Preventing Patient Falls

CDC reports approximately 35 million older adults fall each year – resulting in more than 32,000 deaths. Falls are the leading cause of injury and injury death in older adults (aged 65+). Annually about 3 million older adults are treated in emergency departments for a fall-related injury. Women are more likely to fall than men.

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Risk factors are divided into two categories:

Intrinsic (or pathophysiologic) - those that occur due to a patient's condition, disease process or illness.

- Intrinsic falls are predictable and occur due to:
  - Changes in mobility after a stroke or surgery
  - Eyesight changes as a person ages
  - Confusion or agitation
  - The need for frequent toileting
- Only a small number (less than 1%) are unpredictable – new strokes, TIA's, or syncope

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Extrinsic – those that occur due to an outside condition.

- Extrinsic factors are easily identified and are usually predictable:
  - Wet floors
  - Poor lighting
  - Loose carpets
  - Wires or tubing on the floor
  - Wet or no footwear
  - Medication changes such as:
    - Sleeping aids
    - Medications that affect blood pressure

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What Patients Were Doing When They Fell

There is limited data available, possibly since a minimum number of falls are witnessed, to indicate what a patient was doing when they fell, or in the period immediately prior to the fall. Many patients are found near chairs or close to their beds. Patients that fall the most are those with mobility problems attempting short trips and older patients using assistive devices.

Reports indicate that:

24% of falls occur while ambulating

23% are from beds

14% are from toilets

11% are from wheelchairs or carts

20% are unknown or undetermined

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- Many falls are related to toileting. Patients may not yet be adjusted to the hospital setting or changing body condition that has taken place; changes such as lower blood pressure due to medications, altered limbs due to amputation, or following a surgical procedure.

- Beds may be of a different style, size, or orientation than that of the patient's own and can be confusing. Patients will often report not being familiar with a bed or stating they became confused and thought they were at home and misjudged the height or size of the bed.

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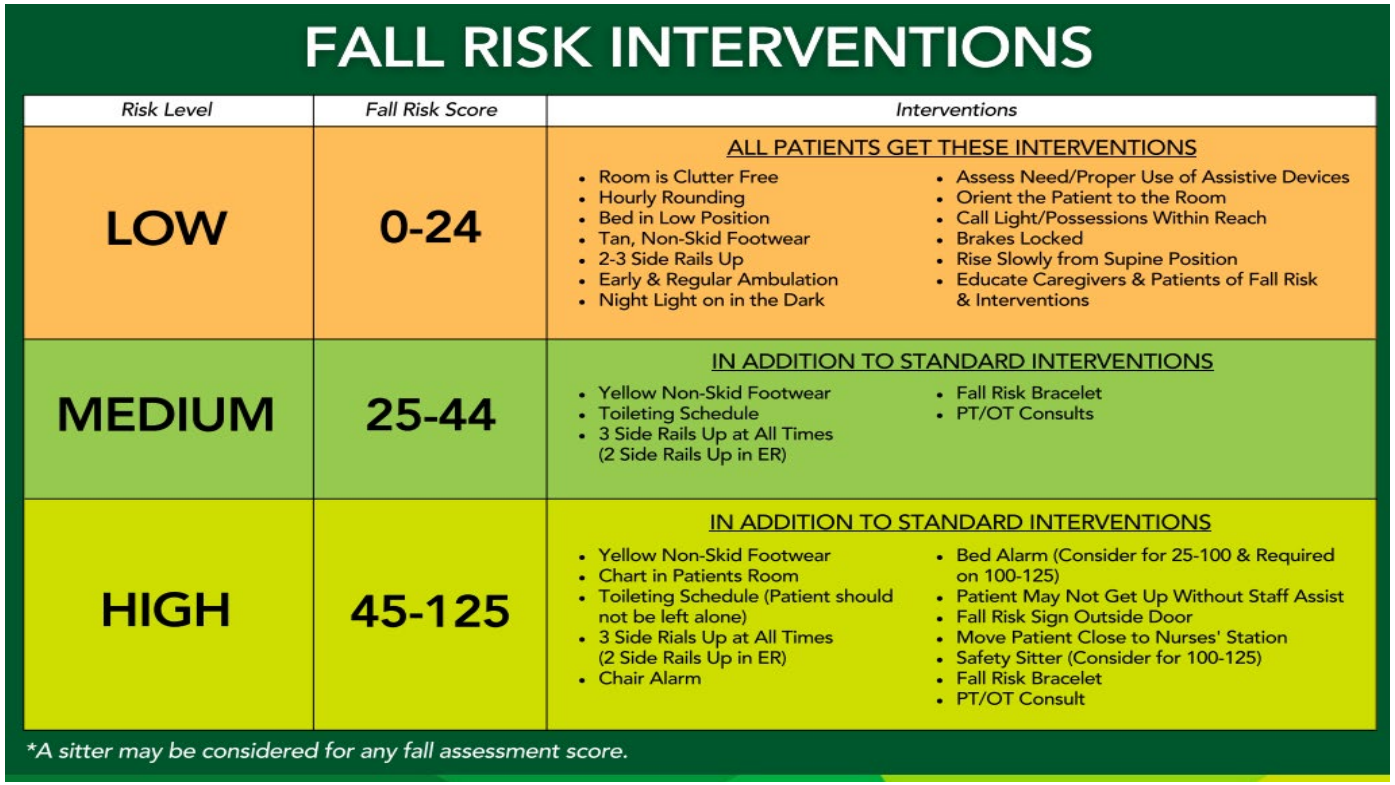
Assessing Fall Risk

