HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: FALL RISK PLAN **Effective Date: 5/31/06**
Policy Number: 144 **Med Staff:**
Regulation: CAH-IG §483.13(a) **Admin:**

I. POLICY

All patients will be assessed upon admission for Fall Risk and periodically re-assessed in order to take precautions to prevent possible injuries while in the hospital.

II. DEFINITIONS

N/A

III. RESPONSIBILITY

All hospital employees when in the patient care areas.

IV. EQUIPMENT

Pink leaf alerts for patient room door
Pink & Green reminder signs on walls in patient rooms
Bed Check alarm system
Floor mats
Patient sitter list (kept at Nurse Station)

V. PROCEDURES
INFECTION CONTROL: CATEGORY II

1. All patients are assessed by the RN or RN/LP within 8 hours of admission using the Fall Risk Assessment form. This includes assessment of the following:
   a. History of falling
   b. Secondary diagnoses
   c. Walking aids
   d. IV Therapy
   e. Gait/Transferring
   f. Mental status
   g. Elimination
   h. Medications
2. The patient Risk Level is assigned by the score obtained by the assessment as follows:
   a. Level III – 0 (no risk) – Universal Precautions
   b. Level II – 1-6 (low risk) – Initiate Fall Risk protocols

c. Level I – 7 and above (high risk) – Initiate High Risk protocols

3. The Fall Risk Level is indicated in the Nursing Care Plan and written on the patient Kardex to alert all nursing staff participating in the patient's care.

4. Inform all nursing staff participating in the patient's care of the Fall Risk Level to implement the appropriate precautions/protocols as follows:

LEVEL III

a. Orientate patient to room and place call light and other articles in reach.

b. Place bed in low position and lock wheels.

c. Give patient safety socks if they do not have safe foot wear with them.

LEVEL II

All of the precautions in Level III plus

d. Place side rails up at all times unless a release is signed by the patient or patient representative.

e. Move patient closer to the Nurses Station if possible.

f. Instruct patient to always call for assistance when getting out of bed and point out reminder signs on the walls. Do this every time you leave the room.

g. Offer bathroom assistance at least every 2 hours while awake.

h. Place Bed Check alarm on bed unless patient signs a release of bed check form.

i. Place pink leaf on outside of patient room door to alert all hospital staff of precautions.

j. Give all family members and/or sitters the instruction sheet of their responsibilities when they are staying with a Risk Level I & II patient.

LEVEL I

All of Levels III and II plus

k. Move patient to room 20, 21 or 22.

l. Make every possible attempt to have a family member or sitter stay with patient at all times.

m. Offer bathroom assistance at least every 1 hour while awake.

n. Place trapeze to bed if patient is on bed rest and bed mobility needs to be increased.

o. Place soft mats on floor beside both sides of bed.

p. Send consult to Rehabilitation (Physical Therapy and Occupational Therapy) to assess for abilities to stand and to walk safely, and/or other diversional therapy.

q. Consult Social Services for assessment of other diversional interactions.

r. Contact physician to assess for possible pharmaceutical treatment to improve patients ability to follow instructions to ask for assistance when getting out of bed.

5. **USE RESTRAINTS ONLY AS A LAST RESORT.** If nothing else is working and restraints are needed, the physician/nurse must assess and re-assess the patient using the Restraint Assessment Flow Sheet and discontinue use as soon as possible. (See the hospital Policy and Procedure for Restraint and Seclusion)

VI. DOCUMENTATION

1. The admission assessment and re-assessments are documented on the *Fall Risk Assessment* form.
2. The Fall Risk is documented on the *Nursing Care Plan* and the patient Kardex used for giving shift report the Nurse and Ward Clerk.
3. The routine daily precautions and protocols are documented in the *Nurses Notes and Routine Care* form by the nursing staff directly caring for the patient.
4. Patient/family/sitter education is documented on the *Interdisciplinary Patient/Family Education Record*.