Hahnemann University HOSPITAL	Patient Care	Policy 7.011
	Subject: **Falls Prevention and Resource**	**Sponsor: Risk Management** **Effective Date: April 2002** **Revised: May 2013** **Reviewed: May 2013** **Review Due: February 2014**
	Reference: Noted at end of policy.	**Page 1 of 7**

I. PURPOSE:

The purpose of this policy is to:

- Establish guidelines for mitigating the risk of patient falls
- Establish a framework for assessing risk factors for patient falls, implementing intervention for reducing the risk for falling, and protecting patients from injury if a fall should occur.
- Establish guidelines for the prevention of patient falls through the practice of diligent assessment, ongoing communication and appropriate proactive action.
- Establish guidelines to define action in the event of a fall and complete the required follow-up assessments and documentation.
- Establish guidelines for staff to retain responsibility for patient safety at all times even if family is present.

This policy pertains to all patient care settings within Hospital.

II. DEFINITIONS and RISK FACTORS:

A. **Accidental Fall:** Fall that occurs unintentionally (example: slip, trip). Patients at risk for these falls cannot be identified prior to a fall and generally do not score at risk for falling on a predictive instrument.

B. **Unanticipated Physiological Fall:** Fall that occurs when the physical cause of the fall is not reflected in the patient's assessed risk factors for falls. These falls are created by conditions that cannot be predicted before their first occurrence (example: seizure, stroke).

C. **Anticipated Physiological Fall:** Fall that occurs in patients whose risk factor score indicated the patient is at risk of falling. Controlled sliding down a wall to the ground or utilization of a physiologic structure is considered a fall. These falls are related to existing and previous risk factors.

D. **Intentional Fall:** Fall that occurs as a result of a patient who voluntarily alters body position to a lower level.

E. **Factors which may increase risk for falls:**

- Fear of falling
- Age
- History of previous fall
- Auditory impairment
- Visual impairment
- History of fracture
- History of bleeding disorder
- Use of restraints
- Obesity
- Hypoglycemia
- Difficulty understanding/retaining instructions
- Mobility/gait impairment
- Sensory impairment
- Dizziness
- Dehydration

- Language barrier
- Taking high risk medications
- Use of assistive devices (walker, cane, crutches, etc.)
- Orthostatic hypotension

F. Secondary diagnoses which may increase risk for falls include, but are not limited to:

- Transient ischemic attack
- Parkinson's disease
- Musculoskeletal deformities or myopathy
- Bowel/bladder incontinence/frequent toileting
- Congestive heart failure
- Stroke
- Diabetes
- Dementia
- Alzheimer's
- Delirium
- Agitation
- Epilepsy
- Withdrawals
- Cardiac arrhythmia
- Depression/anxiety
- Constipation
- Osteoporosis

G. Special Considerations:

- Surgical patients may have an abnormal gait up to 24 hours post anesthesia
- Hypovolemia (for example, obstetrical patients)
- Psychiatric patients may fall from medications and diagnosis
- Intensive care patients who get out of bed may also be restless
- Gero-psych patients are at highest risk for falls
- Forensic shackled patients may be at risk

III. POLICY:

Falls can be a source of serious injuries to patients within healthcare facilities. The assessment and accompanying measures are designed to prevent and /or reduce the number and severity of falls. The ultimate goal of a falls program is prevention of injury. This hospital will take steps to reduce the number and severity of patient falls by:

V. PROCEDURE:

A. Initial Falls Risk Assessment

1. Upon entry into the hospital system or through emergency services, a registered nurse will complete the Morse Fall Scale Risk Screening Tool in the electronic medical record as part of the initial admission assessment per facility policy.

2. For Ambulatory Services, please see the Ambulatory Falls Screening section of this policy

3. The Functional Screening section of the Initial Assessment is completed by the admitting registered nurse. A physician order for therapy services must be obtained for Physical Therapy, Occupational Therapy or Speech Therapy.

