Policy Author	Speech Pathology/ Nursing/ Risk
Origination Date	08/16/2000
Current Review Date(s)	1/8/2017;5/4/2020; 3/14/2022
Current Revision Date(s)	3/2005, 1/8/2014;3/14/2022

MARINHEALTH MEDICAL CENTER
HOUSEWIDE ADMINISTRATIVE MANUAL
ASPIRATION PRECAUTIONS

I. POLICY

A. MarinHealth Medical Center staff, including Registered Nurses (RNs), Speech-Language Pathologists (SLPs), and providers will follow standard protocols to ensure quality therapeutic intervention and safe feeding for patients with disordered swallow.

II. PURPOSE

A. To provide safe consistent treatment of patients with possible dysphagia (disordered swallow) to minimize aspiration and asphyxiation risk. The Joint Commission cites that the Speech-Language Pathologist is in a position to provide information on swallowing to hospital staff, the medical staff and patients and their families.

III. GENERAL INFORMATION

A. Background/ Scope

1. Patients at risk for aspiration and asphyxiation need to be clearly identified. Patients presenting with disordered swallowing function as evidenced by assessment or vocalization of patient/family, nursing assessment, provider assessment or test results will have a provider-requested evaluation by a speech-language pathologist.

B. Definitions

1. Dysphagia to mean disordered swallow
2. Impaired swallow is now referred to as disordered swallow in the literature.

C. Application

1. Nursing department and Speech Pathology department are responsible for the application of the policy and procedure.
2. RNs and SLPs are responsible for completing procedures outlined in this policy.
3. RN and SLP are trained to this policy during New Employee Orientation.

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IV. PROCEDURE

A. Key Steps

1. A provider order entered in the electronic health record (EHR) will designate "Aspiration Risk" for a patient.
    a. If a patient is not being followed by the speech pathology service and the provider deems the patient an aspiration risk, the patient's care plan must be multidisciplinary identifying aspiration risk and must have interventions and expected outcomes.
    b. The SLP will apply the orange aspiration risk clasp to the wristband if the evaluation suggests the presence of disordered swallow function. If the patient is not being followed by the speech pathology service and the provider deems the patient an aspiration risk, it is the nursing staff's responsibility to apply the clasp.
        1) The aspiration precautions clasp will not be removed until the aspiration risk has resolved. A provider order entered in the EHR discontinuing aspiration precautions is necessary before the clasp can be removed.
        2) All caregivers working with the patient noting the "ASPIRATION RISK" wristband must seek further information about the patient's risk before giving the patient anything by mouth.
2. Patients who are designated to be at risk for aspiration by either his/her provider or SLP working with that patient also need to have a sign stating so, placed above the head of his/her bed.
    a. Any patient determined to be at risk for aspiration by SLP will have a goldenrod-colored sign with specific restrictions identified on it placed above the patient's bed.
    b. Aspiration Precautions sign for those designated as aspiration risk by the provider, but not being followed by the speech pathology service will include:
        1) Appropriate hospital personnel should provide nutrition in cases of risk for aspiration, and should remain with the patient throughout the meal.
        2) Diet selection should be the safest determined by the provider or recommended by the speech pathologist. The patient must not be given anything unless it is clearly included in the selected diet.
        3) Patient must be sitting fully upright in bed 90 degrees or sitting up in a chair.
        4) Appropriate hospital personnel must visually inspect mouth to ensure food has been cleared completely before offering the next bite of food.

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5) The patient must not be rushed.
6) In the case of coughing, during the meal, the following procedure should be followed:
    a) Stop feeding-discontinue meal.
    b) Clear mouth and leave patient upright.
    c) Make patient NPO until fully evaluated by SLP.
    d) Notify provider and request order for speech pathology-swallow evaluation. (Note: order must come from provider, not nursing.)
    e) Notify Nutritional Services to hold the patient's tray until revised diet order has been received in EHR from provider following speech pathology-swallow evaluation.
    f) If aspiration event possibly occurred, monitor patient for respiratory distress and any abnormal vital signs.
    g) Alert provider of any change in respiratory status.
7) If the patient has an order for thickened liquids, the container must be labeled.
8) If a swallow evaluation is ordered, the patient is placed on NPO status until the swallow evaluation is completed, unless oral intake is ordered by the provider.

c. The aspiration risk sign must be transferred with the patient when the patient is moved to different room or bed within the same room
    1) The patient's nurse if responsible for making sure an appropriate hand off is communicated to the receiving RN including handing off the Aspiration Risk sign.
    2) Once the individual making the designation "aspiration risk" determines the patient is no longer at risk, they or the patient's RN are responsible for removing the sign.

3. If a competent patient declines to adhere with the dietary recommendations, this will be documented in the ERA. An incident report (SIR) will be completed.
4. Only trained hospital personnel, or family members/private caregivers who have been trained by the speech pathologist to feed the patient, may provide oral intake to a patient who is on aspiration risk precautions.
5. Family members/private caregivers who have been trained by the SLP will be identified by name in the provider order set section of the medical record. It is also the responsibility of the nurse to inquire if the family member has been trained.

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a. In the event a family member decides to feed the patient or chooses to feed the patient items which are not on the recommended diet, they should be advised by the provider, RN, or SLP of the potential for serious outcomes in doing so and nursing will assume providing all oral intake to the patient.
b. In cases where a family member or visitor continues to not adhere to the provider orders for oral intake or provides unsafe feeding care, the nursing supervisor should be advised. Family or visitor can be asked to leave the hospital if feeding is not consistent with the clinical orders and supervision by nursing staff is not available.

B. Required Data Documentation NA

C. Patient Education

1. Patients and their designated family members will receive information on the patient's disordered swallow, diet recommendations and safe feeding strategies from the provider, SLP and RN.

V. AGE SPECIFIC CONSIDERATIONS

A. All patients at risk for aspiration and asphyxiation, all ages.

VI. EQUIPMENT

A. Orange aspiration risk armband clasp

VII. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Title
Attachment A	MarinHealth Swallowing Precautions Sign HS20(102000)
Attachment B	MarinHealth Standard Aspiration Precautions GM100

VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION

A. Replaces: NA
New Title: NA

Policy Author	Speech Pathology/ Nursing/ Risk
Origination Date	08/16/2000
Current Review Date(s)	1/8/2017;5/4/2020; 3/14/2022
Current Revision Date(s)	3/2005, 1/8/2014;3/14/2022

B. Authority/ Reference

1. Palmer, P., Padilla, A. (2022), Risk of an Adverse Event in Individuals Who Aspirate: A Review of current Literature on Host Defenses and Individual Differences. *American Journal of Speech-Language Pathology*, (31), 148-162.
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C. Originators and Authors

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Policy Author	Speech Pathology/ Nursing/ Risk
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E. Approved By

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Policy Author	Pharmacy Dept.
Origination Date	06/18
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Current Revision Date(s)	10/04, 02/09, 05/19

MARINHEALTH MEDICAL CENTER

HOUSEWIDE ADMINISTRATIVE MANUAL

VERBAL, TELEPHONE, AND FAXED ORDERS FROM A PHYSICIAN OR A PHYSICIAN EXTENDER

I. POLICY

A. All orders for therapies, laboratory testing, imaging procedures, medications, and intravenous solutions shall be written legibly and signed by the ordering physician or physician extender.

1. In the event that a physician or physician extender is not present, all dictated verbal or telephone orders shall be received by a licensed health care provider, read back to the prescriber for verification, read back will be confirmed/verified by prescriber and then promptly and legibly recorded in the patient's medical record.
   a. Once this is completed, the order(s) will be carried out.
2. The order(s) will be signed, dated and timed by the ordering physician within 48-hours.
3. Faxed Physician orders are legal orders.
4. All orders must be signed by the physician before they are faxed.

II. PURPOSE

A. To define actions and documentation for patient care delivery in circumstances when the practitioner originating orders are not physically present to commit the order in writing. The patient can expect that the physician's orders will be implemented in a standardized manner.

B. To maintain compliance with federal, state, and other regulatory institutions, which provide guidelines to ensure structure and process criteria to ensure and promote quality health care.

C. To specify the procedure of faxed orders.

III. GENERAL INFORMATION

A. Background/ Scope

1. This section provides general and specific background information on the policy, including aspects related to regulatory compliance. It defines the scope of the policy, specifying to whom it applies and the specific procedures for its application.

B. Definitions

NA

Policy Author	Pharmacy Dept.
Origination Date	06/18
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Current Revision Date(s)	10/04, 02/09, 05/19

C. Application

1. This part of the section identifies the individual(s) or department(s) responsible for applying the policy and procedure. It specifies which staff members or departments will utilize the policy in their daily operations.
2. It also details the specific caregiver roles (e.g., RN, LVN, LCSW) or staff members responsible for executing the procedures outlined in the policy.
3. The section describes how the individuals or departments will be educated or trained on the policy and procedure. It includes information on maintaining competency and ensuring that all departments impacted by this policy have reviewed and agreed to the changes.

IV. PROCEDURE

A. Only an authorized individual may accept verbal and/or telephone orders from a physician or physician extender. At MarinHealth Medical Center (M.H.M.C.), these authorized individuals are:
   1. Provide Registered Nurses.
   2. Registered Pharmacists.

B. Other Licensed Healthcare Professionals may accept, write, and sign orders for only those therapies, which they are authorized to order and administer within their scope of practice.

C. Verbal and/or Telephone Orders must contain the following elements on the documentation record:
   1. The date and time the order was received.
   2. The name of the patient and medical record number.
      a. Commonly recognized at M.H.M.C. as the patient label.
   3. The method of receiving.
      a. For example: Verbal orders would be documented as V.O. Telephone orders would be documented as T.O.
   4. The specific action, therapy or medication to be implemented.
   5. The name of the prescriber (Physician or Physician Extender).
   6. The name and title of the individual receiving the order and that it was “read back and confirmed/verified” by the prescriber, RBC is an acceptable abbreviation.
      a. Note: The prescriber will prompt the individual receiving the order to read it back if it is not done spontaneously.
   7. <u>For medication orders</u>, the order must include the following:
      a. Drug name (brand name or generic)
      b. Exact strength or concentration
      c. Frequency and route of administration
      d. Compliance of the guidelines established by the National Patient Safety Goals on “Do Not Use” abbreviations will be followed.

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D. All writing and signatures MUST be legible to a reader. If your signature is illegible, your printed name must be written next to the signature on the order.
E. An example of an appropriately documented verbal and telephone order are noted below:

EXAMPLE ORDER:

Patient label affixed to Physician's order sheet.

08/12/04 at 1345 T.O. from Dr. Marin Kentfield:

1. *Lopressor 25mg PO TID, first dose now.*
2. *Lasix 40mg IV-Push times-one STAT.*
3. *Bedside EKG times-one now.*

Read Back and Confirmed (RBC) to Prescriber / Florence Nightingale, RN

F. Two registered nurses or a physician and a registered nurse must hear, witness, and document as such, all telephone orders for cessation of life support, terminating ACLS protocols, or changing the code status of a patient.
G. The order will be made scanned into the electronic health record and scanned/faxed to the Pharmacy.

V. AUTHORITY, REFERENCES, APPROVAL

A. Replaces: Previously Revised Version of Policy 1108.1.3, Policy 1109.02
B. Distribution: House Wide Policy & Procedure Manuals
C. References:
   1. Title XXII, State of California
   2. Joint Commission of Hospital Accreditation Standards (2004)
   3. Vanderbilt University Medical Center, 2003 Policy

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Origination Date	06/18
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D. Originators and Authors

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Medical Policy Committee	N/A		01/2009
Board of Directors	N/A		2/2009

Originated By	Medical Unit
Origination Date	2/82
Current Review Date(s)	4/05,4/08, 2/15
Current Revision Date(s)	12/14

Marin Health Medical Center

HOUSEWIDE ADMINISTRATIVE MANUAL

CARE OF PATIENTS IN CUSTODY OF LAW ENFORCEMENT OFFICIALS, A CORRECTIONAL FACILITY OR STATE MENTAL HEALTH FACILITY

I. POLICY

This policy pertains to the care of Marin Health Medical Center (MHMC) patients who are in the custody of city, county, state or federal healthcare, correction or law enforcement agencies.

