

POLICY & PROCEDURE	DATE ISSUED: 9/2009	SUBJECT: FALL PREVENTION: IDENTIFICATION AND MANAGEMENT OF INDIVIDUALS AT RISK		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION	DATE REVISED*: October 2012	SECTION:	POLICY NUMBER: Nursing: Med Staff:	Page(s) Number 1 of 4

**PURPOSE:** To outline the process for risk assessment, prevention and management to prevent injury or harm related to falls:

- To protect patients and promote patient safety
- To effectively identify and intervene with patients who are at risk for falling
- To educate patients, families, and staff members on measures to prevent falls and promote safety.

**GOAL:** All patients will be assessed for risk of falling upon admission, with reassessments routinely performed to determine ongoing need for fall prevention precautions. Fall prevention interventions will be appropriate and implemented based on the assessed patient need.

**DEFINITION:** A fall is an unintended/uncontrolled event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or is reported to have landed on the floor (unwitnessed). When a person *chooses* to put himself or herself on the floor or lower level, *this is not a fall*.

**RESPONSIBILITY:** All staff members are responsible for implementing the intent and directives contained within this policy, and for creating a safe environment of care. All staff are to be aware of their responsibility in preventing patient falls from occurring. BHD leadership and Environmental Services are responsible to ensure that a safe environment of care is maintained.

**PROCEDURE:** All patients have some degree of risk of falling. Certain patients are at increased risk of falling (See Fall Risk Factors, Interventions and Prevention Strategies attachment.)

1. **General fall prevention strategies** are implemented as an integral part of BHD's fall prevention program:

- a. Orient the patient to their surroundings and instruct the patient to request assistance as needed.
- b. Ensure the patient's footwear is adequate; if no footwear is available provide treaded socks.
- c. Ensure that the pathway to the bathroom is free of obstacles and properly lighted.
- d. Ensure that patient care accessible areas are clear of obstacles and free of excessive clutter.
- e. Keep personal items accessible and place assistive devices such as walkers and canes within the patient's reach. Implement and utilize prescribed ambulation strategies (use of gait belt, ambulate with staff assist, etc)
- f. Evaluate the patient's chair and bed height for safety.
- g. Consider peak effect for prescribed medications that affect level of consciousness, gait and elimination when planning care.
- h. Lock wheels on all wheelchairs, beds, commodes, etc.
- i. Wipe up spills immediately and observe environment for potentially unsafe conditions. Notify appropriate department(s) of hazardous conditions.
- j. Ensure adequate lighting
- k. Collaborate with the patient and family regarding an individualized plan of care to prevent falls. Encourage the patient's active involvement in their own care as a fall reduction strategy.

2. **Fall Risk Assessment** is completed:

- On admission to the facility
- Following a fall
- Upon significant change in condition or change in medication regimen increasing risk of a fall
- A minimum of quarterly in the Rehabilitation Centers

The RN and/or appropriate disciplinary team member is responsible for establishing and updating the individual plan of care related to safety and fall prevention. Interventions will be documented in the medical

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record. The patient and family, if available, will be consulted for assistance with individualizing fall prevention interventions.

a. **Upon admission:** The adult patient is assessed for their risk of falling utilizing the Morse Fall Scale. Children are assessed using the I'M SAFE pediatric tool. If the patient is assessed to be at risk of falling (Morse score of 25 or greater):

- i. Initiate appropriate interventions (see attachment) to minimize the patient's risk of falling.
- ii. Refer for evaluation by PT/OT as determined by treatment team
- iii. Identify appropriate interventions on patient's care plan.
- iv. **Communicate risk to team members** (report, shift to shift report, patient handoffs, rounds sheets, communication/bed/census boards)
- v. Apply fall risk wrist band to the patient's wrist and instruct the patient on the patient safety strategy.
- vi. Initiate use of the Falling Leaf Logo to communicate risk:
  1. At the head of the bed (if applicable)
  2. On the spine of the chart
  3. On the room door



▪ **Ongoing risk assessment:** The patient is re-evaluated utilizing the Morse Fall Scale to determine fall risk if there is a fall, a significant change in condition or medication change increasing risk of a fall and per program requirements (see 2 above).

