DIVISION OF ADULT INSTITUTIONS FACILITY PROCEDURE

Facility: Taycheedah Correctional Institution		
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Chapter: 900 Miscellaneous		
Subject: Patient Falls		
Required Posting or Restricted:	☐ **Inmate** ☒ **All Staff**	☐ **Restricted**
Warden's/Center Superintendent's Approval: Warden Sarah Cooper		

PURPOSE

To assess and reassess all patients for the risk of a fall and the potential associated injuries and to implement appropriate interventions to identify these individuals and facilitate safety measures, decreasing the risk for fall.

REFERENCES

American Geriatrics Society: 2019 AGS/BGS Clinical Practice Guidelines
Understanding Fall Risk, Prevention, & Protection (n.d.) Retrieved February 3, 2012
Wis. Stat. s. 302.38- Medical Care of Prisoners.
American Geriatric Society. (2020). *Guideline for the prevention of falls in older persons.* Retrieved from: http://stopfalls.org/faqs/american-geriatrics-society/

DEFINITIONS, ACRONYMS, AND FORMS

Activities of daily living (ADL) – Includes dressing, grooming, hygiene, bathing/showering and toileting activities.

Alarm – A device attached to the patient or patient's equipment (e.g., wheelchair, chair, bed) that sounds an alarm when the patient attempts to move independently.

Care conference – A multidisciplinary group which meets regularly to review and develop the patient's plan of care.

Fall – An unplanned descent to the floor or other equipment which is witnessed or unwitnessed, with or without an injury. This involves all types of falls, including assisted falls, which minimize impact.

No Lift – A patient shall not be manually lifted except in an emergency or life threatening circumstance. Staff should only provide stand by assistance or balance assistance with a gait belt.

Mechanical lift – An assistive device, such as a Sit-to-Stand or Hoyer type lift, used to lift a patient that cannot safely bear weight on their own or whose weight makes it unsafe to move or lift them manually.

a. Non-urgent care may be treated onsite.
b. Intermediate care may be treated onsite or at designated hospital emergency department.

ACP – Advanced Care Provider

CQI – Continuous Quality Improvement

DOC-2466 – Incident Report (WICS)

EMR- Electronic Medical Record

IDT – Interdisciplinary Team

IPOC - Interdisciplinary Plan of Care

POA – Power of Attorney

WICS – Wisconsin Integrated Corrections System

PROCEDURE

I. General Guidelines

A. All patients are at risk for falls. Appropriate interventions will be incorporated into the individual plan of care.

B. Communicate with activated POA or guardian as appropriate.

C. Risk factors for falls are categorized as:
   1. Intrinsic – patient's physiological condition
   2. Anticipated (e.g., fall history, mobility, poor health.)
   3. Unanticipated (e.g., seizures, CVA, syncope.)
   4. Extrinsic - the physical environment
   5. Anticipated (e.g., poor footwear, wheels to beds, unsafe/broken equipment.)
   6. Unanticipated (e.g., reactions to medications.)

C. All staff are responsible for ensuring the safety of the environment, reducing potential falls and associated injuries.

D. Staff are responsible for maintaining a no lift environment.

II. Procedure for Infirmary patients

C. Morse Fall Scale in medical record shall be completed:
   1. Upon initial admission and any subsequent admissions.

2. At specified intervals at a minimum of annually.
3. With significant changes in mental and physical health.
4. After any fall occurrence.

D. Low Risk- Morse Fall Scale 0-24, fall prevention interventions shall be implemented for all patients, despite identified risk level. These include:

1. Orient patient to the environment.
2. Position bed in the lowest position with the brakes locked.
3. Encourage appropriate use of assistive devices (e.g., wheelchair, walker, cane, grab bars, etc.)
4. Determine the safest use of side rails.(with the exception of X4 side rails which are considered a restraint).
5. Position equipment within reach (e.g., call light, wheelchair, cane, etc.)
6. Ensure toileting needs are met appropriately (e.g. toileting schedule, raised toilet seat, commode, etc.)
7. Keep walkways free of cords, spills, debris.
8. Ensure that non-skid footwear is worn when out of bed.
9. Ensure timeliness of comfort rounds (e.g., positioning, offering fluids/snacks, toileting.)
10. Ensure nightlights are on in patient rooms.
11. Evaluate medication effectiveness that predisposes patients to falls (e.g., anti-hypertensives, narcotics, sedatives, etc.) Consult with ACP and/or pharmacist as needed.
12. Facilitate therapy needs as appropriate.
13. Ensure a continuous assessment of patient mobility status.
14. Educate on fall prevention and safety as appropriate.