II. PURPOSE

This policy is designed to ensure in-custody patients remain in a secure environment while at MHMC and that appropriate measures are taken to ensure the safety of MHMC staff, patients and visitors.

MHMC staff is responsible for the care and treatment of the in-custody patient, while the corresponding agency's custodial official is responsible for the security of the patient. Nursing staff assigned to the in-custody patient and custodial official accompanying the patient will collectively determine behavior and activities that will best enhance the care of the patient while maintaining the safety of all parties.

III. DEFINITIONS

A. **In-custody Patient:** Patients can be in-custody by a local law enforcement agency, an inmate from a county jail, an inmate from a state correctional facility (such as San Quentin State Prison), or an inmate from a federal prison (such as Federal Correctional Institution in Dublin). Additionally, in-custody patients may be from mental health facilities such as California's Napa State Hospital.

B. **Custodial Staff:** Staff who, under the jurisdiction of a city, county, state or federal healthcare, correction or law enforcement agency have legal custody over the patient.

C. **Prisoner restraints:** Prisoner restraints are legal devices used to restrict physical movement, e.g., handcuffs, ankle shackles, to maintain custody of prisoners as well as to protect other patients, employees, and/or hospital visitors from potential, violent behavior.

D. **Physical restraints:** Refer to MHMC's Housewide Clinical Manual Restraint / Seclusion Policy #434.1.

IV. COMMUNICATION & DOCUMENTATION

A. **Liaison: MHMC Supervisor of Security Services.** MHMC's Supervisor of Security Services is designated as the liaison between Hospital staff, law enforcement agencies, and correctional facilities and is responsible for meeting with local law enforcement and correction agencies in the area to discuss and evaluate procedures. This liaison should be aware of security procedures contained in contracts between the custodial agency and MHMC to assure agreed upon procedures are communicated effectively to staff.

B. **MHMC Brochure for Law Enforcement**. Upon admission, each custodial agent will be provided with a copy of ***MHMC Custodial Staff's Orientation Brochure*** that defines MHMC's policies with regard to safety, security and treatment of the in-custody patient.

C. **In-Custody Record.** An In-Custody Record shall be maintained by MHMC Security Services. It shall contain an ***Orientation Log*** of location and custodial staff for each incustody patient.

V. RIGHTS OF PATIENTS IN CUSTODY

A. All in-custody patients have the right to accept or refuse medical care, treatment or services.

VI. PROCEDURES UPON ARRIVAL AT

A. Marin Health Medical Center Hospital staff must ensure that in-coming custodial patients are accompanied with their most recent physical, pertinent medical test results and code status with appropriate documents.

B. Arriving custodial officials are required to notify MHMC Security Services prior to or upon arrival at MHMC.

C. MHMC Security Services and or Admitting Personnel shall provide each arriving custodial official (who has custody of the patient) a copy of ***MHMC Custodial Staff's Orientation Brochure*** that defines MHMC's policies with regard to MHMC patients in-custody of custodial agencies or correctional facilities. Staff will then notify Hospital Security of the intended destination of the in-custody patient.

D. If a patient is placed in custody while already here at MHMC, the custodial official and MHMC employee encountering the in-custody patient are required to notify MHMC Security Services and the Clinical Department Director or Supervisor as soon as possible.

E. When MHMC Security Services is notified by a custodial official of the arrival of an incustody patient, or a patient on a police hold, or informed that an existing patient has been placed into custody, MHMC Security Services will obtain and log onto the ***Orientation Log*** the following information:

   a. Name of law enforcement agency
   b. Name of law enforcement contact

   c. Location of the in-custody patient

D. In-custody patients are automatically assigned "Not for Publication" (NFP) status upon admission. Refer to MHMC Housewide Administrative Manual, #1107.10: Not for Publication (NFP): Release of Patient Information.

VII. SECURITY, RESTRAINTS AND ROOM ASSIGNMENT

A. Unless it interferes with required medical treatment, custodial officials shall use necessary restraints such as handcuffs and ankle shackles to secure and prevent the in-custody patients from escape and to provide protection to staff, other patients, and visitors.

B. The required two-point shackle restraint of the in-custody patient may be removed if both the custodial official and nursing staff deem it safe for medically appropriate/ordered interventions (e.g.,: using the bathroom/urinal; ambulating around hospital room).

C. The in-custody patient, along with his/ her custodial official, will be assigned an empty patient room. Two in-custody patients may occupy a semi-private patient room if the law enforcement official finds the two patients to meet compatibility requirements established by the supervising agency. The in-custody patient's custodial official will contact the appropriate agency personnel to determine compatibility if there is any question.

D. In-custody patients shall be secured to the hospital bed with two-point shackle restraints at all times on bilateral ankles. If shackle placement on bilateral ankles is medically contraindicated, optional sites may be used to maintain two-point restraint.

E. Nursing staff is required to continually assess shackle sites for the presence of skin breakdown and implement appropriate prevention interventions; the nurse is responsible for documenting this assessment and any interventions per MHMC Housewide Clinical Manual, #406.2: Maintaining Skin Integrity and #406.11: Photographic Measurement/ Documentation of Pressure Ulcers.

F. Custodial official will accompany the in-custody patient at all times. The number of custodial official present, and their station points, may vary due to correctional agency policy and procedure; however, at least one custodial official must be in the patient's room and actively watching the patient at all times. The supervising agency will deem what is the appropriate number of custodial officials needed to maintain security of the in-custody patient.

G. If the custodial official must leave his/her assigned post for any reason (e.g., meal break, restroom break), the custodial official must arrange his/her relief through the custodial agency.

VIII. FIREARMS SECURITY

A. Custodial officials are permitted to carry firearms on hospital premises and are required to notify the MHMC Security Services upon arrival that they are armed as well as provide the type of weapon/firearm and the name of the official(s) who have possession of firearm(s).

IX. GENERAL SAFETY GUIDELINES

A. All non-essential equipment (such as sharps, tape, gauze, scissors, chemicals, and solutions) should be removed from patient's room to prevent them from being used by the patient as weapons. Telephones must be removed. Sharps container should be removed or out of the patient's reach.

B. Nursing staff should be aware of all equipment and supplies brought in or already in the room.

C. Nursing staff should only bring those supplies pertinent to providing nursing care of the incustody patient.

D. Law enforcement official will monitor all equipment and supplies brought in or already in the room.

E. Visitors are not permitted unless pre-arranged through the custodial agency and proper notification is made to the custodial staff.

F. Staff should announce their presence at patient door to avoid startling the in-custody patient and/or the custodial official.

G. Communications should be kept professional and relevant to nursing care.

H. Staff shall not share sensitive information with the in-custody patient; information including but not limited to future discharge plans, procedure dates, staff's personal information. If in doubt, the staff member should discretely consult with the custodial official.

    1. If staff suspects the in-custody patient may have overheard sensitive information (such as future discharge plans, procedures dates, staff's personal information, etc.), staff shall notify the custodial official immediately.
    2. In-custody patients are not allowed phone privileges and all such attempts to make or receive telephone calls must be relayed to the custodial official immediately.

I. If the physician has deemed the in-custody patient able to tolerate a diet in which a meal tray is served, nursing staff is responsible for ensuring a 'Caution Tray' of the corresponding diet type is ordered.

    1. The 'Caution Tray' diet modifier can be ordered by the nurse; a physician's order is not required.

J. Care assignments should be rotated among nursing staff if the nursing staff expresses any discomfort in caring for the in-custody patient.

K. Physical contact between the hospital staff and the in-custody patient will be restricted only to physical contact required during those nursing interventions essential to the care and treatment of the in-custody patient.

L. If a nurse needs physical assistance from the custodial official, he/she is to ask the law enforcement official for the specific help needed, stating exactly what is to be accomplished. The custodial official has the right to refuse assistance if the request for help is related to patient care. The custodial official who is armed with a weapon may not assist. M. In-custody patient activities such as ambulation must be carried out in the room.

N. If the need arises for the custodial official to restrain an in-custody patient, the nurse will continue to provide emergent medical care as long as the care does not intervene in security procedures. If the care is not emergent, the Nurse will step out of the room until the patient has been restrained.

X. CUSTODIAL STAFF RESPONSIBILITIES AND EXPECTATIONS

A. The custodial staff for all in-custody patients will maintain the safety and security pertaining to the custody of patients.

B. Custodial staff will exercise their judgment/ discretion regarding the in-custody patient's management.

C. If custody of a patient is to be maintained, a representative of the custodial agency must remain with the in-custody patient at all times.

D. Custodial staff may use the in-custody patient's restroom.

E. Custodial staff may take meal periods in the hallway outside the in-custody patient's room.

F. Custodial staff behaviors must remain conducive to a healing environment.

XI. IN-CUSTODY PATIENT IN ISOLATION

A. If an in-custody patient requires placement in respiratory, droplet, and/or contact isolation, nursing staff is responsible for ensuring that the custodial official adheres at all times to hospital infection control policy, while maintaining continual visual observation of the incustody patient. Nursing staff will provide the custodial official with all pertinent personal protective equipment required to maintain adequate infection control and reduce transmission.

XII. CONFLICT BETWEEN STAFF AND LAW ENFORCEMENT OFFICIAL

A. If conflict arises between a staff member and a custodial official, the staff involved will notfy the MHMC Security Services, thus initiating MHMC Chain of Command for Management of Patient Care Concerns #1110.1.2.

XIII. TELEPHONE CALLS FROM SUPERVISING AGENCY

A. Telephone calls from the supervising agency will be referred to the appropriate on-site custodial official by the MHMC Operator. In-custody patients do not receive incoming personal calls. Permission for in-custody patients to call out will be at the complete discretion

of the custodial official and any such call will be made collect and monitored by the custodial official.

B. MHMC Operator or Nursing will refer any other outside telephone calls to MHMC Security Services, who will inform the supervising agency. Family members of in-custody patients must call the supervising agency to learn of patient's condition and progress.

XIV. MEDIA INQUIRIES

A. All media inquiries, including calls from representatives of newspapers, magazines, television and radio stations are to be directed to the Community Relations Department, during normal business hours (Monday – Friday, 8 a.m. to 5 p.m.). Media inquiries during off hours will be directed to the Administrative Nursing Supervisor.

XV. ESCAPE ATTEMPTS

A. If an in-custody patient attempts to escape custody, the nursing staff will step away from the area and allow the custodial official(s) to control the situation per specific custodial facility policy/procedure.

XVI. POST-MORTEM CARE

A. All in-custody patient deaths are coroner reportable. Nursing staff will immediately notify the Physician. The patient's demise is communicated to the law enforcement official and MHMC Security Services, who in turn will each notify the supervising agency. Refer to MHMC Housewide Administrative Manual, #1104.5: Post Mortem Care.

B. The supervising agency has legal custody of the body after death. IV's, catheters, or other tubes are NOT removed. If the body of the deceased in-custody patient is taken to Marin Health Medical Center Hospital's morgue, a law enforcement official is required to accompany the body to the morgue and remain with the deceased until the body is released. C. Post mortem responsibilities of the supervising agency include:

1. arrangement for release of body
2. arrangement for fingerprinting
3. reporting to the coroner

XVII. TRANSPORT OF IN-CUSTODY PATIENT WITHIN HOSPITAL

A. The custodial official(s) from the supervising agency is required to be present during any intra-facility transportation of the in-custody patients. The number of custodial officials present will depend on the supervising agency's policy and procedure.

