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Bronson Methodist Hospital
Bronson Battle Creek Hospital
Bronson Lakeview Hospital
Bronson South Haven Hospital

System Nursing G-07 FALL PREVENTION AND MANAGEMENT POLICY & PROCEDURE

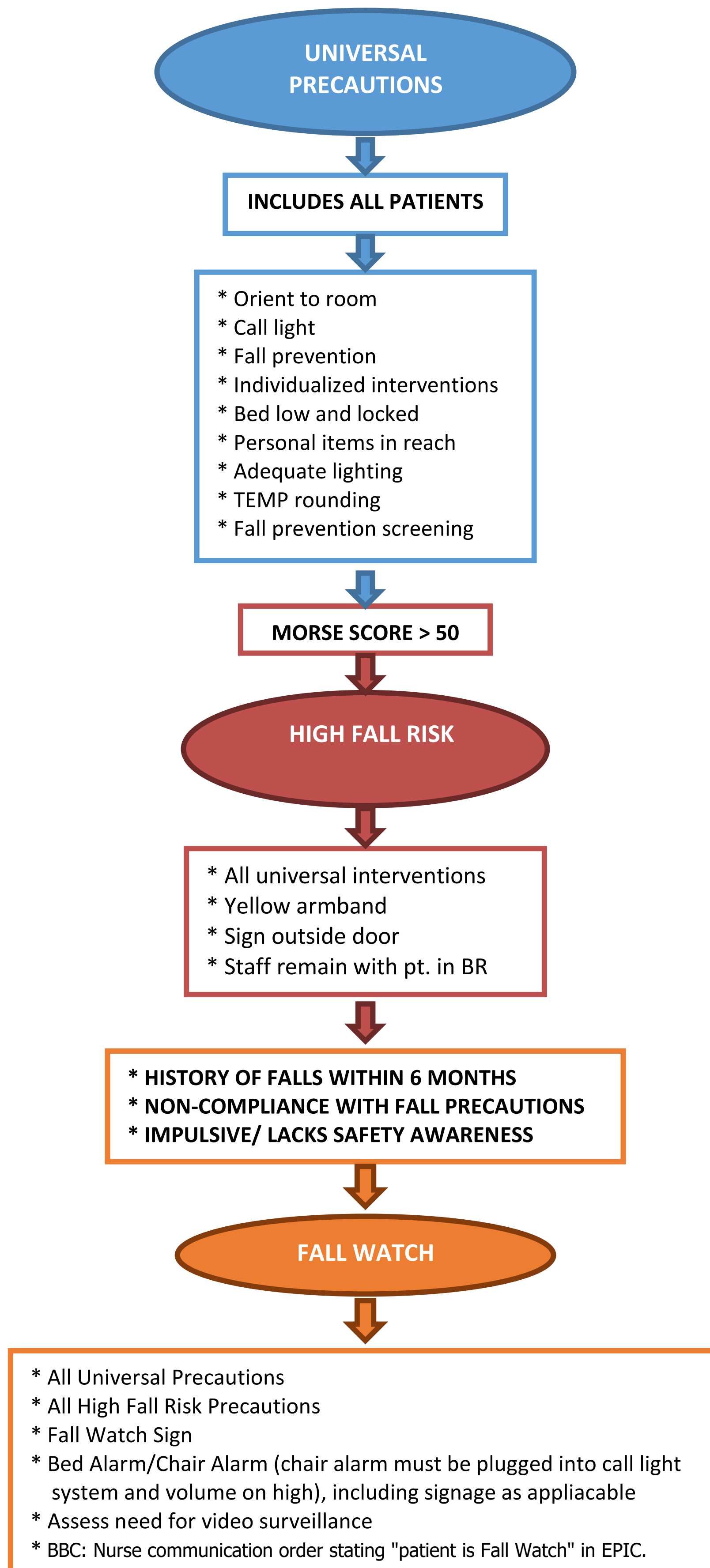
APPLIES TO: Registered Nurse (RN), Student Nurse; Patient Care Assistant (PCA) (interventions as delegated)

PURPOSE: To reduce the number of patient falls in adult patients admitted to the hospital, with the premise that fewer falls means fewer fall injuries.

