

**Institutional Handbook of Operating Procedures
Policy 09.13.39**

Section: Clinical	Responsible Vice President: EVP and CEO Health System
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 fall risk assessment will 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 Scale](#) (MFS) is used to assess all adults (18 years and older).
- b. [Humpty Dumpty Falls Assessment \(HDFA\)](#) tool is used to assess infants and pediatric patients. (Age 3 months to 18 years)

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

Ambulatory areas will refer to policy C52 Ambulatory Fall Risk Prevention/Interventions and Post Fall Reporting to guide their fall risk assessment decisions and interventions.

All patients will 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.

III. Standard of Care

A. An individualized interdisciplinary fall prevention plan of care will be implemented and documented in the EMR based on the assessment score and MFS or HDFA items. Ambulatory areas will implement fall prevention strategies for those identified at risk for falls according to policy C52 Ambulatory Fall Risk Prevention/Interventions and Post Fall Reporting.

B. Overall fall prevention interventions based on MFS risk score:

<p>Environmental Safety Measures may include but are not limited to:</p> <ol style="list-style-type: none"> 1. Orientation to unit. 2. Fall Prevention Partnership Agreement (as applicable to unit). 3. Hourly rounding (or more frequent and as needed to be individualized to patient) using 5 Ps (Potty, Pain Assessment, Placements, Positioning and Pumps).

<ol style="list-style-type: none"> 4. Call bells within reach. 5. “Call Don’t Fall” visual cues in room and bathroom. 6. Encourage the use of safe footwear (if applicable to patient). 7. Ensure glasses are available and within reach (if applicable to patient). 8. Bed in low position. 9. Remove clutter and excess furniture from room. 10. Night lighting (when applicable). 11. Daily exercise or ambulation to maintain strength and reduce debilitation risk (as applicable). 12. Brakes secured on recliner (when in use). 13. If patient uses a wheelchair, brakes are secured when not in use. 14. Use of appropriate size clothing to prevent risk of tripping. 	
<u>Fall Risk Score</u>	<u>Interventions</u>
Moderate Risk Morse Fall Scale (25-44)	In addition to the Environmental Safety Measures noted above, add the following: <ol style="list-style-type: none"> 1. Yellow wrist band (to indicate patient at risk for falls). 2. Fall risk sign posted outside patient door to alert staff of fall risk.
High Risk Morse Fall Scale (45 and above)	All interventions noted above for Environmental Safety Measures and Moderate Risk plus the following: <ol style="list-style-type: none"> 1. Patient’s bed (toilet or chair, if ambulating) may be equipped with alarm to aid with fall prevention. 2. Assess need for 1:1 supervision.

C. Additional fall prevention strategies based on assessment may be considered.

<u>Morse Fall Scale Item</u>	<u>Intervention Strategies</u>
History of Falling	<ol style="list-style-type: none"> 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 fall.
Secondary Diagnosis (poly-pharmacy)	<ol style="list-style-type: none"> 1. Consult with physician and pharmacy. 2. Adjust medications accordingly.
Gait	<ol style="list-style-type: none"> 1. Refer to Physical Therapy for exercise program. 2. Provide opportunities for patient to walk regularly, or according to physician orders. 3. Provide a safe route to the bathroom. 4. Remind patient to use call bell for assistance when getting out of bed or when ambulating from the toilet or chair. 5. Inform family about any identified patient limitations and plan for fall intervention. 6. Provide assistance as needed. 7. Top side rail up to assist with mobility.

Ambulatory Aid	<ol style="list-style-type: none"> 1. Avoid rushing to the bathroom. 2. Provide appropriate aids when available (cane, walker- are safe working condition). 3. Ensure aids are used correctly. 4. Ensure aids are within reach.
IV	<ol style="list-style-type: none"> 1. Assess for fluid balance, hypotension. 2. If using pole as walking aid, provide walker or other assistance (as applicable). 3. Remind of patient and family of physical limitations.
Mental Status	<ol style="list-style-type: none"> 1. Place bed in room near nursing station (when appropriate and available). 2. Involve family for observations; planning care. 3. Frequent reorientation and reminders (as appropriate for patient). 4. Provide frequent reminders to use call bell for assistance when getting out of bed. 5. Consider use of sitter (as appropriate for patient safety). 6. If impulsive, disoriented, consider use of safety alarm for bed/chair/toilet.

D. Overall fall prevention interventions based on HDFA scale risk score may include:

<u>Humpty Dumpty Fall Risk Score</u>	<u>Interventions may include but not limited to:</u>
Low Risk Protocol (Score 7-11)	<ol style="list-style-type: none"> 1. Assess elimination needs and assist as needed. 2. Call light is within reach and patient/family have been educated on its functionality. 3. “Call Don’t Fall” visual cues in room and bathroom. 4. Environment clear of unused equipment, furniture is in place, clear of hazards. 5. Orientation to room. 6. Bed in low position, brakes on. 7. 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. 8. Encourage the use of safe footwear for ambulating patients (when applicable). 9. Use of appropriate size clothing to prevent risk of tripping. 10. Assess for adequate lighting; leave nightlights on (as applicable). 11. Provide fall prevention education to patient/family (as applicable).
High Risk Protocol (Score 12 or above)	<ol style="list-style-type: none"> 1. Yellow wristband (to indicate patient at risk for falls). 2. Encourage the use of safe footwear for ambulating patients (as appropriate). 3. Fall risk sign posted outside patient 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 from room (when applicable). 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 (or more frequent and as needed to be individualized to patient). 13. Move patient closer to nurses’ station (if room is available). <p>Assess need for 1:1 supervision.</p>

E. Fall risk is communicated during handoff including documentation in Epic on the Fall Plan of Care.

IV. In the Event of a Fall

- A. Assessment of patient and documentation of incident in the Health System's designated event reporting tool must be completed.
- B. For each incident, the RN (or designated staff based on scope of practice) will:
 - 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, and 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 HDFA as indicated.
 - 8. Revise initial plan of care (as applicable).
 - 9. Complete the post fall huddle form with applicable members of the team then enter the fall event into UTMB's event reporting system. The unit manager will receive notification of the event through the event reporting system.
- C. Ensure the following is documented for each incident:
 - 1. Document the fall including the post fall assessment, notification of provider (when fall occurred), fall risk score, interventions, notification of the patient's family (if applicable) and any patient/family education provided on the appropriate flowsheet within the EMR.

V. Staff Education

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

VI. 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. Patient and family education will be documented in the designated patient/family interdisciplinary teaching document or appropriate patient education section for the clinical location.

VII. Resources

[Fall Prevention Partnership Agreement - English](#) (under documents and forms)

[Fall Prevention Partnership Agreement - Spanish](#) (under documents and forms)

[Humpty Dumpty Fall Assessment Scale](#)

[Patient Falls Prevention Plan - Express Inservice](#)

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

VIII. Related UTMB Policies and Procedures

[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](#)

[IHOP – 09.13.13 – Unusual Event Reporting](#)

IX. 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>

X. Dates Approved or Amended

<i>Originated: 10/30/1994</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
09/07/2012	07/14/2016
02/04/2020	

XI. Contact Information

Falls Prevention Committee
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