PAM REHAB FALL PREVENTION PROTOCOL

The Fall Prevention Program in the rehab environment is used to identify patients at high risks for falls while also allowing them to progress with safety monitoring, to the highest level of function possible. Frequent monitoring, hourly rounding; help to focus on safety needs of the patient with overall fall reduction.

All patients are assessed at time of admission and daily per primary nursing staff. Patients, who are receiving a score greater than 10 on the nurses note documentation, will be placed as high risk for falls. This includes the following tasks to be completed with identifiers:

- Yellow charm placed on ID band
- Yellow star magnet placed on door frame for identifier of risk.
- Yellow Posey Socks to make staff aware of the high risk for falls.

Any patient who has fallen in the facility will be re assessed post fall. A post fall analysis tool is completed by the RN charge and the safety committee will review this. New identifiers will be put in place as follows:

- Removal of yellow star magnet from door frame.
- Placement of red star on door frame to make all staff aware that a patient has fallen.
- Removal of yellow socks.
- Placement of red socks on patient to identify patient has fallen.

The RN charge will contact the attending physician, family and nursing administration regarding the fall. An incident report is also filed in the reporting system known as RM Pro.

We take great pride in fall prevention at PAM Rehab of Victoria. We appreciate everyone's input to provide safety for all of the patients we serve.

Fall Prevention

Fall Prevention Program

The Fall Prevention Program is to identify patients at high risk for falls and attempt to prevent these falls through staff interventions such as frequent monitoring of the patient need for assistance. (ie: Call bell within reach)

- **ALL STAFF walking by a patient room with a yellow dot will look to determine if the patient is at risk for a fall situation.**
- **A Yellow Fall armband will be placed on the patient's wrist.**

PATIENTS ARE ASSESSED

- **Upon admission**
- **Every shift**
- **After a fall or change in condition**
- **After a transfer to a different level of care**

When a patient falls at WS, we put two yellow dots, then we re-evaluate the fall risk assessment form and then complete RM PRO, and that is to be given to the Manager/Supervisor/Designee.

Rapid Response Teams (RRT)

- Rapid Response Teams (RRTs) are intended to reduce unnecessary adverse outcomes or death by preventing patients from clinical deterioration through early detection and effective interventions by critical care clinicians.
- The GOAL of the RRT is to improve outcomes, reduce mortality and reduce codes outside the ICU setting
- All Employees ,family members, or visitors can activate the RRT.
- The RRT team can be activated for ANY situation where the condition of the patient appears to be deteriorating

When to call a Rapid Response Team (RRT)

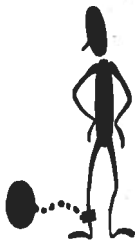
The RRT includes critical care clinicians designated to assist with prevention of emergencies/code by early detection of cause of deterioration in the patient's condition regardless of code status!

Triggers for calling the Rapid Response Team (RRT)

If the patient displays any of the following criteria, call the RRT using the instructions below:

Criteria	Instruction
Staff Concerned or Worried	"The patient does not look/act right", gut instinct that patient is beginning a downward spiral even if none of the physiological triggers have yet occurred.
Change in Respiratory Rate	The patient's RESPIRATORY RATE is less than 8 or greater than 30
Change in Oxygenation	PULSE OXIMETER decreases below 90%
Labored Breathing	The patient's BREATHING BECOMES LABORED
Change in Heart Rate	The patient's HEART RATE changes to less than 40 bpm or greater than 120 bpm
Change in Blood Pressure	The patient's SYSTOLIC BLOOD PRESSURE drops below 90 mmHg or rises above 200 mmHg
Hemorrhage	The patient develops uncontrollable bleeding
Decreased LOC	"The patient becomes SOMNOLENT, DIFFICULT TO AROUSE, CONFUSED, or OBTUNDED"
Onset of Agitation/Delirium	The patient becomes AGITATED OR DELIRIOUS
Seizure	The patient has a SEIZURE
Other Alterations in Consciousness	ANY OTHER CHANGES IN MENTAL STATUS OR CNS STATUS such as a sudden blown pupil, onset of slurred speech, onset of unilateral limb or facial weakness, etc.

Restraints



PAM is committed to creating an environment that will keep the use of restraints to an absolute minimum. All patient's have a right to be *free from restraints*.

- A **physical restraint** is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body that they cannot easily remove that restricts freedom of movement or normal access to one's body.
- A physician's order is needed to apply restraints
- A patient's health, safety and rights must be respected at all times when using restraints.
- All staff with direct patient contact will have initial and on-going education and training in the proper and safe use of restraints.

CARE / NEEDS OF THE DYING PATIENT

The patient and family are the CORE of the care team

End of Life process can cause families and patients to experience loss of control, isolation, loss of hope and loss of self esteem

- PROVIDE ACCESS to any therapy which can improve the patient's quality of life, including alternative or non-traditional treatments PROVIDE access to palliative and Hospice care.
- RESPECT the Patient's right to Refuse Treatment
- RESPECT the Physician's professional responsibility to promote clinical and evidence based research.
- PROVIDE the patient and family for time alone together.
- PROVIDE support , Pain control, Psychological Support, and be a resource for any questions the patient or family may have.

Advanced Directives

All patients have the right to control of their medical treatment. Advanced Directives instruct the healthcare team on the patient's decisions

If a patient has an Advance Directive prior to admission a copy of the directive must be obtained and placed in their chart

An Advance Directive in NOT a DNR

A Medical Power of Attorney form identifies who is to be the medical decision maker in the event the patient is incapable of making their own decisions.

If the person does NOT have a medical power of attorney, there is a "chain of command" for treatment decisions by family members/surrogates outlines by the law.