Table 1. *Fall Precautions: Assessment and Intervention*

	Universal Fall Precautions	High Fall Risk Precautions	Fall Watch
Assessment	Not dependent on score and includes all patients regardless of score	Morse Score of 50 or greater See Appendix A for Morse Fall Scoring.	• At the discretion of the nurse, consider Fall Watch for any of the following risk factors: • History of physiologic falls in last six months. • Non-compliance with fall precautions • Impulsivity/lacks safety awareness
Interventions	• Orientation to room, call light use, and fall prevention, including fall prevention video and *Call to Stop a Fall* sign • Individualized interventions as appropriate to risk factors • Bed in low position, wheels locked • Room free from clutter and spills • Personal items within reach • Adequate lighting based on patient's needs • Anticipatory (TEMP) rounding per protocol • Use of fall prevention scripting in teaching	• All **Universal Fall Precaution** interventions plus the following: • Yellow visual cue; may vary by institution. (e.g. armband indicator, sign outside door) • **A staff member must remain with the patient when assisted to the bathroom** • Staff must be able to verbalize individualized risk factors and interventions and demonstrate that they are in place	• All "High Risk Fall Precautions & Universal Fall Precautions" plus the following: • Fall Watch Sign on doorframe. • Nurse communication order stating "patient is Fall Watch" in EPIC. • Bed alarm and/or chair alarm. • Assess the need for safety surveillance monitoring (Video Surveillance vs. Sitter)
Discussion Points	General discussion/education found in the Patient and Family Guide and within the fall prevention video.	• i.e., "We would like to assist you every time you get out of the bed/chair to ensure your safety, please use your call light and wait for staff before moving". • If patient is not compliant with asking/waiting for assistance try and re-educate importance of safety. • For further non-compliance, consider making patient Fall Watch and use alarms to ensure safety.	• i.e., "We are setting your bed alarm/chair alarm for your safety to remind you to wait for staff assistance before moving and to help notify staff in case you forget. Please continue to use call light for assistance when needed." • If patient non-compliant and safety is at risk consider use of Video Surveillance or Patient Safety Assistant.

Fall Prevention Flowchart



POLICY:

- All patients have a right to be cared for within a safe environment.
- Each patient should be considered part of our fall reduction plan, which includes assessment of risk and initiation of appropriate prevention interventions.
- All patients are assessed for their risk of falls on admission, ongoing assessments occur on a regular basis depending on the patient status, upon changes in patient condition and if the patient falls. In the event a fall occurs, patient assessment will be done to determine possible injury.
- All injuries will be promptly addressed and post-fall interventions will be implemented.

DEFINITIONS:

Fall: A patient fall is a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can). All unassisted and assisted falls are to be reported, including falls attributable to physiological factors such as fainting. The following circumstances are considered falls:

- When a patient rolls off a low bed onto a mat or
- When a patient is found on a surface where you would not expect to find her/him
- If a patient is injured when attempting to stand or sit and falls back onto a bed, chair, or commode
- Some falls can also be classified as developmental falls (reported only if the child is injured) or baby/child drops. BMH: See G-13 Pediatric Fall Prevention.

Fall Precautions: A system of assessment and interventions implemented for all patients to minimize the risk of experiencing a fall. Patients will be categorized into universal and high risk precaution levels based on the Morse Fall Scale (MFS) score and risk factors will be addressed through individualized interventions. See Appendix A for Morse Fall Scoring.

Fall Watch: A system of intense surveillance of a patient when he/she is non-compliant with fall precaution interventions, is impulsive or lacks safety awareness, has a history of a physiologic fall within the last 6 months or at the discretion of the nurse.

Physiological fall: A fall attributable to one or more intrinsic, physiological factors. Physiological falls include:

- Falls caused by a sudden physiologic event such as hypotension, dysrhythmia, seizure, transient ischemic attack (TIA), or stroke
- Falls occurring due to side effects of known “culprit drugs” (e.g., Clinical Nurse Specialist - active drugs and certain cardiovascular drugs)
- Falls attributable to some aspect of the patient’s physical condition such as delirium, intoxication, dementia, gait instability, or visual impairment

Intentional fall: Patients may fall intentionally or falsely claim to have fallen for various reasons, including seeking attention or obtaining pain medication. When the nursing staff has reason to suspect that a reported fall is an intentional fall event, it should be reported to National Database of Nursing Quality Indicators (NDNQI) as such. Because

intentional fall events are not falls by the NDNQI definition, suspected intentional fall events are reported separately; they are not counted in computing the total, injury, or unassisted fall rates.

Bed entrapment: An event involving a patient who is caught, trapped, or entangled in the hospital bed system, which includes the spaces in or around the bed rail, hospital bed mattress, or hospital bed frame.

Morse Fall Scale (MFS): A tool developed by Janice Morse PhD (NURS), PhD (Anthro), FAAN, that predicts physiological anticipated falls. It is used widely in acute care settings, both in hospital and long-term care inpatient settings. The MFS requires systematic, reliable assessment of a patient's fall risk factors. It is a reliable and valid measure of fall risk.

