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The Vermont Psychiatric Care Hospital Policy and Procedure		
Fall Prevention		
Effective: June 2022	Revised: September 2024	Due to Review: September 2026

POLICY

The Vermont Psychiatric Care Hospital (VPCH) identifies hospitalized persons at risk for falls to direct the creation of an individualized plan of care to reduce fall risk and identify environmental factors that may contribute to falls.

Hospitalized persons will be assessed for fall risk during the admission process. A plan of care based on identified risk factors and the following procedure will be implemented on admission or upon identification of risk. Fall risk will be reassessed and updated once per shift, or with change in an individual's condition.

DEFINITIONS

Fall: A fall is defined as an event which results in the hospitalized person or any part of their body coming to rest inadvertently on the floor, or other surface lower than the individual.

Included in this definition are individuals found lying on the floor unable to account for their situation-unwitnessed falls.

PROCEDURE

Assessment of Fall Risk - RN Responsibilities

1. Using the Wilson Sims Fall Risk Assessment Tool (WSFRAT) assess for fall risk upon admission.
    a. The WSFRAT (see Appendix A) is located within the Daily Assessment Flow Sheet in the Electronic Health Record (EHR).
2. A score of 7 or higher signifies a risk for falls and triggers notification to a provider and the addition of FALL RISK to the focus area of the treatment plan, with goals and interventions relevant to the individual's situation clearly stated within the plan. (In some cases, individuals will be deemed at high risk for falls based on medical conditions, such as seizure disorders, or other circumstances and will not score above a 7 on the assessment tool. In these cases, nurses will use their critical thinking to identify the risk and follow through with the updates to the treatment plan, including goal and interventions, and notifications in shift report, etc.)
3. The RN will include fall risk assessment and intervention detail on the shift report form. Interventions shall also be entered as nursing orders in the medical record.
4. Reassess the hospitalized person's risk for falls at least once per shift, and whenever there is a significant change in the individual's condition, which may include: cognition, mobility, a fall by an individual with no previous risk identified or any other situation in which the nurse determines an assessment to be indicated.

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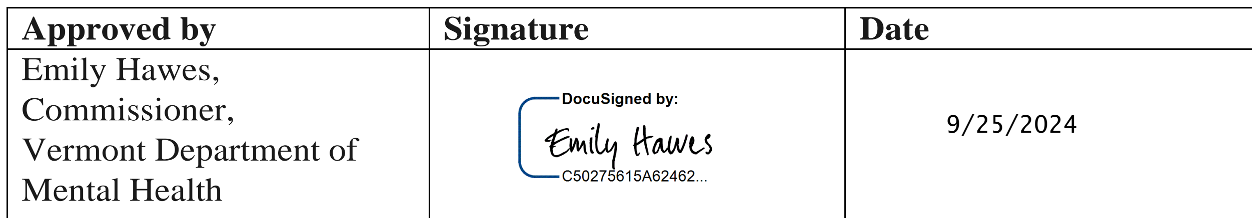
   a. Fall Risk score should reflect highest level of risk observed, acknowledging that risk may fluctuate due to delirium. For example, an individual who is confused during the night but more oriented on days should still be a fall risk. Interventions may be altered from shift to shift but risk remains. See Appendix B: Adult Fall Prevention Strategies
   b. As a person’s condition changes, improving mental status or physical ability may reduce risk, and the interventions targeted to risk factors can be modified.
5. A High-Risk Progress Note that captures a hospitalized person’s fall will trigger a multi-disciplinary review of the event and an update, including a goal and interventions, to the treatment plan.

Post Fall Evaluation and Care:

1. Assess and treat the hospitalized person for injury, if indicated.
2. Notify the on-duty provider.
3. Complete Patient Event Report as directed in event reporting policy.
4. Document the fall in a High-Risk progress Note. See Appendix C: SPLATTS guidelines, for information on key fall reporting points.
5. Treatment plan will be updated and amended as needed.
6. Update the shift report form to include the change in fall risk and interventions, if any.

