The Guam Memorial Hospital Authority Proudly Presents:

FALL PREVENTION PROGRAM

Roseann Apuron, RNC-OB & Jasmin Tanglao, RN

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OBJECTIVES:

AT THE END OF THE PRESENTATION STAFF WILL BE ABLE TO:

1. Recall the key elements of the GMHA Fall Prevention Program
2. Identify components of the Fall Risk Assessment Tools in the Clinical Setting for adult and pediatric populations.
3. Describe current and new nursing interventions for each risk level, for adults and the pediatric populations
4. Describe what to do after a fall incident.
5. Explain how everyone can be a team player in preventing falls here at GMHA.

IMPORTANCE OF THE PROGRAM:

- Patient Safety!
- Comply with Joint Commission Requirements: Reduce the risk of patient harm resulting from falls
- Initiate evidence-based practices to reduce the incidence of falls
- Continue to implement an Interdisciplinary approach to Fall Prevention Hospital-wide
- Continue our Mission:
- To Provide Quality Patient Care in a Safe Environment

WHAT IS A FALL?

- It is an unplanned descent to the floor (or extension of the floor, 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.

STATS ABOUT FALLS IN HC FACILITIES:

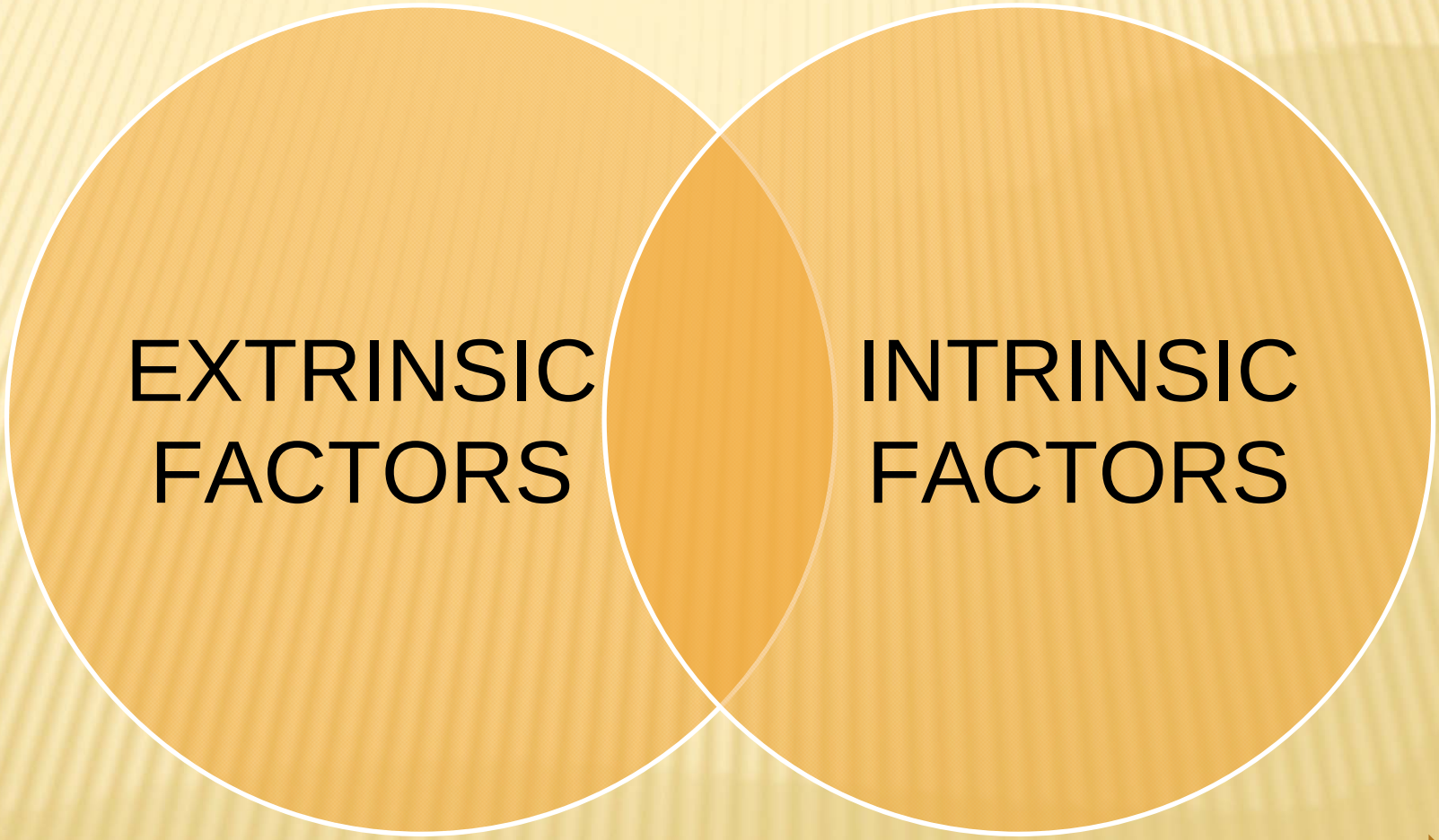
- Patient falls affect between **700,000 to 1 million** patients each year.
- Falls rank among the most **frequently reported** incidence in hospitals and other healthcare facilities.
- In acute care and rehab hospitals, between **30-51%** of falls result in some **injury.**
- Up to **44%** of those injuries are ones that may **lead to death** (i.e. fractures, subdural hematomas, or excessive bleeding).
- Injured patients require additional treatment and sometimes **prolonged hospital stays.**
- The average cost for a fall with injury was about $14,000 in 2015. Today, falls with serious injuries cost hospitals an additional **$27,000.**
- Falls with serious injury are consistently among the **Top 10 sentinel events** reported to The Joint Commission's Sentinel Event database.
- Falls must now be **reported** to the Hospital Improvement Innovation Network (**HIIN**) led by CMS.

