SUBJECT: FALL PREVENTION	REFERENCE #8016
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1 OF: 7
	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITIONS:

- Fall - An unplanned descent to the floor (or extension of the floor; i.e., trash can or other equipment), with or without injury to the patient.

- Assisted Fall - A fall in which any staff member (whether nursing service employee or not) was with the patient and attempted to minimize the impact of the fall by easing the patient's descent to the floor or, in some manner, attempting to break the patient's fall. "Assisting" the patient back to bed or chair after a fall is not an assisted fall.

- Repeated Fall - More than one fall by the same patient after admission to a unit.

- Fall Rate - Number of falls (with or without injury) by unit type during calendar month times 1,000, divided by number of patient days by unit type during the calendar month.

POLICY:

- Every patient care area shall be evaluated for the potential for patient falls. Evaluations shall be completed by the department managers and _____. The following components shall be evaluated for each patient care area:
  - Patient population served
  - Services provided
  - Physical environment
- Findings from the evaluation shall be incorporated into the fall reduction program to reduce the number of patient falls.

- Fall Assessment:
  - All patients shall be assessed upon admission and continuing throughout the stay using the hospital's Fall Assessment Form.
    - The following are tools with published reliability and validity (adults):
      - Morse Fall Scale (1987)
      - Schmid Fall Risk Assessment Tool
      - Fall Risk Assessment Tool [1,2]
      - St. Thomas Risk Assessment Tool In Falling Elderly Patients [1,3]
    - Fall tools for pediatric patients:
      - CHAMPS
      - Cummings Pediatric Fall Assessment Scale
      - GRAF-PIF
      - Humpty Dumpty Fall Scale
      - I'M SAFE

[1] Tested only in older populations on units with extended length of stay.

[2] *Fall Risk-Assessment Tool*, MacAvoy S, Skinner T, Hines M, Appl Nurs Res 1996; 9: 213-218

[3] *Development and Evaluation of Evidence Based Risk Assessment Tool (STRATIFY) to Predict Which Elderly Inpatients Will Fall: Case-Control and Cohort Studies*, Oliver D, Britton M, Seed P, et al., Br Med J 1997; 315: 1049-1053

- Assessment shall include, but may not be limited to:
  - Cognitive impairment
  - Impaired balance, gait or strength
  - Impaired mobility
  - Neurological problems such as stroke and Parkinson's disease
  - Musculoskeletal problems such as arthritis, joint replacement, deformity and foot problems
  - Chronic diseases such as osteoporosis, cardiovascular disease, lung disease and diabetes
  - Nutritional problems
- Review the medications ordered for the patient to determine if these may predispose the patient to falls. Examples of medications that may impact the patient's physiological balance are:
  - Antiarrhythmics
  - Antidepressants
  - Antihypertensives
  - Diuretics
  - Hypoglycemics
  - Laxatives
  - Neuroleptics
  - Nonsteroidal anti-inflammatory agents

        - Psychotropics
        - Sedatives/hypnotics
        - Vasodilators
    - History of falls prior to or during hospitalization shall be documented on care plan.
- Reassessments:
    - Patients shall be reassessed:
        - Daily when at high risk for falls
        - As needed
        - As the patient's condition warrants
        - When new medications are administered
        - Dosage of current medications is changed
        - Patient has undergone an invasive/surgical procedure
        - Post fall
- Preventing Falls:
    - Orient patients to room and call system.
    - Put call light within reach.
    - Put patient’s bed in lowest position with wheels locked.
    - Put personal items within reach.
    - Encourage patients to use handrails and bathroom safety bars.

- Patients at-risk for falls shall be placed as close as possible to the nurses' station.
- Patient fall alarms may be used when the patient is in bed or sitting in a chair.
- Provide individualized toileting interventions (based on needs/patterns).
- Patient/family shall be instructed about safety measures and rationale, including to call for assistance before getting out of bed, rise slowly, keep necessary items within reach and the proper use of canes, walkers, wheelchairs and crutches.
- Family members shall be encouraged to take an active role in observing the patient as frequently as possible and alerting staff of any perceptions regarding the patient's sensorium or physical functioning.
- Ambulatory patients shall wear proper foot gear; nonskid shoes or well-fitting nonskid slippers.
- Encourage use of ambulation aids at all times.
- Wheelchair patients need special instruction about weight distribution and balance of weight.
- Patients on crutches need practice. Make sure your patients are steady on crutches before they walk unattended. Help keep the way clear.
- Pick up everything spilled or dropped on floor. Liquids, paper, even flower petals can be dangerous to a person on crutches.
- Pull wheeled vehicles through doorways, so you lead the way and can see where you are going.
- Keep carts out of the way so they won't create obstacles to others.
- Be alert for anything that is in the path of traffic or makes walking hazardous.
- Provide adequate lighting without glare.

- Interview the patient and his/her family members to determine any factors that may predispose the patient for fall and/or activities that have helped prevent falls in the home environment.
- Ensure Optimal Communication:
  - Regarding the patient's condition and potential for fall with other care providers:
    - During shift changes
    - Include all disciplines
    - When transferring information about the patient
  - With the patient and his/her family about the fall prevention issues and any fall prevention activities to be carried out for the patient
- Implement fall prevention protocol as determined by the patient's assessed needs.

STAFF EDUCATION:

- Staff shall receive inservices on the fall prevention program to include:
  - Fall assessment
  - Techniques to prevent falls
  - Transfer protocols to transfer a patient safely from a wheelchair, stretcher, chair or bed

NOTE:

- Each healthcare organization must choose a fall assessment tool that speaks to the population served and environment.
- There are many fall assessment tools available, such as the Conley Tool, Fall Assessment Tool from John Hopkins, and the Humpty Dumpty Tool (pediatrics) from Miami Children's Hospital.

REFERENCES:

- American Medical Directors Association (AMDA), *Falls and Fall Risk*, Columbia (MD); 2003, p 16

- The Joint Commission, Implementation Guide for NQF-Endorsed Voluntary Consensus Standards for Nursing-Sensitive Care Performance Measures: Patient Falls (NSC-3) and Falls with Injury (NSC-4)

- Mary L. Hook, PhD, APRN, BC; Elizabeth C. Devine, PhD, RN, FAAN; Norma M. Lang, PhD, RN, FAAN, FRCN, *Using a Computerized Fall Risk Assessment Process to Tailor Interventions in Acute Care*, http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety-2/vol1/Advances-Hook_25.pdf