderails of the crib/bed working properly?									

Staff Initials

Any deficiency found during the environmental assessment, needs a corresponding corrective action. Indicate your corrective actions for each deficiency observed.

Name:
Initials:

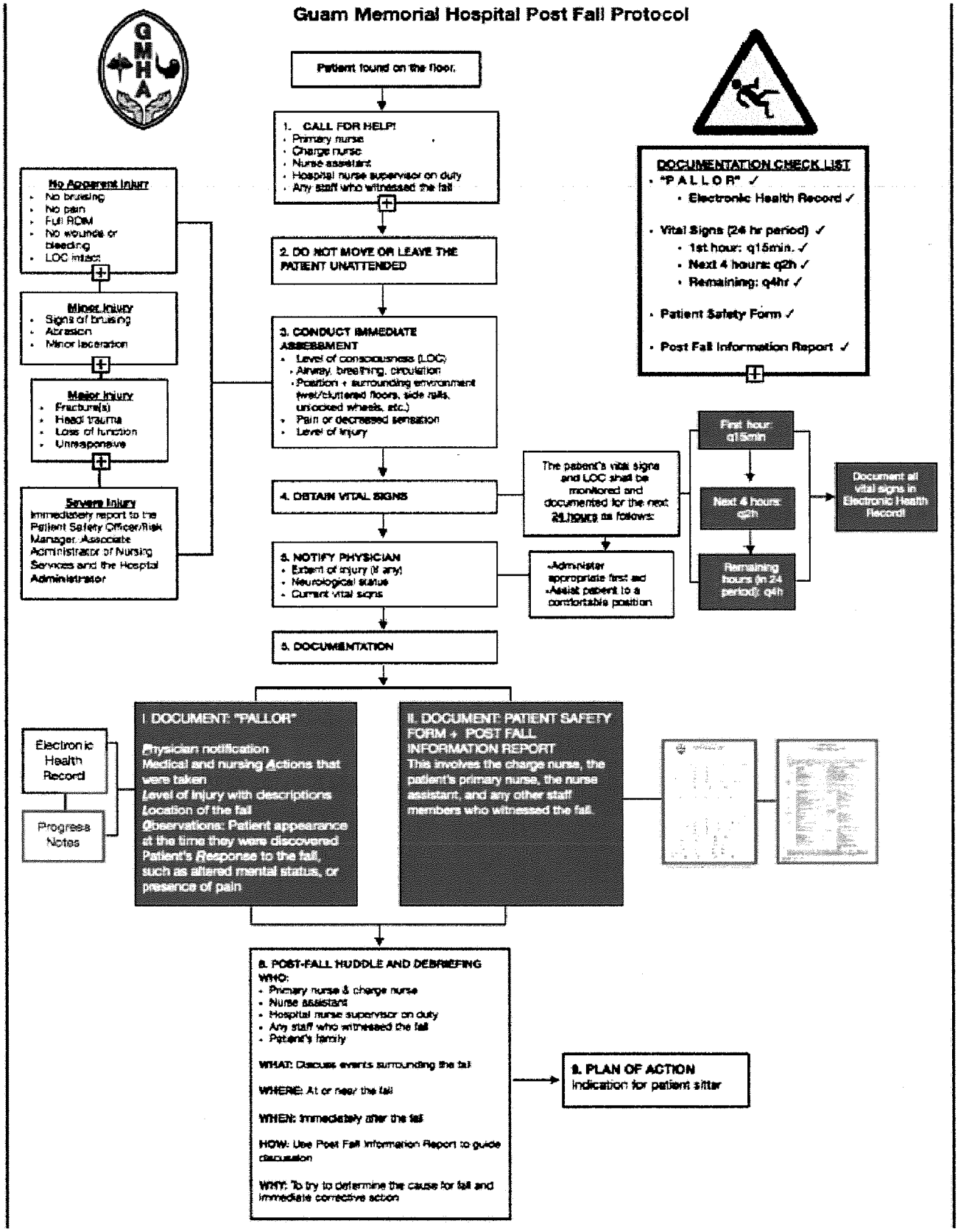
Title:

FALL PREVENTION PROGRAM--
ENVIRONMENTAL CHECKLIST
Guam Memorial Hospital Authority
Form Control # [ ]
Created 10/08