WHAT CONTRIBUTES TO A FALL:

Analysis of falls with injury in the Joint Commission Sentinel Event database reveals the most common contributing factors pertain to:

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, supervision, staffing levels or skill mix
- Deficiencies in the physical environment
- Lack of leadership

CONTRIBUTING FACTORS TO A FALL:



EXTRINSIC FACTORS:

- Poor Lighting
- Medications
- Floor Surfaces
- Excessive Clutter
- Equipment Malfunction
- Footwear
- Inadequate Assistive Devices
- Furniture/ Structural Design

INTRINSIC FACTORS:

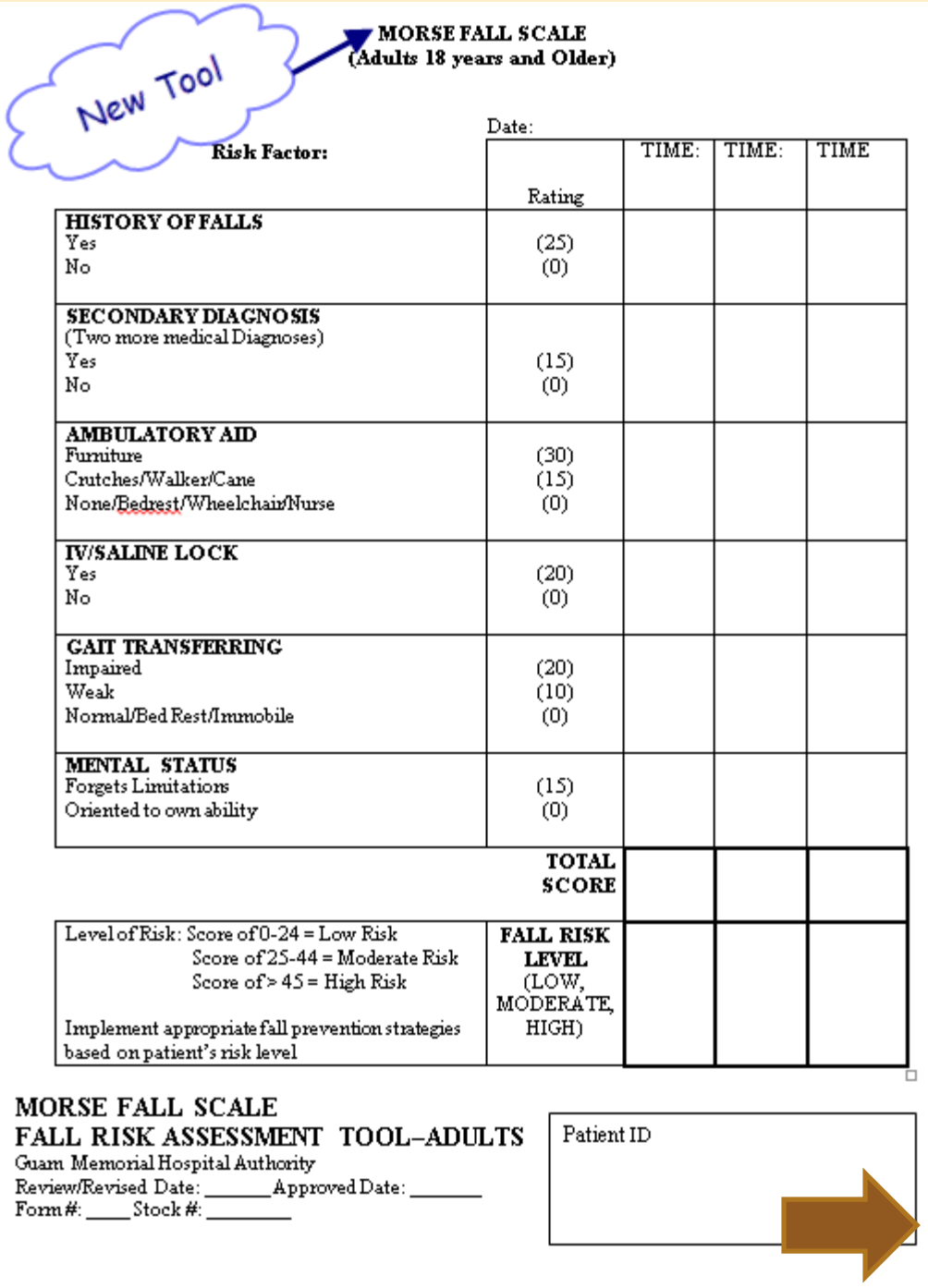
- Previous Falls
- Reduced vision
- Unsteady Gait
- Musculoskeletal System
- Mental Status
- Age and Gender
- Urinary Incontinence
- Illness
- Inadequate Nutrition

PATIENT ASSESSMENT:

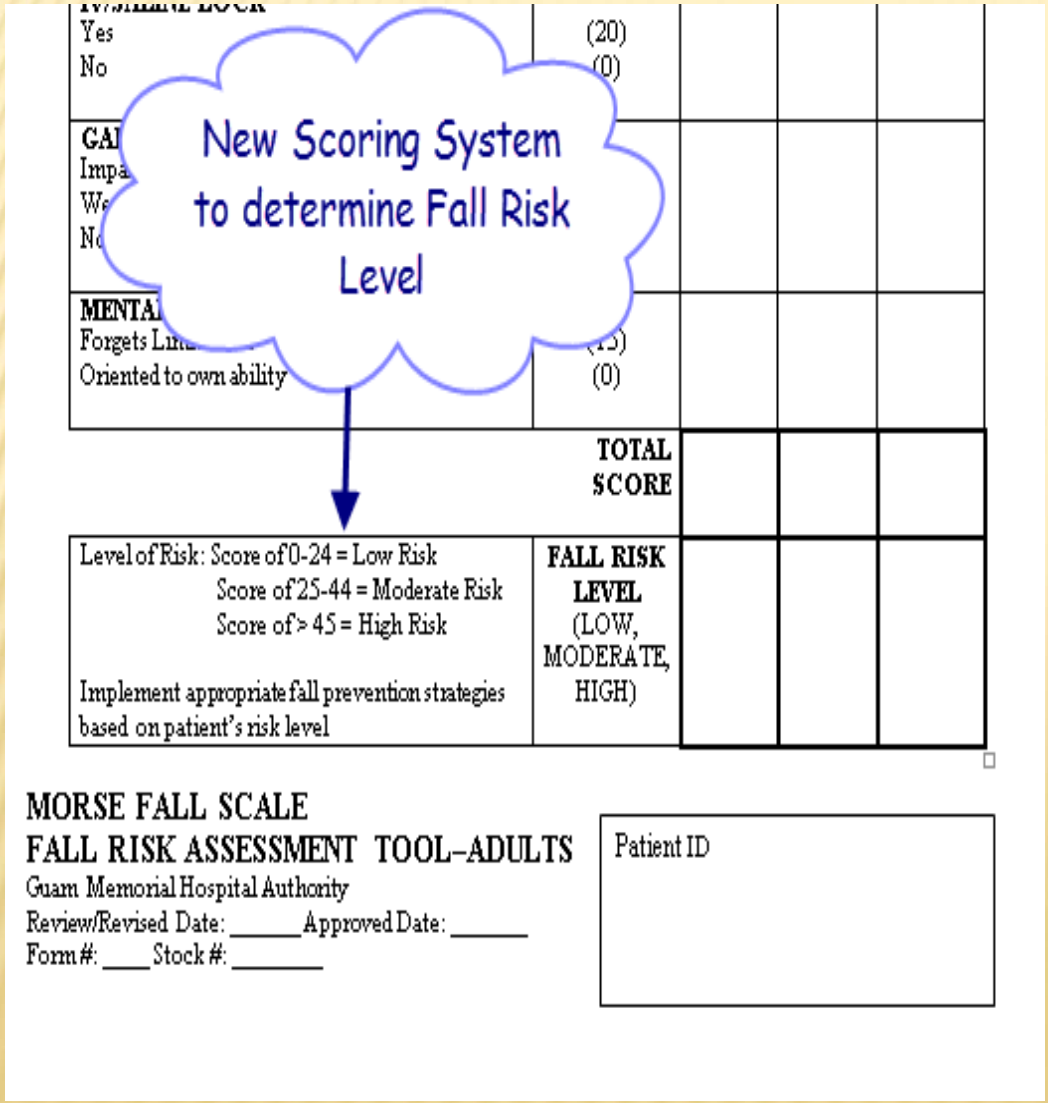
- Upon admission, and every shift, or with any ACOC,
- Fall Risk Assessment Tool:
  - Adults: The Morse Fall Scale (18 years and older).
  - Pediatrics: The Humpty Dumpty Falls Scale (age 3 months to 17 years).
- An Acute Change of Condition is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. "Clinically important" means a deviation that, without intervention, may result in complications or death.