PROCEDURE FOR FALL PREVENTION:

A. Assessment and Interventions:

1. Assess patient using the Morse Fall Scale (MFS) once per shift and with any change in level of care or patient condition. See Appendix A for Morse Fall Scoring.
2. All patients will be considered at risk for falling, regardless of MFS score.
3. Implement and document interventions according to individualized risk factors as the foundation of fall prevention.
4. Document assessment and interventions using electronic health record (EHR) or other department specific documentation system.
5. Adjust and document individualized intervention strategies as patient condition changes.

> *Example of change in patient condition:* A patient may not score as a fall risk in the morning; however, the patient may receive sedation and go for a colonoscopy in the afternoon. Upon return to the unit, the patient may have the additional risk factor of confusion due to the sedation. The 'Mental Status' variable would be added to the care plan and the fall risk score recalculated.

B. Universal Fall Precautions

1. All patients will minimally have the **Universal Fall Risk Precaution** interventions in place.
2. **Universal Fall Precaution Interventions**
    a. Orientation to room, call light use, individualized fall prevention interventions, and the Call to Stop a Fall sign.
    b. Have patient view the Bronson Fall Prevention Video
        1) Viewing of the video may be deferred for 24 hours due to patient condition or family unavailability.
        2) Document video presentation in the Education Activity along with learning assessment.
        3) If unable to show video within 24hours, document that it was deferred under the Readiness section of the Education plan and indicate why.
    c. Individualize interventions as appropriate to risk factors
    d. Bed in low position, wheels locked

e. Room free from clutter and spills
f. Personal items within reach
g. Adequate lighting based on patient's needs
h. Anticipatory rounding per protocol
i. Use of fall prevention scripting to teach patients about fall prevention. Scripting is located on the Bronson Intranet Nurses and Clinician's Page under Fall Prevention Tools.

C. High Fall Risk Precautions

1. Patients scoring 50 or greater on the MFS will be considered a high fall risk.
2. **High Risk Fall Precaution Interventions** (implement in addition to *Universal Fall Precautions* and individualized interventions) (see Table on page 5).
    a. Yellow visual cues, which may vary by institution, (e.g. armband indicators or yellow "Fall Precautions" signs outside door)
    b. A staff member must remain with the patient when assisted to the bathroom
    c. Staff must be able to verbalize individualized risk factors and interventions and demonstrate that they are in place

D. Fall Watch

- Fall Watch is the responsibility of everyone on the unit to ensure patient safety. All hospital employees (provider, nursing/patient care assistants, environmental services, dietary, physical/occupational therapy, transport, respiratory, unit clerks, etc.) passing by the patient room are to look into the room to observe if the patient is safe. If safe, continue on their way. If patient is at risk, the employee is to maintain patient safety and press the call light or call out for assistance.
- Consider placing patient on FALL WATCH if patient meets following criteria:
    - Recent physiological fall in the past six months
    - Person is non-compliant with fall precaution
    - Person is impulsive or lacks safety awareness
    - The discretion of the nurse.
- **Fall Watch Interventions**
    - All "High Risk Fall Precautions" & "Universal Fall Precautions" interventions, plus the following:
        - Fall Watch Sign on doorframe.
        - BBC: Nurse communication order stating "patient is Fall Watch" in EPIC.
        - Bed alarm and/or chair alarm.
        - Assess the need for safety surveillance monitoring (Video Surveillance vs. Sitter)

E. Bed Entrapment

- In choosing safety interventions for fall prevention, it is important to note that side rails present an inherent safety risk, particularly when the patient is elderly or disoriented. Patients assessed to be a fall risk may get entrapped in the bed system while attempting to get out of bed unassisted.

- Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail. When attempting to exit the bed by any of these routes, the patient is at greater risk for entrapment, entanglement, or falling with the possibility of sustaining a significant injury.
- Air pressure mattresses present a greater risk for entrapment than a conventional bed. As a patient moves to one side of an air mattress, that side compresses. This raises the center of the mattress and lowers the side, making a ramp that 'pours' the patient off the bed or against the bed rail.

F. If Current Plan Not Effective

- Reassess fall scale risk factors and associated interventions.
- Initiate and document new interventions aimed at preventing falls to keep the patient safe.

G. For Patients Upon Discharge

- Encourage patient and/or family to continue safety measures at home.
- Provide “Prevent Falls At Home” handout to follow at home as needed.

PROCEDURE FOR POST FALL MANAGEMENT:

1. Perform verbal assessment to the cause of the fall and potential for injury
2. Perform physical assessment including:
   -Complex assessment
   -Vital Signs: Temperature, Pulse, Respiratory Rate, Pulse Ox, Blood Pressure, Pain
3. Environmental assessment to identify any environmental risk factors
4. Notify provider and when appropriate, family
5. Document the fall event in EHR under “Significant Events”. In selecting event type “Fall”, complete all items in Fall Cascade section. Staff with knowledge of the event will document pertinent facts in the medical record. Personal/subjective statements should not be written unless directed by Risk Management.
6. Complete a Patient/Visitor Safety Report

PROCEDURE FOR FALL WITH POTENTIAL HEAD INJURY:

Falls where patients may have sustained a head injury are concerning and additional assessment is valuable. Neurological checks should be completed post fall as appropriate to patient condition.

