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| FALL PREVENTION PROGRAM | | | | NO. | |
| PURPOSE:  To provide specific guidelines regarding fall prevention including the “Falling Star Program”.  STATEMENT OF POLICY:  It is the policy of this facility to identify residents at risk for falls, develop plans of care that address the risk and implement procedures to assist in prevention of falls. The facility will also investigate accidents involving residents sustaining falls to identify possible cause and develop approaches to assist in preventing repeated falls.  The facility will provide training to staff regarding the Fall Prevention Program and encourage Responsible Party participation in assisting to develop interventions to reduce the risk for falls.  PROCEDURE:   1. Procedure for identifying residents who are at risk for falls. 2. On admission (within 4 hours), quarterly and with a significant change in status, the facility will complete a “Fall Risk Assessment”. (Briggs Form #CFS 6-17), which assesses mental status, history of falls, ambulation/elimination status, vision status, gait/balance, systolic blood pressure, medications and predisposing diseases, to identify residents that are at risk for falls. 3. The facility will also utilize the Minimum Data Set and the Resident Assessment Protocols to assist in identifying residents that are at risk for falls. The MDS and RAP’s will be completed according to the Federal Guidelines. 4. Procedure for implementation of preventive measures. 5. Residents that score 10 or above per the “Fall Risk Assessment”, representing high risk, will be identified by placing a “Falling Star” Visual Aid beside their door to alert staff as to their risk for falls. 6. Residents at high risk that are wheelchair mobile will be identified by placing a “Falling Star” Visual Aid on their respective wheelchairs. 7. The facility may identify and use other visual aids as appropriate and necessary. 8. Resident will remain on the “Falling Star Program” and the “Falling Star” Visual Aids will remain posted until both of the following criteria are met: 9. The resident has been maintained for 3 months without a fall AND 10. Per the “Fall Risk Assessment” and the MDS, the resident is no longer assessed as being at risk. 11. Resident and/or responsible party will be notified of the resident’s risk for falls and encouraged to assist with interventions to help prevent falls. 12. Nursing Administration/designee will be responsible for identifying residents that are at risk, posting visual aids and removing visual aids per policy. 13. Procedure for the evaluation and provision of safe environment for residents at risk for falls. 14. Assess the resident’s room on admission and as needed for potential safety hazards. 15. Provide adequate lighting in resident’s room and provide resident teaching, as appropriate, regarding ambulation in unlighted areas. | | | | | |
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| 1. Maintain bed in low and locked position when unattended. 2. Maintain clutter-free rooms and passageways, free from obstructions. 3. Eliminate throw rugs, mats and other tripping hazards. 4. Evaluate long oxygen tubing. While it allows for freedom of movement, it creates a hazard, especially if the tubing is clear. 5. Keep debris off the floor so that residents will not attempt to bend over and pick it up. 6. Maintain call-lights within reach and provide resident teaching, as appropriate, regarding use of the call-light system. 7. Keep frequently used items within the resident’s reach. 8. Assess the need for side rails and use side rails only when necessary to improve or maintain the resident’s functional status. 9. Assess the need for restraints and use when necessary to improve or maintain the resident’s functional status or to treat a medical symptom. 10. Maintain equipment and assistive devices in safe working order 11. Resident/responsible party will be notified of safety measures that have been implemented to reduce the risk for falls. 12. Procedure for investigation and follow-up of accidents involving falls. 13. Facility will complete an investigation for incidents which will include, but not limited to, assessment of the environment; equipment; contributing health history; medication history; attire (footwear and clothing); use of restraints; ambulatory status, including the use of assistive devices and toileting needs. 14. The Nursing Staff will initiate the Investigation after the incident. 15. Interventions will be implemented in an attempt to prevent the resident from sustaining repeated falls. 16. Residents who have falls with head injury or un-witnessed falls will have neurologic checks done per policy. The exception to this would be if the resident is alert and oriented and denies that they hit their head and there is no evidence of head injury. 17. Notification of family and physician will be done when falls or other incidents occur, within a reasonable amount of time. 18. Problems related to falls will be noted on the Care Plan with goals and interventions. The Care Plan will be updated after falls. 19. The Director of Nursing/designee, the Administrator and the IDT in the morning stand-up meetings will review the investigations. 20. Falls with injury will be reported per State specific guidelines. 21. Procedure for documentation of information regarding Incident/Accidents involving falls. 22. Nursing Staff will complete an Accident/Incident Report after the fall. 23. Nursing Staff will initiate the Accident/Incident Investigation after fall. 24. Nursing Staff will document the incident in the “Nurses Notes” portion of the Medical Record. The documentation will include the notification of family and physician and any new interventions which will be put in place to deter further falls. 25. Neurologic checks will be documented on the form for Neurologic Checks in the medical record. Follow Neurologic Check Policy and Procedure. | | | | | |
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| 1. Nursing Staff will document appropriate interventions of the Resident’s Care Plan after the fall. 2. Director of Nursing or Designee will document the fall in Risk Watch. 3. Nursing staff will document in the “Nurses Notes” portion of the medical record (at least every shift), the condition of the resident for at least 72 hours post-fall. Chart will be placed on Hot Rack. 4. Procedure for Staff/Resident/Responsible Party Education regarding the “Fall Prevention Program”. 5. The facility will provide training to staff regarding the fall prevention program at least annually, including reasons and risks for falls, interventions specific to their discipline to reduce the risk for falls and documentation procedures. (See attached training tools). 6. Facility will provide training to new employees during orientation regarding the fall prevention program, including reasons and risks for falls, interventions specific to their discipline to reduce the risk for falls and documentation procedures. (See attached training tools). 7. Facility will educate the resident/responsible party regarding the resident’s increased risk for falls, involved resident/responsible party in decisions regarding interventions, and inform resident/responsible party regarding safety measures that are implemented. 8. Families will be give a Fall Fact and Statics sheet upon admission of the resident to the facility. (See attached letter). 9. Families that are not able to attend the care planning session will be sent a copy of the fall care plan and will be asked for their input on interventions for the prevention of falls for the resident. (See attached letter).   ATTACHMENTS:   1. Nursing Alert 2. Test for Balance Tool 3. Reasons and Risks for Falls in the Elderly 4. Fall Protocol 5. Letter to Families 6. Care plan letter | | | | | |
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