3. **Fall Occurrence and Post Fall Procedures/Management:** There are three key elements of post fall procedures/management.

- **Initial post-fall assessment:** Assess the patient and provide emergency care as appropriate.
- **Conduct a Post-Fall Huddle:** Quickly assemble the team to find out what happened.
- **Documentation, Follow-up and Post-Fall Management**
  - a. **Initial Post Fall Assessment:** Implement emergency medical interventions as appropriate and ensure patient safety. Patients experiencing a fall with loss of consciousness or injuries exceeding minor hematomas and lacerations require medical clearance. Do not move the patient until injuries are identified, and until safety of movement is assured by the licensed staff. The first priority is to safeguard the patient and assess the patient for any obvious injuries
  - b. **Post-Fall Huddle:** The next step is to find out what happened by conducting a Post-Fall Huddle and documenting findings on the Patient Fall Incident Report. The huddle should include the RN, LPN, CNA's, the manager, Rehabilitation Services staff, the patient/family as appropriate/available and any other staff having information about the patient that are available. The information needed (in SBAR format) is:
    - i. Date/time and exact location of fall
    - ii. Patient's and any witness's description of fall (if possible)
    - iii. What the patient was trying to do at the time of the fall
    - iv. What factors may have contributed to the fall
    - v. Fall risk factors and precautions in place at the time of the fall
    - vi. Severity of injury
    - vii. Recommendations for interventions/revisions to plan of care to safeguard patient and prevent another fall
  - c. **Documentation, Follow-up and Post-Fall Management:** Following the post-fall assessment, huddle and any immediate measure to protect the patient:
    - i. A Fall Incident Report should be completed per Incident/Risk Management Reporting Guidelines.

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- ii. A detailed progress note should be entered into the patient's record. Document what occurred in the progress notes including: patient appearance at time of discovery, patient response to event (including pain), evidence of injury, location, medical provider notification, additional notifications as appropriate and medical/nursing actions.
- iii. Refer the patient for further evaluation by physician/APNP if indicated to ensure other serious injuries have not occurred
- iv. Notify the family/guardian
- v. Notify Nursing Program Coordinator/Administrative Resource
- vi. Review fall prevention interventions, modify care plan as appropriate and refer to the interdisciplinary treatment team
- vii. Initiate referral for evaluation by PT/OT as clinically indicated. Consult Physical Therapist for additional suggestions for changes to plan of care
- viii. **Communicate to all shifts and staff that the patient has fallen and is at risk to fall again. Implement Change of Condition assessment/intervention/evaluation as indicated and/or ordered.**

**POST-FALL MANAGEMENT PROTOCOL (for a minimum of 48 hr. following the fall)**

**Patient Experiencing a Fall without striking head or neck:**

1. Determine vital signs to include sitting/standing blood pressure and pulse.
2. If diabetic, check blood glucose
3. Determine circumstances leading to the fall with corrections.
4. For the 48 hours following the fall:
  - a. Obtain vital signs every 8 hours
  - b. Observe for possible injuries not evident at the time of the fall (limb reflex, joint range of motion, weight bearing, etc.)
  - c. Observe for mental status changes
  - d. Monitor/assess if restrictions in mobility appear warranted due to the fall
5. At 48 hr. post fall evaluate the need to continue additional monitoring.
6. All falls will be reported to the attending physician or nurse practitioner and the NPC/AR as soon as possible

**Patient Experiencing a Fall involving striking the head or neck:**

1. Use the same protocol outlined above and, in addition:
  - a. Perform neuro-checks every two hours for the first 12 hours, and then
  - b. Every four hours while awake for the next 36 hours.
2. Alert the attending physician for any changes.
3. Alert attending physician for all falls with head involvement in patients receiving anticoagulants.
4. At 48 hr. post fall evaluate the need to continue additional monitoring.
5. All falls will be reported to the attending physician or nurse practitioner and the NPC/AR as soon as possible

**FALL PREVENTION PROGRAM EVALUATION:** BHD will evaluate the fall reduction program on an on-going basis to determine the effectiveness of the program.

1. Each BHD program will complete a fall aggregated analysis every 6 months to review trends and identify opportunities for improvement.
2. An individual Root Cause Analysis (RCA) will be completed for any falls that are determined to be high risk events or sentinel events.