ADULT TOOL:

- Morse Fall Scale
- Evidence- Based
- 6 areas of assessment:
  - Fall History
  - Secondary Diagnosis
  - Ambulatory Aid
  - Saline Lock / IV
  - Gait Transferring
  - Mental Status



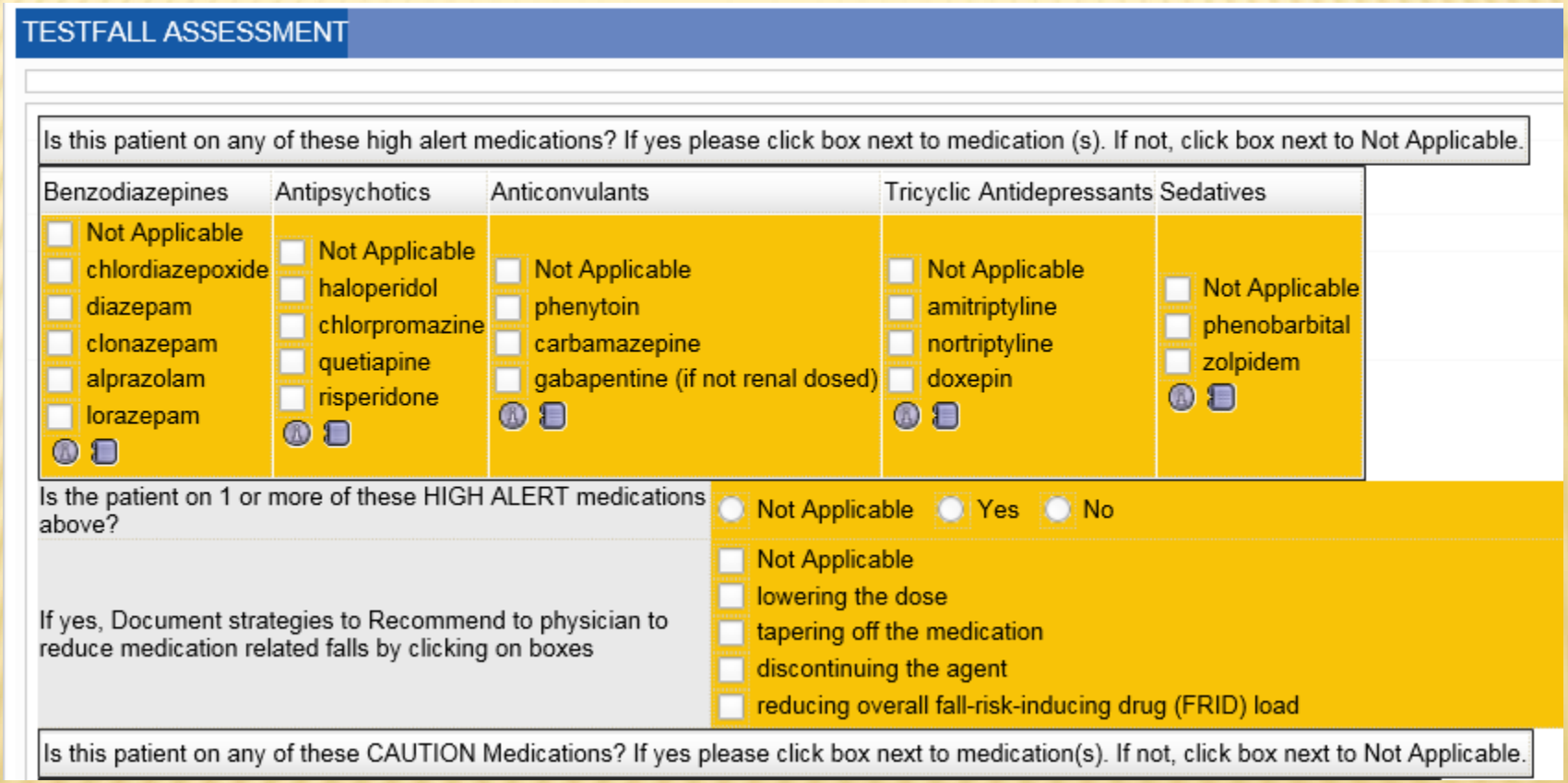
MORSE FALL SCALE RISK LEVELS:



- Low Risk:
  0-24
- Moderate Risk:
  25-44
- High Risk:
  Greater then 45

ADULT MEDICATION ASSESSMENT:

HIGH ALERT MEDS:


TESTFALL ASSESSMENT

Is this patient on any of these high alert medications? If yes please click box next to medication (s). If not, click box next to Not Applicable.

