

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION B: THE NURSING PROCESS CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING REASSESSMENT</p> <p>POLICY AND PROCEDURE 6.7: FALL RISK SCREENING, ASSESSMENT AND MANAGEMENT</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Connecticut Valley Hospital</p>

Standard of Practice:

The Registered Nurse (RN) will perform a fall risk screening upon admission, annually, or when there is a change in the patient's condition.

Standard of Care:

The patient and his/her family can expect that every effort to minimize the risk of patient harm resulting from falls will be undertaken through screening, assessment and treatment by staff throughout his or her hospitalization.

Policy:

Registered Nurses shall initiate Falls Risk Screening as part of the admission nursing process, annual reassessment and whenever the patient's change in condition warrants and take immediate action to address any identified risks.

Definitions:

Falls: An uncontrolled, unintentional, downward displacement of the body to the ground or other object. This includes witnessed and unwitnessed falls, but excludes falls resulting from aggressive acts, medical conditions, sports-related activities or other purposeful actions.

Frequent Falls: Three or more falls in a thirty day period.

Serious Falls: A fall with sustained injuries requiring medical intervention beyond first aid.

Near Fall: A sudden loss of balance that does not result in a fall. This can include a person who slips, stumbles or trips, but is able to regain control prior to falling. This also applies to the individual who is assisted to the floor by staff regardless of whether or not the patient sustained injury.

Unwitnessed Fall: When a patient is found on the floor and neither the patient nor anyone else knows how he/she got there.

Procedure:

A. Upon Admission

1. The RN will conduct a fall risk screening at the time of the admission process utilizing CVH-574. The patient's name, MPI#, Division and Type of Screening sections are completed. The Nurse signs, prints, and dates the form.
2. Each of the 9 Fall Screening Categories are assigned a rating of zero to three. The nurse then adds individual scores to derive a Total Score.
3. A total score of 0-10 is considered to be Low Risk for falls and no immediate action is necessary.
4. A total score of 11-20 denotes a Medium Risk for falls.
5. A total score of 21-33 signifies High Risk for falls.
6. Any patient with a score of 11 or greater shall be considered "At Risk for Falls".
7. The RN places a Fall Risk sticker on the spine of the patient's medical record binder.
8. The RN notifies the Attending Psychiatrist during business hours (8:30 a.m. to 4:30 p.m.) and the On-Call Physician after business hours, weekends and holidays.
9. The RN records the physician name and date of notification on the Fall Risk Screening.
10. The RN files the completed CVH-574 in the Progress Note Section of the medical record following the latest History and Physical form.
11. The Attending Psychiatrist/On-Call Physician assesses the patient, orders a physical therapy consultation, other consultations as warranted, and evaluates the patient's medication regime. During business hours the Attending Psychiatrist contacts the patient's assigned Ambulatory Care Services (ACS) Provider to collaboratively evaluate the case. After hours, weekends and holidays, the on-call physician conducts the evaluation. The results of the Physician evaluation are documented on the lower half of CVH- 574.

B. During Hospitalization

1. In the event that a patient falls, the RN immediately assesses the patient's condition and documents observations in the Progress Notes located in the Progress Note Section of the medical record.
2. The Charge or designated Nurse notifies the ACS Provider during business hours and the On-Call Physician after hours, weekends and holidays and initiates an Incident Report.
3. Upon notification by the RN, the Physician of record will evaluate the patient for injuries and completes the incident report.
4. On the next business day after the fall, the RN notifies the Attending Psychiatrist of the fall.
5. The Attending Psychiatrist initiates a meeting with the ACS Provider to complete the Fall Assessment, CVH-575. In the event that the fall is classified either as *frequent* and/or *serious* based on the definitions provided, the Attending Psychiatrist will include the Division Medical Director in the completion of the assessment.

6. As part of the fall assessment, the need for a treatment plan review is given consideration.
7. The completed Fall Assessment is filed in the Progress Note section of the medical record in chronological order with the Integrated Progress Notes.
8. As part of the Nursing Reassessment, annually the nurse will initiate a new Fall Risk Screening.