

**MILLE LACS BAND OF OJIBWE
HEALTH AND HUMAN SERVICES POLICY & PROCEDURE**

Department: Substance Use Disorder-Four Winds

Policy Number: HHS-SUD-FW 4754

Policy Title: Fall Risk Assessment

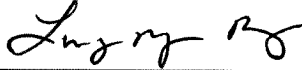
Attachments: Edmonson Falls Risk Assessment Form

Revision History:

Revised by/Date: Lindsay Misquadace-Berg 7/2021

Approved by:

Lindsay Misquadace-Berg, Four Winds Director



Date:

10/15/21

Approved by:

Nicole Anderson, Commissioner of HHS



Date:

11-30-2021

POLICY STATEMENT: The Four Winds Lodge Treatment Director and RN Supervisor, or designee, are responsible for implementing written procedures for obtaining medical intervention, when needed, for any client, to provide diagnostic assessment and treatment planning assistance related to fall risks and to assure that all staff are aware of and receive training on fall risk assessment procedures.

PURPOSE: The purpose of this policy is to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development and safety of each client.

PROCEDURES:

A. All Nursing Fall Assessments will be based on evidence-based risk indicator. The following list of evidence-based fall risk factors will be assessed by the RN at time of each fall risk assessment:

1. Age.
2. Mental Status.
3. Elimination.
4. Medications.
5. Diagnosis.
6. Ambulation/Balance.
7. Nutrition.
8. Sleep
9. Disturbance.
10. History of falls.

B. Registered Nurses shall complete an Edmonson Falls Risk Assessment:

1. On admission if client's physical condition makes him/her at risk for falls or if there is a recent history of falls.
2. Prior to initiating a protective device.
3. When client has had a serious fall.
4. When there is a change in physical condition that puts the client at risk for falls.

C. Notify LIP if there has been a change in client condition that puts him/her at risk for falling.

D. Document the Edmonson Fall Risk Assessment in medical chart.

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E. If a client is identified as a fall risk, interventions need to be documented on client’s Initial Service Plan and Individual Treatment Plan. Include specific interventions to meet fall protection standard of care as follows:

1. Offer education regarding fall protection standard to client.
 - a. Clients receive direct supervision to anticipate fall risk and prevent falls.
 - b. Clients are placed on routine unit rounds observation.
 - c. Clients receive orientation to the unit environment.
 - d. If wheelchair used, wheelchair safety is reviewed with client.
 - e. If hospital bed or chair is used, bed/chair safety is reviewed with client.
 - f. Access to necessary personal items at night is accommodated as possible.
 - g. Clear pathways are maintained.
 - h. Appropriate lighting is provided.
 - i. Client education on safe use of any device is provided (if in use).
 - j. Specific fall preventions necessary to meet fall protection standard of care.
2. Ongoing notification to all staff of client’s specific fall risk.
3. Observation level is indicated.
4. Relocate client to highly visible area.
5. Alert staff to fall risk on bed board/communication tool.
6. Other fall prevention interventions.

F. Post-Fall Documentation

1. Complete an incident report.
2. Complete documentation:
 - a. Nursing progress note.
 - b. Falls Risk Reassessment.
 - c. Update the client’s individual nursing plan of care or Comprehensive Treatment Plan and IAPP as clinically indicated.

G. Re-assessment of fall risk can be initiated with any change of status in client’s ambulation, mental status, elimination, medications, nutrition, and/or sleep.

Internal and/or External References	HHS- Incident Reporting Minnesota Rule SLF-4665.3300 Ordinance #19- Chapter 9 section 902
Compliance - Posting Date	11/30/2021 
Replaces – Policy Number	
Next Review - Due Date	