DIVISION OF ADULT INSTITUTIONS **POLICY AND PROCEDURES**	**DAI Policy #:** 500.31.02	**Page** 1 of 6
	Original Effective Date: 08/30/12	**New Effective Date:** 04/20/18
	Supersedes: 500.31.02	**Dated:** 08/30/12
	Administrator's Approval: Jim Schwochert, Administrator	
	Required Posting or Restricted: ☐ **Inmate** ☒ **All Staff** ☐ **Restricted**	
Chapter: 500 Health Services		
Subject: Fall Risk Assessment Within the Hemodialysis Unit		

POLICY

All patients shall be assessed for fall risk upon admission to the Dialysis Unit by the Dialysis RN. Reassessment shall be performed at least annually and as needed for any change in condition, post-hospital discharge or transfer to another dialysis unit.

REFERENCES

5-Diamond Patient Safety Program – www.kidneypatientsafety.org
Counts, C.S. (Ed.). (2015). Core Curriculum for Nephrology Nursing, Fifth Edition Pitman, NJ: American Nephrology Nurse's Association
Morse Falls Assessment Tool

DEFINITIONS, ACRONYMS AND FORMS

ACP – Advanced Care Provider

DOC-2466 – Incident Report (WICS)

DOC-3021A – Dialysis Progress Notes

DOC-3664 – Hemodialysis Fall Assessment Tool

DOC-3423 – Hemodialysis Treatment

DOC-3424F – Neurological Assessment Flow Sheet

DOC-3510 – Patient Care Plan

EMR – Electronic Medical Record

HSU – Health Services Unit

IPOC – Interdisciplinary Plan of Care

Morse Fall Scale – Fall assessment tool in EMR

PT – Physical therapy

RN – Registered Nurse

WICS – Wisconsin Integrated Corrections System

PROCEDURE

I. Initial Screening

Initial fall risk assessment screening shall be completed by the RN during the dialysis admission interview. Screening shall be completed utilizing DOC-3664 – Hemodialysis Fall Assessment Tool or the Morse Fall Scale (EMR).

II. Fall Risk Levels

If the patient is identified to be a fall risk, initiate interventions according to the level necessitated per DOC-3664 – Hemodialysis Fall Assessment Tool or a Morse Fall Scale (EMR) score: 0-24 Low risk, 25-44 Medium risk, 45-100 High risk. Initiate other appropriate interventions to minimize the patient's risk of falling.

A. Low Fall Risk or Level I Protocol:
   1. Orient patient to surroundings.
   2. The patient's dialysis chair, or bed, should be locked and easily assessable for patient transfers.
   3. Orient patient to staff.
   4. Instruct patient to ask for assistance when needed.
   5. Instruct patient to utilize scale grab bars to assist with balance.
   6. Place ambulatory assistive devices within easy reach post treatment.
   7. Patients using ambulatory assistive devices are to be offered assistance entering and exiting the treatment area.
   8. Encourage all ambulatory patients to use skid-proof footwear.
   9. All personnel shall be responsible for eliminating environmental hazards. Maintain clean and dry walking surfaces.
   10. Patient care staff to escort patient into and out of the treatment area, as needed. Provide assistance with weighing and exiting the treatment area, as needed.
   11. Educate patient to unit call light system.
   12. Instruct patient to notify health staff when feeling dizzy, weak, or lightheaded, and ask for assistance.

B. Medium Fall Risk Level II Protocol
   All of Low Risk or Level I plus:
   1. Patient care staff to escort patient into and out of the treatment area. Provide assistance with weighing and exiting the treatment area.
   2. Instruct patient to ask for assistance for any relocation.
   3. All items for patient use should be within easy reach.
   4. Consult with the ACP. Seek medication for altered elimination episodes if present, i.e., urinary urgency, diarrhea.
   5. Notify provider for medication review, if applicable.
   6. Reassess for safe footwear. Avoid patient weighing in socks.
   7. Evaluate for assistive device needs, such as wheelchair, cane and walker.

8. Reinforce use of assistive devices, if used.
9. Wheelchair shall be in a locked position unless attended.
10. Evaluate need for physical therapy, i.e., strength training and transfer alternatives. Discuss request for PT referral with HSU ACP.
11. Reassess for clutter-free, well-lit environment.
12. Educate personal care workers, if applicable, to verbally report to staff when patient arrives for treatment.

C. High Fall Risk Level III Protocol:
All of Low and Medium Risk or Level I and II, plus:
1. Frequently reorient and repetitively reinforce need for patient care staff assistance.
2. Frequent observation of patient.
3. Consider seat assignment in more visible area.
4. Assist patient with all activities.
5. Provide staff watch.
6. If supportive device (safety restraint) is needed, apply per current recommendations and policies.

