Los Angeles County Department of Health Services

Policy & Procedure Title:	DHS System-Wide Fall Prevention Program		
Category:	300-399 Operation Policy	**Policy No.:**	311.101
Originally Issued:	1/25/2012	**Update (U)/Revised (R):**	10/01/2014 (R)
DHS Division/Unit of Origin:	Office of Nursing Affairs		
Policy Contact – Employee Name, Title and DHS Division: Grace Ibanez, RN, Nursing Director, Office of Nursing Affairs			
Contact Phone Number (s):	(213) 240-7702		
Distribution: DHS-wide ☒	**If not DHS-wide, other distribution:**		

PURPOSE:

The purpose of this policy is to provide guidelines for the 1) identification of patients at risk for falls; 2) implementation of fall reduction strategies; and 3) post fall evaluation and management.

DEFINITION(S):

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient. All types of falls are to be included whether they result from psychological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls, such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall. *The Joint Commission*

Rehabilitation Fall: A fall is a loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair, excluding falls resulting from "purposeful actions". ("Adapted from Veteran Healthcare Administration's definition of a fall.")

Purposeful Action: A rehabilitation therapy session performed with the intent of challenging a patient's balance or to attempt a functional activity the patient is unable to perform without assistance.

POLICY:

Outpatient Clinics (Hospital-Based and Ambulatory Care Network) will screen patients and mitigate risks for falls and harm, based on the patient population, setting, and environment. Documentation, as applicable, will include:

- Fall screening.
- Fall risk.
- Fall prevention measures implemented and patient education provided.

Hospitalized inpatients (1 year of age and older) will be assessed on admission, and reassessed daily, on transfer to another unit, with condition change, and post fall. The staff will document the following in the medical record:

- Using the appropriate Fall Risk Assessment Tool, the initial assessment and ongoing reassessments.
- Patient/family education related to falls.
- Ongoing safety precautions.
- Any fall incident, related assessment, and notification of physician/family.

Emergency Department patients will be screened for fall risk using specific assessment screening elements. The staff will document all fall reduction interventions and patient/family education in the medical record.
Appropriate fall prevention measures will be implemented for all patients identified as 'at risk for falls'. If any screening criteria element is positive, a licensed healthcare professional will implement and document interventions to reduce the 'risk of falls' to include patient/family education.

Organization/Facility Assessment of Fall Risk:

There is, at minimum, an annual assessment of each facility's patient fall risk to determine prevention and intervention measures. The assessment may include, but not limited to, periodic environmental rounds, patient safety rounds, medical staff committee determination of risk based on clinical conditions, and review of adverse events (related to falls).

Performance Improvement, Quality Control, Monitoring, Reporting, and Benchmarking will be performed on a quarterly basis utilizing the identified DHS Fall Database.

DHS Employee Fall Prevention Program education will include training to all current DHS providers, nursing and clinical ancillary staff on the DHS System-Wide Fall Prevention Program. Additionally, the DHS System-Wide Fall Prevention Program will be incorporated into the New Employee Orientation Program.

PROGRAM COMPONENTS:

Fall Prevention Program	Inpatient	Outpatient
• Policy	√	√
• Procedure	√	√
• Screening • Assessment • Reassessment	NA √ √	√ √ (if screened as at risk) NA
• Risk Determination	√	√
• Plan of Care	√	NA
• Fall Prevention Measures -Interventions -Education -Patient -Family	√ √ √ √ √	√ √ √ √ √
• Post Fall Evaluation and Management, Algorithm	√	√
• Documentation	√	√
• Performance Improvement, Quality Control, Monitoring, Reporting and Bench-marking	√	√
• Staff Education	√	√

PROCEDURES:

I. Outpatient Setting (Hospital-Based and Ambulatory Care Clinics):

A. Screening for fall risk may be applied across a clinic or patient-specific:

- Certain patient populations, settings, and environments pose an equivocal increased risk for falls. Risk may be based on factors including, but not limited to, patient demographics, diagnoses, medical condition, clinical situation, mobility, and ambulatory/mobility equipment needs.

  Clinic-wide screening may include:
  - Periodic Environmental Rounds
  - Validation of clinic-wide safeguards (e.g., hand rails, level flooring/surfaces, wheelchair/walker access, grab bars)
  - Patient education
  - Staff education
  - Evaluation of previous year's fall data

To screen each adult and/or pediatric patient (over 1 year of age) for fall risk using the age appropriate screening tool.