Guidelines to consider for neurological checks unless otherwise ordered

- Q15 minutes x 1 hour
- Q1/2 hour x 2 hours
- Q 1 hour x 8 hours
- Q2 hours x 24 hours

EVIDENCE BASED REFERENCES:

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Appendix A: **Definitions of Morse Fall Scale and Corresponding Point Value**

**Interventions listed below each risk factor are suggestions of appropriate interventions. Each patient's situation should be addressed on an individual basis.*

Risk factor / Intervention	Points
HISTORY OF FALLING • If the patient has not fallen, this is scored 0 • If the patient has fallen during the present hospital admission or if there was a history of physiological falls within the past six (6) months, such as from seizures or an impaired gait prior to admission ▪ Note: If a patient falls for the first time, then his or her score immediately increases by 25 **INTERVENTION** I. Assess and document circumstances of previous fall II. Develop strategy to prevent recurrence of previous fall III. Alert staff about circumstances of 1st fall IV. Conduct rounds every 1-2 hours V. Keep hearing aids, glasses, dentures with patient VI. Provide and review the "Partnering for Safety: Stop a fall" section within the Patient & Family Guide booklet	NO 0 YES 25
SECONDARY DIAGNOSIS • More than one medical diagnosis is listed on the patient's chart **INTERVENTION** I. Observe patient for potential medication side effects/drug interactions or fall related side effects II. Consult with pharmacy to determine interactions from polypharmacy III. Consult with pharmacy: STOPPING MEDS VS TAPERING IV. Consider changing from IV pain meds to oral, ASAP V. Provide assistance when out of bed/chair VI. Use non-opioids to assist in controlling pain when appropriate VII. Assess for substance withdrawal where appropriate VIII. Review CAM/CAM-ICU result and assess for etiology if positive	NO 0 YES 15
AMBULATORY AID • None/Bed rest/Wheelchair • Crutches/Cane/Walker • Patient ambulates clutching onto the furniture for support **INTERVENTION** I. Assess need for toileting every 1-2 hours to avoid rushing to bathroom II. Instruct on correct use of walking aide III. Evaluate need for walking aide (this will reduce the fall score) IV. PT consult to teach use of walking aides V. Instruct patient and/or family to call for help when getting up	NO 0 YES 15 YES 30
INTRAVENOUS THERAPY/SALINE LOCK **INTERVENTION** I. Educate about risk related to IV II. Ambulate per provider order III. Assess for fluid balance IV. Assess for hypotension V. If using IV pole as walking aid, provide walker, assess toileting needs with rounding every 1-2 hours VI. Assess need for toileting every 1-2 hours to avoid rushing to bathroom VII. Remind about physical limitations VIII. If patient is independent, teach how to disconnect and move IV pole to ambulate	NO 0 YES 20
GAIT	

• Normal/Bedrest/ Wheelchair
• Weak
  ▪ The patient is stooped but is able to lift his/her head while walking without losing balance. If support from furniture is required, this is with a featherweight touch for reassurance, rather than grabbing to remain upright.
• Impaired
  ▪ The patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair and/or bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance. Steps are short and the patient shuffles.
• If the patient is in a wheelchair, the patient is scored according to the gait he or she used when transferring from the wheelchair to the bed.
 	
INTERVENTION
I. Assess need for ambulatory aide
II. Use gait belt for ambulation
III. Do not leave alone in bathroom
IV. Refer to PT for exercise program
V. Ambulate regularly per provider order
VI. Assure clear lighted path to bathroom
VII. Remind to use call bell for assistance when getting up
VIII. Teach about calling RN for SCD removal prior to ambulation
	0
	10
	
	20

MENTAL STATUS • Oriented to own ability • Overestimates/Forgets limitations ▪ When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with their activity order, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the activity order or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and is scored as 15. **INTERVENTION** I. Frequent observations II. Do not leave patient unattended in bathroom III. Place in room near nursing station IV. Hourly rounding to assess comfort needs V. Implement bowel and bladder program VI. Frequent reorientation and reminders VII. Bed/chair alarm VIII. Do not leave unattended in diagnostic areas IX. If gait also impaired, use bed/chair alarm X. Assess safety surveillance need XI. Assess for delirium utilizing Cam/CAM-ICU and identify causes if positive XII. Involve family for observations, planning care	 0 15