utmb Health

Institutional Handbook of Operating Procedures Policy 09.13.39	
Section: Clinical	Responsible Vice President: Senior Vice President, Chief Medical & Clinical Innovation Officer
Subject: General Clinical Procedures and Care	Responsible Entity: Nursing Services

I.   Title
Patient Falls Prevention Plan

II.   Policy
UTMB Health is committed to patient safety and a culture of trust. Preventing patient falls and injury involves all staff and all health professionals. Ensuring an optimal safe environment will minimize the number of accidental falls. The environment will be free from hazards and durable medical equipment will be used safely.

Fall Risk Assessment

A.   *Initial Assessment:*
    1.   A Registered Nurse (RN) completes a fall risk assessment on all inpatients within 24 hours of admission including patients in observation status.
    2.   Tools:
        a.   Morse Fall Scale (MFS) for adults (18 years and older).
        b.   Humpty Dumpty Falls Assessment (HDFA) for infants and pediatric patients. (Age 1 year to 18 years). Patients under one (1) year old are considered at risk for falls and interventions should be in place as indicated.

B.   *Re-Assessment:*
    1.   Completed every shift, with any change in the patient's condition, and after a fall.

C.   *Special consideration:*
    1.   Emergency Department (ED): A fall risk assessment will be completed at the time of ED nursing focused assessment.
    2.   Ambulatory areas: Refer to policy C52 (Ambulatory Fall Risk Prevention/Interventions and Post Fall Reporting) for guidance on fall risk screening and interventions.
    3.   Surgery, diagnostic tests, and procedures may warrant a reassessment due to change in patient's condition.

III.   Procedures
    A.   Standard of Care
    1.   Implement and document an individualized interdisciplinary fall prevention plan of care based on assessment scores (MFS or HDFA)
    2.   Fall risk is communicated during handoff, including documentation in Electronic Health Record (EHR) in the fall prevention plan of care.

    B.   Standard environmental Safety Measures (all patients) may include but are not limited to:
    1.   Orientation to unit/room.
    2.   Assess elimination need and assist as needed.

3. Fall Prevention Partnership Agreement (as applicable to unit).
4. Purposeful rounding using 5 Ps (Pumps, Pain, Potty, Position, Possessions).
4. Call bell within reach (patient/family educated on its functionality). Glasses (if applicable), ambulatory aids, or other patient items also within reach.
5. Fall prevention visual cues in patient room.
6. Appropriate bed for patient's age, development, and acuity (see Appendix A) and in lowest position.
7. Encourage the use of safe footwear (if applicable to patient) and appropriately sized clothing.
10. Remove clutter and excess furniture from room (if possible).
11. Night lighting (when applicable).
12. Daily exercise or ambulation to maintain strength and reduce debilitation risk (as applicable).
13. Brakes secured on bed, wheelchair, and recliner (when in use).

C.   Risk-Based Interventions (Adults):
1. Moderate Risk (MFS 25-44):
    a. Standard environmental Safety Measures (as applicable) PLUS:
        i. Yellow wrist band (to indicate patient at risk for falls).
        ii. Yellow fall risk sign posted outside patient door.
        iii. Determine need for bed, chair, or toilet alarm based on the following criteria (Fall Alarm Decision Tree linked below under Related UTMB Policies and Procedures):
            I. Fall within the last 6 months
            II. Need for ambulation assistance
            III. Poor mobility judgement
            IV. Altered mental status
        iv. Determine the need for virtual sitter based on the following criteria (VMT or One-to-One Decision Tree linked below under Related UTMB Policies and Procedures):
            I. High Priority Patients
                1. Must be redirectable
                2. High fall risk (MFS =/> 45)
                3. Patient pulling at lines
                4. Fallen prior to admission or while hospitalized
                5. History or risk of elopement
            II. Mid Priority Patients
                1. Must be redirectable
                2. Meets diagnosis criteria: AMS, Respiratory, Pain
                3. History of treatment for alcohol/drug withdrawal
                4. High fall risk (MFS =/> 45)
            III. Low Priority
                1. Must be redirectable
                2. Meets the diagnosis criteria: Cardiac, DM
                3. Moderate fall risk (MFS 25-44)
            IV. Refer to Nursing Service Policy 7.2 Patient Safety Observation for additional policy and clinical resource information related to sitter utilization.
        v. Determine the need for one-to-one sitter (direct observation) by meeting one or more of the following criteria (VMT or One-to-One Decision Tree linked below under Related UTMB Policies and Procedures):
            I. Patient is not redirectable