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Approved by:

\_\_\_\_\_  
Dr. Thomas Harding, MCBHD Medical Director

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Dr. Dawn Puls, Physical Care Medical Director

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Cheryl. Schloegl, Associate Administrator of Nursing

Revised 10/12/12

**Attachments:**

**#1: Use of the Morse Fall Risk Assessment**

**#1a I'M SAFE Pediatric Fall Assessment Tool**

**#2: Fall Risk Factors, Interventions and Prevention Strategies**

**#3: BHD Patient Fall/Risk Management Report**

**References:**

The Joint Commission: NPSG.09.02.01, Reduce the risk of patient harm resulting from falls.  
 Boushon B, Nielson G, Quigley P, Rutherford P, Taylor J, Shannon D. *Transforming Care at the Bedside How-to-Guide: Reducing Patient Injuries from Falls*. Cambridge, MA: Institute for Healthcare Improvement: 2008.  
 Root causes tips strategies for addressing the top three root causes of falls. *Joint Commission Journal on Quality and Safety* [serial online]. June 2003; 3(6):5  
 Morse, J.M. (1997). Preventing patient falls. Thousand Oaks: Sage Broda. 1999  
 Safety operating instructions.  
 Pediatric Falls: State of the Science: Child Health Corporation of America Nursing Falls Study Task Force, 2009  
 VA National Council on Patient Safety (NCPS) Fall Prevention Tool Kit May 2004.

**Attachment #1:**

**Use of the Morse Fall Risk Assessment**

**Procedure:**

Obtain a Morse Fall Scale Score by using the variables and numeric values listed in the "Morse Fall Scale" table below. (Note: Each variable is given a score and the sum of the scores is the Morse Fall Scale Score. Do not omit or change any of the variables. Descriptions of each variable and hints on how to score them are provided below.) The "Total" value obtained is recorded in the patient's medical record.

**Morse Fall Scale**

Variables	Numeric Values	Score
1. History of falling	No	0
	Yes	25
2. Secondary diagnosis	No	0
	Yes	15
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture		0
		15
		30
4. IV or IV Access	No	0
	Yes	20
5. Gait Normal/bed rest/wheelchair Weak Impaired		0
		10
		20
6. Mental status Oriented to own ability Overestimates or forgets limitations		0
		15

**Morse Fall Scale Score = Total \_\_\_\_\_**

**Morse Fall Scale Descriptions and Scoring Hints**

1. **History of falling**
  - Scored as 25 if the patient has fallen during the present hospital admission or if immediate history of physiological falls, such as from seizures or impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.
2. **Secondary diagnosis**
  - This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.
3. **Ambulatory aid**
  - Scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this variable scores 15; if the patient ambulates clutching onto the furniture for support, score this variable 30.
4. **IV or IV Access**
  - This is scored as 20 if the patient has an IV apparatus or a saline/heparin lock inserted; if not, score 0.
5. **Gait**
  - The characteristics of the three types of gait are evident regardless physical disability/underlying cause.
    1. Normal gait: patient walks with head erect, arms swing freely at side, and strides without hesitation. This gait scores 0.
    2. Weak gait (score 10), patient is stooped but is able to lift the head while walking without losing balance. If support from furniture is required, this is with a featherweight touch almost for reassurance, rather than grabbing to remain upright. Steps are short and the patient may shuffle.
    3. Impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair and/or bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance. Steps are short and the patient shuffles.
    4. If the patient is in a wheelchair or on bed rest, the patient is scored according to the gait he or she used when transferring from the wheelchair to the bed.
6. **Mental status**
  - Mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?" If the patient's reply is consistent with assessed abilities/limitations, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with abilities or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and is scored as 15.

Risk Level	Morse Fall Scale Score	Action
Low Risk	0 – 24	Implement <b>Low Risk</b> Fall Prevention Interventions
Medium Risk	25 – 44	Implement <b>Medium Risk</b> Fall Prevention Interventions
High Risk	45 and higher	Implement <b>High Risk</b> Fall Prevention Interventions and Falling Leaf

Attachment 1a

## I'M SAFE

### Pediatric Fall Assessment Tool

The patient's risk for falling is assessed at admission. The patient is reassessed upon significant change in condition or medication change increasing risk of fall.