XVIII. DISCHARGE OR TRANSFER TO ANOTHER ACUTE CARE FACILITY

A. Nursing staff will quietly inform the custodial official – out of earshot of the in-custody patient - of pending discharge of the in-custody patient.

B. Prior to the patients discharge, the Case Manager will confirm and finalize the discharge plan with exception to patients in the Emergency Department.

C. Prior to the patients discharge, report will be called into a clinical representative at the receiving custodial agency.

D. Upon discharge, all appropriate medical records must be copied and sent with the incustody patient. Appropriate Medical Records include:

1. History & Physical
2. Lab Reports and EKGs
3. Progress Notes
4. Discharge Summary
5. Patient Transfer Report

E. Law enforcement official from the supervising agency will arrange transportation for stable in-custody patients either being discharged to the supervising agency or transferred to another acute care facility. Refer to MHMC Housewide Administrative Policy/Procedure Manual, #1104.1: Admissions, Transfers, Discharges regarding the transfer of unstable or critically ill, and in-custody patients to another acute care facility.

REFERENCES: MHMC Policy "Security Sensitive Patients" #1610.22 MHMC Policy "Unauthorized Weapons" #1112.5
MHMC Policy "Custodial Staff Orientation" #1610.40

WRITTEN BY: Name Date:

DISTRIBUTION: Housewide

REPLACES: MHMC Housewide Administrative Manual Policy # 1106, Role of Marin County Sheriff Deputies
REVIEWED BY:

Environment of Care	Date: 3-18-2014

REVISED BY: Jeffrey Vieira Date: 03-1-2014

APPROVED BY:

Environment of Care	Date: 3-18-2014
Nursing Management Team	Date: 3-11-2014
Policy and Procedure Committee	Date: 7/23/2014
Medical Executive Committee	Date: 12/15/2014
Quality and Patient Safety Committee	Date: 01/27/2015
Board of Directors:	Date: 02/03/2015

Policy Author	Nursing
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MARINHEALTH MEDICAL CENTER
HOUSEWIDE CLINICAL MANUAL
PAIN MANAGEMENT

I. POLICY

A. Marin Health Medical Center (MHMC), as a Joint Commission-accredited hospital, meets their standards of practice for pain assessment and management. This policy outlines the practices at MHMC to assess and manage our patients' pain.

II. PURPOSE

A. The management of a patient's pain at MHMC is guided by evidence-based practices. This policy serves to outline those practices at every level of care and to ensure all state and federal regulatory requirements are met.

III. GENERAL INFORMATION

A. Background/ Scope

1. Patients at MHMC can expect to routinely be asked about their experience of pain, have it treated in a timely manner, and then to be asked whether the therapy provided adequate relief.
2. Pain assessments are tailored to meet the needs of each patient using approved validated tools that consider that patient's age, physiologic condition, medical history, preference, and cognitive/developmental status, and functional goals.
3. Patients can expect to be involved in their care decisions regarding pain management.
4. At time of discharge, patients will have pain management strategies and plans in place so they can expect ongoing pain relief outside of the hospital setting.
5. For the OB patients - refer to WIC policy #3050.34: Pain Management of the OB patient During the Intrapartum Period.

B. Definitions

1. **Comprehensive Pain Assessments** are completed with any new pain finding or event, and when a patient is new to the RN (e.g., upon admission or at shift change). These assessments include the location and level of the pain, a description of the pain using the patient's words, and the acceptable level of pain according to the patient.
2. **Focused Pain Assessments** are based on knowledge of Comprehensive Pain Assessments or knowledge derived from caring for the patient. The

focused assessment includes pain scoring before and after medications for pain, and sedation scoring if medication could be potentially sedating. At minimum, document focused pain assessment with vital signs per unit policy.

3. **PRN (Pro Re Nata)** medications are given as needed to treat a symptom such as pain. The nurse will conduct the appropriate assessment of the patient's clinical condition and administer the appropriate route and dose of PRN medication per provider orders.
4. **Assume Pain is Present (APP)** is a phrase appropriate for:
    a. Unresponsive patients who cannot self-report and have no pain behaviors to assess, but have underlying pathology thought to be painful
    b. Patients undergoing painful activities/procedures

C. Application

1. Providers at MHMC will anticipate a patient's discomfort and order appropriate therapies to relieve a patient's pain in a timely manner.
2. RNs will assess a patient's reported pain using valid and reliable assessments and reassessment of provided treatments. RNs will act in a timely manner on provider orders for pain relief, and will notify provider promptly if such orders are proven to be ineffective or unsafe.
3. Pharmacists will prepare analgesic medications (in accordance with the provider's order); and consult with nursing, medical staff, patient and family regarding pharmacological management of pain.
4. Specialists in non-pharmacologic techniques of pain management (e.g. Physical Therapists, Occupational Therapists, representatives from the Center for Integrative Health and Wellness) can provide services, interventions, and techniques for appropriate patients.
5. The Palliative Care Team/ Pain Team may be consulted by any caregiver for any patient experiencing chronic or unrelieved pain (see Policy #1106.43 Palliative Care Referral Policy). For difficult pain management issues, consider a consultation by a hospital Pain Specialist.
6. Newly-hired RNs will demonstrate knowledge of this policy and competency in pain management by the end of their initial 90 days.

IV. PROCEDURE

A. Key Steps

1. Assess pain with each full set of vital signs (temperature, heart rate, blood pressure, and respirations) per unit frequency.
2. Use an appropriate validated behavioral pain scale for patients unable to report their pain.

   a. Verbal and non-verbal pain scores are not interchangeable. Pain scores may only be compared to others using the same tool.
3. Utilize one pain assessment tool for the duration of the patient's hospitalization unless the patient's condition warrants a change of tool.
4. Reassess pain on an ongoing basis as part of routine care.
5. Wake the patient to assess pain and/or sedation if there is any concern. Conduct a full respiratory assessment of rate, depth, regularity, and noise for a full 60 seconds before doing so.
   a. It may be acceptable to let the patient sleep if they are stable on their pain regimen during the day and have a normal respiratory and sedation status.

B. Required Data Documentation

1. Document the pain score prior to any intervention intended to relieve pain, and always before pain medication administration.
2. Complete comprehensive pain assessments with the initial head-to-toe assessment at the start of the shift or at admission per unit policy.
3. Other assessments, depending on the medication used for pain management, may include:
   a. Sedation score (specifically the Pasero Opioid Sedation Score if opioids are in use)
   b. Respiratory rate counting for a full 60 seconds
   c. Other physiologic parameters
4. Document a focused pain assessment after pain medication administration at the following times:
   a. **IV:** Within 30 minutes
   b. **IM/SQ:** Within 60 minutes
   c. **PO/PR:** Within 60 minutes
   d. **Epidural/ Intrathecal bolus:** Within 30 minutes
   e. **Sublingual:** Within 30 minutes
5. Use the Pasero Opioid Sedation Score (POSS) tool, before giving any dose of an opioid for pain relief to prevent oversedation. The POSS will be reassessed and documented, and appropriate nursing measures, after the opioid administration at the same time intervals as the pain reassessment (see Attachment C).

C. Patient Education

1. The patient will receive education on non-pharmacologic options for pain management.

2. The patient will receive education on the medications used to manage pain, including the safe dosing, side effects, and expected actions.

V. AGE SPECIFIC CONSIDERATIONS

A. For patients under 18 years old who are experiencing pain, consider contacting the Child Life Specialist. (Refer to WIC Policy # 3080.56: Pain Management in Infants, Children and Adolescent). Age-appropriate pain measures include:

1. **Infants**: distraction (mobiles, toys), positioning (swaddle, rocking, nesting, infant swing), parental presence, non-nutritive sucking on pacifier, and touch (patting, rubbing). Additionally, 24% oral sucrose is used for procedural pain for infants >28 wks. gestation up to 12 months of age. (See Policy #430.08.)
2. **Toddlers**: distraction (music, video, singing, bubbles, pop-up books), positioning (parent holding, swaddling), breathing (blowing bubbles, pretending to blow candles, wolf blowing down house) and cutaneous stimulation (touch, massage, ice/heat).
3. **School-age patients and adolescents**: distraction (detailed books, music with headphones, videotapes, video games), parental presence, relaxation techniques (progressive relaxation).

B. For the **extremely aged**, non-verbal, or cognitively-impaired patients, a valid and reliable pain scale appropriate to the patient's level of cognition will be used.

1. Nonpharmacologic and cognitive behavioral activities may be helpful, if appropriate.
2. If a painful procedure was done recently, and the patient is unable to verbalize pain, assume pain is present, treat for pain, and reassess for changes in behavior.
3. Utilize family reports of behaviors that may indicate pain.

VI. EQUIPMENT

A. End-tidal CO_2 and respiration monitors will be used if patients demonstrate a POSS score of 3 or greater (see Attachment C)
B. Oxygen saturation monitor for patients on Patient-Controlled Anesthesia (PCA) infusion
C. Vital Sign monitor
D. Patient-Controlled Anesthesia (PCA) infusion channel
E. Intraspinal Narcotic infusion channel
F. IV infusion pumps
G. Medication dispensing unit

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VII. APPENDICES

Appendices and Attachments	Title
Attachment A	Adult Pain Assessment Tools
Attachment B	Pediatric Pain Assessment Tools
Attachment C	Sedation Scales
Attachment D	PRN Analgesic FAST-PACE Assessment Tool
Attachment E	PRN Analgesic Decision Trees for Opioid Naive
Attachment F	PRN Analgesic Decision Trees for Opioid Tolerant

VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION

A. Replaces: NA
New Title: NA

B. Authority/ Reference

1. UCSF Pain Management Policy 10115382
2. Nettina, Sandra M. (2019). Lippincott Manual of Nursing Practice, Eleventh Edition. Philadelphia, Pennsylvania: Lippincott Williams and Wilkins.
3. Housewide Administrative Manual Policy # 1106.43 Palliative Care Referral Policy
4. WIC Policy #3050.34: Pain Management of the OB Patient During the Intrapartum Period
5. NICU Policy #420-08: Pain Control in Infants with Use of 24% Oral Sucrose Solution

C. Originators and Authors

Department or Function	Name	Title	Date
Originating Departments Nursing	NA		11/1991
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D. Reviewed or Revised By

Department, Committee or Function	Subject Matter Experts Name	Title	Date
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Hospital Board of Directors	Andrea Shultz	Chair, Hospital Board of Directors	04/04/2023

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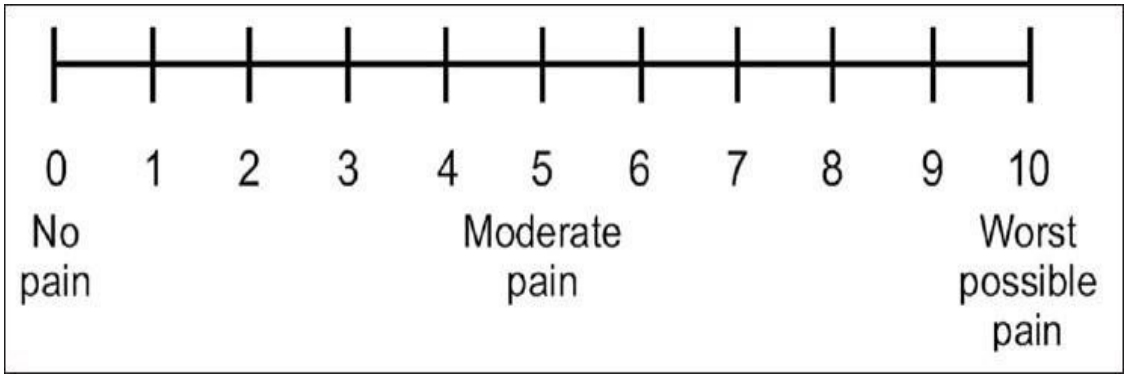
Attachment A: Adult Pain Assessment Tools

Adult Self-Reporting Pain Tools

Tool	Recommended Age and Indications for Use	Recommended Unit/Area for Use
Numeric Rating Scale (NRS) (0-10, eyes closed, patient calm)	Ages ≥ 6 years to adult; patient must be, able to understand numeric comparisons/quantity	Adult patient care areas

Numeric Pain Rating Scale (0-10)



How to use: Ask the patient, "On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you've experienced, at this moment, what number represents your overall pain level?" Patient to select one whole value within this scale.

