Fall Prevention

A fall is defined as an unplanned descent to the floor with or without injury. Patient falls contribute to mortality and increased morbidity in the general patient population. Implementation of a falls/injury risk assessment and prevention program targets those at risk due to such factors as environmental challenges, functional limitations, and patient and family educational deficits. However, all patients may be at risk for falls.

General precautions that are in place for all patients include:
- Orientation to surroundings and use of call light
- Keeping bed in low, locked position
- Keeping floors obstacle free
- Keeping personal belongings and call light within patient’s reach at all times
- Intentional rounding
- Use of non-skid footwear
- Adequate lighting
- Encouraging patient and families to call for assistance when needed

Safety huddles are held at the beginning of each shift with all staff for the purpose of going over recent falls and current fall risks on unit. Because of increased risk of injury with a fall, information about fall risk will include the "ABCS" - Age 85 or greater, Bones (Osteoporosis, recent fracture or other bone disorder), Coagulopathy (on anticoagulants or with a bleeding disorder) and Surgery (during current admission). This information will be passed on in shift report and documented on whiteboard along with patient’s fall risk assessment.

Acute Care Inpatient (ONC, OSN, MED/SURG, CCU, PCU, CNV and ARU)

The following list of equipment may be used to prevent patient falls:

1. Call light within reach for patient and/or family
2. Alarm systems for doors, chairs, toilets, or beds as appropriate
3. Lift equipment to provide safe patient movement and prevention of falls
4. Gait belt or appropriate assistive devices (walker, cane, etc.)
5. Yellow socks or yellow arm band
6. Visual doorway identifier
7. In-room patient white boards designating fall risk assessment as Low, Mod, or High
8. Fall risk alert on Medical Record or bed board
9. Omnibelt as a reminder for patients with impulsive behavior
**Frequency of Fall Assessment:**
- Assess patient fall risk using the *Modified Morse Fall Scale*
- Assess patient risk of injury with fall using the *ABCS Risk Assessment*

1. Upon admission
2. Upon transfer from one unit to another
3. Following any change of patient status that may affect fall risk
4. Following a fall
5. Every shift
   a. Document the assessment in the medical record
   b. Document on patient white board as LOW, MOD, or HIGH risk
   c. In addition to the risk assessment tool, the nurse is expected to apply her/his clinical judgment about the patient's risk for falls

**Fall Risk Interventions:**
- Implement basic fall prevention interventions as listed in supportive data for ALL patients.

- **Add the following interventions when designated Moderate Risk:**
  1. Provide assistance with toileting during rounds
  2. When assisting patient to bathroom, stay nearby
  3. Evaluate effects of medications that increase the individual’s risk of falling with assistance from pharmacy, as appropriate
  4. Determine if appropriate to move patient closer to nurse’s station or constant care room
  5. Partner with patient to determine which side of the bed they usually get out of - consider placing tethers (IV pump, Foley bag, etc.) on that side of the bed
  6. Consider implementing use of appropriate equipment as in equipment list above

- **Add the following interventions when designated High Risk:**
  1. Implement yellow identifier at patient room entrance
  2. Place yellow socks and/or yellow bracelet on high fall risk patient
  3. Assure patient is able to be visualized from hallway if staff not present
  4. When assisting patient to the bathroom, stay in the bathroom, within arm’s reach, to monitor and assist patient
  5. Use of chair, toilet and bed alarms are highly recommended
  6. Consider use of constant observer
  7. Implement “no-passing” zone on high fall risk patients: After reviewing high risk patients at safety huddle, all staff on unit are aware that these patient’s call lights are highest priority. All staff will accept responsibility to assure call light is answered immediately.

**EMERGENCY DEPARTMENT**
- The following list of equipment may be used to prevent patient falls:
  1. Light within reach for patient and/or family
  2. Lift equipment to provide safe patient movement and prevention of falls
3. Gait belt or appropriate assistive devices (walker, cane, etc.)
4. Yellow socks or yellow arm band
5. Yellow/visual doorway identifier
6. Room curtains to remain open if patient is alone
7. In-room patient white boards designating fall risk assessment as Low, Mod, or High
8. Fall precaution icon added to ED tracking board
9. Additional interventions as ordered by MD

WOMENS AND CHILDREN’S

- **Moderate and High Risk** Nursing Interventions (over the age of 8 yrs):
  1. Provide distraction to the patient as appropriate
  2. Assist moderate risk fall patients to the bathroom, staying close to the bathroom door to listen to patient activity
  3. Determine if appropriate to move patient closer to nurse’s station