Fall Risk Score Criteria	Score if Present	Score if Not Present	Score Assigned to Patient
<b>I</b> mpairment (OT/PT service involved, orthostatic/dizzy)	1	0	
<b>M</b> edications (seizures medications or narcotics)	2	0	
<b>S</b> edation/anesthesia within the previous 24 hours	2	0	
<b>A</b> dmitting diagnosis (neuro or ortho diagnosis)	1	0	
<b>F</b> all History	1	0	
<b>E</b> nvironment of care (restraints, oxygen, Foley catheter, other per RN judgment)	1	0	
<b>Fall risk score</b> (Sum of the scores for each criteria)			

**Fall Risk Score = 1 or 2:** patient is considered to be at **moderate risk** for falling. Interventions usually include:

- 1) Some assisting with activity/mobility per the patient's individualized care plan.
- 2) Reinforcing patient/family education regarding fall prevention and individualized care plan.
- 3) Communication of fall risk status to the next provider of care.
- 4) Orient patient/family to request help with ambulation.

**Fall Risk Score = 3 or greater,** the patient is considered to be at **high risk** for falling. Interventions usually include:

- 1) Assistance with activity/mobility.
- 2) Reinforcing patient/family education regarding fall prevention and individualized care plan.
- 3) Periodic assessing of elimination needs.
- 4) Close observation particularly when in a wheel chair or out of bed; this includes not allowing the patient to ambulate without assistance.
- 5) Assessing need for 1:1 observation.
- 6) Accompanying patient with ambulation and transfers especially when related to elimination needs.
- 7) Educating on risk factors and the related care plan.
- 8) Communication of fall risk status to the next provider of care.

Person completing: \_\_\_\_\_  
Signature/Date/Time

## Attachment 2

### FALL RISK FACTORS, INTERVENTIONS and PREVENTION STRATEGIES

It is generally accepted that patient falls are caused by multiple factors. A popular classification scheme of falls is based on the assumption that they result from a complex interaction of intrinsic and/or extrinsic risk factors.

**Intrinsic risk factors** (i.e., integral to the patient's system, many of which are associated with age-related changes):

- **Previous fall** - studies have cited a history of falls as the most significant factor associated with patients being more likely to fall again.
- **Reduced vision** – vision affected by, for example, a decline in visual acuity, decreased night vision, altered depth perception, decline in peripheral vision, or glare intolerance.
- **Unsteady gait** - manner and style of walking.
- **Musculoskeletal system** – impact from factors such as muscle atrophy, calcification of tendons and ligaments, and increased curvature of the spine (osteoporosis) are associated with ability to maintain balance and proper posture.
- **Mental status** – status affected by confusion, disorientation, inability to understand, and impaired memory.
- **Acute illnesses** – rapid onset of symptoms associated with seizures, stroke, orthostatic hypotension, and febrile conditions.
- **Chronic illnesses** - conditions such as arthritis, cataracts, glaucoma, dementia, diabetes and Parkinsonism.

**Extrinsic risk factors** (i.e., external to the system and relating to the physical environment):

- **Medications** - those that affect the central nervous system, such as sedatives and tranquilizers, benzodiazepines, and the number of administered drugs.
- **Bathtubs and toilets** – equipment without support, such as grab bars.
- **Design of furnishings** – height of chairs and beds.
- **Condition of ground surfaces** - floor coverings with loose or thick-pile carpeting, sliding rugs, upended linoleum or tile flooring, highly polished or wet ground surfaces.
- **Poor illumination conditions** - intensity or glare issues.
- **Type and condition of footwear** - ill-fitting shoes or incompatible soles such as rubber eraser soles, which, though slip resistant, may stick to linoleum floor surfaces.
- **Improper use of devices** - bedside rails and mechanical restraining devices that may actually increase fall risk in some instances.
- **Inadequate assistive devices** - walkers, wheelchairs and lifting devices.

### INTERVENTIONS and PREVENTION STRATEGIES

#### General safety interventions

Given the numerous intrinsic and extrinsic factors leading to falls, it is possible to consider each factor and identify positive steps and safe interventions proven effective for preventing falls. A few examples of general interventions might be helpful before discussing measurement and development processes for risk assessment or a comprehensive program to reduce fall incidents.

