Subject:  Fall/Wandering Prevention

Purpose:  To identify patients at risk for falls or wandering.

Policy:  Patients will be assessed for risk of falls or wandering upon admission or observation to Intensive Care Telemetry/Medical/Surgical/Peds/Skilled Care Center/Intermediate Care Facility/WCC/ASC.

Protocol Level If Applicable:

Independent or interdependent.

Special Information/Supportive Data:

All patients will be assessed upon admission for a history of or current mental confusion, agitation, forgetfulness or inability to understand or follow directions. A change in mental or psychosocial status requires reassessment.

The following patients will be placed on fall prevention:
Patients who have been admitted as a result of a fall or patients who have fallen during this hospital stay.
Patients with impaired judgment or perception
Patient exhibiting side effects of medication
Patient verbalizing intent/desire to leave or go home
Patients who are non-compliant in calling for assistance
Patients admitted to Skilled Care Center

Equipment List:

Fall Prevention Signage – placed outside of the patient’s room
Yellow ID bracelet
“Wander Guard” alert device as warranted
Purple ID bracelet-for confused-patients

Content:

Assessment
Assess each patient for:

1. History of falling, confusion, agitation, disorientation, forgetful, including history of being “lost” or wandering.
2. Neurological:
   a. Impaired Physical Mobility
   b. Sensory Deficit
   c. Dementia
3. Circulatory
   a. Decreased Cardiac Output
   b. Impaired Gas Exchange
   c. Altered Cerebral Tissue Perfusion
4. Cognitive - Perceptual
   a. Knowledge deficit
   b. Altered Thought Processes
      1. Confusion
      2. Poor judgement
      3. Forgetful
      4. Fearful
5. Physiological
   a. High Risk for Injury
   b. Pneumonia/hypoxia
   c. Altered Elimination
   d. Electrolyte imbalance
   e. Pain
   f. Infectious process
6. Coping - stress
   a. High Risk for Violence: Self-directed or Directed at Others
   b. High Risk for Self-harm
   c. Ineffective individual coping
   d. Life altering change
7. Role relationship
   a. Impaired communication
   b. Grieving
   c. Social isolation
   d. Separation from family/home environment
8. Pharmacological
   a. Prescription of mind altering medications
   b. Consider untoward side effects of current medications
   c. Effects of diuretics and urgency of elimination
   d. Any medications which can affect behavior, remember to include over the counter medications and herbal supplements, alcohol or and illicit drugs.
9. Identify environmental risk factors which may influence the behavior which causes increased confusion or agitation.

Interventions
According to assessment/reassessment of clinical indicators above:
1. Treat underlying conditions, i.e., UTI, pain, compromised respiratory status, fearfulness, hunger, infectious process etc. Implement and communicate wandering precautions to all care givers and family: i.e. apply tracking device to wrist or ankle.
2. The Risk Assessment Tool will be used upon patient admission and daily.
   Risk Assessment Tool
   0-4 Mum Sign Low
   5-8 Plain Yellow Sign Medium
   7-9 Yellow with Red Start Sign High
3. Place identified patients with risk factors on Fall Prevention Program.
   a. Place yellow Identification Bracelet on patient, replacing clear identification from admitting. TOR - green ID bands remain on, just place yellow band for Fall Risk identification.
   b. Notation made in computer under Injury/Risk Assessment will be reflected on Medact.
c. “Mum” to the appropriate fall prevention signage.

d. Integrate information into Nursing Care Plan/Problem List.

e. Initiate the necessary progressively restrictive devices based on patient need.

4. When possible:

a. Discuss the Fall Prevention Program with the patient, family or significant other(s) and provide Fall Prevention Literature.

b. If possible move the patient to a room close to the nurse’s station.

5. Suggested safety measures:

a. Keep bed in lowest position.

b. Use side rails based on patient assessment.

c. Keep bed and wheelchair wheels locked.

d. Keep call button, telephone and personal items within patient’s reach.

e. Utilize night lights.

f. Report unsafe environmental conditions to Environmental Services, Maintenance, or Safety as appropriate.

g. Place in room close to nurses station or in a monitored room.

h. Bed alarm in the bed or chair as needed.

i. 1:1 observation. (Restraint Protocol applies)

6. If a fall occurs:

a. Notify Supervisor or Director immediately. The patient’s condition needs to be assessed to determine evidence of physical injury before moving the patient.

b. Describe incident on the Variance Report Form and notify physician.

c. Review medications given prior to fall and if indicated, discuss need to change medication or dosage with physician. Attach copy of MAR to Variance Report Form.

d. Complete Fall Follow Up form and send to PI Department.

e. Note any change in patient treatment on Medact.

7. All hospital employees should note any yellow signage outside the patient’s room and be aware that this patient is at risk for falls and needs to be watched more closely, and they should check on the patient’s activity. Remain with patient, using call light to alert nursing staff of any problems.

8. Assess environment for “safe” wandering

a. clutter free

b. bed in low position with wheels locked

c. night lights

d. call light available

9. Implement non-restrictive interventions and document patient response:

a. Use consistent staff

b. Presence of family/friends

c. Limit number of personnel

d. Do not interrupt sleep

e. Provide care and treatment explanations

10. Implement less restrictive devices and evaluate for effectiveness:

a. bed rails

b. recliners

c. wedges

d. bed alarms

e. wheel chair

11. The care team may consider restraints if the above interventions are unsuccessful and the patient is aggressive, assaultive, combative or at risk of injuring himself. A physician’s order is needed. Follow Administrative Policy #123 and Nursing Protocol #19 (Restraints/Seclusion)
Documentation:

Observe patient at least every 2 hours. Document every 8 hours. Any unusual or risky behaviors should be documented as they occur in the Nursing Progress Notes.

REFERENCES:

4. Carpenito, Linda Juall, Nursing Diagnosis: Applications to Clinical Practice. Potential to self harm; Potential for harm to others.
5. Benchmarking & Site Visits of Hospitals, Long Team Care Facilities and Mental Health Units.