Verbal Descriptor Scale (VDS) (none, mild/moderate/severe, eyes closed/patient calm)	Ages >6. Able to understand terms mild, moderate, and severe as comparisons	Adult patient care areas

Policy Author	Nursing
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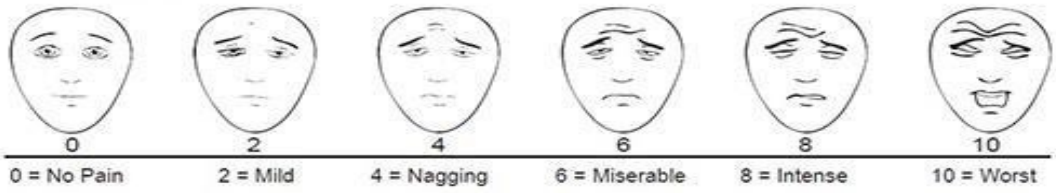
FACES Pain Scale-Revised (FPS-R)	Patients must select the face that best represents their experience of pain in that moment.	Adult patient care areas

FACES Pain Scale-Revised (FPS-R):



How to use: Show patient the faces scale. Explain the tool, “These faces show how much something can hurt.” Point to zero picture and state, “This one shows no pain.” Point to ten picture and state, “This one shows worst pain experienced”. Then ask patient, “What face best represents your pain level right now?” *Patients* must select the face that best represents their experience of pain in that moment.

Adult Behavioral Pain Assessment Tools		
Tool	**Recommended Age and Indications for Use**	**Recommended Unit/Area for Use**
Checklist of Nonverbal Pain Indicators (CNPI)	Adults unable to self-report	Adult hospital, acute and transitional care units

Policy Author	Nursing
Origination Date	11/1991
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Checklist of Nonverbal Pain Indicators (CNPI)

How to use: Observe the patient for a minute at both rest and during movement before selecting a score for each behavior. Select only one numeric value per observed behavior with movement and at rest.

0 = NOT OBSERVED | 1 = OBSERVED WITH MOVEMENT AND/OR AT REST

BEHAVIOR INDICATORS	WITH MOVEMENT	AT REST
1. **Vocal complaints; nonverbal** (Sighs, gasps, moans, groans, cries)		
2. **Facial Grimaces/Winces** (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)		
3. **Bracing** (Clutching or holding onto furniture, equipment, or affected area during movement)		
4. **Restlessness** (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. **Rubbing** (Massaging affected area)		
6. **Vocal complaints; verbal** (Words expressing discomfort or pain [e.g., "ouch," "that hurts"]; cursing during movement; exclamations of protest [e.g., "stop," "that's enough"])		
SUBTOTAL SCORES	+	
TOTAL CNPI SCORE (ADD BOTH SUB TOTALS)		/12

Policy Author	Nursing
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Critical Care Pain Observation Tool (CPOT)	Critically ill adults unable to self-report	Adult critical care areas

How to use: Observe the patient for a minute before selecting a score for each behavior. Muscle tension should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses. Select only one numeric value per behavior. If the patient is ventilated assess for compliance with the ventilator. If the patient is not ventilated assess for vocalization.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
Facial expressions 	Relaxed, neutral	0	No muscle tension observed	
	Tense	1	Presence of frowning, brow lowering, orbit tightening and levator contraction, or any other change (e.g., opening eyes or tearing during nociceptive procedures)	
	Grimacing	2	All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)	
Body movements	Absense of movements or normal position	0	Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)	
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	
	Restlessness	2	Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement	0	Alarms not activated, easy ventilation	
	Coughing but tolerating	1	Coughing, alarms may be activated but stop spontaneously	
	Fighting ventilator	2	Asynchrony: blocking ventilation, alarms frequently activated	
OR				
Vocalization (extubated patients)	Talking in normal tone or no sound	0	Talking in normal tone or no sound	
	Sighing, moaning	1	Sighing, moaning	
	Crying out, sobbing	2	Crying out, sobbing	
Muscle tension (Assess last) **Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned**	Relaxed	0	No resistance to passive movements	
	Tense, rigid	1	Resistance to passive movements	
	Very tense or rigid	2	Strong resistance to passive movements, incapacity to complete them	
			TOTAL CPOT SCORE	**/8**

Policy Author	Nursing
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Attachment B: Pediatric Pain Assessment Tools

Pediatric Self-Reporting Pain Tools

Tool	Recommended Age and Indications for Use	Recommended Unit/Area for Use
Numeric Rating Scale (NRS) (0-10, eyes closed, patient calm)	Ages ≥ 6 years to adult; patient must be able to understand numeric comparisons/quantity	All pediatric patient care areas
Verbal Descriptor Scale (VDS) (none, mild/moderate/severe, eyes closed/patient calm)	Ages > 6 and able to understand terms mild, moderate, and severe as comparisons.	All pediatric patient care areas
Wong-Baker FACES Scale	Ages ≥3 years to adult, able to recognize faces	All pediatric patient care areas

Wong-Baker FACES Pain Rating Scale

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Pediatric Behavioral Pain Assessment Tools

Name of tool	Recommended age and indications for use
Neonatal Pain and Assessment Scale (N-PASS)	Premature and term infants 0-100 days of age, and 23 weeks gestation and above

Neonatal Pain and Assessment Scale (N-PASS)

BEHAVIOR INDICATORS	SEDATION SCORING	SEDATION		NORMAL/ PAIN	PAIN/AGITATION		PAIN/ AGITATION SCORING
		-2	-1	0/0	1	2	
Crying Irritability		No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals; Consolable	High-pitched or silent-continuous cry; Inconsolable	
Behavior State		No arousal to any stimuli; No spontaneous movement	Arouses minimally to stimuli; Little spontaneous movement	Appropriate for gestational age	Restless, squirming; Awakens frequently	Arching, kicking; Constantly awake or Arouses minimally no movement (not sedated)	
Facial Expression		Mouth is lax; No expression	Minimal expression with stimuli	Relaxed appropriate	Any pain expression, intermittent	Any pain expression, continual	
Extremities Tone		No grasp reflex; Flaccid tone	Weak grasp reflex; decreased muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay; Body is not tense	Continual clenched toes, fists, or finger splay; Body is tense	
Vital Signs HR, RR, BP, SaO_2		No variability with stimuli; Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline; SaO_2 76-85% with stimulation – quick increase	Increase greater than 20% from baseline; SaO_2 less than or equal too 75% with stimulation – slow increase; Out of sync/ fighting vent	
Gestation/ Corrected age	N/A						
TOTAL SEDATION SCORE	/-10					TOTAL PAIN/ AGITATION SCORE	/13

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	SEDATION	PAIN/AGITATION
How to Use	• Sedation does not need to be assessed/scored with every pain assessment • Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior.	• Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior.
Scoring/ Documentation	• Sedation scores are negative scores only • Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) • NPASS Sedation total score has a range from 0 to -10 possible. • Document total NPASS Sedation score in the medical record.	• Pain/Agitation scores are positive scores only • Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. • Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. • NPASS Pain/Agitation total score has a range from 0 to 13 possible. • Document the total NPASS Pain/Agitation score in the medical record

Interpretation	• Desired levels of sedation vary according to the situation.
	• Discuss and determine sedation goal with provider.
	  • "Deep sedation": goal score of -10 to -5
	  • Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea
	  • "Light sedation": goal score of -5 to –2
	• Reassess patient per frequency in local sedation policy
	  • A negative score without the administration of opioids/ sedatives may indicate:
	  • The premature infant's response to prolonged or persistent pain/stress
	  • Neurologic depression, sepsis, or other pathology
		• Does not provide pain intensity rating.
		• Any score greater than 3 indicates the possibility of the presence of pain in the infant
		  • Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological).
		  • Reassess patient per frequency of local pain policy.
		  • If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.

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Neonatal Infant Pain Scale (NIPS)	Term newborns – to less than one year

Neonatal Infant Pain Scale (NIPS)

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
FACIAL EXPRESSION	**Relaxed Muscles** Restful face, neutral expression	**Grimace** Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression - nose, mouth and brow)	N/A	
CRY	**No Cry** Quiet, not crying	**Whimper** Mild moaning, intermittent	**Vigorous Cry** Loud scream; rising, shrill, continuous	
BREATHING PATTERNS	**Relaxed** Usual pattern for this infant	**Change in Breathing** Indrawing, irregular, faster than usual; gagging; breath holding	N/A	
ARMS	**Relaxed/Restrained** No muscular rigidity; occasional random movements of arms	**Flexed/Extended** Tense, straight arms; rigid and/or rapid extension, flexion	N/A	
LEGS	**Relaxed/Restrained** No muscular rigidity; occasional random leg movements	**Flexed/Extended** Tense, straight legs; rigid and/or rapid extension, flexion	N/A	
STATE OF AROUSAL	**Sleeping/Awake** Quiet, peaceful sleeping or alert random leg movement	**Fussy** Alert, restless, and thrashing	N/A	
TOTAL NIPS SCORE				/7

The NIPS assesses six behavioral indicators in response to painful procedures in preterm newborns (gestational age < 37 weeks) and full-term newborns (gestational age > 37 weeks to 6 weeks after delivery).

How to use: Observe the infant for one minute before selecting a score for each behavior. Select only one numeric value per behavior.

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Face, Legs, Activity, Cry, Consolability (FLACC)	Pediatric patients unable to self-report, ages 2 months to 18 years of age who are unable to self-report pain.

Face, Legs, Activity, Cry, Consolability (FLACC)

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, **sad appears worried**	Frequent to constant quivering chin, clenched jaw, **distressed looking face, expression of fright/panic**	
LEGS	Normal position or relaxed, **usual tone & motion to limbs**	Uneasy, restless, tense, **occasional tremors**	Kicking, or legs drawn up, **marked increase in spasticity, constant tremors, jerking**	
ACTIVITY	Lying quietly, normal positions moves easily, **regular, rhythmic respirations**	Squirming, shifting back and forth, tense, **tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs**	Arched, rigid or jerking, **severe agitation, head banging, shivering, breath holding, gasping, severe splinting**	
CRY	No cry, (awake or asleep)	Moans or whimpers; occasional complaint, **occasional verbal outbursts, and/or grunting**	Crying steadily, screams or sobs, frequent complaints, **repeated outbursts, constant grunting**	
CONSOLABILITY	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractable	Difficulty to console or comfort, **pushing caregiver away, resisting care or comfort measures**	
			TOTAL R-FLACC SCORE	/10

The Faces-Legs-Agitation-Cry-Consolability – Revised (FLACC-R) is a behavior-based scale for children who cannot report pain either due to age or developmental stage. Suggested for use in children developing normally from ages 1-4 years or in children with developmental delays from ages 1 year to adult.

How to Use: Observe the patient for a minute before selecting a score for each behavior. Select only one numeric value per behavior.

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Attachment C: Sedation Scale

Pasero Opioid-Induced Sedation Scale (POSS)

POSS Score	Description	Nursing Action
S	Sleepy, easy to arouse	Acceptable, no action needed
1	Awake and alert	Acceptable, no action needed
2	Slightly drowsy, easily aroused	Acceptable, no action needed
3	Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable, initiate beside respiratory rate and end tidal CO_2 monitoring until POSS score is less than 3. Notify provider and recommend decreasing opioid doses by 25-50%, lengthening time interval between opioid doses, and/or alternating with non-opioid pain relief options
4	Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable, hold all opioids and consider calling a RRT and prepare to administer naloxone. Initiate beside respiratory rate and end tidal CO_2 monitoring until POSS score is less than 3. Notify provider or anesthesiologist.

