

TITLE: FALL PREVENTION PROTOCOL
MANUAL: CLINICAL PROCEDURE MANUAL

POLICY # F 01.5
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Effective Date: 10/00

Approval _____

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VALUES CONTEXT

Our value of service assures that we respond to the needs of the whole person.

PURPOSE\EXPECTED OUTCOME (S)

The purpose of this policy is to reduce the incidence of patient falls (inpatient) at Santa Rosa Memorial Hospital including identification of patient at risk for falls, implementing action to prevent harm, and providing a safe therapeutic environment.

POLICY

Santa Rosa Memorial Hospital believes that patients are at greater risk for falls when hospitalized. Therefore all hospitalized patients are considered a fall risk, and will be assessed to minimize their risk of falling. SRMH staff will work to actively reduce the risk of falls across the continuum of care by ensuring a safe physical environment and appropriate identification of fall risk patients.

A. SUPPORTIVE DATA

1. A fall is defined as a sudden unanticipated change in body position in a downward direction, which may or may not result in a physical injury (this definition does not include an assisted lowering of a patient to a chair or the floor).
2. Identification of patients that may be at risk for an accidental fall during hospitalization is necessary. All patients are assessed for their risk of falling on admission, every shift, upon change in condition, post fall, and when transferred.
3. Patients determined to be a fall risk and assessed to have confusion, short-term memory loss, and/or poor safety awareness, are considered "high fall risk." Additional safety precautions for high fall risk patients will be utilized such as bed near the nurse's station and activate bed alarm. Although a fall risk score is assessed on each shift, patients identified as at risk for fall at any time during hospitalization will remain on the Fall Prevention Protocol for the duration of hospitalization unless documented otherwise by an RN or a Physician. Any patient experiencing an accidental fall will remain on the Fall Prevention Protocol for the remainder of the admission.

SCOPE/Responsible Persons

Direct health care providers based on scope of practice. In addition all SRMH employees have a role in fall prevention by being aware of fall risk patients within the work environment, and working to maintain an environment free from hazards. Also the patients have a responsibility to comply with fall prevention interventions within the scope of their abilities.

PROCEDURE**A. ENVIRONMENTAL AND HOSPITAL SAFETY**

All hospital staff are responsible for reducing fall risks and ensuring a safe environment free from hazards. All clinical and non clinical staff are aware of high fall risk patients, and will work within their scope of practice to prevent patient falls. Staff work as a team to eliminate hazards, by involving Environmental Services and Engineering as appropriate.

This includes, however is not limited to:

- 1. Monitor cords, equipment, and uneven surfaces to eliminate trip hazards.**
- 2. Clean up spills and place caution signs if floors are wet.**
- 3. Ensure patients immediate physical safety while notifying appropriate clinical staff if unsafe patient activity is observed.**

B. ASSESSMENT

1. Assess risk score using Morse Fall Scale (see Appendix A) on each shift at time of RN assessment and reassess if patient orientation or alertness changes.
2. Monitor gait, balance and fatigue with ambulation.
3. Monitor after change in medication for possible side effects:
 - Sedation
 - Hypotension
 - Impaired balance
 - Impaired elimination
 - Impaired reaction time
- 4. Reassess safety interventions currently in place and update as appropriate.**
- 5. Morse Fall Scale (See Appendix A for description)**

The Fall Risk Score is assessed on admission and reassessed on each shift and for any change in orientation or level of consciousness.

The Fall Prevention Protocol is implemented for adult and geriatric patients who score 50 or more total points on the Morse Fall Scale. These patients are identified at High Risk for falling.

Factor	Points
History of falling	Yes = 25 No = 0
Presence of Secondary diagnosis	Yes = 15 No = 0
IV therapy or peripheral IV lock	Yes = 20 No = 0
Type of gait	Weak = 10 Impaired = 20
Use of walking aids	Normal/bedrest/wheelchair = 0 Cane/crutches/walker = 15 Uses furniture = 30
Mental status	Overestimates/forgets own limitations = 15

6. The following criteria are utilized to identify patients who are considered at increased risk of harm from falls:
 - a. AGE - Patients age 85 and older
 - b. BONES-Patients who have a history of osteoporosis, previous fractures, or prolonged steroid use.
 - c. COAGULATION-Patients who are taking anti-coagulation medication due to the increased risk of bleeding as a result of trauma caused by a fall.
 - d. SURGERY- Patients who have recently undergone surgical procedure. This information does not alter the patient’s Morse Fall Scale Score, but provides increased awareness for staff regarding patient’s risk of harm from falls.