II. Delirium observed and demonstrated by one or more of the following:
1. Intense restlessness
2. Severe confusion or disorientation
3. Delusions
4. Visual or tactile hallucinations
III. Impulsive and unlikely to call for assistance when needed to prevent fall

    vi. When determining the need for an alarm, virtual sitter, or one-to-one sitter, clinical judgement can override an individual risk screening score. Documentation or rationale for not applying one of these interventions, when indicated, must be documented in the patient's electronic medical record (EHR).

2. High Risk (MFS 45 and above):
   a. All standard environmental safety measures and moderate risk interventions (as applicable) PLUS:
      i. Red fall risk sign placed outside patient room
      ii. Move patient closer to nurses' station (if room is available)
      iii. Determine need for bed, chair, or toilet alarm (based on criteria listed under moderate risk). Refer to Fall Alarm Decision Tree linked under Related UTMB Policies and Procedures.
      iv. Determine the need for virtual or one-to-one sitter (based on the criteria listed under moderate risk), if not already considered. Refer to VMT or One-to-One Decision Tree linked under Related UTMB Policies and Procedures.

3. Additional Strategies:
   a. Address specific MFS items (as applicable). Examples are history of falling, secondary diagnosis (polypharmacy), gait issues, ambulatory aid usage, IV therapy use considerations, and mental status.
   b. Refer to Elsevier Fall Prevention skills for additional information and interventions for specific items noted above.

D. Risk-Based Interventions (Pediatric):
1. Low Risk Protocol (HDFA 7-11):
   a. Standard environmental safety measures (as applicable) PLUS:
      i. Ensure appropriateness of patient bed.
         NOTE: Specific pediatric beds may not be available in the ED. In those situations, ensure parent or guardian is aware of bed safety when specialty beds are not available for pediatric patients being held in the emergency room.
      ii. Side rails X2 or X4 up; assess large gaps, such that a patient could get extremity or other body part entrapped; use additional safety precautions.
      iii. Yellow fall risk sign placed outside patient room.

2. High Risk Protocol (HFDA Score 12 or above):
   a. Standard environmental safety measures and low risk protocol interventions (as applicable) PLUS:
      i. Yellow wrist band.
      ii. Red fall sign placed outside patient room.
      iii. Accompany patient when ambulating and do not leave unattended in bathroom.

        iv. Protective barriers to close off spaces, gaps in the bed. Utilize "Safe Sleep Escalation Pathway" if parent refuses appropriate bed or is co-sleeping with child.

        v. Keep door open at all times, unless specified isolation precautions are in use.

        vi. Move patient closer to nurse's station (if room is available).

        vii. Determine the need for one-to-one sitter (direct observation) based on same criteria for adults as noted above.

3. Additional strategies:
   a. Address specific HFDA items (as applicable). Examples are diagnosis, cognitive impairments, environmental factors, response to surgery/sedation/anesthesia, and medication usage.
   b. Refer to Elsevier Fall Prevention (Pediatric) skills for additional information and interventions.

E. Fall Incident Response

1. **Immediate Response:**
   a. RN (or designated staff based on scope of practice) will:
      i. Conduct a thorough physical exam for injuries.
      ii. Perform neuro checks with signs of head trauma or complaints of headache post fall.
      iii. Take vital signs, including orthostatics.
      iv. Notify provider.
      v. Immediately reassess for areas of redness, ecchymosis, and swelling and / or pain every shift over the next 24 hours.
      vi. Ensure patient is safe to move; place back in bed.
      vii. Reassess patient's risk using MFS or HDFA as indicated.
      viii. Notify patient's point of contact for hospitalization regarding fall.
      ix. If the patient has suffered an injury, see IHOP 09.13.18 Disclosure of Unanticipated Outcomes.