Morse Fall Scale

- A method for assessing the likelihood of falling.
- Scoring six variables:
  - History of falls
  - Secondary diagnosis
  - Ambulatory aids
  - IV/Heparin lock
  - Gait/Transferring
  - Mental Status



FALL RISK INTERVENTIONS

Risk Level	*Fall Risk Score*	*Interventions*
LOW	**0-24**	ALL PATIENTS GET THESE INTERVENTIONS • Room is Clutter Free • Hourly Rounding • Bed in Low Position • Tan, Non-Skid Footwear • 2-3 Side Rails Up • Early & Regular Ambulation • Night Light on in the Dark • Assess Need/Proper Use of Assistive Devices • Orient the Patient to the Room • Call Light/Possessions Within Reach • Brakes Locked • Rise Slowly from Supine Position • Educate Caregivers & Patients of Fall Risk & Interventions
MEDIUM	**25-44**	IN ADDITION TO STANDARD INTERVENTIONS • Yellow Non-Skid Footwear • Toileting Schedule • 3 Side Rails Up at All Times (2 Side Rails Up in ER) • Fall Risk Bracelet • PT/OT Consults
HIGH	**45-125**	IN ADDITION TO STANDARD INTERVENTIONS • Yellow Non-Skid Footwear • Chart in Patients Room • Toileting Schedule (Patient should not be left alone) • 3 Side Rials Up at All Times (2 Side Rails Up in ER) • Chair Alarm • Bed Alarm (Consider for 25-100 & Required on 100-125) • Patient May Not Get Up Without Staff Assist • Fall Risk Sign Outside Door • Move Patient Close to Nurses' Station • Safety Sitter (Consider for 100-125) • Fall Risk Bracelet • PT/OT Consult

**A sitter may be considered for any fall assessment score.*

Move the patient to a higher risk level if you feel it is appropriate.

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Assessing Fall Risk

Graf-Pif Score Worksheet (Pediatric Patients)

Length of Stay	1 – 4 days 0 points 5 – 9 days 1 point 10 – 14 days 2 points 15 – 19 days 4 points	____
NO IV/Heparin Lock	IV/Heparin Lock 0 points NO IV/Heparin Lock 1 point	____
Physical or Occupational Therapy	No PT/OT 0 points Recent, current or planned PT/OT 1 point	____
Antiepileptic Medication	No antiepileptic med 0 points Antiepileptic med 1 point	____
Ortho/Muscular/ Skeletal Diagnosis	Ortho/Muscular/ Skeletal Diagnosis 1 point	____
History of Fall in the past month or fall during this hospitalization	If yes to either 2 points	____

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Preventing Falls and Reducing Injury

- Conditions fluctuate greatly during the hospital stay. The clinician must be proactive in taking steps to identify potential fall patients and reduce those risks.
- Place the patient in fall precautions any time your clinical judgment indicates the need to do so.
- Select appropriate interventions matched against the risk factors.