Benzodiazepines	Antipsychotics	Anticonvulants	Tricyclic Antidepressants	Sedatives
Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
chlordiazepoxide	haloperidol	phenytoin	amitriptyline	phenobarbital
diazepam	chlorpromazine	carbamazepine	nortriptyline	zolpidem
clonazepam	quetiapine	gabapentine (if not renal dosed)	doxepin	
alprazolam	risperidone			
lorazepam				

Is the patient on 1 or more of these HIGH ALERT medications above? Not Applicable Yes No

If yes, Document strategies to Recommend to physician to reduce medication related falls by clicking on boxes

- Not Applicable
- lowering the dose
- tapering off the medication
- discontinuing the agent
- reducing overall fall-risk-inducing drug (FRID) load

Is this patient on any of these CAUTION Medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.

ADULT MEDICATION ASSESSMENT :

CAUTION MEDS:

Is this patient on any of these CAUTION Medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.

Opiods	Antihistamines	Muscle Relaxants	SSRI Antidepressants	Cardiovascular Agents	Other
☐ Not Applicable ☐ fentanyl ☐ meperidine ☐ morphine ☐ hydromorphone ☐ oxycodone ☐ hydrocodone ☐ butorphanol ☐ codeine ☐ tramadol	☐ Not Applicable ☐ diphenhydramine ☐ hydroxyzine ☐ promethazine ☐ benztropine	☐ Not Applicable ☐ cyclobenzaprine ☐ baclofen ☐ methocarbamol	☐ Not Applicable ☐ paroxetine ☐ fluoxetine ☐ sertraline	☐ Not Applicable ☐ clonidine ☐ doxazosin ☐ digoxin	☐ Not Applicable ☐ metoclopramide ☐ trazodone

Is the patient on 2 or more of these CAUTION medications above?	○ Not Applicable ○ Yes ○ No
If yes, Document strategies to Recommend to physician to reduce medication related falls by clicking on boxes	☐ Not Applicable ☐ lowering the dose ☐ tapering off the medication ☐ discontinuing the agent ☐ reducing overall fall-risk-inducing drug (FRID) load

Note: Thrombolytics should be considered due to the risk of bleeding related to a fall incident… Important info to share in post fall huddle!

PEDIATRIC TOOL:

- The Humpty Dumpty Scale
- Evidence-Based
- 7 assessment criteria:
  - Age
  - Gender
  - Diagnosis
  - Environmental Factors
  - Response to Surgery/Sedation/ Anesthesia
  - Medication Usage

New Tool

THE HUMPTY DUMPTY SCALE
(3 months – 18 years)

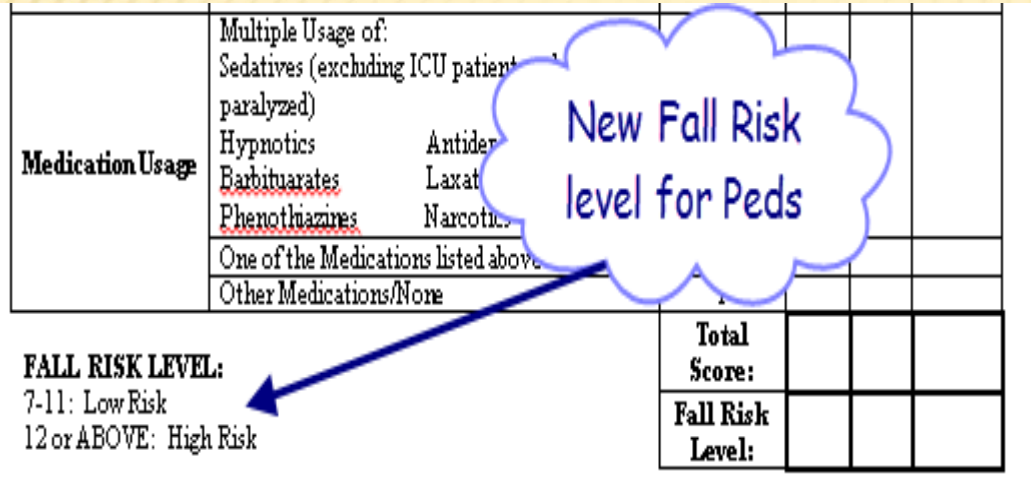
			DATE:		
			TIME:		
Parameter	**Criteria**	**Score**	**SCORE**		
Age	Less than 3 years old	4			
	3 to less than 7 years old	3			
	7 to less than 13 years old	2			
	13 years old and above	1			
Gender	Male	2			
	Female	1			
Diagnosis	Neurological Diagnosis	4			
	Alterations in Oxygenation Respiratory Diagnosis, 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 Antidepressants Barbituarates Laxatives/Diuretics Phenothiazines Narcotics	3			
	One of the Medications listed above	2			
	Other Medications/None	1			
		Total Score:			
		Fall Risk Level:			

FALL RISK LEVEL:
7-11: Low Risk
12 or ABOVE: High Risk

THE HUMPTY DUMPTY SCALE
FALL RISK ASSESSMENT TOOL– PEDIATRICS
Guam Memorial Hospital Authority
Review/Revised Date: _____ Approved Date: _____
Form #: ____ Stock #: _____

Patient ID

HUMPTY DUMPTY FALL SCALE RISK LEVELS:



- Only 2 Levels
- Low Risk:
  7-11
- High Risk:
  12 or Above

PLAN OF CARE (POC):

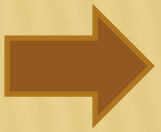
- Implement POC based on the risk assessment score.
- A **Fall Risk Care Plan** will be initiated for patients indicated as **High Risk**.
- Risk level is either low risk, moderate risk, or high risk.
- POC shall be modified based on changes in the patient's condition. Any significant changes in the patient's condition must be **communicated to all staff members** involved in the patient's care.
- Discontinue POC if no longer considered a fall risk

NURSING INTERVENTIONS (ADULT):

- **Low Risk** (score of 0-24): Implement the Standard Fall Precautions:
  - 1. Environmental orientation/re-orientation.
  - 2. Call light use demonstrated and within reach.
  - 3. Personal possessions within safe patient reach.
  - 4. Handrails (bathrooms, room, and hallway).
  - 5. Hospital bed in low position (while resting in bed); raise bed (when the patient is transferring out of bed).
  - 6. Bed brakes locked.
  - 7. Wheelchair wheel locks in "locked" position when stationary.
  - 8. Patient footwear (nonslip, well-fitting).
  - 9. Use night lights or supplemental lighting.
  - 10. Floor surfaces kept clean and dry.
  - 11. Keep care areas uncluttered.
  - 12. Follow safe patient handling practices.
  - 13. Place “Call Don’t Fall” visual cues in patient rooms.
  - 14. Encourage daily exercise or ambulation to maintain strength and reduce risk of debilitation if possible.