C. CARE PLAN

A plan of care is developed with appropriate interventions individualized to patient needs that may include any of the following interventions.

D. FALL RISK REDUCTION INTERVENTIONS are chosen based on assessment of patient need and appropriateness. Interventions that should be considered for an individualized plan of care include:

1. **Visually identifying the patient as High Fall Risk (Score 50 or > on Morse Fall Scale)**
 - a. Placing YELLOW armband on patient wrist.
 - b. Providing YELLOW non-skid slippers for patient

- c. Placing Fall Risk signage “Star Alert” on door frame of patient’s room.
- d. Consider placement in a room or area of high visibility near nursing station.

Communicating Fall Risk Status

The patient’s fall risk status and appropriate interventions are communicated using SBAR with nursing and other licensed ancillary staff:

- a. “High Fall Risk” is identified on Status Board in the EMR and on the Patient Census Board on unit.
 - b. Activate bed alarm at all times when patient is in bed. Assure bed is connected to call light system, Also implement chair alarm or occupancy alarm as appropriate.
 - c. Patients on bed alarms are identified on Patient Census Board on unit and at bedside.
 - d. Communicate High Fall Risk status at shift report and that Bed Alarm is on.
 - e. Utilizing “Ticket to Ride” to communicate fall risk status when patient is going off the floor for a procedure.
 - f. Safety issues will be discussed at patient care conferences.
- 2. Increasing frequency of observation and assistance to the patient for care needs and ambulation.**
- a. Monitoring patient and environment for safety at least every 1 hour. Place call light and frequently used items within reach.
 - b. Patients identified, as a high fall risk will be prompted for toileting every 2 hours while awake and PRN overnight. Offer bedpan, urinal, or assistance to bathroom at mealtime, at bedtime, and upon awakening.
 - c. Supervise patients directly (within visual observation) or indirectly (within hearing and verbal distance of the patient) while on the commode or in the bathroom.
 - d. Closely monitor patients for change in fall status following the administration of medications
 - e. Be alert to and investigate noises from patient rooms.
- 3. Implementing actions to prevent falls or to reduce the severity of a fall.**
- a. Using gait belt to transfer patients to a commode, chair or when ambulating. Keep a gait belt at bedside for patients identified as a fall risk.

- b. Maintaining bed in low position when occupied by a patient with upper siderails in the up position.
- c. Maintaining equipment with wheels in locked position at all times.
- d. Making sure floor is dry and removing any environmental obstacles from the patient's walking area.
- e. Reorienting to surroundings and environment as needed.

4. Educating patient and family regarding the risk of falling.

- a. Reminding patient to call for help when getting out of bed.
- b. Patients benefit from having family at the bedside to provide comfort & reassurance. Discuss high fall risk status with patient and/or family upon initial score of 50 or greater.
- c. Reviewing Fall Prevention patient education materials with patient and family.
- d. Discussing benefits of continuous supervision with family as appropriate.

7. Environmental Factors

- a. Utilizing night light in patient room if indicated
- b. Beds that have split rails-keep the bottom side rail in the lowered position.
- c. Floors are uncluttered and trip hazards mitigated.
- d. There are skid proof surfaces in tubs, showers and bathroom floors.
- e. Wheeled furniture is locked to prevent slippage when leaned on for support.
- f. Slip resistant footwear is provided for patient use.
- g. Side rails on gurneys will be in the upright position at all times.
- h. Obtaining walker, cane or wheelchair from home if patient has need of assistive devices prior to admission. Assist with/supervise transfers and ambulation.

E DOCUMENTATION

- 1. Fall risk score upon admission, each shift assessment and repeated as reassessed must be documented in the patient health record.
- 2. Notification of high fall risk status to patient, and family upon initial score of 50 points or greater.
- 3. Teaching to patient and/or family.
- 4. Document "risk for injury related to fall risk" on care plan.

FPOST FALL FOLLOW UP

1. Determine need for spinal immobilization before moving patient. Ask patient if they can feel their hands and feet, wiggle fingers and toes.
2. If there is no risk of spinal injury, return patient to bed or chair using proper body mechanics.
3. It is strongly encouraged to use a mechanical lifting device to return the patient to bed.
4. If patient has potential for spinal injury, call Rapid Response Team and provide spinal immobilization before moving patient.
5. Assess and document circumstances of the fall; location, medications, vital signs and patient's response to fall.
6. Notify the physician of the fall.
7. Notify the family or designee of the fall.
8. Implement fall risk precautions if not already in force.
9. Perform baseline neuro check for potential head injury Q4 hours for 24 hours post fall.
10. At the SRMH campus evaluate the possibility of transferring the patient to the observation room.
11. Evaluate the need for Q15 – Q30 min safety checks.
12. If a patient falls more than once, discuss with physician the need for a sitter or additional safety measures.
See [Sitter Policy NA6-56](#) or [Restraint Policy #B3-30](#).