#### Interventions:

- **Orient the patient to their surroundings** and instruct the patient to request assistance as needed.
- **Ensure adequate lighting**
- **Ensure the patient's footwear is adequate**; if no footwear is available provide treaded socks
- **Ensure that the pathway to the bathroom is free of obstacles and properly lighted** and that all patient care accessible areas are clear of obstacles and free of excessive clutter.
- **Keep personal items accessible and place assistive devices such as walkers and canes within the patient's reach.**
- **Evaluate the patient's chair and bed height for safety.**
- **Consider peak effect for prescribed medications** that affect level of consciousness, gait and elimination when planning care.
- **Lock wheels on all wheelchairs, beds, commodes, etc.**
- **Wipe up spills immediately and observe environment for potentially unsafe conditions.** Notify appropriate department(s) of hazardous conditions.
- **Collaborate with the patient and family regarding an individualized plan of care to prevent falls.** Encourage the patient's active involvement in their own care as a fall reduction strategy.

### Suggested High Risk Fall Prevention Interventions

These interventions are designed to be implemented for patients with multiple fall risk factors and those who have fallen. These interventions are designed to reduce severity of injuries due to falls as well as to prevent falls from reoccurring, supplementing standard fall prevention interventions. The interventions are suggestions to aid in the decision-making for the client.

Suggested Intervention Strategies									
Intervention	Level of Risk			Area of Risk					
	High	Med	Low	Frequent Falls	Altered Elimination	Muscle Weakness	Mobility Problems	Multiple Medications	Depression
Low beds	X	X	X	X	X	X	X	X	X
Non-slip grip footwear	X	X	X	X	X	X	X	X	X
Assign patient to bed that allows patient to exit toward stronger side	X	X	X	X	X	X	X	X	X
Lock movable transfer equipment prior to transfer	X	X	X	X	X	X	X	X	X
Individualize equipment to patient needs	X	X	X	X	X	X	X	X	X
High risk fall room setup	X	X		X	X	X	X	X	X
Non-skid floor mat	X	X		X	X	X	X	X	X
Medication review	X	X		X	X	X	X	X	X
Exercise/strengthening program	X	X		X	X	X	X	X	X
Toileting plan/worksheet	X	X			X				
Falling Bear initiated/AD-band	X			X	X	X	X	X	X
Perimeter mattress	X			X	X	X	X		
Hip protector garment	X			X		X	X		
Bed/chair alarm	X			X		X	X		
Use of wheel chair Lap Buddy	X			X		X	X		

Note: this list is not all-inclusive, nor is it required to be used. Clinicians should use their best judgment in implementing recommendations based on the patient assessment. (Source: VHA NPCS Toolkit, May 2004)

**PATIENT FALL Incident/risk Management Report**  
**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION**

**(PLEASE PRINT)** Quality Management No. \_\_\_\_\_  
**SEE INSTRUCTIONS ON BACK OF LAST PAGE**

1. DATE of FALL	2. TIME	3. LOCATION of INCIDENT		
		Unit	Program	Room
		Area		
4. NAME OF PERSON/S INVOLVED (Last, First, Initial)	5. Patient(P) Employee(E) Visitor(V), Security/Contract (S/C) Student Volunteer		6. MEDICAL RECORD NUMBER	7. Visitors, Students or Volunteers: A. Home Address _____ City _____ State _____ Phone _____  For QA Use
A.	<input type="checkbox"/> P <input type="checkbox"/> E <input type="checkbox"/> S/C <input type="checkbox"/> V <input type="checkbox"/> Studnt <input type="checkbox"/> Volunteer			
B.	<input type="checkbox"/> P <input type="checkbox"/> E <input type="checkbox"/> S/C <input type="checkbox"/> V <input type="checkbox"/> Studnt <input type="checkbox"/> Volunteer			
<b>SITUATION</b> Was fall witnessed? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>By whom:</b> _____ _____		<b>Location of fall:</b> <input type="checkbox"/> Bedroom <input type="checkbox"/> Bathroom <input type="checkbox"/> Day Room <input type="checkbox"/> Hallway <input type="checkbox"/> Other: _____	<b>Patient fell:</b> <input type="checkbox"/> From Bed <input type="checkbox"/> From Chair <input type="checkbox"/> From toilet/commode <input type="checkbox"/> From standing position <input type="checkbox"/> Other:	<b>Reason for fall per patient interview</b> <b>What happened?</b>  <b>What were you trying to do?</b>  <input type="checkbox"/> NA: patient non-verbal/unable to answer