Appendix A: Wilson Sims Fall Risk Assessment
Appendix B: Inventory of Approved Fall Prevention Strategies
Appendix C: "SPLATTS” Fall Documentation to Enhance Event Reporting



Approved by	Signature	Date
Emily Hawes, Commissioner, Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	9/25/2024

Appendix A

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Screen Shot View Wilson-Sims Falls Risk Assessment

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Patient Assessment: PSYCH ADMISSION ASSESSMENT	
FALL RISK ASSESSMENT	
Age	○ 0 = 18-59 ○ 1 = 60-70 ○ 2 = 71 >
Gender	○ 0 = Male ○ 1 = Female
Mental Status:	○ 0 = Oriented and Cooperative ○ 1 = Oriented and Uncooperative ○ 2 = Confused, Memory Loss, Forgets Limitations, Intoxicated
Physical Status:	○ 0 = Healthy ○ 1 = Generalized Muscle Weakness ○ 2 = Dizzy, vertigo, syncope, orthostatic hypotension ○ 3 = Cachexia and Wasting
Elimination;	○ 0 = Independent and Continent ○ 1 = Catheter, Ostomy ○ 2 = Elimination with Assistance, Diarrhea or Incontinence ○ 3 = Independent and Incontinent, Urgency, or Frequency
Impairments:	○ 0 = None ○ 1 = Uncorrected visual, hearing, language, speech ○ 2 = Limb amputation ○ 3 = Neurological paralysis, paresthesia
Gait or Balance:	○ 0 = Able to walk/stand unassisted or fully ambulatory. ○ 1 = Physically unable to walk/stand (but may attempt) ○ 2 = Walks with cane ○ 3 = Unsteady walking, standing, walker, crutches, furniture
History of falls in past 6 months:	○ 0 = No History ○ 1 = Near falls or fear of falling ○ 2 = Has fallen 1-2 times ○ 3 = Multiple falls, more than 2 times
MEDICATIONS	
Mood Stabilizer Medications:	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
Benzodiazepines:	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
Diuretics:	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
Narcotics:	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
Sedatives/Hypnotics:	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
Atypical Anti Psychotics	○ 0 = Not taking prior to admission ○ 1 = Taking prior to admission ○ 2 = Newly ordered
DETOX PROTOCOL	
7 points if on Detox Protocol	○ 0 = Not on Detox Protocol ○ 7 = On Detox Protocol
FALL RISK SCORE:	0.0 *(NOTE: computer generates a number based on the sum of the above items)*
FALL RISK LEVEL:	○ Score 0-6 = Low Risk ○ Score 7 or Above = High Risk
Fall Risk? (RN clinical judgment)	○ Yes ○ No *(NOTE: This item allows the RN to use clinical judgment to override a computer-generated Fall Risk score*
Fall Risk Comments:	*(NOTE: RN writes comments about fall risk factors or clinical judgment here)*

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Appendix B

Adult Fall Prevention Strategies
Orient patient to the environment on admission, transfer and as needed.
If applicable place bed in low position with brakes locked
Ensure footwear are fitted, non-skid, low heeled and secured properly
Utilize appropriate lighting on night shift to allow for safe access to bathroom
Wipe up spills immediately and teach patients to call for assistance with spills
Arrange furniture/objects safely. Remove unneeded furniture to assure an uncluttered path to the bathroom or doorway.
Ensure patient use of handrails in bathroom.
Assist with elimination as appropriate and in a timely fashion (i.e. Use bedside commode; toileting schedules; frequent toileting with assistance).
Evaluate effects of medications that predispose patient to falls in collaboration with Pharm. and Medical Staff.
Educate patient and family regarding fall prevention strategies and their role. Document education that is provided.
Fall Risk notification applied to front of paper chart
Add Fall Risk information (goal and intervention) to shift report form.
Assess for presence of delirium, treat reversible causes, and use medication when appropriate to decrease patient distress
Move to room closer to nurse's station for better observation
Consider use of Geri-Chair
Consider a frequent toileting schedule
Observe patients at least every 30 minutes and assess need for assistance.
Frequent checks; 15-minute checks
Provide constant observation

Appendix C

"SPLATTS"

Keys to Enhance Fall Documentation

Symptoms experienced at the time of fall(s).

Previous number of falls or near falls

Location of fall(s)

Activity engaged in at time of fall(s)

Time (hour of day) of fall(s)

Trauma (physical and psychological) associated with fall(s)

Strategy to prevent next fall