Documenting patient falls

Falls are a major cause of injury and death among elderly people. In fact, the older the person, the more likely he’ll die due to a fall or its complications. In acute care hospitals, 85% of all inpatient incident reports are related to falls; of those who fall, 10% fall more than once and 10% experience a fatal fall. In nursing homes, about 60% of residents fall every year and about 40% of those residents experience more than one fall.

If your patient falls despite your preventative measures, stay with him and don’t move him until you’ve done a head-to-toe assessment and checked his vital signs. Assign another person to notify his health care provider. Provide any emergency measures necessary, such as securing an airway, controlling bleeding, or stabilizing a deformed limb. Ask the patient or a witness what happened. Ask the patient if he hit his head or is in pain. If you don’t detect any problems, return him to bed with another person’s help.

WHEN A VISITOR FALLS

Despite your best efforts to maintain a safe environment, falls may occur. If a visitor falls, document the event on an incident report. If he needs medical attention, send him to the emergency department.

**Essential documentation:** Document a visitor’s fall on an incident report, not in your patient’s medical record. Include the date and time in the incident report, and record the visitor’s name, address, and telephone number. Also, record the exact location of the fall and the visitor’s report of how it occurred. Describe only what you saw and heard and what actions you took to provide care at the scene. Unless you saw the fall, write “found on floor.” Record the name of the physician and anyone, such as the nursing supervisor, you notified and the time of notification.

Assess the visitor and record any bruises, lacerations, or abrasions. Describe any pain or deformity in his extremities, and record vital signs, including orthostatic blood pressure. Document the visitor’s neurologic assessment. Include slurred speech, weakness in his extremities, or a change in mental status.


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Essential documentation: If a patient falls despite precautions, be sure to file an incident report and chart the event. Record how the patient was found and the time he was discovered. Stick to your objective assessment, avoiding any judgments or opinions. Assess the patient and record any bruises, lacerations, or abrasions. Describe any pain or deformity in his extremities, particularly his hip, arm, leg, or lumbar spine. Record vital signs, including orthostatic blood pressure. Document your patient’s neurologic assessment. Include slurred speech, weakness in the extremities, or a change in mental status. Record the name of the health care provider and other persons notified, such as family members, and the time of notification. Include instructions or orders given. Also document any patient education.

PREVENTING FALLS
Patient falls resulting from slips, slides, knees giving way, fainting, or tripping over equipment can lead to prolonged hospitalizations, increased hospital costs, and liability problems. Because falls raise so many problems, your facility may require you to assess each patient for his risk of falling and to take measures to prevent falls. If your facility requires a risk assessment form for patients, complete it and keep it in the patient’s chart. Those at risk require a care plan reflecting interventions to prevent falls.

Essential documentation: Record the time and date of your entry. Describe the reasons for implementing fall precautions for your patient, such as a high score or a risk for falls assessment tool. Document your interventions, such as frequent toileting, reorienting the patient to his environment, and placing needed objects within his reach. Include the patient’s response to these interventions. Note measures taken to alert other health

Reducing the risk of falls
There are no foolproof ways to prevent a patient from falling, but the Joint Commission on Accreditation of Healthcare Organizations recommends the following steps to reduce the risk of falls and injuries. Be sure to document your safety interventions in the appropriate place in the medical record.

Physical measures
● Provide adequate exercise and ambulation.
● Offer frequent food and liquids.
● Provide regular toileting.
● Evaluate medications (hypnotics, sedatives, analgesics, psychotropics, antihypertensives, laxatives, diuretics, and polypharmacy increase the risk of falling).
● Assess and manage pain.
● Promote normal sleep patterns.

Psychological measures
● Reorient the patient to his environment.
● Communicate with the patient and his family about the risk for falls and the need to call for help before getting up on his own.
● Teach relaxation techniques.
● Provide companionship, such as sitters or volunteers.
● Provide diversionary activities.

Environmental measures
● Orient the patient to his environment.
● Use appropriate lighting and noise control.
● Consider a bed alarm.
● Provide a safe space layout (long-term care), such as a low-lying bed or mattress or pads on the floor.
● Place assistive devices within the patient’s reach at all times.
● Provide bed adaptations (long-term care).
● Provide accessibility to needed objects at all times.
● Ensure frequent observation of any patient at risk, such as moving him closer to the nurses’ station and involving family.
● Provide side rail adaptations and alternatives.
● Use appropriate seating and equipment.
● Provide identifiers of high-risk status, such as an arm band or an identifier on the patient’s bed or door.