Adult Ambulatory Care Fall Screening Criteria (see Attachment 1).
Pediatric Ambulatory Care Fall Screening Criteria (patient > 1 year of age) (see Attachment 1A).

B. Patients identified as high risk during either screening methods will have a licensed professional further determine, implement, and document appropriate prevention measures including patient/family education.

C. Outpatient Fall Prevention measures.

1. Maintain a safe, hazard free environment (remove any obstacles from patient pathway).
2. Place 'at-risk' patients who are identified as needing assistance on exam table only at the time of examination, with staff present.
3. Provide assistance with toileting, when appropriate, for safety reasons (ensure privacy when doing so).
4. Ensure adequate lighting.
5. Use wheelchair locks when indicated.
6. Keep beds, stretchers, and/or gurneys in lowest, locked position with side rails up, as appropriate.
7. Keep call light, as applicable, within reach.
8. Identify and manage areas of concern during Environmental/Safety Rounds.
9. Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
10. Notify appropriate professional for focused fall reduction interventions and patient/family education, including, but not limited to:
    - Diagnosis and treatment underlying etiology of fall risk
    - Ensure 'fall risk' alert armband is in place based on patient condition and determination of fall risk.
11. Provide patient/family education regarding:
    - Fall risk determination.
    - Safety measures for prevention of falls during their outpatient visit.
    - Rising slowly from a sitting or lying position.
    - If possible, consider having patient relocate to an area that allows closer nursing observation.
12. Offer wheelchair, if appropriate.
13. Ensure assistive devices (e.g., cane, crutches, walker, wheelchair) are within reach of the patient.
14. Assist patients walking with medical equipment, as appropriate (e.g., wound vacuum devices, IV poles, oxygen tubing, tanks, etc.).
15. Alert subsequent providers that patient is a fall risk (e.g., during transfers or hand-off to another clinical area/service).

D. Post-Fall Procedure

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm and complete all post fall documentation in the medical record (see Attachment 4)

II. Inpatients

A. **Assessment/Reassessment**

Fall screening in the outpatient area does not replace the requirement to complete a population and age appropriate fall risk assessment on admission**.**

1. Upon admission, the RN will assess all adult inpatients and children > 1 year of age for their risk for falls utilizing the appropriate Fall Risk Assessment Tool.
   a. Adults: Morse Fall Assessment Scale (see Attachment 2)
   b. Pediatrics: Humpty Dumpty Scale (see Attachment 3)
      i. Patients admitted to inpatient units will be assessed with the age appropriate tool such as the Humpty Dumpty Scale (pediatrics) or Morse Scale (adults).
2. Patients will be reassessed daily, upon inter-unit transfer, upon change of status, or post fall to determine the need for fall prevention measures implementation.

B. **Risk Determination**

1. Adults
   a. **Low risk:** Any adult patient who receives a score of 0-24 on the Morse Fall Scale is considered as low risk. Level 1 interventions will be implemented for these patients.
   b. **Moderate risk:** Any adult patient who receives a score of 25-50 on the Morse Fall Scale is considered as moderate risk. Level 2 interventions will be implemented for these patients in addition to Level 1 interventions.
   c. **High risk:** Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients in addition to Level 1 and 2 interventions.

2. Pediatrics
   a. **Low risk:** Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and “General Fall Prevention Interventions for All Children” will be implemented for these patients.
   b. **High risk:** Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for High Risk for the duration of his/her hospitalization.
   c. If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a fall risk reassessment may be performed and documented to justify the

discontinuation of the high risk for falls identification and implementation of fall prevention measures.

d. If, in the nurse's judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures.

C. **Initiation of Plan of Care**

When a patient is identified as moderate or high risk for falls, the RN will initiate a plan of care related to the patient's identified risk factors. Injury and/or fall prevention strategies, including patient/family education will be incorporated into the plan of care for at risk patients.

D. **Fall Prevention Measures**

When a patient is identified as moderate or high risk for falls either on admission or during his/her hospitalization, the RN will implement the following fall prevention measures:

1. Identify patient as being moderate or high risk for falls and communicate patient's fall risk status. Identification and communication strategies could include, but are not limited to, the following:
   a. Place a colored 'fall risk' alert armband on the patient.
   b. Place a sign at the entrance to the patient's room and/or head of the patient's bed.
   c. Place a fall precaution sticker on front of the patient's chart.