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Attachment D: PRN Analgesic FAST-PACE Assessment Tool

- **F = Functional goals**: Does the analgesia help the patient achieve their mobility goals?
- **A = Airway:** Is there potential risk of respiratory depression? Do they have concurrent sedating medications, sleep apnea, or other airway concerns?
- **S = Sedation score**: How sedated is the patient? Use the Pasero Opioid Sedation Scale (POSS) or Richmond Agitation Sedation Scale (RASS) (in critical care) to determine if is it safe to administer opioids.
- **T = Tolerance to opioids**: Has the patient recently been taking opioids? Does the patient have a history of Opioid Use Disorder (OUD) or Substance Use Disorder (SUD)? If yes, they will likely have increased opioid requirements.
- **P = Pain intensity score**: What is the patient's pain score? It is important to consider the patient's pain report, however, this is just one element of the pain assessment. If the person reports pain that is mild or under control, opioids are generally not needed.
- **A = Age:** Start low and go slow, especially with older adult and children.
- **C = Comorbidities**: Will patients underlying disease state affect how the medication is metabolized or excreted? Check their renal and liver function values.
- **E = Evaluation of pharmacokinetics**: What is the mechanism of action of the drug and how will the drug interact with other agents the patient is ordered?

Policy Author	Nursing
Origination Date	11/1991
Current Review Date(s)	9/2013, 08/2022, 2/2023
Current Revision Date(s)	01/2007, 4/2019, 1/2023

Attachment E: PRN Analgesic Decision Trees for *Opioid Naive*

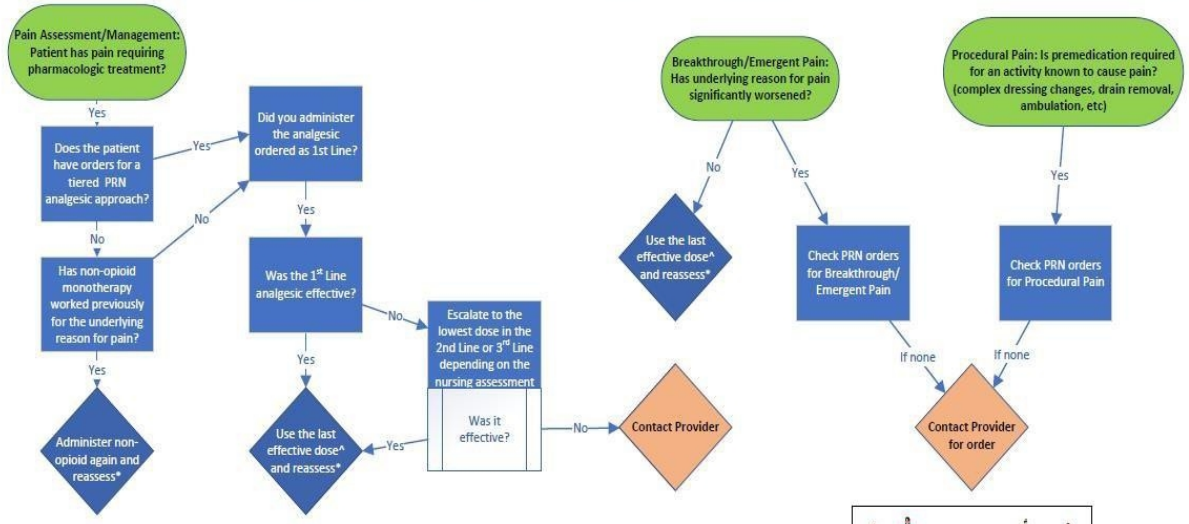
UCSF Health PRN Analgesic Decision Tree For Opioid Naïve* Patients

*Patients who are not receiving opioid analgesics on a daily basis or patients who consume opioids for fewer than 7 days in the 60 days prior to hospital admission

Effective March, 2022

Guiding principles:

- We highly encourage the use and documentation of nonpharmacological methods (for example ice, heat, reposition and distraction)
- Start low go slow. Always reconsider the lowest effective opioid dose in pain management, and slowly increase the dose and/or frequency only if the patient's pain is unresponsive to the previously administered medication
- Administer oral agents prior to IV whenever possible
- Use multimodal therapy and nonpharmacological interventions whenever appropriate
- Contact provider if unclear which medication or dose to administer, if available opioid and non-opioid orders do not control pain, or if intolerable adverse effects are present



*Reassess pain within 30 minutes after an IV dose and 90 minutes after enteral/oral dose

^Identify the range time interval (e.g. every 4 hours) to determine the total amount of drug already given during that timeframe. The total drug administered within that range must not exceed the maximum dose allowed.

UCSF Medical Center
Center for Nursing Excellence and Innovation

Please direct any questions to Marilyn Bazinski, Pain CNS (marilyn.bazinski@ucsf.edu)

Policy Author	Nursing
Origination Date	11/1991
Current Review Date(s)	9/2013, 08/2022, 2/2023
Current Revision Date(s)	01/2007, 4/2019, 1/2023

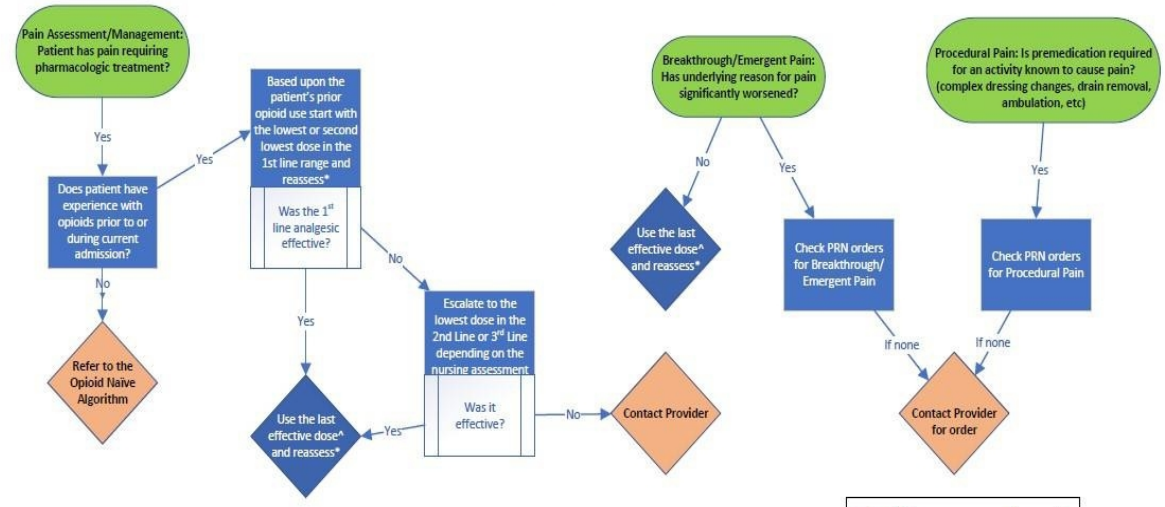
Attachment F: PRN Analgesic Decision Trees for *Opioid Tolerant*

UCSF Health PRN Analgesic Decision Tree For Opioid Tolerant* Patients

*Patients receiving at least **60 mg** oral morphine equivalents (OME) per day for 1 week or longer

Effective March, 2022

Guiding principles:
- We highly encourage the use and documentation of nonpharmacological methods (for example ice, heat, reposition and distraction)
- Start low go slow. Always reconsider the lowest effective opioid dose in pain management, and slowly increase the dose and/or frequency only if the patient's pain is unresponsive to the previously administered medication
- Administer oral agents prior to IV whenever possible
- Educate your patients about multimodal therapy and nonpharmacological interventions
- Contact provider if unclear which medication or dose to administer, if available opioid and non-opioid orders do not control pain, or if intolerable adverse effects are present



*Reassess pain within 30 minutes after an IV dose and 90 minutes after enteral/oral dose
^Identify the range time interval (e.g. every 4 hours) to determine the total amount of drug already given during that timeframe. The total drug administered within that range must not exceed the maximum dose allowed.

UCSF Medical Center
Center for Nursing Excellence and Innovation

Please direct any questions to Marilyn Bazinski, Pain CNS (marilyn.bazinski@ucsf.edu)

I. POLICY

A. Patients who present a significant risk to themselves are identified, assessed, and provided interventions to reduce risk of self-harm and ensure safety.

B. All patients who are being evaluated or treated for behavioral health conditions as their primary reason for care must be screened for suicidal ideation using a validated screening tool.

II. PURPOSE

A. Patients are dependent upon the hospital for their safety and well-being, so it is essential to initiate appropriate safety measures when patient safety and well-being are at risk.

B. Patients being treated primarily for a medical condition may have comorbid behavioral health conditions, a change in clinical status that carries a poor prognosis, or psychosocial issues. These patients may be at risk for suicide, and it is important for clinicians to properly assess these individuals for suicidal ideation as part of their overall clinical evaluation when indicated.

III. GENERAL INFORMATION

A. Background/Scope

1. All patients who present to the Emergency Department or who are admitted to the hospital, including outpatient areas, with a primary diagnosis or primary complaint of an emotional or behavioral disorder, including substance abuse and dependence disorders, require a suicide risk assessment.
2. The risk assessment may be deferred for patients who are primarily receiving treatment for a medical condition whether or not their condition was due an act of self-harm.
3. The risk assessment is required when the focus of treatment is an emotional or behavioral disorder.
4. Those who have already attempted suicide are presumed to be a high suicide risk, so they require immediate attention to secure their safety as well as timely psychiatric intervention as their medical condition permits.

B. Definitions

1. **Columbia-Suicide Severity Rating Scale (C-SSRS**): a tool for assessing and monitoring suicide risk.
2. **EHR**: electronic health record
3. **Suicide risk assessment:** a comprehensive clinical evaluation performed by a

healthcare professional to determine an individual's immediate and long-term likelihood of dying by suicide.

C. Patient Specific Considerations

1. This policy will be applicable to all inpatient units and the Emergency Department.
    a. Inpatient behavioral health will follow the unit specific policy (refer to BH 506.1 Assessment of the Suicidal Patient).
    b. As required by The Joint Commission, all patients age twelve (12) and above, with a primary behavioral health condition, will be screened for suicidal ideation using a validated screening tool.

B. Responsible Parties

1. Initial suicide screening will be performed by a Registered Nurse (RN) as part of the nursing assessment.
2. Social Workers, psychologists, and psychiatrists may perform follow up assessments as a result of the initial screening or may initiate a new screening based on clinical presentation or other assessment.
3. Upon hire nursing and behavioral health staff will receive training in suicide screening and assessment.
    a. Competency will be assessed and maintained annually thereafter.

IV. PROCEDURE

A. Key Steps

1. The patient's immediate safety needs and the initial most appropriate setting are addressed by the attending MD and nursing staff.
    a. All safety measures will be carried out in a respectful and informative manner with attention to patient's rights and dignity. The suicide risk assessment is performed by the hospital Licensed Clinical Social Worker, or a psychologist or psychiatrist with staff privileges. The suicide risk assessment includes identification of the specific factors and features of the patient's situation that may increase or decrease the risk for suicide.
    b. Assessment, reassessment, and treatment of emotional and behavioral problems are addressed as indicated by the overall psychosocial assessment and as the medical condition of the patient permits.
2. All admitted patients will be screened for suicide risk using a validated screening tool. The Columbia Suicide Severity Rating Scale (C-SSRS) is the

screening tool that will be utilized at MarinHealth Medical Center (refer to Appendix 1).

   a. Additionally, the physician or RN will determine whether the patient is on an involuntary psychiatric hold (W&I Code Sections 5150 & 5250).
      i. The physician or nurse will order a Psychiatric Consult or contact the on duty LCSW to complete a Psychosocial Assessment and Suicide Risk Assessment.

