ATTENTION NURSES:

We have made some changes to our current policy regarding immediate treatment following a fall. It is not only good practice, but the Department of Health states that when a resident experiences a fall, interventions MUST be put into place immediately following to prevent further falls. To assist with this process I have collaborated with members of IDT to develop a Fall Decision Tree (attached you will find a copy).

When a resident experiences a fall the following procedure will be completed:

1. Nurse will pull the Assumption Home Fall Report.
    a. This form has been revised:
        i. The first side of the form is similar to the previous form. It includes the following:
            1. Resident information.
            2. Type of fall.
            3. Witness.
            4. Care Plan Compliance:
                a. This would indicate whether ALL interventions in resident's plan of care were being followed.
            5. Physical Device Use:
                a. Alarms
                b. Side Rails
                c. Raised Mattress
                d. Rising restrictive device: any device that inhibits resident from coming to standing position (lap buddy, seat belt, etc).
            6. Description of Occurrence:
                a. This should indicate a description of the fall as reported by witness and/or resident.
            7. Family Notification.
            8. Nurse Signature.
            9. IDT Review: This is only to be completed by IDT during safety analysis.
        ii. The second side of form includes the Fall Decision Tree.
            1. When a resident falls the nurse must implement the fall decision tree and complete all necessary interventions.
            2. Immediate fall treatment:
                a. Vitals Signs:
                    i. Nurse will obtain vital signs and document.
                        1. If hypotensive the nurse will encourage resident to change positions slowly.
                        2. If decreased oxygen saturations is noted, nurse will administer O2 per S.O. or ensure placement of existing oxygen.

b. BS: If resident is diabetic, nurse will obtain blood glucose level.
    i. If <60 and resident is not alert→nurse will administer glucagon per S.O.
    ii. If <60 and resident is alert→nurse will administer carbohydrate snack.
    iii. If >400→nurse will update MD.
c. Pain:
    i. If resident presents with complaints of pain, nurse is provided with interventions to implement:
        1. Analgesic administration
        2. Cold compress
        3. Distraction
d. ROM:
    i. Alteration noted from resident baseline→ nurse will update MD.
e. Extremity Appearance:
    i. Rotations or deformities noted→do not move resident and update MD.
f. Head contusion:
    i. Start Neuros
        1. If neuros are altered or resident is on anticoagulation therapy→nurse will update MD.
g. Skin:
    i. If impairment noted related to fall→cleanse with NS and dress appropriately→update RN for further assessment.

3. Notice that if you note no alteration in any category there is an arrow indicating this with box which MUST be initialed to demonstrate completeness
4. All arrows from the above initial treatment interventions then guide the nurse to the additional fall prevention interventions. The nurse will utilize additional interventions as a guide to implement interventions that would assist in the prevention of further falls until assessment can be completed by registered nurse.
    a. Environmental Interventions:
        i. Non-skid footwear applied.
        ii. Monitoring equipment placement:
            1. Tubing
            2. Wheelchair
            3. Walker

4. Bed

iii. Increase lighting
iv. Reduce environmental clutter
v. Secure rugs

b. Activity Involvement:
   i. Engage resident in meaningful recreational activity.
   ii. Assistive Device Use
      1. Ensure use of assistive devices.
      2. Ensure function and use of mobility alarms.

c. Sensory perception:
   i. Application of corrective lenses and/or hearing aids.

d. Behavior:
   i. Physical Redirection
   ii. Safety Reminders
   iii. Distraction
   iv. Verbal Redirection
   v. If the above fail:
      1. May utilize pharmacological interventions when applicable.

e. Exploration of Needs:
   i. Nurse will collect data regarding resident needs at time of fall and intervene to meet needs.

iii. The Fall Decision Tree is meant to be a guide and documentation tool simultaneously. Each box will have a small line where initials or data can be charted to ensure implementation of interventions or collection of data...so PLEASE complete. Remember if it's not documented it's NOT done.
iv. The interventions provided MUST be communicated in report.
v. The nurse will then complete the progress note in PCC entitled "FALL." There have been some minor changes made to this template including:
   1. Time of fall.
   2. Description of Extremity Appearance.
   3. Immediate interventions provided (Top of Decision Tree).
   4. Fall prevention interventions provided (Bottom of Decision Tree).
vi. The Fall Report/Fall Decision Tree will then be routed to the RN's.