2. Fall Prevention Measures (Adults)

Level 1 Interventions for patients assessed as low risk (0-24), as applicable:

- The patient's risk for falls will be discussed with interdisciplinary team members.
- Provide patient/family education related to fall prevention.
  - Purpose and importance of fall/injury prevention measures.
  - Use of call light.
  - Maintain bedrails in appropriate position.
  - Safe ambulation/transfer techniques.
  - Importance of wearing non-skid footwear.
  - Reporting environmental hazards to nursing staff (e.g., spills, cluttered passages).
- Family/significant others may assist with fall reduction strategies once fall management training is completed. (Note: Staff remains responsible for overall safety of patients even with family in attendance).
- Perform intentional rounds.

- Orient patient to surroundings and hospital routines.
- During exchange of patients between staff, hand-off communication should include fall risk level supervision provided, and observation of unsafe behavior (e.g., shift report, break, patient transport/transfer).
- Set the bed in the lowest position with brakes locked. For patients with indwelling catheters, the bed height may be raised minimally (not more than 2 inches) in order to keep drainage bag (e.g., Foley bag) from touching the floor.
- Place personal belongings within reach on the bedside stand/table.
- Reduce room clutter. Remove unnecessary equipment and furniture.
- Provide non-skid (non-slip) footwear.

Level 2 Interventions for patients assessed as moderate risk (25-50) as applicable:

- Place fall prevention stickers to the front of the medical record.
- Place a sign at the entrance to the patient's room and/or head of the patient's bed.
- Offer toileting, minimally, every 2 hours.
- Activate the bed alarm and wheelchair seatbelt alarm, if appropriate.

Level 3 Interventions for patients assessed as high risk (51 and higher) as applicable:

- Increase intentional rounds based on patient needs.
- Collaborate with interdisciplinary team for therapy schedule/activities.
- Cohort patients, when possible.
- Provide continuous in-person observation with a trained staff member as needed for safety reasons.
- Place the patient in a room or area where they can be easily observed.
- Offer toileting, minimally, every 2 hours.
- Stay with patient at all times while toileting out of bed.
    - Refusal by patient for direct observation during toileting must be documented in the patient's medical record, as applicable. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.).
    - Notify the appropriate licensed professional of patient's refusal.
- Restraints are discouraged, however, if needed, apply per hospital specific restraint policy.

3. Fall Prevention Measures (Pediatrics)
    a. General Fall Prevention Interventions for All Children:

Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all children:

- Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
- Leave crib side rails up at all times unless an adult is at the bedside.
- Bed type and size shall be determined based on child's developmental and clinical needs.
- Instruct patient/parent on how to prevent falls in the hospital setting:
    - Maintain side rails in appropriate position.
    - Maintain crib rails up.
    - Do not allow the child to jump on the bed.
    - Do not allow the child to run in the room or hallway.
    - Do not allow the child to climb on hospital furniture or equipment.
    - Explain the Importance of wearing non-skid footwear.
    - Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.
    - Notify nursing staff of environmental hazards (e.g., spills, cluttered passages).
    - Supervise the child's activities (e.g. walk next to the child and provide support as strength and balance are regained).

b. Fall Prevention Measures for High Risk

- Consider locating the child closer to nursing station for closer observation.
- Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion and pain.
- Offer assistance with toileting, minimally, every 2 hours while awake.
    - Stay with child at all times while toileting out of bed.
    - Refusal by the child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
    - Notify the appropriate licensed professional of child's parent/guardian's refusal.
- Provide calming interventions and pain relief.
- Accompany patient with ambulation.
- Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications).
- Set bed alarms, as appropriate, to alert when child is exiting the bed.
- Evaluate need for and encourage family to remain at the child's bedside.
- Assess need for continuous in-person observation with a trained staff member, as needed, for safety reasons.

- Provide patient/family education related to fall prevention (in addition to education related to general injury prevention above):
  - Purpose and importance of fall/injury prevention measures.
  - Use of call light/maintaining bedrails in appropriate position.
  - Safe ambulation/transfer techniques.
  - Instruct family of pediatric patients to inform the nurse and/or physician if the child seems to be less coordinated than usual, or complains of dizziness or feeling weak.
  - Instruct family of pediatric patients that until the child regains his/her strength, someone should walk alongside him/her to provide support and protection in case he/she loses his/her balance.