3. If the patient has a **moderate** suicide risk level:
   a. RN to notify attending of risk level
   b. Place a Social Work consult
   c. Assess safety of the patient's environment
   d. ACSW or LCSW will complete Suicide Risk Assessment and Psychosocial Assessment (refer to ADM 1106.24.2 Psychosocial & Psychiatric Evaluation and Treatment Services).
4. If the patient has **high** suicide risk level:
   a. RN to notify attending of risk level
   b. Notify Administrative Nurse Supervisor (ANS) to initiate 1:1 observation using safety attendant or unit staff then the patient will require an appropriate level of observation in accordance with CLN 436.04.1 Sitter Usage, Assessment, Implementation, and Discontinuation.
   c. Place consult to Psychiatry CL Team
   d. Assess safety of patient's environment
   e. Expedite patient belongs inventory and store outside of the room
   f. Ensure special diet caution tray
   g. LCSW will complete Suicide Risk Assessment and Psychosocial Assessment (refer to ADM 1106.24.2).
   h. Complete High Suicide Risk Safety Checklist (refer to Appendix 2).
5. Convert Room for Safety
   a. Converting an inpatient room for safety may be done with other interventions and is not a stand-alone safety measure.
      i. Conversion of a regular room to room modified for safety is a coordinated effort from Nursing, Security, Engineering and Facilities Planning, Nutrition Services, and may include other departments.
      ii. The decision to modify a room for safety will be determined by the interdisciplinary team and will consider the risks versus benefits of removing routine equipment and supplies used for patient care.
      iii. Remove items that may be used by the patient to inflict harm to self (refer to Appendix 2 and 3).
      iv. Locate the patient in a room that maximizes safety such as near a nursing station when appropriate.
      v. Assess and disable patient room bathroom door if lockable.

6. Initial Assessment and Follow up (performed by LCSW)
    a. The LCSW who assessed the patient, with input from the support system, reports back to the attending MD and nursing staff regarding the patient's estimated suicide risk. In addition, the report includes their evaluation of how the patient's overall psychosocial situation is being addressed based on the initial psychosocial assessment and follow up services. These may include:
        i. Arrangements for a psychiatrist consultation. Indicators are the patients being on an involuntary hold and/or having symptoms of a major mental illness.
        ii. Arrangements for psychiatric inpatient treatment. This would be likely under both of the above circumstances.
        iii. Recommendations for behavioral management
        iv. Concurrent psychosocial treatment during acute medical treatment.
        v. Providing information and referral resources to staff, the patient, and the support system.
7. Discharge
    a. The patient and family are provided follow up information and resources including methods of managing crisis situations. Crisis Hotline numbers and follow up is provided according to the assessed needs of the patient.

B. Documentation

1. Documentation and Reassessment in the EHR (performed by RN and LCSW)
    a. Emergency Department RNs
        i. C-SSRS will appear within the ED Narrator
    b. Unit RNs
        i. RNs will document the C-SSRS for new admissions under the admission navigator
            - If the result is, "Unable to Calculate" the documentation was wrong and incomplete and will need to resolved before moving on.
        ii. If the patient is unable to be assessed, document the reason.

iii. If the patient was already screened in the Emergency Department, the patient does not need to be rescreened unless there is a change in patient's condition.

iv. Document presence of safety attendant and reasons for safety attendant use

v. A documented moderate or high-risk C-SSRS will trigger the suicide documentation group to open under Daily Cares/Safety Flowsheet and Vital Signs/Vital Signs Complex Flowsheet. If the documentation group does not open and is needed to document safety precautions, it can be manually added.

c. Notification of the referral to the on-duty or on-call LCSW is made on the care plan with elaboration as needed in the nursing notes. Documentation of safety precautions is done in the nursing notes.

d. The initial psychosocial assessment and the initial suicide risk assessment are documented in the EHR. LCSW reassessment and follow up documentation is done in the EHR.

V. AUTHORITY STANDARDS and REFERENCES

A. California Welfare & Institutions Code, Sections 5150 & 5250 et sec.

B. CMS §482.13(c)(2), The Right to Receive Care in a Safe Setting

C. The Joint Commission National Patient Safety Goals (NPSG) Standard NPSG.15.01.01 EP 1, EP 2

VI. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Document Title
Appendix 1	Columbia Suicide Severity Rating Scale (C-SSRS)
Appendix 2	High Suicide Safety Checklist
Appendix 3	Sharps List/Dangerous Objects

VII. Subject Matter Experts Reviewers

Department, Committee or Function	Subject Matter Experts Name	Person's Title	Date
Critical Care			01/01/1997
Behavioral Health		Clinical Nurse Manager	03/17/2017
Behavioral Health	Rebecca Maxwell, LCSW	Director	09/01/2020

Department, Committee or Function	Subject Matter Experts Name	Person's Title	Date
Critical Care			01/01/1997
Behavioral Health	Rebecca Maxwell, LCSW Liz Fischel, LCSW Gwen Sampson Brown, RN Stephen Allison, MD	Director, Behavioral Health Manager, Clinical Social Work Clinical Nurse Manager Chair, Psychiatry	09/28/2023
Behavioral Health	Rebecca Maxwell, LCSW	Director	06/15/2024

Appendix 1: Columbia Suicide Severity Rating Scale (C-SSRS)

Colors indicate level of risk.
Yellow: low
Orange: moderate
Red: high

Ask questions that are bolded	Past Month	
	YES	NO
1. Have you ever wished you were dead or wished you could go to sleep and not wake up?		
2. Have you actually had any thoughts of killing yourself?		
If YES to #2, ask questions 3, 4, 5 and 6. If NO to #2, go directly to question 6.		
3. Have you been thinking about how you might do this? i.e., "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it".		
4. Have you had these thoughts and had some intention of acting on them? i.e., "I have the thoughts but I definitely will not do anything about them".		
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? i.e., collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Lifetime	
	Past 3 months	
7. If YES, was this within the past three months?		

Item 1: Behavioral health referral at discharge.

Item 2: Behavioral health referral at discharge.

Item 3: Behavioral health consult (psychiatric nurse/social worker) and consider patient safety precautions.

Item 4: Immediate notification of physician and/or behavioral health and patient safety precautions.

Item 5: Immediate notification of physician and/or behavioral health and patient safety precautions.

Item 6 (over six months ago): Behavioral health consult (psychiatric nurse/social worker) and consider patient safety precautions.
Item 6 (3 months ago or less): Immediate notification of physician and/or behavioral health and patient safety precautions.

Appendix 2: High Suicide Safety Checklist

	If already screened in the ED	If not yet screened
Prior to arrival	Completed by bedside RN/charge RN and safety attendant. ☐ Place patient in a room that maximizes safety, preferably in the SPH rooms. ☐ Contact security for room assessment and to secure patient belongings (remove from room). ☐ Complete skin/safety check and provide patient with purple scrubs. ☐ Remove all unnecessary equipment and prepare room for safety. ☐ Maintain 1:1 observation at all times including bathroom use.	
Upon arrival	Completed by bedside RN/charge RN and safety attendant. ☐ Place patient in room that maximizes safety. ☐ Contact security for room assessment and to ensure patient belongings have been secured (remove from room). ☐ Remove all unnecessary equipment and prepare room for safety. ☐ Ensure bathroom door cannot be locked (contact engineering if necessary) or review process to access bathroom if door is lockable. ☐ Call light cord shortened and zip tied to bed frame (if call light necessary). ☐ Maintain 1:1 observation at all times including bathroom use. ☐ Maintain use of purple scrubs. ☐ Verify that Psychiatric C-L team is following patient. ☐ Order safety tray for meals: disposable diet tray (plastic utensils, paper plates, no	☐ Complete C-SSRS**, if high-risk**: ☐ Place patient on 1:1 observation. ☐ Notify Charge RN/ANS, Primary Provider, and consult order to Psych C-L. ☐ Place patient in room that maximizes safety. ☐ Complete skin/safety check and provide with purple scrubs. ☐ Contact security for room assessment and to ensure patient belongings have been secured (remove from room). ☐ Remove all unnecessary equipment and prepare room for safety. ☐ Ensure bathroom door cannot be locked (contact engineering if necessary) or review process to access bathroom if door is lockable. ☐ Call light cord shortened and zip tied to bed frame (if call light necessary). ☐ Order safety tray for meals – disposable diet tray (plastic utensils, paper plates, no cans/glass, no hard plate cover, or plastic tray).

	cans/glass, no hard plate cover, or plastic tray).	
Room safety	☐ Remove: chairs, tables, nonessential medical equipment, any loose/nonessential items. ☐ Remove or secure: nonessential cords, hospital phone (including chargers for personal devices), computers, curtains, sharps container (empty). ☐ Empty content and secure: cabinets, closets, lockers (in room and restroom). ☐ Ensure any windows are locked; no patio access is permitted at any time.	
Reassess every shift	☐ Patient in purple scrubs – unless otherwise specified by Psychiatry. ☐ Ensure bathroom door cannot be locked (contact engineering if necessary) or review process to access bathroom if door is lockable. ☐ Unnecessary equipment removed (per room safety plan above). ☐ Call light cord shortened and zip tied to bed frame (if call light necessary). ☐ Ensure sharps container is empty. ☐ Patient observed at all times by safety attendant (including when visitor in room and direct line of site during showering and toileting). ☐ Ensure use of safe meal service (disposable diet tray, plastic utensils, paper plates, no cans/glass, no hard plate cover, or plastic tray). ☐ No personal items in room unless otherwise specified by Psychiatry team. ☐ Assess for change in acuity, contact Psych CL as needed, assess patient's room for safety; provide patient/family education as needed.	

Appendix 3: Sharps List/Dangerous Objects

Personal Items	Dietary	Medical Supplies
Metal picks	Metal silverware	Needles/sharps that are unattended by a medical professional
Hair clips	Glass drinking cups	Push pins/tacks
Pins	Ceramic plates/bowls, etc.	Glass essential oil bottles
Tweezers	Aluminum cans	Glass medication containers
Fingernail files/ clippers		*ensure sharps container is changed daily
Scissors		
Needles		
Hooks		
Disposable razors/razor blades		
Metal cans		
Glass products		
Breakable hard plastic		
Makeup compact case		
Letter opener		
Knife (all types)		
Coat hangers		
Picture frames with glass/metal		
CDs		
Pens/pencils		

I. POLICY

A. To promote a safe environment at MarinHealth Medical Center, all hospital staff will assume that all patients are at risk of falling and their care must include appropriate measures to prevent a fall individualized to each patient's needs.

B. Every nurse (RN) will address the patient's fall risk in their assessments, and they will identify measures to take to prevent falls. Safety measures to prevent falls will be shared and supported by all staff during transitions throughout the hospital, and reassessed whenever there is a significant change in status, including post-procedure, on transfer to another unit, or after a fall.

II. PURPOSE

A. To provide guidance in fall prevention to all health care staff caring for patients at the Medical Center.

III. GENERAL INFORMATION

A. Background/Scope

1. All patients are considered at risk for falls while in the Medical Center for many reasons:
    a. Muscle and strength weakness
    b. Gait and balance disorders/impaired mobility
    c. Visual Disturbances
    d. Cognitive impairment/mental status alteration
    e. Agitation/delirium
    f. Dizziness/vertigo
    g. Postural hypotension
    h. Polypharmacy
    i. Age
    j. Sleep disturbances
    k. Incontinence/frequent toileting/diuretic
2. Environmental factors that contribute to falls in the hospital include the unfamiliarity of the surroundings and lighting controls, spills or wet floors, electrical cords, and device tubing, to name a few. All staff receive education to be mindful of patient and visitor safety in their daily work.
3. The responsibility for the fall risk assessment is with the RN assigned to care for the patient. Based on the nursing assessment, care providers will maintain an environment of care appropriate for the patient's assessed fall risk.
4. After the RN's assessment is completed, the provider orders appropriate therapy to assist with safe patient mobilization if indicated.

