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 and transfer to another unit. Change in mental/physical status, and daily on evening shift. Reassess post fall and prn.

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 at high risk for injury based on:
- Advanced age (over 85)
- Hx of fracture within 3 months, osteoporosis, bone mets
- Anticoagulation
- Detox patient
- Less than 24 hours post operative patient

Equipment List:

Fall Prevention Signage – placed outside of the patient’s room
Yellow ID clip
“Wander Guard” alert device as warranted
Pink ID bracelet-for confused-patients
High risk for injury signage
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
- 5-9 Plain Yellow Sign: Medium
- 10 or above Yellow with Red Star Sign: High

3. 
   a. Initiate Fall/Injury Precautions Standing Nursing Intervention Form.
   b. Integrate information into Nursing Care Plan/Problem List.
   c. Initiate the necessary progressively restrictive devices based on patient need.

4. Suggested safety measures for all patients:
   a. Discuss the Fall Prevention Program with the patient, family or significant other(s) and provide Fall Prevention Literature.
   b. Keep bed in lowest position.
   c. Use side rails based on patient assessment.
   d. Keep bed and wheelchair wheels locked.
   e. Keep call button, telephone and personal items within patient’s reach.
   f. Eliminate unsafe environmental conditions to Environmental Services, Maintenance, or Safety as appropriate.
   g. Appropriate footwear when up. If patient is given a new medication for sleep, a bed alarm will be activated for 72 hours, low bed if patient’s condition warrants.

5. Low Risk 0-4
   a. Mum sign on patient’s room door.
   b. Ambulatory assistive device/gait belt (when checked)

6. Medium Risk 5-9
   a. Plain yellow sign, Yellow clip
   b. Patient and family education
   c. Use gait belt during any transfer/ambulation
   d. Ambulatory assistive device (when checked)
   e. Initiate bed/chair alarm – if checked, stay with patient while toileting

7. High Risk – 10 or above
   a. Yellow sign with red star, yellow clip
   b. Initiate bed/chair alarm
   c. Stay with patient while toileting
   d. Ambulatory assistive device/gait belt
   e. Patient and family education
   f. Med review by Pharmacy
   g. Low bed (when checked)
   h. Place close to Nurses’s Station (when checked)

8. If a fall occurs:
   a. Notify Supervisor or Director immediately. Once supervisor arrives, 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.
   d. Note any change in patient treatment on Medact.

9. 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.

10. Assess environment for “safe” wandering
    a. clutter free
    b. bed in low position with wheels locked
    c. call light available
11. 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

12. Implement less restrictive devices and evaluate for effectiveness:
   a. bed rails/use for repositioning
   b. recliners
   c. wedges
   d. bed alarms
   e. wheel chair

13. 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.

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**Documentation:**
Observe patient at least every 2 hours. Document every 24 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 Term Care Facilities and Mental Health Units.