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Maintain a Safe Environment

- Identify individual safety needs (glasses, hearing aids, assistive devices)
- Place frequently used items within reach (call bell, bedside table, phone)
- Remove hazards (items in path, tubing or cords on floors)
- Safeguard bedrails and pad as needed
- Provide adequate lighting and night lights

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Supervision

- Provide appropriate level and least restrictive level of supervision or surveillance to allow for therapeutic actions.
- Initiate and maintain “precaution status” for patients who are at risk for falling.
- Communicate information about risk to nursing personnel.
- Hand-off report

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Monitor Gait and Mobility

- High risk patients often fall when they are trying to perform daily activities or move about without assistance. Identify them with an armband, sticker, special slippers, blanket, or visuals on the chart or door to quickly alert personnel of their status.

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Monitor Gait and Mobility

- Minimize bedrest orders
- Provide self-care assistance
- Provide appropriate mobility devices
- Monitor the need for appropriate mobility devices
- Provide adequate rest periods

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Getting Up and Down

- Many patients fall while attempting to move from a standing position to a chair or bed. Teach them the proper technique to transition from a standing position with a walker to a chair or bed.
- Grasp the walker and back up to the bed or chair until it is felt against the back of the legs.
- Leave one hand on the walker and move the other to the arm rest of the chair.
- Move the second hand to the arm rest and sit down.

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Meet Elimination Needs

- Most falls occur while a patient is attempting to meet elimination needs.
- Establish a toileting schedule for patients that are known fall risks.
- Offer to assist 1-2 hours after a meal for the best results.
- Monitor the patient's elimination needs and patterns.
- Monitor the patient's diet.

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Patient Education

- Don’t assume understanding
  - Provide education to the patient and family
  - Reinforce frequently
- Encourage family participation
  - Teach family members about activities, medications, diet, elimination
- Consider neurological deficits
  - Your patient may repeatedly do the same thing because they don’t understand

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What To Do When A Patient Falls

- Follow your hospital policies and guidelines
  - Leave the patient on the floor until help arrives and the patient has been cleared to be moved.
- The following actions need to take place:
  - Assessment of the patient
  - Notification and communication
  - Monitoring and reassessment
  - DOCUMENT
  - RLS Incident Report

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Assessment After a Fall

- Do not move the patient from the floor
  - Vital signs
  - Cranial nerve assessment
  - Skin assessment
  - Check for sensation and movement in the lower extremities
  - Assess for loss of consciousness
  - Observe for leg rotation
  - Note any pain or tenderness
  - Determine the patient's perception of the fall
  - If severe injury is suspected, stabilize the patient and obtain physician orders

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Notification and Communication

- Provider
- Family
- Quality & Risk Management (RLS Incident Report)
- Communicate to receiving department if the patient is moved
- Note times and to whom the notification was made

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Monitoring and Reassessment

- Frequent neurological checks
- Accompany the patient to Radiology or the Emergency Department
- Document findings – EMR as a Nurse's Note titled "Fall"
  - Post Fall Huddle
  - Return to Department Director

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Documentation

- Include measures taken to prevent the fall
- After the fall, document:
  - All observations
  - Patient statements
  - Assessments
  - Notifications
  - Interventions
  - Evaluations
  - Incident report

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Legal Implications

- Falls are the most common reason for medical negligence suits. There is an increase in the naming of the provider and nurse as well as the facility in the lawsuit.

- The legal decision is typically based on whether the care given deviated from the appropriate standard of care within a specific diagnosis.

- A standard of care is what a clinician would do under the same or similar circumstances.

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Pre-fall elements must be evident in the chart:

- Risk assessment
- An individual care plan
- Interventions to prevent fall risk
- Evaluation of the plan of care

Documentation must be comprehensive and complete and is expected to show the patient was continually evaluated and the appropriate precautions were taken.

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Questions that may be asked when the chart is reviewed:

- Was there failure to monitor the patient?
- Was there failure to ensure patient safety?
- Were medication errors involved?
- Did the nursing staff fail to respond?
- Was improper technique used or failure to supervise properly?

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Course Summary

Assess your patient's fall risk every shift.

Maintain a safe environment and identify individual safety needs.

Provide supervision for patients identified as "High Risk".

If a patient falls, do not move the patient until an assessment is made by the Rapid Response Team.

Document all observations, details of the fall, and all notifications made.

Refer to the Fall Prevention Policy for more information.

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