NURSING INTERVENTIONS (ADULT):

- **Moderate Risk** (score of 25-44): Implement the Standard Fall Precautions and the following:
  - 1. Family members stay with patient or inform staff if leaving.
  - 2. An Alert clasp identifier for fall (YELLOW clasp) will be placed on the patient's ID bracelet.
  - 3. Place a "Caution: Fall Risk" sign in front of the patient's room. 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.
  - 5. Emphasize on preventing falls, stress patient education, elaborating more on obtaining assistance when getting out of bed.



NURSING INTERVENTIONS (ADULT):

- **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. Initiate Plan of Care (POC). Notify the Physician.
  - 2. Include Fall Precaution in patient's indicator profile (iMed).
  - 3. Re-educate patient and family on Fall Prevention Interventions-notify nurses if patient will be left alone in room.
  - 4. If situation permits, relocate patient closer to nurses' station.
  - 5. Referrals or consults to address individual assessed problems (rehabilitative, dietary, social services, and pharmacy).
  - 6. **Environmental checklist** (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.

NURSING INTERVENTIONS (PEDIATRICS):

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 on its functionality.
- 3. Place "Call Don't Fall" visual cues in patient rooms.
- 4. Keep environment clear (unused equipment or 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 (parents and patients).

NURSING INTERVENTIONS (PEDIATRICS):

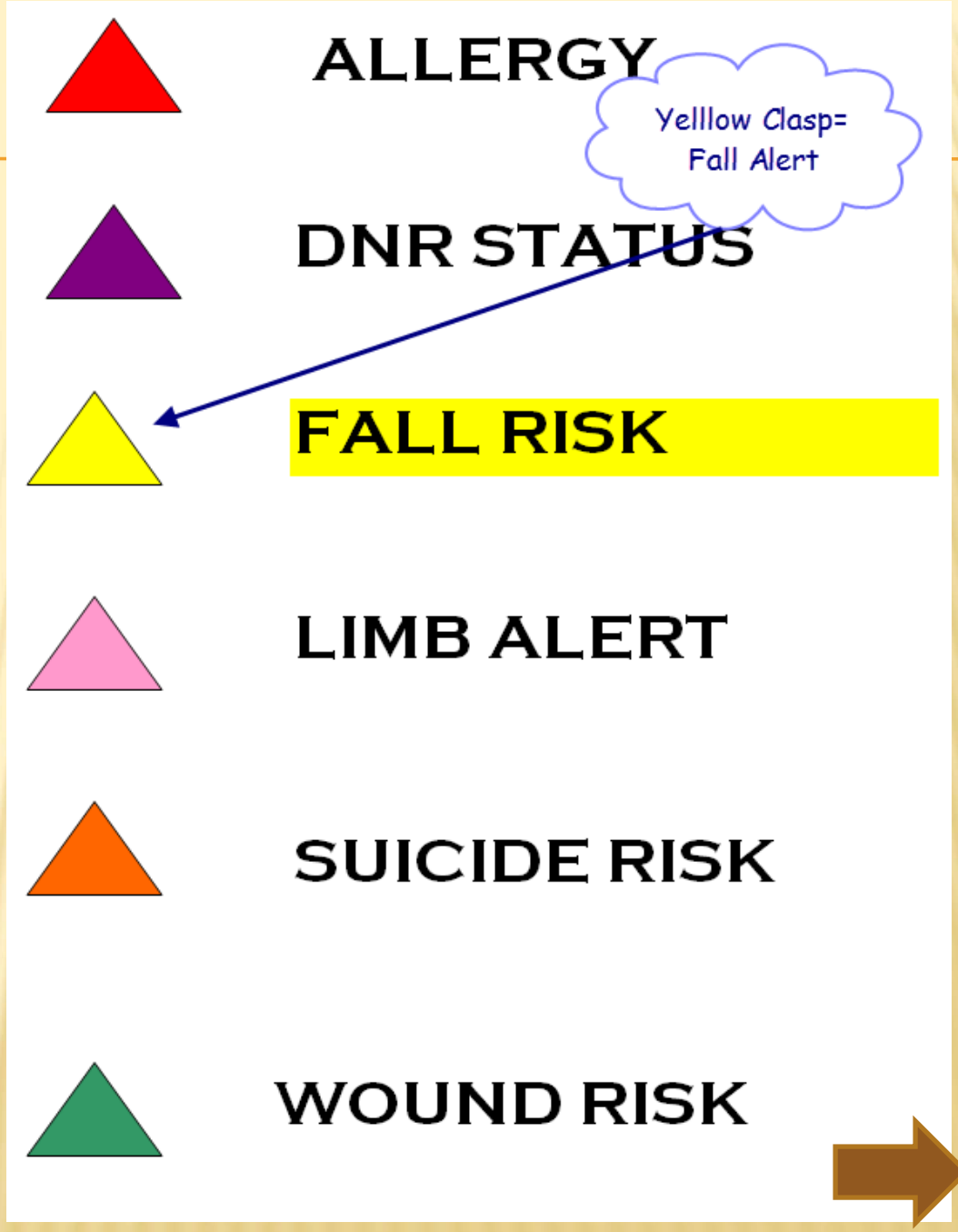
High Risk (score of 12 and above): Implement the Standard Fall Precautions and the following:

- 1. Place a "Caution: Fall Risk" sign in front of the patient's room and initiate POC.
- 2. Accompany patient with ambulation.
- 3. Family member involvement.
- 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. Apply protective barriers if possible 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. Location: Move patient closer to nurses' station, if possible.
- 9. **Environmental checklist** (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.

SIGNS IN ALL PATIENT ROOMS/AREAS:

ALERT CLASP:

- For Moderate Risk Patients
- Nursing Staff: Please place alert clasp on patient if applicable!



FOR MODERATE/HIGH FALL ALERT PATIENTS:

- For Moderate Risk (Adult) or High Risk (Pediatric) Patients
- Nursing Staff place this sign on the door to **alert ALL STAFF** of the patient's risk for fall.

