Section 9 Clinical Policies Subject 9. 13 General Clinical Procedures and Care Policy 9.13.39 Patient Falls Prevention Plan	10/30/94 -Originated 09/07/12 -Reviewed w/ changes -Reviewed w/o changes 10/03/12 -Effective Nursing -Author

Patient Falls Prevention Plan

Definitions

Fall: An unplanned descent to the floor with or without injury to the patient. Include falls when a patient lands on a surface where you wouldn't expect to find a patient. All types of falls are included, whether they result from physiological reasons (fainting) or environmental reasons (slippery floor), or assisted falls, when another person attempts to minimize the impact of the fall by assisting the patient's descent to the floor. Also report patient that roll off a low bed onto a mat as a fall." (NDNQI February 2012)[1]

Morse Fall Scale (MFS): is a fall risk assessment tool that predicts the likelihood of an adult patients' falling so that preventive strategies and resources may be targeted to prevent falls in the patients most likely to fall.

Humpty Dumpty Fall Assessment (HDFA): is a tool that can help to predict the likelihood of a pediatric patient fall.

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 shall be free from hazards and durable medical equipment will be used safely.

Fall Risk Assessment

A fall risk assessment shall be completed by a Registered Nurse (RN) as part of the Nursing Admission Assessment on all inpatients within 24 hours of admission including patients in observation status.

a. Morse Fall Score (MFS) shall be used to assess all adults (18 years and older).
b. Humpty Dumpty Falls Assessment Tool shall be used to assess infants and pediatric patients. (Age 3 months to18 years)

In the Emergency Department, a fall risk assessment shall be completed at the time of ED nursing focused assessment.

All patients shall be re-assessed every shift, with any change in the patient's condition, and after a fall.

Note: *Surgery, diagnostic tests and procedures may warrant a reassessment due to change in patient's condition.*

Procedure

Standard of Care

An individualized interdisciplinary fall prevention plan of care shall be implemented and documented in the EMR based on the assessment score and MFS items.

Any healthcare professional or staff who observes a patient with red socks (indicators of fall risk) ambulating unassisted, should support and stand beside

Procedure, continued

the patient until assistance arrives. Overall fall prevention interventions based on MFS risk score:

Fall Risk Score	Interventions
All patients/ families	Environmental safety measures may include but not limited to: 1. Orientation to unit. 2. Fall Prevention Partnership Agreement. 3. Hourly rounding using 5 Ps (Potty, Pain Assessment, Placements, Positioning and Pumps). 4. Call bells within reach. 5. "Call Don't Fall" visual cues in room and bathroom. 6. Safe footwear. 7. Ensure glasses are available and within reach. 8. Bed in low position. 9. Remove clutter and excess furniture from room. 10. Night lighting. 11. Daily exercise or ambulation to maintain strength and reduce debilitation risk. 12. Brakes secured on wheelchair.
Moderate Morse Fall Scale (25-44)	1. Yellow wrist band. 2. Sign posted outside door.
High Morse Fall Scale (45 and above)	1. Yellow wrist band. 2. Red socks on patient 3. Sign posted outside door. 4. Patient's bed may be equipped with bed alarm and on at all times.

Additional Fall prevention strategies based on assessment may be considered. Fall prevention interventions that may be included based on MFS item:

Morse Fall Scale Item	Intervention Strategies
History of Falling	1. Expect a 2nd fall. 2. Develop a strategy to prevent recurrence-at the same time with the patient doing the same activity. 3. Develop a patient specific fall-intervention program. 4. Huddle to alert staff about the circumstances of the 1st falls. 5. Red socks on patient. 6. Sign posted outside door.
Secondary Diagnosis (poly-pharmacy)	1. Consult with physician and pharmacy. 2. Adjust medications accordingly.