**Contributing factors: Please check all that apply**

<b>Environment</b> <input type="checkbox"/> Evidence of slippery/wet floor <input type="checkbox"/> Lighting in room poor <input type="checkbox"/> Clutter on floor <input type="checkbox"/> Improper bed height <input type="checkbox"/> Wheelchair unlocked <input type="checkbox"/> Wheelchair footrests in the way <input type="checkbox"/> Improper use of assistive device <input type="checkbox"/> Clothing or bed sheet interfered/too long <input type="checkbox"/> Ill fitting shoes <input type="checkbox"/> Untied laces	<input type="checkbox"/> Bare feet or stocking feet <input type="checkbox"/> Obstructed path/furniture, etc. <input type="checkbox"/> Bed alarm not working <input type="checkbox"/> Chair alarm not working <input type="checkbox"/> Supervision/staffing issues <b>Activity/Patient factors</b> <input type="checkbox"/> Reaching for item out of reach <input type="checkbox"/> Trying to get to the bathroom <input type="checkbox"/> Trying to get out of bed	<input type="checkbox"/> Agitation or confusion <input type="checkbox"/> Altered gait/balance <input type="checkbox"/> Altered ability to perform ADL's <input type="checkbox"/> Faint/dizzy/weak/fatigue <input type="checkbox"/> New/change in BP meds <input type="checkbox"/> New/change in pain meds <input type="checkbox"/> New/change in psychotropic meds <input type="checkbox"/> Change in BP <input type="checkbox"/> Change in mental status/behavior <input type="checkbox"/> Change in mobility status <input type="checkbox"/> Other:
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**BACKGROUND (fall risk factors, precautions in place at time of fall)**

<b>Patient's fall risk factors</b> <input type="checkbox"/> Prior fall history (home, previous facility or during this stay) <input type="checkbox"/> Medication changes within past 2 days <input type="checkbox"/> Impaired mobility <input type="checkbox"/> Impaired mentation <input type="checkbox"/> Impaired communication <input type="checkbox"/> Active change in condition <input type="checkbox"/> Impaired/altered elimination patterns (nocturia, urgency, frequency, diarrhea, incontinence) <input type="checkbox"/> Other:	<b>Fall precautions in place at time of fall:</b> <input type="checkbox"/> Falling Leaf <input type="checkbox"/> Bed/Chair Alarm on <input type="checkbox"/> 1:1 supervision <input type="checkbox"/> Lap Buddy <input type="checkbox"/> Low bed <input type="checkbox"/> Mat at bedside <input type="checkbox"/> Room close to nurses station <input type="checkbox"/> Patient teaching <input type="checkbox"/> Other:
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**ASSESSMENT and Immediate Actions taken:**

_____ _____ _____	<b>Fall resulted in:</b> <input type="checkbox"/> no injury <input type="checkbox"/> injury requiring minor first aid <input type="checkbox"/> injury requiring treatment greater than first aid (includes x-ray, head injury with need for ongoing neuro checks, ER visit or Code 4)
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**RECOMENDATION:** What can we do to prevent this from happening again? *Review and revise Care Plan as appropriate.*

<input type="checkbox"/> More frequent rounding/supervision <input type="checkbox"/> Toileting plan <input type="checkbox"/> Assess for low bed, mat, bed/chair alarm <input type="checkbox"/> Assess for Lap Buddy <input type="checkbox"/> Non-slip footwear	<input type="checkbox"/> Use of hip protector garment <input type="checkbox"/> Use of mechanical lift device <input type="checkbox"/> Initiate Falling Leaf <input type="checkbox"/> Improve wheelchair positioning <input type="checkbox"/> Move room closer to nurses' station	<input type="checkbox"/> Remove clutter/identify items pt. wants nearby <input type="checkbox"/> Patient education re risk/strategies <input type="checkbox"/> PT/OT evaluation <input type="checkbox"/> Request review of medications Other:
Physician: _____ Date/time _____ RN: _____	<b>Notifications:</b> Date/time _____ AR/NPC: _____ Guardian: _____	Administrator: _____ Date/time _____ SW/QMRP: _____