G Reporting Patient Falls

- a. Patient Falls must be reported through the standard incident reporting process which is available to throughout the facility.

H Education and Competency of the Staff

- a. Patient Care Providers (licensed and unlicensed) are educated on the Fall Risk Program at new hire orientation.
- b. Education for Fall Risk Program includes how to identify patients at risk for falls, how to communicate the risk level to the patient, family and other members of the health care team, and the use of fall precautions and interventions.

I Analysis and Review of Patient Falls Data

- a. The SRMH Falls and Restraint Committee is responsible for analysis and review of patient fall data, and reports to the SRMH Patient Safety committee.

J Pediatrics (See appendix B)

<p>Authoring Department: Patient Care Services</p>	
<p>References: Viney, Mary, et al, American Society for Healthcare Risk Management, “Sharing Practices that Prevent Falls, Pressure Ulcers and Infections. February 2009 Audio Conference IHI Joint Commission Standards: National Patient Safety Goal9-Reduce the Risk of Patient Harm Resulting from Falls Hourly Rounding AJN Oct. 2006 Waters, T. “When is it safe to Manually Lift a Patient?” AJN August 2007 Vol. 107 No. 8 1) Wood, L. et. al. (1992) Fall risk protocol and nursing care plan. <u>Geriatric Nursing</u>, 13(4), 205-6. 2) Morse, J.M. (1993). Nursing research on patient falls in health care institutions. <u>Annual Review of Nursing Research</u>, 11 299-316.</p>	
<p>Reviewed/Revised by: Falls & Restraint Committee, Linda Phillips RN, MS, Eileen Jensen RN MSN FNP</p>	
<p>Approvals: Practice Council Restraint/Falls Task Force MEC</p>	<p>Distribution: All Patient Care Departments</p>

APPENDIX A Morse Fall Scale

The Fall Risk Score is assessed on admission and reassessed daily and for any change in orientation or level of consciousness.

Factor	Points	Description
History of falling	Yes = 25 No = 0	During present Hospitalization or <i>Immediately</i> prior to admit <i>Ask Patient , Check admit assessment or H & P</i>
Presence of Secondary diagnosis	Yes = 15 No = 0	Does the patient have 2 or more medical diagnoses? - Examples: diabetes, HTN, seizures, ostomy, sleep apnea, deaf/blind, arthritis, chronic pain, COPD, ostomy, <i>Check admit assessment or H & P</i> <i>Consider the effect of multiple medications when scoring</i>
IV therapy or peripheral IV lock	Yes = 20 No = 0	
Type of gait	Weak = 10 Impaired = 20	Normal = head erect, arms swing freely, striding unhesitantly. Weak = stooped but able to lift head without losing balance. If support from furniture needed – only featherweight touch for reassurance. Short steps or shuffle. Impaired = difficulty rising, pushes off on chair arms. Head down or watches ground. Poor balance, grasps on furniture – white knuckle <i>Review patient health care record. Consider the effect of multiple medications when scoring</i>
Use of walking aids	Normal/bedrest/wheelchair = 0 Cane/crutches/walker = 15 Uses furniture = 30	Normal = no walking aids (even if assisted by a nurse), uses wheelchair , is on bedrest or doesn't get up at all Uses furniture = Clutches onto furniture for support <i>Review patient health care record.</i>
Mental status	Overestimates/forgets own limitations = 15	Check patients own self-assessment of his or her own ability to ambulate. “Are you able to go to the bathroom alone or do you need assistance?” or “Do you feel safe getting up by yourself?” If patient’s reply is not consistent with MD or RN ambulation orders or if patient’s assessment is unrealistic –score as 15. <i>Consider the effect of multiple medications when scoring.</i>

APPENDIX B Pediatric Patients

1. Neonates and infants are by definition at risk for falls due to their developmental age. Such patients are maintained in bassinets for their safety. No assessment/reassessment of fall risk are required for these patients.

2. Toddlers are by definition at risk of falls due to their developmental age. Such patients are to be supervised and assisted as necessary if attempting to ambulate, and are to be maintained safely in their beds at all other times. No assessment/reassessment of fall risk for these patients are required for these patients.