B. Falls Risk Assessments

A Falls Risk Assessment will be completed by a registered nurse to determine if a patient is at risk for falls. The proper order for determining the patient's fall risk shall be:

1. Morse Scale Assessment:

   a. Patients who score 0-24 are considered at "Low Risk" for falls.

   b. Patients who score 25-44 on the Morse Scale are considered "Moderate Risk" for falls.

   c. Patients who score 45 and above are considered "High Risk" for falls.

   d. Diagnoses that may be treated with medications which may potentially place the patient at an increased risk for falls.

   e. Individually prescribed high risk medications as well as multiple medications may place the patient at a higher than normal risk for falls.

   f. If there is/are secondary diagnos(es) listed, the medication classifications related to the secondary diagnos(es) will be the determinant of the potential falls risk. Table A "Medication Classifications" provides **some** of the highest risk medication classes that place the patient at highest risk for falls.

Table A: Medication Classifications

Anti-seizure medications	Laxatives	Sedative/hypnotics
Benzodiazepines	Narcotic analgesics	Blood Thinners*
Diuretics	Psychotropics	Skeletal muscle relaxants
Sedating Antihistamine		

*Blood thinners may include but are not limited to: anticoagulants, aspirin, over the counter herbal agents which may impact clotting times.

C. Medication Classification Assessment

1. If the patient is prescribed medications from the Medication Classification List (Table A), the patient may be considered to be "At Risk" for falls.

2. Patients who are administered blood thinners may be considered to be "at risk" for falls.

3. Interventions and medication management interventions shall be planned and implemented and documented according to each patient's risk level and individual needs. These will be documented in the electronic medical record. . I.

D. An additional follow-up assessment of patient's fall risk level must be completed at the following times and must include **all** of the following:

- every shift
- with a change in status
- upon transfer to a higher level of care
- with administration of new medications identified as creating high risk for falls
- following completion of procedures requiring medications that are often associated with fall risk

- as condition warrants reassessment such as change in mental status and increased confusion
- with a change in primary nurse

E. The follow-up assessment will be documented on the Morse Fall Scale. This information should be updated every shift or more frequently as needed.

3. New information from follow-up fall risk assessments should also be reflected in the electronic medical record documentation AND the Interdisciplinary Plan of Care.

F. Mandatory Fall Alert Interventions

1. All patients identified as "High Risk" for falls should have Falling STAR intervention implemented to alert other healthcare workers, family and visitors of the fall potential.

2. All patients reporting a history of falling within the past three months and/or have fallen during current hospitalization will require a bed check.

The following measures will be considered:

"Low and Moderate" Risk Interventions:

a. Patients will be offered toileting facilities close to patient offering assistance with toileting every hour while awake.

b. Assign patients to beds that permit exiting on patient's stronger side when possible.

c. Utilize bed and/or chair alarms if appropriate

d. Periodic re-orientation

e. Referrals to appropriate disciplines such as Physical Therapy

f. Involve patient in diversional activity -1:1 consideration when indicated

"High" Risk Interventions:

a) Implement all clinically appropriate low and moderate risk Interventions.

b) High Risk patients scoring 45 or higher on the Morse Fall Scale will follow the **Falling Star Program** and have yellow colored armband placed on the wrist, a yellow colored sign with a star on the patient's door and above the patient's bed, and yellow no slip/skid socks applied to serve as identifier's/preventative measure for the entire health care team.

c) Use a bed check device as warranted by patient's clinical status and history of falls. See unit-specific fall policy for Psychiatric Medical Care Unit (PMCU).

d) Patient Fall Risk status will be reported during each opportunity for "Hand-Off Communication": shift report, communication with other departments for testing or procedures, or upon transfer

e) Patients who are on strict bed rest do not need to wear the no-slip/ skid socks.

f) Evaluate patient's hydration status, which research evidence has shown to be a factor in a patient's risk for falls.

g) Make sure the bed is secured and locked in low position; call light within reach and 2-3 side rails up.

h) Evaluate medications to reduce the potential risk of injury from falls.

G. Environmental Considerations

1. Patient care areas should be assessed during periodic safety tours to identify environmental factors which may contribute to patient falls.
2. Environmental fall risk assessments should be completed periodically even if a specific unit or population has previously been assessed and determined to present minimal fall risk.
3. When assessing environmental fall risk factors, consider the types of patients served, the services provided and the physical environment (e.g., is the population elderly, mobile, post-surgical, etc.).
3. Environmental fall risk reduction assessment should be integrated into existing Fall Risk Reduction Programs.