CAUTION: FALL RISK

NO PASS ZONE:

On you tube, please watch this 2:27min video: The No Pass Zone- UC Health

NO PASS ZONE:(AS PER GMHA CLINICAL ALARMS POLICY (A-PS900)

- "IT is the job OF ALL HOSPITAL EMPLOYEES to assist patients, their families, our visitors and each other. A call light/bell indicates a need. All employees are expected stop and check when a call light is on."
- The "NO PASS" rule shall apply

"NO PASS" RULE

- Never pass them by
- Observe patient privacy

- Provide what they are asking for if you can, OR
- Access someone who can
- Safety first, never put patients at risk
- Smile and use AIDET

AIDET

- Acknowledge: knock on door, wash hands, address by patient name, state purpose
- Introduce: staff name & occupation
- Duration: report to patient how long before someone can assist, stay with them
- Explanation: what you're doing and why, in understandable language, ask if any questions
- Thank you: thank them for alerting staff and wash hands

WHAT ALL STAFF CAN DO:

- Reposition call light, telephone, bedside table, chairs, trash can, tissues or other personal items within reach
- Assist with making phone calls or answering the telephone
- Change TV channels or turn TV on or off
- Turn lights on or off
- Obtain personal items such as blanket, pillow, towel, washcloth, slippers and toiletries
- Obtain other items such as pens, pencils, books, magazines, etc
- Open and/or close privacy curtains
- Reduce clutter
- If entering an isolation room, follow proper PPE requirements

WHAT NON-CLINICAL STAFF CANNOT DO:

- Only NURSING STAFF can do the following:
  - Manage an IV and/or infusion pump
  - Offer pain relief
  - Remove meal trays or water pitchers
  - Assist patients with eating and drinking
  - Physically assist a patient
  - Turn off any alarms
  - Explain clinical matters/treatments, unless appropriate to your discipline
  - Raise or lower a patient bed
  - Transfer a patient between bed to bathroom, bed to chair, chair to bed, etc
  - <u>If you are a non-clinical staff member responding to an alarm and determine if the patient is in immediate distress, call for help IMMEDIATELY!</u>

NO PASS ZONE… REMINDERS:

- Do NOT Pass the patient's room, ignoring the call light
- Notify nursing staff of the patient's call if you do no notice anyone responding
- Knock on the patient's door, ensure privacy, and as what the patient may need
- In LR or OBW Do Not Enter the patient's room, please alert staff that the patient is calling

ENVIRONMENTAL CHECKLIST:

- Any nursing staff can complete the checklist
- Inform the appropriate department of any deficiency for corrective action

Patient's Room
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
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
Are all assistive devices/mobility aids functional and appropriate for the patient?
Is the patient wearing appropriate footwear? (rubber sole socks)

Siderails
Are the siderails of the crib/bed working properly?

OTHER NURSING INTERVENTIONS:

- Shift Huddles to identify high risk patients on the floors
- Communication Boards
- Hourly rounding checking the 5 Ps:

  Pain, Position, Proximity- Personal Belongings/Call light , Pathway, Potty,
- 4 bed alarms: Tele-PCU, MSW, SW, SNU

ROUNDS CONDUCTED IN MED-SURG WARD:

NEW BED ALARMS:

PATIENT/FAMILY EDUCATION:

- Upon admission- instruct on how to prevent falls. Outcomes of this education shall be documented appropriately.
- In the event of a fall- the patient's family shall be notified.
- 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.

PATIENT/FAMILY EDUCATION ON ADMISSION:

"Call Don't Fall" Educational Material During Admission

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

850 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

"Call Don't Fall" Educational Material During Admission pg. 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.

EDUCATION FOR FAMILY/FRIENDS:

Fall Prevention Information for Family & Friends

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

CAUTION:FALL RISK

INFORMATION FOR FAMILY & FRIENDS

Fall Prevention Information for Family & Friends pg. 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.

WHAT TO DO AFTER A FALL INCIDENT:

- Immediate assessment by a registered nurse, rendering necessary first aid and treatment.
- 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
- The patient's vital signs and level of consciousness shall be monitored and documented for the next 24 hours as follows:

  First Hour: Every 15 minutes

  Next Four Hours: Every 2 hours

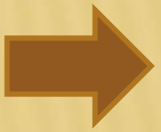
  Remaining Hours (in 24 period): Every 4 hours
- The attending physician shall be notified immediately. Inform the physician of the extent of the injury (if any), the neurological status of the patient, and the current vital signs.

WHAT DO NURSES DOCUMENT?

- In the event a fall has occurred, the following shall be documented in the patient's notes (iMED):
- Remember: PALLOR
  - **P**hysician notification of fall incident
  - 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.

WHAT TO DO AFTER A FALL INCIDENT:

- Complete the Patient Safety Form and the Post Fall Information Report (as soon as possible and before the end of the shift).
  - 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.
- A "Post-Fall Huddle" shall occur immediately.
- 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 meet to discuss reported falls and determine corrective actions to improve patient outcomes.
- 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.



POST FALL HUDDLE:

- Who: Primary nurse, Charge nurse, Nurse assistant, Hospital Nurse Supervisor on-duty and any other staff who witnessed the fall
- What: Discuss events surrounding the fall
- Where: At or Near Fall Location
- When: Immediately after the fall
- How: Use Post Fall Information Report to guide discussion
- Why: To try determine cause for fall and immediate corrective action

POST FALL INFORMATION REPORT:

No Changes to this Form!

INTERNAL USE ONLY
DO NOT PHOTOCOPY
I MEMORIAL HOSPITAL AUTHORITY
FALL INFORMATIONAL REPORT

EVENT TRACKING # _____

Patie _____ MR # _____ Hospital # _____

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

Patient found on the floor:	☐ Yes	☐ No	**Patient fell:**	☐ In Bathroom
Witnessed Fall	☐ Yes	☐ No		☐ Beside the Bed
Assisted Fall	☐ Yes	☐ No		☐ In Walkway
Repeated Fall	☐ Yes	☐ No		☐ Others: _____

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

IDENTIFIER PLACED IN ☐ Outside the room ☐ ID Band ☐ Patient Indicator (iMED)

FLOOR CONDITION ☐ Dry ☐ Wet ☐ Slippery ☐ Damaged

Details: _____

BED POSITION ☐ High ☐ Low

RESTRAINT USE ☐ None ☐ Physical ☐ Chemical ☐ Siderails x 4

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 ☐ Bedbound ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches

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

MEDICATION USE WITHIN THE LAST 6 HOURS ☐ Yes ☐ No

☐ Opiod ☐ Sedative ☐ Anticonvulsant ☐ Cardiac Medication ☐ Diabetic Medication

WHAT WERE THE CONTRIBUTING FACTORS

☐ Mental Status	☐ Equipment	☐ Lighting
☐ Toileting Attempt	☐ Improper footwear	☐ Staffing Issue
☐ Bed not in lowest position	☐ Wheelchair/Bed not locked	

Details: _____

Post Fall Huddle: Yes No
Staff Present or Why if NOT DONE:

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

STAFFING PATTERN:

Unit Census _____ # of RN: _____ # of LPN: _____ # of NA: _____

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

INJURIES: ☐ **NONE** ☐ **MINOR INJURY** ☐ **MAJOR INJURY** ☐ **DEATH RELATED TO FALL**

MINOR INJURY	**MAJOR INJURY**
Bruise	Fracture
Abrasions	Head Trauma
Minor Laceration	Loss of Function

Details of Injury

Healthcare Professional's Immediate Action

MD Notified: Date: _____ Time: _____

MD Orders: _____

Ensure that Vital Signs and Level of Consciousness are done every 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.
Ensure that all healthcare workers involved in the patient's care is notified of the patient's fall.

Staff member completing the form:
Print Name: _____ Date: _____ Time: _____

Signature: _____

PERFORMANCE IMPROVEMENT:

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

PERFORMANCE IMPROVEMENT DATA:

FALL OCCURRENCE

2015 Data

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	CY2015
ICU	2	0	1	0	0	1	0	0	1	0	0		5
MSW	1	2	0	0	2	3	2	1	5	5	1		22
TELE-PCU	0	1	3	0	1	2	2	1	4	0	3		17
PEDS/PICU	1	0	0	0	1	0	0	0	0	1	0		3
SURG	1	3	0	3	2	2	4	6	2	2	0		25
HEMO	0	0	0	0	0	0	0	1	0	0	0		1
ER	2	0	0	0	1	0	0	0	0	0	0		3
ANCILLARY	0	0	0	0	0	1	0	0	0	0	0		1
SNU	2	3	0	3	1	0	3	0	1	2	1		16
Visitor	0	0	0	0	0	0	2	0	0	0	0		2
OB WARD									1	0	0		1

Total Falls: 101

			MONTHLY FALL OCCURENCES BY NURSING UNITS										
2016	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
ICU	0	0	0	0	0	0	0	0	0	0	0	0	0
MSW	0	4	2	1	0	2	0	2	1	1	1	3	17
TELE/PCU	1	1	1	3	1	1	1	1	1	0	1	1	13
PEDS/PICU	0	0	0	1	0	1	0	0	0	0	0	0	2
SURG	3	1	2	2	0	2	4	1	0	2	0	2	19
HEMO	0	0	0	0	0	0	0	0	0	0	0	0	0
ER	1	0	0	0	0	0	0	0	0	0	0	0	1
ANCILLARY	0	0	0	0	0	0	0	1	1	0	0	0	2
SNU	1	4	0	0	0	1	1	0	1	0	0	1	9

Total Falls: 63

			MONTHLY FALL OCCURENCES BY NURSING UNITS										
2017	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
ICU	0	0	0	0	0	0	0	0	1	0	0	0	1
MSW	1	0	2	0	2	4	0	1	2	4	3	1	20
TELE/PCU	0	1	0	7	2	1	2	1	1	1	4	1	21
PEDS/PICU	0	0	0	0	0	1	0	0	0	0	0	0	1
SURG	2	4	2	2	3	1	2	2	2	3	2	1	26
HEMO	0	0	0	0	0	0	0	0	0	0	0	0	0
ER	1	1	0	0	0	0	1	0	0	0	0	0	3
ANCILLARY	0	0	0	0	0	0	0	0	0	0	0	0	0
SNU	1	2	1	0	2	2	3	1	0	2	0	0	14