2. Attached you will see a copy of The Fall Report and Decision Tree...please review. This will begin Monday the 15th!!!!!

FALL DECISION TREE/FALL INCIDENT REPORT EDUCATION

I have reviewed the attached information regarding the FALL DECISION TREE/FALL INCIDENT REPORT and by signing am confirming understanding of the materials.

SIGNATURE:_____

DATE:_____

IMMEDIATE FALL INTERVENTION

FALL

- v/s
  BP_____ P_____T_____R_____O2_____
  - Hypotensive: Encourage to change positions slowly _____
  - O2 Sats < 90% on RA→Admin O2 per SO. _____
    Ensure placement of O2. _____
- DIABETIC: BS_____
  - <60 –not alert→ Glucagon per SO. _____
    - OR
    - <60- alert→ Carb Snack _____
  - >400- Call MD _____
- PAIN
  - No c/o- O/10 on FLACC _____
  - Pain: 0-10:___ FLACC: _____ Site: _____
    - Analgesic Administered _____
    - Cold Comp-ress _____
    - Distraction _____
- ROM
  - Alteration from base-line.
    - Update MD _____
- EXTREMITY APPEARANCE
  - Per base-line _____
  - Rotations or deformities DON'T MOVE RESIDENT
    - Update MD _____
- HEAD CONTUSION
  - Start Neuros _____
    - Alterations or Anti-coagulation use→ Update MD _____
  - No Impair-ment. _____
- SKIN
  - Skin Impairment r/t Fall. _____
    - Cleanse with NS and Dress appropriately. _____
      - Update RN

ADDITIONAL PREVENTION INTERVENTIONS

ENVIRONMENTAL

- Non-skid footwear _____
- Equipment Placement→ Tubing Wheelchair Walker Bed _____
- Increase Lighting _____
- Reduce Environme-ntal Clutter _____
- Secure Rugs _____

SENSORY PERCEPTION

- Corrective Lenses Applied _____
- Hearing Aids Applied _____

EXPLORATION OF NEEDS

Collect data regarding resident needs and meet needs- (attempting to toilet, reaching for item, hunger, thirst, etc):

_____
_____
_____
_____
_____
_____

BEHAVIORAL INTERVENTIONS

Res presenting with behaviors contributing to falls-anxiety, self-transfer attempts, physical aggression, verbal aggression.

- Physical Redirection _____
- Safety Reminders _____
- Distraction _____
- Verbal Redirection _____

Pharmacological Interventions when applicable- if non-pharmacological interventions are deemed ineffective.

ACTIVITY INVOLVEMENT

Engage resident in meaningful recreational activity:

_____
_____
_____
_____
_____
_____

ASSISTIVE DEVICE USE

- Ensure use of walker/brace/amb aid/positioning devices. _____
- Ensure use and function of mobility alarms when applicable. _____

Document all interventions provided and the efficacy in progress notes

ASSUMPTION HOME
FALL REPORT
(REVISED 2010)

Resident Name:_____ Date:_____ Medical Record #:_____

Type of FALL:
☐ FALL-(Any un-intentional placement to ground.) ☐ Intercepted FALL ☐ FALL from Low Bed

Witness: ☐ YES ☐ NO Witness:_____

Care Plan Compliance: ☐ YES ☐ NO→Review of Fall Prevention Plan with staff involved. Sig:_____ Date:_____

Physical Device Use: ☐ YES ☐ NO

IF YES→ ☐ BED ALARM ☐ CHAIR ALARM ☐ TAB ALARM ☐ RAISED EDGE MATTRESS
☐ ½ SIDE RAIL ☐ FULL SIDE RAIL ☐ RISING RESTRICTIVE DEVICE ☐ OTHER:_____

DESCRIPTION OF OCCURRENCE:

_____
_____
_____
_____

FAMILY NOTIFICATION: _____ DATE/TIME: _____
NURSE SIGNATURE: _____ DATE/TIME:_____

IDT REVIEW:
Director of Nursing SIGNATURE/DATE: _____
Administrator SIGNATURE/DATE: _____
Additional IDT Members:

_____
_____
_____