5. The fall risk assessment will be charted on the EHR (refer to Appendix 6), or on appropriate paper forms should the computer system be unavailable or not used in a particular procedural area.
6. Patient and family education regarding the individual fall risk factors pertaining to them will be completed as part of the fall prevention strategy. Families and visitors are valuable partners in support of the patient's fall prevention plan and should be engaged by the care team to support fall prevention measures.

B. Definitions

1. **Fall**: any sudden unintentional change in position that causes an individual to land at a lower level, on an object, on the floor, or on the ground.
2. **EHR**: electronic health record

C. Patient Specific Considerations

1. Pediatric Considerations (refer to Appendix 7).
    a. Assessment and care of the pediatric patient should include the knowledge that younger children are at risk of falling. Falls are most common after 4 months of age, when the infant has learned to roll over, but they can occur at any age.
    b. All infants are considered high risk for falling, and high-risk prevention interventions will be implemented. Parents/caregivers must be informed of the following safety precautions:
        i. Never place a child unattended on a raised surface that has no guardrail or safety stop.
        ii. Maintain hand contact while caring for a child when the crib side rails are down.
    c. The Maternity and NICU departments use an approved validated tool to assess the fall risk of their infant and pediatric patient population.
    d. Pediatric patients under age fourteen (14) will not receive Fall Risk alert clasp on the armband as it can be a choking hazard.

D. Responsible Parties

1. All individuals who provide direct patient care or have duties inside patient care areas are to be alert to any potential fall risks for staff or patients in the Medical Center.
2. The patient's assigned RN will assess the patient's fall risk at the start of the shift and again per unit policy. The RN will share the patient's fall risk and any prevention measures in place during care transitions.
3. Certified Nursing Assistants (CNAs), rehab personnel, and other staff who provide direct patient care are responsible for being aware of the patient's fall risk and any fall prevention measures in place, and they will support all efforts to prevent patient falls.

IV. PROCEDURE

A. Key Steps

1. Medical Center RNs will use the approved validated fall risk assessment which scores the patient's risk of falling while in the hospital setting as a guide to creating an individualized fall prevention strategy for each patient.
    a. The score determines whether the patient is a Standard or High Fall Risk Interventions (refer to Appendix 1).
    b. All clinical staff will ensure these interventions supported and used consistently.
2. Clinical staff will receive education on fall prevention and safe patient handling during hospital orientation and periodically, based on clinician needs.
3. Should a fall occur, Medical Center staff take steps appropriate to the degree of injury and according to best practices and regulatory guidelines.

B. Documentation

1. The RN will assess the patient's fall risk on admission, after procedures, on transfer to another level of care, and at the start of every shift per unit assessment frequency. These data are entered into the EHR (or on paper forms during downtime).
2. Appropriate fall prevention measures will be put in place and documented in the EHR every shift by the RN.
3. If a fall occurs, a Post-Fall Huddle Worksheet (refer to Appendix 4) will be completed and submitted to the unit's manager or director. Data collected on this form is used to complete the Safety Incident Report in the risk management system (refer to ADM 1106.11.5 Safety Event Reporting).
4. If a fall occurs with known or suspected injury, a Rapid Response (refer to CLN 1105.12 Rapid Response Team) is called and documented in the EHR (or on paper during downtime). Once the patient is stabilized, a new fall risk assessment will be completed by the RN and any needed fall protocol measures will be documented anew.

C. Patient Education

1. On admission, patients and families will receive education about the heightened risk of falling in the hospital setting individualized to the patient's condition.
2. Patients will be educated about their assessed fall risk and the measures in place to prevent falls by their care team.
3. Procedural areas will include post-procedure fall risk education to their patient education at time of discharge if relevant.

V. AUTHORITY STANDARDS and REFERENCES

A. The Joint Commission. Provision of Care, Treatment, and Services (PC). PC.01.02.08 EP 1.

B. Susan Li, Kamalakar Surineni, Falls in Hospitalized Patients and Preventive Strategies: A Narrative Review, The American Journal of Geriatric Psychiatry: Open Science, Education, and Practice, Volume 5, 2025, Pages 1-9, ISSN 2950-3868, https://doi.org/10.1016/j.osep.2024.10.004.

VI. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Document Title
Appendix 1	Standard or High Fall Risk Interventions
Appendix 2	Steps to Take If a Fall with Injury Occurs
Appendix 3	Post-Fall Huddle Algorithm
Appendix 4	Post-Fall Huddle Worksheet
Appendix 5	Outpatient or Visitor Fall Workflow
Appendix 6	Adult Fall Risk Assessment Tools (STRATIFY)
Appendix 7	Pediatric Fall Risk Assessment Tool (Little Schmidy)

VII. Subject Matter Experts Reviewers

Department, Committee or Function	Subject Matter Experts Name	Person's Title	Date
			07/01/1996
Hospital Board of Directors		Chair, Hospital Board of Directors	12/04/2014
Education	Danielle Shockey, MSN, RN	Clinical Educator, Medical and Surgical Care Unit	06/01/2022
Nursing Directors	Andrew Apolinarski, RN Chief Nursing Officer	Chair, Nursing Directors	07/22/2022
Nursing Leadership	Matthew Mullis, MSN, RN	Director of Nursing	11/5/2025

Appendix 1: Standard or High Fall Risk Interventions

Standard or High Fall Risk Interventions	
Standard Fall Prevention Interventions	Fall prevention emphasizes bedside rail risk reduction. Side rails contribute to patient fall risk by creating barriers. Use of side rails must be assessed specific to individual patient needs. Refer to ADM 434.1 Restraint Seclusion for side rails as restraint policy. **All Staff are Responsible to:** 1. Assess fall risk upon admission, significant change in status, on transfer to another unit, every eight (8) hours, and after a fall. 2. Assess patient's coordination and balance before assisting with transfer and mobility activities. 3. Continue hourly rounding to address the "5 P's"; (positioning, pain, personal, placement and pickup). 4. Instruct patient and significant others to call for assistance. 5. Consider self-releasing safety devices. 6. Orient and re-orient to call light with every patient contact. 7. Provide treaded footwear for all patients. 8. Assess floor for spills/wetness and take action. 9. Ensure bed is in low position, bed wheels are in locked and upper side rails are in the upright position. 10. Eliminate clutter: electrical cords, unnecessary equipment. 11. Ensure that the call light, bed control, personal items, telephone, walking aides, urinal, visual/hearing aides are within the patients reach. 12. Ensure there is a clear, well-lit path to the bathroom that the floors are dry. 13. Remind family members to call for help when mobilizing patients. 14. MD order for a physical therapy evaluation of gait, balance a transfer mobility, if appropriate. 15. Consider supervision when using bedside commode or bedpan.
High-Risk Fall Prevention Interventions	These interventions are to be implemented for patients with multiple risk factors and those who have fallen in the past year. The interventions are in addition to the Standard Fall Prevention Interventions listed above. 1. Assign bed next to nurse's station if available. 2. Fully escort from bed, wheelchair, chair, commode, and toilet at all times. 3. Supervise during toileting. Do not leave the patient or close the door. 4. Consider issuing patient a gait belt and use to assist with patient ambulation and transfers. 5. Use bed/chair alarms to notify staff when patient mobilizes without calling for assistance. 6. Consider assigning a bedside sitter (refer to CLN 436.04.01 Bedside and Virtual Sitter Deployment). 7. Consider use of "low boy" bed, floor pads, or restraints if indicated. 8. Initiate **Fall Bundle** a. Add yellow fall risk wristband charm b. Add High Fall Risk poor placard using Workflow Management c. Add yellow "Bed Alarm: bands on upper siderails d. Keep bed alarm/chair alarm on at all times e. Add Fall Care Plan f. Initiate Virtual Safety Companion camera if necessary.

Appendix 2: Steps to Take When a Fall with Injury Occurs

Steps to take When a Fall Occurs with Injury		
Time	Description	Responsible Party
Immediately after fall	1. Call Rapid Response for any fall with significant patient injury. g. Provide for the patient's safety. h. Assess for injuries (abrasion, contusion, laceration, fracture, head injury). Provide needed care to stabilize patient. i. Initiate safe fall recovery techniques. Utilize assistive devices as needed. j. Obtain and record sitting/standing (if appropriate) vital signs. k. Notify physician and obtain orders. l. Assess for change in range of motion. m. Document assessment & interventions in the medical record. n. Notify Clinical Unit Supervisor, or Director and Administrative Nursing Supervisor in their absence per chain of command. 2. Complete Falls Investigation Safety Incident Report (SIR) in risk management system.	1. Staff who discovers patient a. - h. Primary RN and RRT 2. Administrative Nursing Supervisor
Once patient is stabilized or transferred	1. The Charge RN will conduct a debriefing (refer to Appendix 4) on the event with the assigned RN, CNA, and any other relevant staff who were either present for the fall or have knowledge of the events leading to the fall. Debriefing to include identification of contributing factors and identified changes to the plan of care. Discuss details of the incident and document on the Post-Fall Huddle Worksheet (refer to Appendix 4). a. This form is not part of the permanent medical record and is given to the Unit Manager or Director. 2. RN to document a narrative entry in the nursing notes summarizing the event in SBAR format. Document any changes to the physical assessment and document any injuries to patient in the dermal assessment. Perform a new fall risk assessment and update the care plan in the EHR if necessary. RN is also to notify the family/DPOA and the provider of fall and document these calls in the EHR.	1. Charge RN 2. Primary RN or Charge RN

Appendix 3: Post-Fall Huddle Algorithm

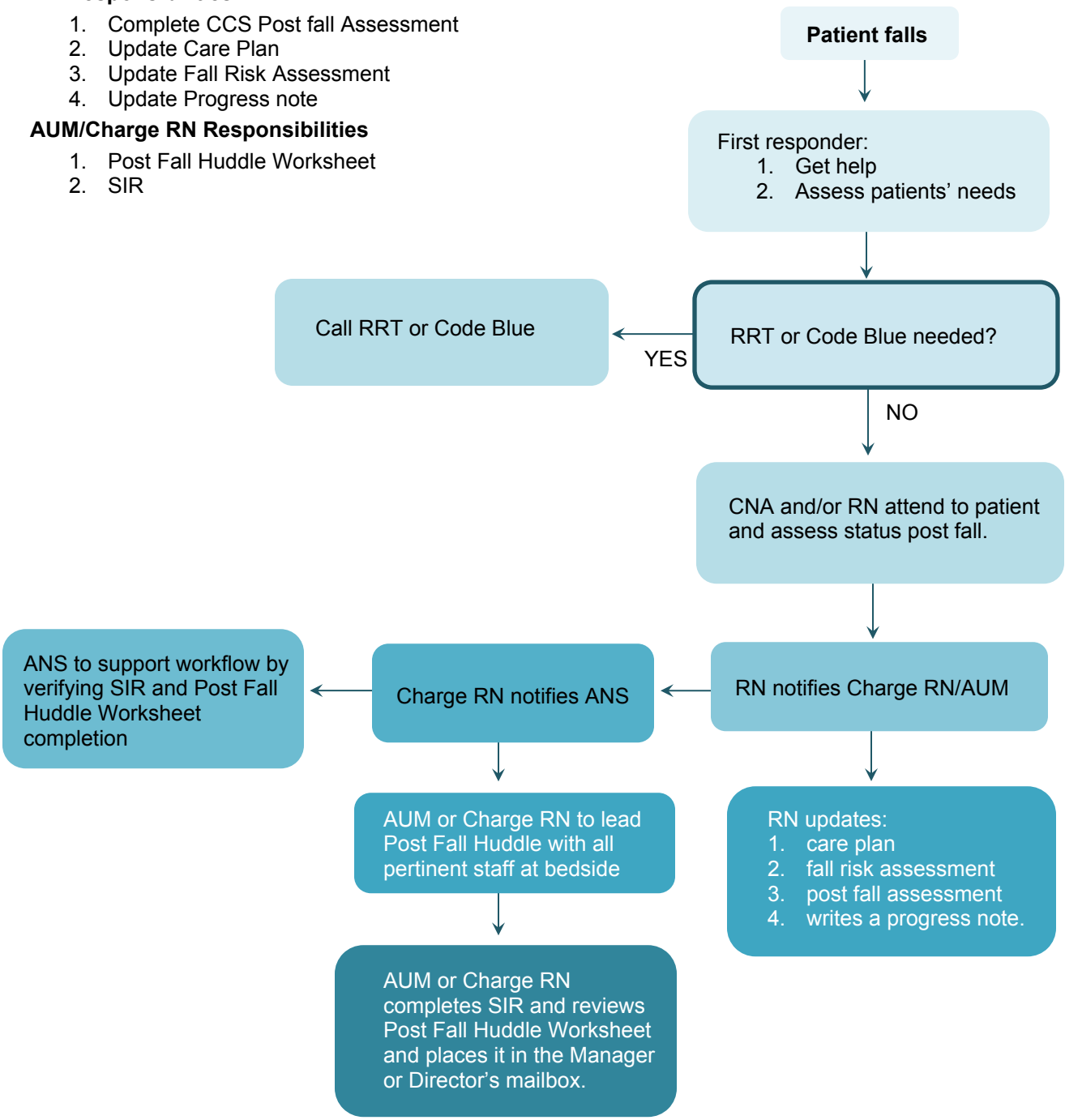
When a patient is found down from a fall, the patient must be assessed for a possible RRT or Code Blue situation, If the patient is stable, attend to the patient's needs.

RN Responsibilities

1. Complete CCS Post fall Assessment
2. Update Care Plan
3. Update Fall Risk Assessment
4. Update Progress note

AUM/Charge RN Responsibilities

1. Post Fall Huddle Worksheet
2. SIR



Appendix 4: Post-Fall Huddle Worksheet

Search for Post Fall Huddle on Intranet

SECTION A: FALL EVENT DETAILS **(TO BE COMPLETED BY RN)**

DEPARTMENT / NURSING UNIT WHERE FALL OCCURRED: _____
TIME SINCE LAST RISK ASSESSMENT: _____
☐ 0-12 Hours ☐ 12-24 Hours ☐ 24-48 Hours ☐ 48-72 Hours ☐ 72 Hours-1 Week ☐ >1 Week

WAS AN RRT CALLED? ☐ Yes ☐ No ANS NOTIFIED:_____ (DATE/TIME):_____

(Notify ANS for ALL FALLS)

TYPE OF FALL: ☐ Baby/Child Drop ☐ Developmental Fall ☐ All Other
PHYSIOLOGICAL EVENT FALL? ☐ Yes ☐ No
PATIENT'S FALLS RISK LEVEL PRIOR TO THE FALL: ☐ Above 6 ☐ Less than or equal to 6
HAS PATIENT BEEN OUT OF BED IN LAST 24 HRS? ☐ Yes ☐ No ☐ Unknown

PT/OT SUPERVISION WHEN FELL? ☐ Yes ☐ No ☐ Unknown

PHYSICAL LOCATION OF FALL/PATIENT ACTIVITY AT TIME OF FALL: ☐ From bed ☐ Shower/tub
☐ Between bed and bathroom ☐ From BSC ☐ From toilet ☐ Between chair and bathroom ☐ Hallway
☐ From gurney ☐ Other: _____

WAS FALL OBSERVED BY EMPLOYEE? ☐ Yes ☐ No
WAS FALL ASSISTED BY EMPLOYEE? ☐ Yes ☐ No
BY WHOM? ☐ Nursing Staff ☐ PT or OT Staff ☐ Other Staff: _____

MEDICATIONS ADMINISTERED WITHIN 6 HOURS PRIOR TO FALL (PLEASE SPECIFY):
☐ Pain medication: _____ ☐ Anticoagulant: _____ ☐ Antihistamine: _____
☐ Benzodiazepine/Sedative: _____ ☐ Diuretic/Laxative: _____
☐ Antihypertensive: _____ ☐ Other Pertinent Meds: _____

WAS MEDICATION A FACTOR IN THE FALL? ☐ Yes ☐ No

WAS PATIENT AGITATED OR CONFUSED AT TIME OF FALL? ☐ Yes ☐ No
INTENTIONAL FALL SUSPECTED? ☐ Yes ☐ No If **YES**, what is suspected purpose: _____

INTERVENTIONS/SAFETY MEASURES IN PLACE PRIOR TO THE FALL (CHECK ALL THAT APPLY): Low bed
☐ Lap belt ☐ Sitter ☐ Safety Companion ☐ Room close to Nsg. Station ☐ Call light in place ☐ Chair alarm
☐ Bed alarm ☐ Cane ☐ Walker ☐ Wheelchair ☐ Leg Prosthesis ☐ NonSkid Hospital Slippers ☐ Patient's own shoes
☐ No Footwear ☐ Fall prevention care plan ☐ Fall alert outside door ☐ Fall Risk yellow charm
☐ Fall Risk Yellow band Bed Rail ☐ Other _____

WAS THE PATIENT IN RESTRAINTS AT THE TIME OF THE FALL? ☐ Yes? No ☐ Unknown
Type: ☐ Soft Limb ☐ Vest ☐ Mitts ☐ Waist/Waist Belts ☐ Leather ☐ Side rails up ☐ Net Bed

ADDITIONAL ITEMS THAT MAY HAVE CONTRIBUTED TO THE FALL:
☐ Cords ☐ Room clutter ☐ Family/Visitor not following protocol ☐ Unattended in bathroom/bedside commode
☐ Other _____

SECTION B: POST FALL CHECKLIST (TO BE COMPLETED BY RN, VERIFIED BY AUM/CN)

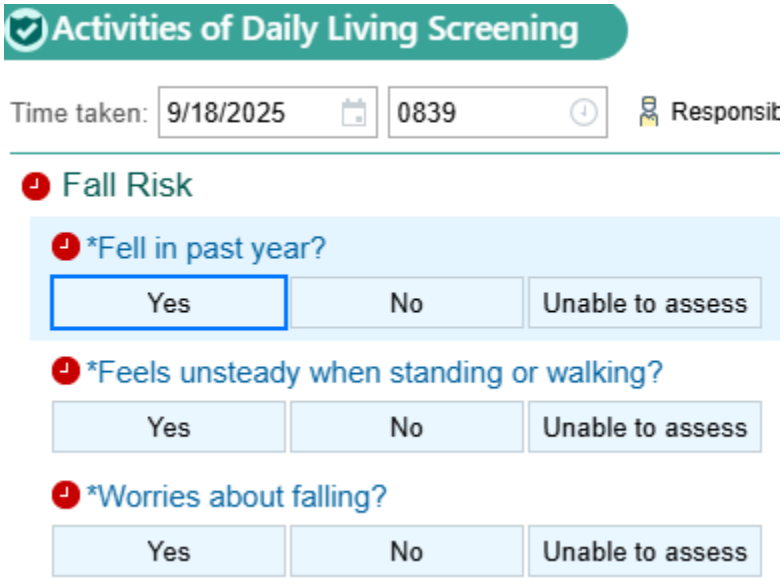
☐ MD NOTIFICATION AND DOCUMENT ACCORDINGLY. **NAME** OF MD NOTIFIED: _____
☐ DOCUMENT NEW FALL RISK ASSESSMENT
☐ COMPLETE PROGRESS NOTE INCLUDING: 1) WAS THE FALL WITNESSED 2) MENTAL STATUS ASSESSMENT AFTER FALL 3) WHO WAS NOTIFIED 4) DISPOSITION OF PATIENT AFTER FALL
☐ NOTIFY UNIT NURSING LEADERSHIP AND ANS (DOCUMENT IN NOTIFICATION TAB)
☐ **NOTIFY PATIENT'S FAMILY, or SIGNIFICANT OTHER, or RESPONSIBLE PARTY DATE/ TIME NOTIFIED** _____
☐ DISCUSS WITH STAFF WHAT LED TO THE FALL, AND WHAT COULD HAVE BEEN DONE DIFFERENTLY
☐ ENSURE FALL BUNDLE IS IN PLACE (I.E. UPDATE CARE PLAN TO REFLECT HIGH FALL RISK, UTILIZE SAFETY CAMERA, LAP BELT, NET BED, LOWER BED, MOVE PT CLOSER TO NURSING STATION, PT/FAMILY EDUCATION)
☐ IF STAFF MEMBER INJURED AT THE TIME OF THE FALL, *COMPLETE EMPLOYEE INJURY DOCUMENTATION*

Appendix 5: Outpatient or Visitor Fall Workflow

Outpatient or Visitor Fall
1. Call a Rapid Response for any fall with possible injury (staff, patient, visitor). 2. Refer visitors and outpatients to the Emergency Room for evaluation. a. If the fallen patient declines an ER referral, write, “ER referral refused” on the Safety Incident Report (SIR). b. Refer outpatients to their attending MD for evaluation and follow-up. 3. Promptly refer concerns expressed by the patient/family or visitor to the Administrative Nursing Supervisor. 4. Follow Post-Fall Huddle Algorithm and complete the Safety Incident Report per Appendix 4 of this policy.

Appendix 6: Adult Fall Risk Assessment Tool (STRATIFY)

Adult Fall Risk Assessment Tool (STRATIFY)



ABCS in the Assessment flowsheet tab in Falls/STRATIFY

Fall prevention plan can be implemented even if the STRATIFY and ABCS Risk for Injury screens are both negative – requires clinical judgment and consideration of individual factors that contribute to risk for fall or risk for injury from a fall.

STRATIFY Fall Risk Assessment
Did the patient present to hospital with a fall or has ...
Is the patient agitated?
Is the patient visually impaired to the extent that eve...
Is the patient in need of especially frequent toileting?
Transfer score:
Mobility score:
Combined score (transfer + mobility):
Does the patient have a combined transfer and mob...
STRATIFY Fall Risk Score
Risk for Injury from Fall
Age 80 yrs or older; or frail due to a clinical condition?
Bone conditions including osteoporosis, previous fr...
Coagulopathy/or anticoagulants (excludes DVT pro...
Major abd/thoracic/neuro/ortho/spine surgery or LE ...

STRATIFY in the Assessment flowsheet tab in Falls/STRATIFY

Appendix 7: Pediatric Fall Risk Assessment Tool (Little Schmidy)

"Little Schmidy" Fall Scale	
*Mobility	
*Mentation	
*Elimination	
*History of Illness Related Falls	
*Current Medications	
*Little Schmidy Fall Score	
Clinical Judgment: At risk?	

Pediatric Fall Risk Assessment Tool (Little Schmidy)	
Categories	Scoring options: Select one from each category. Add all scores together to calculate Little Schmidy Fall Score.
Mobility	0 – Ambulates with no gait disturbance 0 – Unable to ambulate or transfer 1 – Ambulates or transfers with assistive device 1 – Ambulates with unsteady gait and no assistive device
Mentation	0 – Developmentally appropriate and alert 0 – Coma, unresponsive 1 – Developmentally delayed 2 - Disoriented
Elimination	0 – Independent 0 – Diapers 1 – Independent with frequency or diarrhea 1 – Needs assist with toilet
History of Falls Related to Illness	0 – No 1 – Yes, before admission 2 – Yes, during admission
Current Medications	0 – None (i.e., anticonvulsant, opioids, benzodiazepines) 1 – Anticonvulsants, opioids, benzodiazepines

The bedside RN performs the assessment per unit protocol to determine the patient's fall risk and the fall prevention steps to put in place.