2. **Documentation:**
   a. Review and revise initial plan of care.
   b. Complete the post fall huddle with applicable members of the team.
   c. Enter the fall event into UTMB's event reporting system. The unit manager will receive notification of the event through the event reporting system.
   d. Ensure the following is documented for each incident: Document the fall including the post fall assessment, notification of provider (when fall occurred), fall risk score, interventions, notification of the patient's family and any patient/family education provided on the appropriate flowsheet within the EHR.

F. Education and Training

1. **Staff Education**
   Staff education regarding fall assessment, fall prevention plan of care, safe use of equipment and use of monitors, alarms, and sitters occurs during the new employee orientation process, annually, and reinforced as appropriate.

2. **Patient Education**

     a. Educate and involve the patient, family, and/or significant other regarding fall risk reduction including home safety measures.

     b. Provide age-appropriate fall risk education as needed.

     c. Document patient and family education in the designated interdisciplinary teaching document or appropriate patient education section for the clinical location.

IV. Related UTMB Policies and Procedures

Fall Alarm Decision Tree

VMT or One-to-One Decision Tree

IHOP – 09.13.13 – Unusual Event Reporting

IHOP 09.13.18 Disclosure of Unanticipated Outcomes

Nursing Practice 7.2.57 Patient Fall and Allergy Color - Coded Bands

Fall Risk Prevention/Interventions and Post Fall Reporting within UTMB Outpatient Setting- Clinic/ Ambulatory Procedural Care Facility/ Ancillary Service Outpatient Facility

Appendix A – Pediatric Bed Selection

Fall Prevention Partnership Agreement - English

Fall Prevention Partnership Agreement - Spanish

Humpty Dumpty Fall Assessment Scale

Patient Falls Prevention Plan - Express Inservice

Safe Sleep Escalation Pathway

Elsevier Performance Manager Fall Prevention in Hospitals, Adults

Elsevier Performance Manager Fall Prevention in Hospitals, Pediatric

Elsevier Performance Manager Fall Prevention in Home, Easy to Read

Elsevier Performance Manager Fall Prevention in Home

Elsevier Performance Manager Home Care Safety, Modifying Safety Risks

V. Additional References

Morse, J. M. (2009). Preventing patient falls: Establishing a fall prevention program (2nd ed.). New York, NY: Springer Publishing Company, LLC.The Joint Commission E-Edition. (2019, July 1). Provision of Care, Treatment, and Services chapter; PC.01.02.08: The hospital assesses and manages the patient's risks for falls. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

The Joint Commission E-Edition. (2019, July 1). Provision of Care, Treatment, and Services chapter; PC.02.03.01: The hospital provides patient education and training based on each patient's needs and abilities. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

Agency for Healthcare Research and Quality. (2017). The Falls Management Program: A quality improvement initiative for nursing facilities. Retrieved from https://www.ahrq.gov/sites/default/files/publications/files/fallspxmanual.pdf

VI. **Dates Approved or Amended**

Originated: 10/30/1994	
Reviewed with Changes	Reviewed without Changes
09/07/2012	07/14/2016
02/04/2020	
8/26/2024	

VII. Contact Information

Falls Prevention Committee
(409) 772-8396

Appendix A
Pediatric Bed Selection

A. Clinicians should place pediatric patients in a bed that is appropriate to the acuity and development of the patient while ensuring a safe and effective environment of care.
B. Infants under 12 months of age will only be placed in cribs, bassinets, isolettes, or warmers.
C. If the clinical team determines that the patient should be placed in an alternative type of bed, based on acuity and/or development, then an order must be placed in the patient's chart. For infants who should be in cribs, once the infant has been successfully extubated, he/she should be placed in a crib.
D. Parents or legal guardians of children who request to deviate from these guidelines should be educated on potential fall/injury risks of inappropriate bed placement. Education should be documented in the electronic medical record.
E. Parents, guardians or others should not share a crib or bed with an infant or child.
F. For children exhibiting normal growth and development for their age with no alterations in level of consciousness or mental status, the following parameters for bed or crib selection should be applied:

Age	Appropriate Types of Bed(s)
Neonates (≤ 4weeks old)	Isolette, radiant warmer, bassinet, or crib
Infants (> 4 weeks - 1 year of age)	Crib
Toddlers (>12 months to 30 months)	Crib with enclosure
Children (>30 months)	Bed
Adolescents	Bed