E. **Post-Fall Procedure:**

After a patient fall initiate the Post-Fall Evaluation and Management Algorithm (see Attachment 4) and complete all post fall documentation in the medical record

III. Emergency Department (ED)

A. Screening (adult, pediatric, psychiatric, and all other ED areas) will take place at the time of triage assessment using age appropriate fall risk screening criteria:.

Adult

1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure or syncope
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit – sight/hearing/speech impairment
7. Unsteady gait/weakness

Pediatrics

1. History of previous fall
2. Use of assistive device for ambulation/mobility
3. History of seizure in last 6 months
4. Alcohol/drug withdrawal/intoxication symptoms
5. Altered mental status/confusion
6. Sensory deficit – sight/hearing/speech impairment
7. Developmental problems causing difficulty walking
8. Neurologic diagnosis/condition causing difficulty walking (e.g., Muscular Dystrophy)

B. Identify all patients who meet any one of the criteria as a possible fall risk.
C. All patients who are identified as a fall risk will have a fall risk armband placed.
D. Additional interventions will be implemented as applicable for the individual patient.

Adult Interventions

1. Provide assistance with ambulation
2. Move patient to allow closer nursing observation
3. Place the patient directly on bed (or on gurney)
   i. Bed or gurney in lowest, locked position
   ii. Side rails up
4. Provide patient/family education on fall prevention measures
   i. Environmental orientation
   ii. Call light
   iii. Call for assistance, as needed.
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
7. Assess for elimination needs every 2 hours.
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons.
   i. Provide privacy when patient is toileting, if requested.
   ii. Refusal by patient for direct observation during toileting must be documented in the patient's medical record.
   iii. Notify the appropriate licensed professional of patient's refusal.

Pediatrics Interventions

1. Assist with ambulation
2. Move patient to allow closer nursing observation.
3. Place the patient directly on bed (or on gurney)
   i. Bed or gurney in lowest, locked position
   ii. Side rails up
4. Provide patient/family education on fall prevention measures
   i. Environmental orientation
   ii. Call light
   iii. Call for assistance, as needed
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
7. Assess for elimination needs every 2 hours.
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons
   i. Provide privacy when patient is toileting, if requested
   ii. Refusal by child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
   iii. Notify the appropriate licensed professional of child's parent/guardian's refusal.
9. Encourage family to stay at patient's bedside.

E. Post-Fall Procedure:

After a patient fall, initiate the Post-Fall Evaluation and Management Algorithm (see Attachment 4) and complete all post-fall documentation in the medical record.

REFERENCES/AUTHORITY:

Child Health Corporation of America Nursing Falls Study Task Force. Pediatric Falls: State of the Science. *Pediatric Nursing*. 2009;35:227-231.

Examining Inpatient Pediatric Falls: Understanding the Reasons and Finding the Solutions. *The Joint Commission Perspectives on Patient Safety*. September 2004; 5-6.

Graf E. Magnet Children's Hospitals: Leading Knowledge Development and Quality Standards for Inpatient Pediatric Fall Prevention Programs. *J Pediatr Nurs*. 2011;26:122-127.

Harvey K, Kramlich D, Chapman J, Parker J, Blades E. Exploring and Evaluating Five Paediatric Falls Assessment Instruments and Injury Risk Indicators: An Ambipespective Study in a Tertiary Care Setting. *J Nurs Management*. 2010;18:531-541.

Hill-Rodriguez, D., Messmer, P. R., Williams, P. D., Zeller, R. A., Williams, A. R., Wood, M. and Henry, M. The Humpty Dumpty Falls Scale: A Case-Control Study. *JSPN*. 2009, 14(1): 22-32

Irvin, D. Psychiatric Unit Fall Events. Journal of Psychosocial Nursing. 1999;37(12):8-16.

The Joint Commission Standards, Provision of Care, Treatment, and Services (PC) 01.02.08 EPs 1 and 2

Morse, J.M. (1997). Preventing Patient Falls. Thousand Oaks, Sage Publications

Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. Canadian Journal on Aging, 8,366-377.

U.S. Food and Drug Administration. *A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts*. Retrieved May 2, 2006, from http://www.fda.gov/cdrh/beds/bed-brochure.html.

