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 Score (MFS) is used to assess all adults (18 years and older).
   b. Humpty Dumpty Falls Assessment Tool is used to assess infants and pediatric patients. (Age 3 months to 18 years)

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

   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 items.

   B. Any healthcare professional or staff who observes a patient with red socks (indicators of fall risk) ambulating unassisted, should support and stand beside the patient until assistance arrives. Overall fall prevention interventions based on MFS risk score:

<table>
<thead>
<tr>
<th>Fall Risk Score</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients/families</td>
<td>Environmental safety measures may include but not limited to:</td>
</tr>
<tr>
<td></td>
<td>1. Orientation to unit.</td>
</tr>
<tr>
<td></td>
<td>2. Fall Prevention Partnership Agreement.</td>
</tr>
<tr>
<td></td>
<td>3. Hourly rounding using 5 Ps (Potty, Pain Assessment, Placements, Positioning and Pumps).</td>
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<tr>
<td></td>
<td>4. Call bells within reach.</td>
</tr>
<tr>
<td></td>
<td>5. “Call Don’t Fall” visual cues in room and</td>
</tr>
</tbody>
</table>
7. Ensure glasses are available and within reach.
9. Remove clutter and excess furniture from room.
11. Daily exercise or ambulation to maintain strength and reduce debilitation risk.

| 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. |

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

<table>
<thead>
<tr>
<th>Morse Fall Scale Item</th>
<th>Intervention Strategies</th>
</tr>
</thead>
</table>
| 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. |
| 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.

**D.** Overall fall prevention interventions based on risk score - Humpty Dumpty Assessment scale risk score may include:
E. Fall risk is communicated during handoff including documentation on the PATH or ISBAR form.

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. The RN 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.
5. Reassess for areas of redness, ecchymosis, and swelling and / or pain every shift x 24

<table>
<thead>
<tr>
<th>Fall Risk Score</th>
<th>Interventions may include but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk Protocol</td>
<td>1. Assess elimination needs and assist as needed.</td>
</tr>
<tr>
<td>(Score 7-11)</td>
<td>2. Call light is within reach and educates patient/family on its functionality.</td>
</tr>
<tr>
<td></td>
<td>3. “Call Don’t Fall” visual cues in room and bathroom.</td>
</tr>
<tr>
<td></td>
<td>4. Environment clear of unused equipment, furniture’s in place, clear of hazards.</td>
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<tr>
<td></td>
<td>5. Orientation to room.</td>
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<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>8. Use of non-skid footwear for ambulating patients.</td>
</tr>
<tr>
<td></td>
<td>9. Use of appropriate size clothing to prevent risk of tripping.</td>
</tr>
<tr>
<td></td>
<td>10. Assess for adequate lighting, leave nightlights on.</td>
</tr>
<tr>
<td></td>
<td>11. Patient and family education available to parents and patients.</td>
</tr>
</tbody>
</table>

| High Risk Protocol       | 1. Yellow wrist band.                                                                                            |
| (Score 12 or above)      | 2. Red socks on patient.                                                                                         |
|                          | 3. Sign placed on door.                                                                                          |
|                          | 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.                                                                        |
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.

V. 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.

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

VII. 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 hand-out as needed.

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

VIII. 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 (H DFA): is a tool that can help to predict the likelihood of a pediatric patient fall.

IX. Resources
Fall Prevention Partnership Agreement - English

Fall Prevention Partnership Agreement - Spanish

Mosby’s Patient Education: Fall Prevention Guidelines for Patient and Families

Mosby’s Patient Education: Home Safety and Preventing Falls

Mosby’s Patient Education: Fall Prevention: Elderly

Mosby’s Patient Education: Falls and Hip Fractures Among Older Adults
X. 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 – 09.13.33 – Unusual Event Reporting

XI. Additional References
Morse, Janice M (2009). Preventing patient falls: Establishing a fall prevention program. 2nd ed. New

Provision of Care, Treatment, and Services PC.01.02.08: The hospital assesses and manages the patient's
risks for falls. © 2014 The Joint Commission. Published by Joint Commission Resources. All rights
reserved.

Provision of Care, Treatment, and Services PC.02.03.01: The hospital provides patient education and
training based on each patient’s needs and abilities. © 2011 The Joint Commission. Published by Joint
Commission Resources. All rights reserved.

Agency for Healthcare Research and Quality: The Falls Management Program: A Quality

XII. Dates Approved or Amended

| Originated: 10/30/1994 |
| Reviewed with Changes     | Reviewed without Changes     |
| 9/07/2012                 | 07/14/2016                   |