**REPORT COMPLETED BY**

PRINT NAME AND TITLE	SIGNATURE	PHONE NUMBER	DATE & TIME
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**MANAGEMENT REVIEW**

Findings/Recommendations \_\_\_\_\_  Administrator/Designee notified for Sentinel Event

Print Name and Title	Signature	Phone Number	Date & Time
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**ADMINISTRATOR/DIRECTOR REVIEW**

**PATIENT FALL INCIDENT/RISK MANAGEMENT REPORT  
GENERAL INSTRUCTIONS**

**Conducting a BHD Post-Fall "Huddle" and completing Patient Fall Incident Report**

Within 15-30 minutes of a patient fall, the RN will gather team members (including patient, support staff who witnessed fall, etc.) to review the event and identify interventions to prevent another fall for this patient. Do not place form in the medical record.

**PLEASE PRINT** all information being described/identified on this form.

**DO NOT** put a copy of the Incident/Risk Management Report in the patient/resident's medical record.

**COMPLETE** this form and make sure that your supervisor or designee has received it before the end of your shift and before you leave the premises.

SEE Milwaukee County Behavioral Health Division Policy and Procedure for Incident Reporting for additional instructions.

**DO NOT** complete this form for incidents other than patient falls.

**Post-fall interventions that also must be addressed:**

- Perform post fall monitoring
- Revise plan of care to include prevention strategies and recommendations based on HUDDLE review.
- Communicate fall and increased risk to physician, next shift, other team members, family/guardian (if applicable)

**SPECIFIC INSTRUCTIONS FOR EACH ITEM**

1: Print the date of incident.

2: Print the time incident occurred; use military (24-hour) time.

3a: Print the location of the incident, indicate program and unit.

3b: Record room, area or any other location.

4: Print the name of each person involved in the incident (do not list witnesses here). If more than three individuals are involved, use another form.

5: Check if patient/resident (P), employee (E), visitor (V), security or contract personnel (S/C), student (Student), or volunteer involved in the incident.

6: If a patient was involved, the medical record number must be listed.

7: If a visitor, student or volunteer was involved please record home address, city, state, and phone number here.

**FALL** – A fall is an unintended/uncontrolled event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or is reported to have landed on the floor (unwitnessed). When a person *chooses* to put himself or herself on the floor or lower level, *this is not a fall*.

**Describe the incident:**

- Check all contributing factors that apply related to patient's activity and environment at time of the fall
- Indicate fall risk factors and fall precautions in place at the time of the fall
- Describe patient assessment and immediate actions taken
- Document recommendations to prevent another fall/care plan recommendations

**Notifications to complete as soon as possible after the incident**

-For Patient/Resident Fall, notify the physician, RN, and Attending psychologist during regular working hours, QMRP during regular working hours, NPC during regular working hours, and AR during other hours.

-Notify your supervisor or designee for all incidents. For allegations of caregiver misconduct and injuries of unknown origin notify supervisor immediately

-Notify the parent or legal guardian (including power of attorney) if appropriate, and if ward is a patient/resident document notification in progress note.

Print your name, title, sign, and put in your work phone number. Put in the date and time when report was completed.

Supervisor/designee to review the outcome, comment on the need for further review, and send to the treatment team if there is a clinical issue. For Sentinel Event, notify Administrator/Designee or Administrator on call immediately and begin investigation immediately.

Program Administrator/Designee must review the incident within three working days of receiving the report, determine the need for additional review, and refer for further programmatic, departmental or BHD committee review(s). Program Administrator/Designee should send original incident report within three working days to Quality management, and when completed, send supplemental reviews and additional outcomes.

*This form must be completed before the end of shift during which incident occurred and before leaving the premises. The original and yellow copy must be given to your supervisor or designee. If your supervisor/designee is unavailable leave in his/her mailbox and notify your supervisor and the program administrator by voice or e-mail. Remember to notify your supervisor immediately (or if unavailable any supervisor) for sentinel events, allegations of caregiver misconduct, and possible injuries of unknown origin.*