Patient ID

ATTACHMENT J:

Guam Memorial Hospital Post Fall Protocol



ATTACHMENT K:

POST FALL INFORMATION REPORT (page 1)

INTERNAL USE ONLY
DO NOT PHOTOCOPY
GUAM MEMORIAL HOSPITAL AUTHORITY
POST-FALL INFORMATIONAL REPORT

EVENT TRACKING #: _____

Patient Name: _____ MR #: _____ Hospital #: _____

Date of Occurrence: _____ Time of Occurrence: _____ Unit/Room: _____

Patient found on the floor: ☐ Yes ☐ No

Witnessed Fall: ☐ Yes ☐ No

Assisted Fall: ☐ Yes ☐ No

Repeated Fall: ☐ Yes ☐ No

Patient Fell in: ☐ Bedside ☐ Bathroom ☐ Walkway ☐ Other: _____

FALL RISK LEVEL : ☐ Low Risk ☐ Moderate ☐ High Risk

IDENTIFIER PLACED IN: ☐ Chart ☐ Outside ☐ Door ☐ ID Band

FLOOR CONDITION: ☐ Dry ☐ Wet ☐ Slippery ☐ Damaged

Details:

BED POSITION: ☐ High ☐ Low

RESTRAINT USE: ☐ None ☐ Physical ☐ Chemical ☐ Side rails x4

CALL BUTTON AT REACH: ☐ Yes ☐ No

LIGHTING: ☐ Bright ☐ Dull ☐ Dimmed/Night light only

ENVIRONMENT: ☐ Cluttered ☐ Clean and organized

ENVIRONMENT CHECKLIST DONE FOR THE SHIFT: ☐ Yes ☐ No

MOBILITY: ☐ Ambulatory ☐ Bed-bound ☐ Walker
Wheelchair ☐ Cane ☐ Crutches ☐

MOBILITY AID USED AT THE TIME OF FALL: ☐ Yes ☐ No

MEDICATION USE WITHIN THE LAST 8 HOURS: ☐ Yes ☐ No Details: _____

WHAT WERE THE CONTRIBUTING FACTORS:

☐ Mental Status ☐ Equipment ☐ Lighting ☐ Toilet Attempt
☐ Improper Footwear ☐ Staffing Issue Bed not ☐ in lowest position ☐ Wheels not locked

Details: _____

ATTACHMENT K:

POST FALL INFORMATION REPORT (page 2)

INTERNAL USE ONLY
DO NOT PHOTOCOPY
GUAM MEMORIAL HOSPITAL AUTHORITY
POST-FALL INFORMATIONAL REPORT

ASSESSMENTS:

LEVEL OF CONSCIOUSNESS:

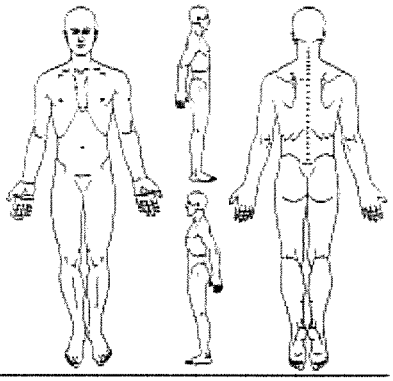
☐ Responsive as normal ☐ Less responsive than usual ☐ Unresponsive

INJURIES:

☐ No evidence of injury
☐ Minor Injury
Bruising, Abrasions, Minor Laceration
☐ Major Injury
Fracture, Head Trauma, Loss of Function
☐ Severe Injury
Death

PAIN or DISCOMFORT:

☐ No evidence of pain or discomfort
☐ Showing signs of pain or complaining of pain



Details: _____

STAFFING PATTERN:

UNIT CENSUS: _____ # of RN: _____ # of LPN _____ # of NA: _____

DESCRIPTION OF FALL: (State only facts of what was seen or heard by you)

HEALTHCARE PROFESSIONAL'S IMMEDIATE ACTION:

MD Notified: _____ Date: _____ Time: _____

MD Orders:

Ensure that Vital Signs of Consciousness are done every 15 minutes for the first 15 minutes for the first hour, then every two (2) hours for the next four (4) hours, then every four (4) for the next 24 hours.

Post Fall Huddle: Yes _____ No _____

Staff Present or Why if NOT DONE: