Vermont Psychiatric Care Hospital Policy and Procedure

Fall Prevention

Revised: 07/2022	Review Date: 6/2024

POLICY

The Vermont Psychiatric Care Hospital (VPCH) shall objectively and systematically identify 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.

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

All 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. Fall risk will be reassessed and updated once daily, or with change in an individual's condition.

Assessment of Fall Risk – RN Responsibilities

1. Using the Edmondson Psychiatric Fall Risk Assessment assess hospitalized persons for fall risk upon admission to the hospital.
    a. The Edmondson tool is located within the Daily Assessment Flow Sheet in the Electronic Health Record. Each data field within the Fall Risk Assessment must be addressed to get an accurate score.
2. A score of 90 or greater signifies a high risk for falls and triggers an 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 90 on the assessment tool. In these cases, nurses will use their critical thinking skills 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 enter this information on the shift report form.
4. Reassess the hospitalized person's risk for falls at least once daily, 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.
    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 mutli-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. Complete Patient Event Report as directed in event reporting policy.
3. Document the fall in a High-Risk progress Note. See Appendix C: SPLATTS guidelines, for information on key fall reporting points.
4. Treatment plan will be updated and amended as needed.
5. Update the shift report form to include the change in fall risk and interventions, if any.

ATTACHMENTS

Appendix A: Edmondson Psychiatric 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	Emily Hawes Digitally signed by Emily Hawes Date: 2022.07.06 12:16:30 -04'00'	

APPENDIX A

EDMONSON PSYCHIATRIC FALL RISK ASSESSMENT ©	
Complete daily & upon admission * More than one item may be circled in each category if appropriate for the patient.	
Age **8** Less than 50 **10** 50-79 **26** 80-over	
Mental Status **-4** Fully alert/oriented at all times **12** Agitation/anxiety **13** Intermittently confused **14** Confusion/disorientation	
Elimination **8** Independent with control of bowel/bladder **12** Catheter/Ostomy **10** Elimination with Assist **12** Altered elimination (incontinence, nocturia, frequency) **12** Incontinent but Ambulates Independently	
Medications **10** No Medications **10** Cardiac Medications **8** Psychotropic Medications (including benzodiazepines and antidepressants) **- OR -** **12** Increase in these medications and/or PRN (psych, pain) medication received in the last 24 hours	
Diagnosis **10** Bipolar/ Schizoaffective Disorder **8** Substance abuse/Alcohol abuse **10** Major Depressive Disorder **12** Dementia/ Delirium	
Ambulation/Balance **7** Independent/Steady gait/Immobile **8** Proper Use of Assistive Devices (cane, walker, w/c) **10** Vertigo/Orthostatic Hypotension/Weakness **8** Unsteady/Requires Assist and Aware of Abilities **15** Unsteady but Forgets Limitations	
Nutrition **12** Has had very little food or fluids in the past 24 hours **0** No apparent abnormalities with appetite	
Sleep Disturbance **8** No Sleep Disturbance **12** Report of Sleep Disturbance by patient, family or staff	
History of Falls **8** No History of Falls **14** History of Falls in the last 3 months	
Total *(add all nine columns)* Score of 90 or greater signifies high risk for falls	

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