Procedures. Continued

Morse Fall Scale Item	**Intervention Strategies**
Gait	1. Refer to Physical Therapy for exercise program. 2. Walk regularly. 3. Safe route to bathroom. 4. Remind to use call bell for assistance when getting out of bed. 5. "Call Don't Fall" visual cues in room and bathroom. 6. Review Fall Prevention Partnership Agreement. 7. Inform family about limitations and plan for fall intervention. 8. Provide assistance. 9. Top side rail up to assist with mobility.
Ambulatory Aid	1. Avoid rushing to the bathroom. 2. 5 P's (Potty, Pain Assessment, Placements, Positioning and Pumps) of hourly rounding. 3. Provide appropriate aids (cane, walker- are safe working condition). 4. Aids used correctly. 5. Aids within reach.
IV	1. Assess for fluid balance, hypotension. 2. If using pole as walking aid, provide walker. 3. If urinary urgency, hourly rounding with emphasis on 5P's (Potty, Pain Assessment, Placements, Positioning and Pumps). 4. Remind of physical limitations.
Mental Status	1. Place bed in room near nursing station 2. Hourly rounding with emphasis on 5P's (Potty, Pain Assessment, Placements, Positioning and Pumps). 3. Involve family for observations; planning care. 4. Frequent reorientation and reminders. 5. Remind to use call bell for assistance when getting out of bed. 6. "Call Don't Fall" visual cues in room and bathroom. 7. Review Fall Prevention Partnership Agreement 8. Consider use of sitter 9. If impulsive, disoriented, consider use of bed alarm.

Overall fall prevention interventions based on risk score - Humpty Dumpty Assessment scale risk score may include:

Fall Risk Score	**Interventions may include but not limited to:**
Low Risk Protocol (Score 7-11)	1. Assess elimination needs and assist as needed. 2. Call light is within reach and educates patient/family on its functionality. 3. "Call Don't Fall" visual cues in room and bathroom. 4. Environment clear of unused equipment, furniture's in place, clear of hazards.

Procedure, continued

Low Risk Protocol (Score 7-11), continued	5. Orientation to room. 6. Bed in low position, brakes on. 7. Side rails X2 or 4 up, assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety precautions. 8. Use of non-skid footwear for ambulating patients. 9. Use of appropriate size clothing to prevent risk of tripping. 10. Assess for adequate lighting, leave nightlights on. 11. Patient and family education available to parents and patients.
High Risk Protocol (Score 12 or above)	1. Yellow wrist band. 2. Red socks on patient. 3. Sign placed on door. 4. Accompany patient with ambulation. 5. "Call Don't Fall" visual cues in room and bathroom. 6. Do not leave child unattended in bathroom. 7. Educate Patient/Family regarding falls prevention. 8. Remove all unused equipment out of room. 9. Protective barriers to close off spaces, gaps in the bed. 10. Keep door open at all times unless specified isolation precaution are in use. 11. Evaluate medication administration times. 12. Check patient minimum every hour. 13. Move patient closer to nurses' station. 14. Assess need for 1:1 supervision.

Fall risk is communicated during handoff including documentation on the PATH form. Transportation will provide mode of transportation based on the fall prevention plan of care.

In the Event of a Fall

Assessment of patient and documentation of incident in the UHC Patient Safety Net (PSN) must be completed.

The RN shall:

1. Conduct a thorough physical exam for injuries.
2. Perform neuro checks with signs of head trauma or complaints of headache post fall.
3. Take vital signs, including orthostatics.
4. Notify provider.
5. Reassess for areas of redness, ecchymosis, swelling and / or pain every shift x 24 hours.
6. Ensure patient is safe to move, place back in bed.
7. Reassess patient's risk using MFS or Humpty Dumpty as indicated.
8. Revise initial plan of care.
9. Inform staff of fall (Huddle).

Procedures, continued

10. Registered Nurse will complete Patient Safety Net (PSN) and the Nurse Manager will be informed as indicated.

Documentation
Document the fall including the post fall assessment, fall risk score, interventions, notification of the patient's family and patient/family education on the daily nursing record or EMR.

Staff Education
Staff education regarding fall assessment and fall prevention plan of care shall occur during the new employee orientation process and be reinforced as appropriate.

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

Provide age appropriate fall risk education hand-out as needed. McKesson Resources are available from the Clinical References activity within Epic.

Patient and family education shall be documented in the designated patient/family interdisciplinary teaching document.

Resources

Fall Prevention Partnership Agreement - English
Fall Prevention Partnership Agreement - Spanish

MOSBY'S NURSING SKILLS

1. Mosby's Patient Education: Fall Prevention Guidelines for Patient and Families
2. Mosby's Patient Education: Home Safety and Preventing Falls
3. Mosby's Patient Education: Fall Prevention: Elderly
4. Mosby's Patient Education: Falls and Hip Fractures Among Older Adults

Related Policy

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

References

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2. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. AHRQ Publication No. 08-0043, April 2008. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/nurseshdbk/ (See Chapter 10:

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8. Improvement Initiative for Nursing Facilities Chapter 2 Fall Response at http://www.ahrq.gov/research/ltc/fallspx/fallspxman2.htm
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