C. Moderate Risk/Morse Fall Scale 25-50; interventions shall be implemented, in addition to Low Risk interventions, with the use of indicated equipment for all patients identified as such.

1. Identify the patient as a fall risk in the medical record.
2. Monitor patient hourly and as needed.
3. Maintain close supervision.
4. Instruct the patient to ask for assistance with mobility and positioning needs.
5. Offer toileting every two hours and as needed.
6. Facilitate medication review by ACP as indicated.
7. Collaborate with IDT to develop fall prevention plan of care strategies.
8. Use top side rails X2.
9. Reassess and reinforce use of assistive devices.
10. Communicate this identified risk with other disciplines/departments (e.g., Dialysis, Dental, Security, etc.) as appropriate.

D. High Risk/Morse Fall Scale >50; interventions shall be implemented, in addition to Low Risk and Moderate Risk interventions, with the use of indicated equipment for all patients identified as such.
   1. Frequently reorient patient.
   2. Frequently reinforce with the patient the need for assistance.
   3. Frequent, direct observation of the patient.
   4. Assist/Monitor patient with all activities.
   5. Consider 1:1 observation
   6. Incorporate the use of safety devices (e.g., bed alarm, lap belt) as indicated.

E. All patients shall have a safety goal identified on their individual plan of care, with appropriate interventions indicated, documented and monitored for effectiveness.

F. Fall occurrence, witnessed or unwitnessed:
   1. Provide to patient's immediate needs.
   2. Ensure complete physical assessment is completed by a Nurse Clinician, including vital signs.
   3. Initiate Post Fall Evaluation and Neurological Checks Order in the medical record in the following circumstances
      a. Fall with head involvement.
      b. Unwitnessed fall with or without head involvement.
      c. Loss of consciousness.
   4. Follow guidelines Neurological Checks Order for 24 hours post fall.
   5. Facilitate any additional care needs, completing any ACP orders provided.
   6. Document events, assessment and interventions in the medical record.
   7. Assessment of patient related to the fall is required every shift for the next 72 hours.
   8. Complete DOC-2466 – Incident Report (WICS).
   9. Evaluate the occurrence (e.g., how, when, where, why.)
   10. Evaluate the patient's current plan of care. Collaborate and facilitate changes as indicated, update IPOC in the medical record.
   11. Inform Infirmary supervisor(s) of the date and time of a patient fall.
   12. Communicate with Infirmary staff and other disciplines as necessary, ensuring consistency in patient plan of care.
   13. Evaluate effectiveness of interventions, adjusting as needed.
   14. Update ACP as necessary.

G. Review of fall occurrences
   1. All fall occurrences shall be documented in the medical record and on a DOC-2466 – Incident Report (WICS). The Infirmary Supervisor(s) shall receive a copy of all DOC-2466s.
   2. All falls shall be monitored by the Infirmary Supervisor(s) through the CQI process.

III. Fall Prevention and Management Interventions for Infirmary Patients

A. The following interventions shall be considered when the patient assessment score indicates they are at risk for a fall. These interventions shall be implemented on a case-by-case basis. More than one precaution may be implemented if necessary.
   1. Place a fall identifier outside of the patient room and at the bedside.
   2. Encourage the patient to call for assistance with transfers and ambulation.
   3. Keep the call light within reach. Patient must perform a return demonstration of use of call light.
   4. Keep bedpan within reach at bedside or commode at bedside.
   5. Utilize alarm system(s), if necessary, as a reminder not to attempt to transfer without assistance.
   6. Leave night light on at night.
   7. Contact activated POA or guardian to inform that patient is at risk for falls. Discuss potential fall interventions.
   8. Toilet patient every two hours.
   9. Assist with ambulation or transfers, utilizing mechanical lifts when necessary.
   10. Keep upper side rails of bed up at all times.
   11. Place a mat on the floor, if patient tries to get out of bed without assistance.
   12. Evaluate for one-on-one observation.
   13. Provide non-skid footwear.
   14. Keep room free of clutter, spills, cords or other equipment.
   15. Keep bed in lowest position and locked at all times.
   16. Place patient in room near nurse’s station.
   17. Consider protective head gear.
   18. Implement diversion activities or exercise.
   19. Review medications.
   20. Schedule care conference with family/POA/guardian.