- **Moderate and High Risk** Nursing Interventions (under the age of 8 yrs):
  1. All Infants and children up to the age of 8 years are considered at minimum a Moderate Risk
  2. Side rails, crib rails, and side walls are always in the 'up' position unless care is provided
  3. Families are educated on proper falls prevention techniques when holding, feeding, snuggling, bathing, carrying, and other activities that take place when the infant or child is not in their bed

EDUCATION OF PATIENT AND FAMILY

- Using Teach Back method, educate the patient/family about fall prevention to include:
  1. Reasons for precautions (i.e. recent fall, impaired mobility, medications, recent surgery, use of anticoagulants)
  2. Assistive devices (i.e. walkers, gait belts, lift equipment)
  3. Fall prevention precautions (i.e. yellow socks, yellow flag, bed or chair alarm)
  4. How to request assistance

POST FALL PROCEDURE

- Fill out fall event/post fall assessment in ad hoc charting
- Document fall in the Progress Notes
- Assure SafelinQ report is completely filled out by person witnessing fall
FALL PRECAUTIONS

Patients with a high fall risk (Morse score > 45) need to have **fall precautions** in place at all times.

- **Bed or chair alarm on:** Make sure the Posey alarm is used (not the in-bed alarm,) and that the pad that is under the patient (in the bed or the chair) is the one plugged in to the sensor! You can label the bed and chair cords with labels near the top to make it easier to quickly identify which one is which. When a green light shines from the top of the alarm – it is armed and functioning.
  - Standard work: before you move a patient from bed to chair & before getting the patient out of bed, unplug the bed strip and plug in the chair strip. When the patient sits in the chair, it will automatically be set, and the bed alarm won’t sound while you are moving the patient.

**Documenting Morse Fall Scale in Cerner:**

- Found in Care Compass
• Or in AdHoc

Morse Fall Scale in QS:

Maternal Chart:

Maternal falls usually occur post-delivery, first or second time getting out of bed.
• Assess vital signs, sensory/motor of legs prior to getting out of bed.
• Assist out of bed first and second time out of bed post-delivery.
Newborn Chart:

Newborns at risk for falling out of adults arms and off day bed or patient bed
- Recommend adults don’t hold baby when they are at risk of falling asleep
- Recommend baby doesn’t lay on day bed or patient bed without being held.

Morse Fall Scale Reference Text
https://www.lucidoc.com/cgi/doc-gw.pl?ref=everg5:29072

Initial Assessment or Re-assessment:
1. Initial: admission, first scale done in hospital
2. Re-assessment: any thereafter

History of Falling:
1. If the patient has a history of falls within 3 months of admission – this value may change if they fall while they are here, YES = 25 points
2. If no falls w/in last 3 months, and no fall during hospitalization, NO = 0 points

Secondary Diagnosis:
1. If only one diagnosis is listed on the patient’s chart, score as NO = 0 points
2. If more than one medical diagnosis is listed on the patient’s chart, score as YES = 15 points
**Mobility Aid:**

1. If a patient walks independently with no assistance of any kind, score 0
2. If a patient walks without a walking aid (even if does walk with a nurse assist), or is on bedrest and does not get out of bed at all, score 0
3. If the patient uses crutches, a cane, walker, or wheelchair, score 15
4. If the patient ambulates clutching onto furniture for support, score 30

**IVF Infusion/Narcotics/Diuretics:**

1. If no infusing IV, no narcotics, no diuretics, score NO = 0 points
2. If patient has an infusing IV or is taking any narcotics or diuretics, by any route, score YES = 20 points

**Gait/Transferring:**

1. Normal gait = walking with head erect, arms swinging freely at the side, striding without hesitation, score 0
2. Bedrest/immobile = patient does not ever get out of bed and walk at all (by MD order or unable), score 0
3. Weak gait = May be stooped in walking, but able to lift the head and walk without losing balance, steps are short and may be shuffling, score 10
4. Impaired = May have difficulty getting out of a chair, head down, watches the ground, poor balance, cannot walk without assistance or a walking aid, score 20

**Mental Status:**

This is based on patient’s self-assessment of their ability to walk. Ask the patient, “Are you able to walk to the bathroom alone, or do you need help?”

1. If the patient’s reply judging their ability is consistent with their true ability and the MD activity orders, the patient is scored 0 (oriented to own ability.)
2. If the patient’s response is not consistent with their actual capability and MD orders for activity, then they are judged to be overestimating their abilities or forgetful of limitations = 15 points