Seifert K. We're not falling for that! AAACN Viewpoint. 2010;32(2):1,8-11

VA National Center for Patient Safety (NCPS). NCPS Falls Toolkit. Retrieved May 2, 2006, from http://www.va.gov/NCPS/SafetyTopics/fallstoolkit/index.html.

Health Services
LOS ANGELES COUNTY

Attachment 1

Hospital Based Outpatient Falls Screening Criteria (Adult)

A "yes" response to any of the following questions identifies the patient as "at risk" for falls

☐ Y ☐ N Have you fallen within the last 30 days?

☐ Y ☐ N Do you need help with walking? (another person, use of cane/ walker/crutches)

☐ Y ☐ N Falls Risk

Print Name/ Signature _____ (Print Name) _____ (Signature)

Falls Prevention Measures and Patient/Family Education Provided

☐ Fall alert wrist band in place

☐ Assistive device within reach

☐ Wheelchair provided

☐ Moved to allow closer nursing observation

☐ Other _____

☐ Patient/Family education provided

___fall risk determination

___general safety measures for fall prevention

___instructed to call for assistance if needed

___other _____

Licensed Provider _____ (Print Name) _____ (Signature) _____ (Date)

IMPRINT PATIENT I.D.

Health Services
LOS ANGELES COUNTY

Attachment 1A

Hospital Based Outpatient Falls Screening Criteria (Pediatric)

A "yes" response to any of the following questions identifies the patient as "at risk" for falls

☐ Y ☐ N Does the child have developmental problems causing difficulty walking (e.g. unsteady on feet, uncoordinated, needs help from another person or walker/crutches)?

☐ Y ☐ N Has the child had dizziness or a seizure in the last 6 months?

☐ Y ☐ N Falls Risk

Print Name/
Signature

Print Name _____ Signature _____

Falls Prevention Measures and Patient/Family Education Provided

☐ Fall alert wrist band in place

☐ Assistive device within reach

☐ Wheelchair provided

☐ Moved to allow closer nursing observation

☐ Other _____

☐ Patient/Family education provided

___fall risk determination

___general safety measures for fall prevention

___instructed to call for assistance if needed

___other _____

Licensed
Provider _____ _____ _____

Print Name Signature Date

IMPRINT PATIENT I.D.

Health Services
LOS ANGELES COUNTY

Attachment 2

Morse Fall Risk Assessment		
Risk Factor	**Scale**	**Score**
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / Walker	15
	None / Bed Rest / Wheel Chair / Nurse	0
IV / Heparin Lock	Yes	20
	No	0
Gait / Transferring	Impaired	20
	Weak	10
	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

Morse Fall Score	
High Risk	51 and higher
Moderate Risk	25 - 50
Low Risk	0 - 24

Health Services
LOS ANGELES COUNTY

Attachment 3

Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Humpty Dumpty Scale and Prevention – Inpatient Program

Parameter	Criteria	Score (Circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alteration in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to Own Ability	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4
	Patient Uses Assistive Devices or Infant-Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/Anesthesia	Within 24 Hours	3
	Within 48 Hours	2
	More Than 48 Hours/ None	1
Medication Usage	Multiple Usage of: Sedatives (Excluding ICU Patients Sedated and Paralyzed), Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/ Diuretics, Narcotic	3
	One of the Meds Listed Above	2
	Other Medications/None	1
	Total	

Health Services
LOS ANGELES COUNTY

Attachment 4

Post-Fall Evaluation and Management Algorithm

First Responder

- Stay with patient. Call for help.
- Check patient for pain or injury, check LOC
- Report fall to licensed personnel.
- Provide comfort measures until licensed staff member arrives and assesses patient for injury

Licensed Provider:

- Assesses patient asap after fall
- Provides follow-up orders, medical, and diagnostic work-up, and care as indicated
- Reviews patient's medications. If patient is on anticoagulation therapy and has struck head, consider indication for radiographic exams, including head CT or MRI
- If patient shows change in neurological status, considers transfer to a higher level of care.
- Notifies emergency contact and documents notification in medical record
- Recommends additional steps for fall prevention

RN Staff:

- If patient has struck head/face and/or is on anticoagulation therapy, immediately notify physician, and initiate neuro checks. If physician does not respond at bedside within the hour, follow medical chain of command.
- Documents clinical status and description of fall in medical record
- Completes Fall Risk Reassessment and updates care plan
- Implements additional intervention as needed or as ordered. (e.g., increased level of supervision)