IV. Procedure for General Population Patients

A. Morse Fall Scale in medical record shall be completed:
   1. Upon initial intake to TCI.
   2. With significant changes in mental and physical health.
   3. After any fall occurrence.

B. Low Risk /Morse Fall Scale 0-24
   1. Encourage appropriate use of assistive devices (e.g., wheelchair, walker, cane, grab bars, etc.) if applicable.
   2. Position equipment within reach (e.g., wheelchair, cane, etc.) if applicable. Encourage patient to keep walkways free of cords, spills, debris.
   3. Evaluate medication effectiveness that predisposes patients to falls (e.g., anti-hypertensives, narcotics, sedatives, etc.) Consult with ACP and/or pharmacist as needed.
   4. Facilitate therapy needs as appropriate.
   5. Educate on fall prevention and safety as appropriate.

C. Moderate Risk/High Risk Morse Fall Scale 25-50 or higher
   1. Consult ACP and Infirmary Manager/Designee.
   2. Patient shall be housed in the infirmary.
   3. Follow Moderate/High risk interventions in Infirmary.

D. Fall occurrence, witnessed or unwitnessed:
   1. Provide to the patient’s immediate needs.
   2. Ensure assessment is completed by a Nurse Clinician with vital signs.
   3. Initiate Post Fall Evaluation and Neurological Checks Order in the medical record in the following circumstances:
      a. Fall with head involvement.
      b. Unwitnessed fall with or without head involvement.
      c. Loss of consciousness.
   4. Follow guidelines Neurological Checks Order for 24 hours post fall.
   5. Facilitate any additional care needs, completing any ACP orders provided.
   6. Document events, assessment and interventions in the medical record.
   7. Assessment of patient related to the fall is required every shift for the next 72 hours.
   8. Complete DOC-2466 – Incident Report (WICS).
   9. Evaluate the occurrence (e.g., how, when, where, why.)
   10. Inform HSU supervisor/designee of the date and time of a patient fall.
   11. Evaluate effectiveness of interventions, adjusting as needed.

E. Review of fall occurrences
   1. All fall occurrences shall be documented in the medical record and on a DOC-2466 – Incident Report (WICS). The Infirmary Manager(s) shall receive a copy of all DOC-2466s.
   2. All falls shall be monitored by the Infirmary Manager(s) through the CQI process.

Staff Responsibilities

A. Infirmary Manager shall:
   1. Ensure that the quantity and characteristics of falls is reviewed monthly.
   2. Participate in the Health and Safety committee.
   3. Ensure that fall risk CQI is a continuous process.
   4. Ensure that the policy is adhered to by all Infirmary/HSU staff.

B. The ACP shall refer patients admitted to the Infirmary with the following conditions or deficits for therapy evaluations:
   1. Difficulty completing ADLs.
   2. Those who are geriatric and/or over 50 years of age; patients with orthopedic issues, past or present, that limit function or have the potential to do so.
   3. Any form of paralysis patients who have difficulty with mobility or transfers.
   4. Any patient that has a Morse Fall Scale greater than 25

C. Therapy staff shall:
   1. Identify those patients who need specialized cares or routines, such as ambulation, special devices, special transfers or other techniques, etc., and communicate to nursing staff.
   2. Conduct balance assessments for all high risk patient referrals on a case-by-case basis.
   3. Develop an intervention program for individual patients to reduce their fall risk.

D. Pharmacy staff shall:
   1. Review, upon request of the ACP or nursing, medications that may increase the risk for falls.
   2. Notify the provider if a drug interaction or medication level increases the likelihood of falls.
   3. Indicate to the provider any suggested labs to monitor drug levels that may be contributory to increasing falls