I. Post-Fall Management:

1. Assess for injury (e.g., abrasion, contusion, laceration, fracture, head injury, bleeding). If patient fell forward and hit chin, consider neck injury and handle patient to assume this until physician notification. If patient has injury, notify Fall Alert by calling code line 80 to assess patient and lead post falls huddle. Completed “Post Fall Assessment Form” will be forwarded to Facility Falls Champion by Fall Team leader.
2. Obtain radiologic studies and lab tests as indicated by physician or licensed independent practitioner.
3. Complete Post-Fall Assessment Form and return to immediate supervisor
4. Obtain vital signs, a physical assessment and neuro checks after every fall according to the following sequence:
    - Every 15 minutes x 4; every 30 min x2, every 1 hour x 2; every 2 hours x2 then every 4 hours x 48 hours
    - If vital signs are critical or the patient is deteriorating continue vital signs every 15 minutes and call the physician and the Rapid Response Team
    - Place patient on bed check and assess availability to move patient closer to the nurse’s station.
5. Notification of fall:
    - physician (if not previously called)
    - patient’s emergency contact
6. Objective documentation in the medical record should include, but is not limited to:
    - description of the fall episode
    - name of notified physician
    - actions taken to reduce risk of concurrent falls
7. Monitor patient as condition warrants per policy
8. Report the fall to the charge nurse and at shift reports
9. Complete an Incident Report through eSRM.
10. Modify the Interdisciplinary Plan of Care as patient’s condition warrants
11. Risk Management and Unit Director to follow up for latent injury on day four post fall and update Incident report if necessary.

12. Post-Fall Management for those patients who are on blood thinners:

    a. Notify physician immediately for head injury to determine if radiologic studies (*i.e.,* CT scan, MRI) are needed.

13. If an injury has occurred, regardless of location, a Root Cause Analysis meeting will be scheduled.. This will include primary staff caring for the patient, manager of area, CNO, risk manager, falls champion and other staff as falls champion determines.

14. The post falls assessment form will be transmitted electronically to corporate risk management and the respective Senior Director of Patient Care Services (SDPCS).

J. Ambulatory Care Screening

Ambulatory care setting at Hahnemann University Hospital are defined as Heart Failure, Antenatal Testing Unit, Radiation Oncology, Blood Donor Center, 4 North Tower Pre-procedure, 9 Main, Sleep Center, Pulmonary Function Laboratory, Endoscopy, Cardiac Care Center, Outpatient Oncology, and Abdominal Transplant Services. Patients presenting to the above ambulatory care settings will be screened for risk for falls by the point of care personnel. In the above ambulatory services areas, patients are screened for risk for falls by observing the patient's ability to stand and walk on their own and through interview utilizing the following questions:

1. Do you have trouble standing
2. Do you have trouble walking on your own
3. Do you have trouble dressing or undressing yourself? For those areas that require hospital gown for examination)
4. Do you currently use a wheelchair, walker, cane or anything else to help you walk?

If the care provider determines the patient will have difficulty, or, if the patient answers 'yes' to any of the questions, the care provider will provide assistance to the patient during transfers and treatment and offer a wheelchair if appropriate.

For those patients not at increased risk for falls, the ambulatory care services areas will follow standard safety measures including, but not limited to periodic safety tours, maintaining unobstructed and clean pathways, and ensuring safe room set up.

A facility developed screening tool will be completed in these areas and placed in patient's records.

O. Responsible Person

The Falls Champion shall be responsible for assuring that all Hospital staff adhere to the requirements of this policy, that these procedures are implemented and followed at the Hospital, and that instances of noncompliance with this policy are reported to the Chief Nursing Officer.

P. Auditing and Monitoring

The Clinical Quality Department shall audit adherence to this policy in its Comprehensive Clinical Audits. Audit Services shall audit adhere to this policy in its full scope audits.

Q. Enforcement

All Hospital staff and Medical Staff Members whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, including the Medical Staff Bylaws, Rules and Regulations.

VI. REFERENCES:

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- McGreevey, M (2005, September). Examining inpatient pediatric falls: Understanding the reasons and finding the solutions, *Joint Commission Perspectives on Patient Safety*, 5(9), 5-6.

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- VA National Center for Patient Safety (NCPS). (2000). *NCPS Concept Dictionary*.

- Attachment F: Children Are at Risk of Falling While Hospitalized

APPROVALS:

Medical Executive Committee: **June 2013**

Administration: **June 2013**

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