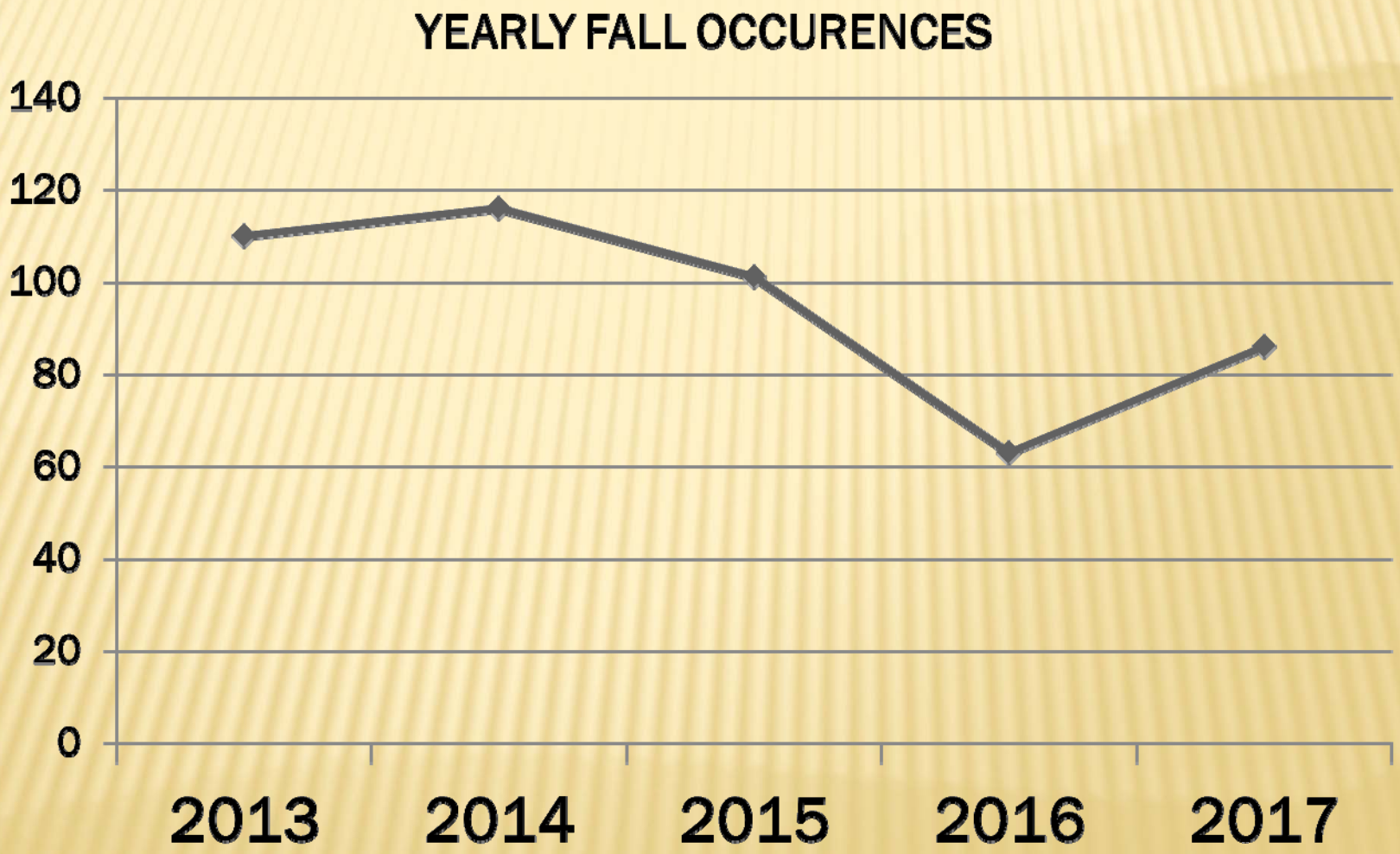
Total Falls: 86

PERFORMANCE IMPROVEMENT DATA:

		CY '15	CY '16	CY '17
SHIFT OCCURRENCE	AM SHIFT	23	15	33
	PM SHIFT	37	22	26
	GY SHIFT	30	25	30
OCCURRENCE 1HR BEFORE/AFTER SHIFT		32	18	31
TYPE OF FALL	WITNESSED	17	11	15
	ASSISTED	11	9	11
	REPEATED	12	8	12
LOCATION OF FALL	BATHROOM	13	10	25
	BEDSIDE	76	45	55
	WALKWAY	0	2	2
	OTHERS	3	6	7
FLOOR CONDITION	DRY	88	61	86
	WET	3	1	3
	SLIPPERY	2	0	0
	DAMAGED	0	0	0
RESTRAINT USE	NONE	78	57	73
	PHYSICAL	5	2	1
	CHEMICAL	0	0	0
	SIDERAILS X 4	10	4	7

		CY '15	CY '16	CY '17
MEDICATION USE	OPIODS	6	5	10
	SEDATIVE	11	3	7
	ANTICONVULSANTS	0	4	4
	CARDIAC MEDS	10	6	11
	DIABETIC MEDS	2	0	2
CONTRIBUTING FACTORS	MENTAL STATUS	48	28	36
	TOILETING ATTEMPT	32	27	34
	BED NOT IN LOWEST POSITION	0	0	0
	EQUIPMENT	2	1	1
	IMPROPER FOOTWEAR	1	0	3
	WHEELCHAIR/BED NOT LOCKED	2	1	1
	LIGHTING	0	0	0
	STAFFING ISSUE	1	0	0
TYPE OF INJURIES	NONE	78	53	72
	MINOR	15	9	15
	MAJOR	0	1	1
	DEATH	0	0	0

PERFORMANCE IMPROVEMENT DATA:



AN INTERDISCIPLINARY APPROACH:

- Nursing Services Department
- Rehabilitative Services
- Dietetic Services
- Pharmacy Department
- Social Services
- Medical Services

INTERDISCIPLINARY ROLES:

Rehabilitative Services

- Will perform a functional screening on the identified patients.

Dietetic Services

- All inpatients are screened for nutritional risk by a member of the health care team within 24-48 hours of admission.

Pharmacy Department

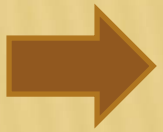
- Review, Verification, Interpretation of Medication Orders. The pharmacist shall interpret all medication orders and resolve all questions or problems prior to dispensing medications.

Social Services

- Will conduct a Social evaluation of family or home situation for safe and secure placement at discharge.

Medical Services

- ** New component to team, important component for patient care.



YOUR INTERDISCIPLINARY FALL PREVENTION TEAM:

INTERDISCIPLINARY TEAM

- Nursing: Roseann Apuron & Jasmin Tanglao (Fall Committee Co-Chairpersons)
- Rehab Dept: Nora Garces
- Social Services: Ciena Materne
- Dietetic Services: Kristy Joy Mary
- Pharmacy: Jason Boyd
- Medical Staff: Dr. Kozue

NURSING UNIT REPRESENTATIVES:

- ER: Essel Kerr
- SSD/UC/Radiology: Belle Rada
- ICU: Alvin Resurreccion
- Hemo: Veronica Censon
- L&D: Carlo Losinio
- MSW: Sherena Rosadino
- NICU: Avelina Opena
- OBW: Joanna Morales
- OR: Sr. Seville Cabuhat
- Peds: Rosa Segovia
- SNU: Elizabeth Camacho
- SW: Maria Blanquita Torres
- Tele-PCU: Raven Agpaoa

5 KEY TAKE AWAY POINTS…

- Patient Safety is EVERYONE'S responsibility
- NO PASS ZONE- if you hear a call- check the pt
- Licensed staff are responsible for completing assessments, including adult medication assessments, and initiating care plans.
- All Nursing Staff can help with interventions
- Post Fall Huddles must occur!

THANK YOU..... FROM YOUR FALL TEAM!!

Questions and Suggestions??

THANK YOU!

- To ensure comprehension of this online course please complete the online examination on our GMHA Portal:
  - GMHA Fall Prevention Program Exam
  - Your URL is: testmoz.com/1595894
  - Please follow instructions on the next page in order to login
  - A score of 80% or greater is necessary to pass the exam. If you do not pass the exam, please re-take the exam until a passing score is achieved. Exams are timed and any questionable submissions will be reported to your Supervisors for disciplinary action.

USER NAME & PASSWORD:

- In ALL CAPS, Please Indicate your Unit as one of the following:
- For Nursing: ADMN, ADMNNL (for non-licensed), SSD, RAD, ER, ICU, HEMO, LR, MSW, NICU, OBW, OR, PEDS, SNU,SW, TELE
- For all other Depts: enter the first four letters of your department in ALL CAPS:
- For example: PHAR for Pharmacy staff
- followed by your first initial, full last name and employee ID number (found on your ID badge) with NO SPACES in between.

For Example:

- ADMNRAPURON123456

- Student Quiz Passcode:GMHA