III. Document Level of Applicable Interventions

A. Non-live sites follow a DOC-3510 – Patient Care Plan.

B. EMR sites follow: Fall Prevention/Management IPOC

C. Non-live sites shall Initiate fall risk identification including:
1. Yellow colored warning sticker on patient clipboard, List level of fall risk on the sticker.
2. Yellow colored warning sticker on patient Kardex.
3. Yellow colored warning sticker on patient dialysis chart.

D. Notify the assigned HSU of the fall assessment findings.

IV. Ongoing Risk Assessment Includes:

A. Complete a new Fall Scale for any changes in the patient's health condition that may affect the fall risk status at each dialysis treatment. Intervene with appropriate measures and revise the plan of care when appropriate.

B. Asking the patient at each dialysis treatment if he/she has sustained a fall since the last dialysis session. Document on in health record and follow identified procedures for falls outside of dialysis.

C. Reassessing the patient for a change in fall risk with any change in condition, post hospital discharge, and at transfer to another dialysis unit.

D. Complete a fall risk assessment annually.

V. If Patient Experiences a Fall at Dialysis:

A. Perform a physical assessment and take vital signs prior to moving the patient.
   1. If there is any evidence of serious injury or complaints of neck/back discomfort, do not move the patient until consultation or evaluation by a prescriber has been completed.
   2. Further assess vital signs and physical condition.

B. Contact emergency services as necessary.

C. Assess how, when and where the fall occurred.

D. If patient was observed to have hit their head, the fall was unwitnessed, or the patient reports they hit their head, complete Neurological Flow sheet DOC-3424F or Neurological Assessment in EMR. The assigned HSU is to complete the remaining Neurological and Post Fall Assessments once the patient is discharged from the dialysis treatment.

E. Once deemed safe to move the patient, help the patient up into a chair. Notify Nephrology ACP, HSU, Dialysis Unit RN team leader and the Hemodialysis Nursing Supervisor.

F. Hold Heparin during the dialysis treatment if potential injury was sustained. Consult with the Nephrology ACP regarding the future use of Heparin.

G. Have a heightened alert for patients receiving anticoagulant therapy.

H. Document an assessment of the patient's status on the DOC-3021A – Dialysis Progress Notes. Include the nature of any injury and the type of fall.

I. Complete DOC-2466 – Incident Report (WICS).

J. Document patient fall in the health record.

K. Update Fall Prevention/Management.

L. Refer to appropriate fall risk level for future interventions.

M. For fall with significant injury, notify emergency services as necessary.

VI. If Patient Reports, or Notification is Received Regarding a Fall Outside of Dialysis:

A. Assess patient for any injuries.

B. Ask how, when and where the fall occurred. Assess for any contributing factors.

C. If patient was observed to have hit their head or the fall was unwitnessed, staff shall complete Neurological Assessment and document in the health record.

D. The assigned HSU to complete the remaining neurological assessments once patient is discharged from the dialysis treatment.

E. Heightened alert for patients receiving anticoagulation therapy.

F. Consult ACP as appropriate.

G. Hold Heparin, if indicated, during the dialysis treatment. Consult with the Nephrology ACP regarding the future use of heparin if potential injury was sustained.

H. Document an assessment of the patient's status, the nature of any injury, and the type of fall in the DOC-3021A – Dialysis Progress Notes.

I. Confirm that a DOC-2466 – Incident Report (WICS) was filed by consulting with the HSU Manager, Hemodialysis Nursing Supervisor or a Security Supervisor.

J. For falls with significant injury, notify emergency services as necessary.

VII. Review of Falls

All falls shall be reviewed by the Dialysis Continuous Quality Improvement Committee and reported on the Hemodialysis Monthly Report.

Bureau of Health Services: _____Date Signed: _____
James Greer, Director

_____Date Signed: _____
Paul Bekx, MD, Medical Director

_____Date Signed: _____
Mary Muse, Nursing Director

Administrator's Approval: _____Date Signed:_____
Jim Schwochert, Administrator

DIVISION OF ADULT INSTITUTIONS FACILITY IMPLEMENTATION PROCEDURES

Facility: Name		
Original Effective Date: 00/00/00	**DAI Policy Number:** 500.31.02	**Page** 6 of 6
New Effective Date: 00/00/00	**Supersedes Number:** 500.31.02	**Dated:** 08/30/12
Chapter: 500 Health Services		
Subject: Fall Risk Assessment Within the Hemodialysis Unit		
Will Implement ☐ As written ☐ With below procedures for facility implementation		
Warden's/Center Superintendent's Approval:		

REFERENCES

DEFINITIONS, ACRONYMS, AND FORMS

FACILITY PROCEDURE

I.

A.

B.

1.

2.

a.

b.

c.

3.

C.

II.

III.

RESPONSIBILITY

I. Staff

II. Inmate

III. Other