COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Patient Fall Prevention Plan		**NUR-023**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all patients in all areas of Mangum Regional Medical Center.

PURPOSE

Preventing falls among patients in the hospital setting requires a multifaceted approach. This plan provides the framework for a comprehensive falls prevention program designed to reduce the risk of patient harm resulting from falls and methods to evaluate the effectiveness of the program.

DEFINITIONS

Fall-is defined as an unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or is reported to have landed on the floor (un-witnessed) not due to any intentional movement or extrinsic force such as stroke, fainting, seizure.

Accidental falls- occur when patients fall unintentionally. For example, they may trip, slip, or fall because of a failure of equipment or by environmental factors such as spilled water or urine on the floor.

Unanticipated physiologic falls- occur when the physical cause of the falls is not reflected in the patient's risk factor for falls. A fall in one of these patients is caused by physical conditions that cannot be predicted until the patient falls. For example, the fall may be due to fainting, a seizure, or a pathological fracture of the hip.

Anticipated physiologic falls- occur in patients whose score on risk assessment scales (e.g. Morse Fall Scale (MFS) indicates that they are at risk of falling. According to the MFS, these patients have some of the following characteristics: a prior fall, weak or impaired gait, use of a walking aid, intravenous access, or impaired mental status.

A. Falls are classified into the following categories:
    1. Fall without injury

2. Fall with minor injury (minor cuts, minor bleeding, skin abrasions/contusions/tears, swelling, pain)
3. Fall with major injury (fractures, subdural hematomas, other major head trauma, cardiac arrest, excessive bleeding, lacerations requiring sutures, loss of consciousness, and death)

POLICY

Name of Hospital believes that patients are at greater risk for falls when hospitalized. Therefore all hospitalized patients are considered a fall risk and will be assessed to minimize their risk of falling. Name of Hospital staff will work to actively reduce the risk of falls across the continuum of care by ensuring a safe physical environment and appropriate identification of fall risk patients.

PROCEDURE

A. All staff are responsible for reducing fall risks and ensuring a safe environment free from hazards. All clinical and non-clinical staff will work within their scope of practice to prevent patient falls. Staff works as a cohesive team to eliminate the potential for patient falls through an all hazards approach. This is accomplished by:

a) Monitoring the hospital environment for potential hazards and taking proactive actions to mitigate any fall risks to the patients by assessing: cords, equipment, uneven surfaces to eliminate trip hazards, and lighting.
b) Immediately clean up spills and place caution signs if floors are wet.
c) Ensure patients immediate physical safety is maintained while notifying appropriate clinical staff if unsafe patient activity is observed.

B. Patients will be assessed for their fall risk at a minimum, but not limited to :

1. On admission to the hospital
2. On any transfer from one unit to another within the hospital
3. Following any change of status
4. Following a fall
5. On a regular interval, such as each shift
6. Patient's mobility status will be assessed by the primary care nurse and the rehab therapy on an ongoing basis at a minimum on each shift and with changes in the patient's mobility status. All disciplines shall communicate any changes in the patient's mobility status via face-to-face communication and on the Mobility Fall Precautions Poster to be maintained at the patient's head of bed.

C. Patients will be assessed using a standardized fall assessment tool. Assessment of risk factors for falls is essential for a number of reasons:

a) It aids in clinical decision making.
b) Use of a standardized assessment helps ensure that key risk factors are identified and therefore can be acted on.
c) It allows the targeting of preventive interventions to the correct patients.
d) It facilitates care planning. Care plans can better focus on the specific dimensions that place the patient at greatest risk.

e) It facilitates communication between health care workers and between care settings.
f) Workers have a common language by which they describe risk.
g) The hospital will utilize the Morse Fall Scale Risk Assessment for adults (See below). The Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling. It consists of six (6) variables that are quick and easy to score, and it has been shown to have predictive validity and inter-rater reliability.
h) The Humpty Dumpty Fall Risk Assessment Scale (See Attachment PTR-023B) will be utilized for pediatric patients. For pediatric fall prevention interventions see Attachment PTR-023C.

Morse Fall Scale (MFS)

Item	***Scale***	***Scoring***
1. History of falling; immediate or within three (3) months	No 0 Yes 25	_____
2. Secondary diagnosis (more than one (1) diagnosis listed on the patient chart)	No 0 Yes 15	_____
3. Ambulatory aid a. None/bed rest/nurse assist/wheelchair b. Crutches/cane/walker c. Furniture	0 15 30	_____
4. IV/Heparin Lock	No 0 Yes 20	_____
5. Gait/Transferring a. Normal/bed rest/immobile b. Weak c. Impaired	0 10 20	_____
6. Mental status a. Oriented to own ability b. Forgets limitations	0 15	_____
TOTAL SCORE MORSE FALL RISK **>=51 High Risk** **25-50 Moderate Risk** **<= 24 Low Risk**		

The items in the scale are scored as follows:

a. ***History of falling*:** This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as

from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. **Note:** If a patient falls for the first time, then his or her score immediately increases by 25.

b. ***Secondary diagnosis*****:** This is scored as 15 if more than one (1) medical diagnosis is listed on the patient's chart; if not, score 0.

c. ***Ambulatory aids*****:** This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.

d. ***IV/Heparin Lock*****:** This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.

e. ***Gait*****:** A ***normal gait*** is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a ***weak gait*** (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an ***impaired gait*** (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and they watch 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.

f. ***Mental status*****:** When using this Scale, mental status is measured by checking the patient's own self-assessment of their own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging their own ability is consistent with the ambulatory order on the nursing assessment tool, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate their own abilities and to be forgetful of limitations and scored as 15.

g. ***Scoring and Risk Level*****:** The score is then tallied and recorded on the patient's chart. The Risk level (see below) and recommended actions (e.g. no interventions needed, standard fall prevention interventions, and high-risk prevention interventions) are then identified.

D. Implement Standard fall precautions for all patients. Standard fall precautions are called universal because they apply to all patients regardless of fall risk. Standard fall precautions constitute the basics of patient safety. They apply across all hospital areas and help safeguard not only patients, but also visitors and staff in many cases. Maintaining a safe and comfortable environment is the responsibility of the hospital independent of a patient's particular risks for falls, because failure to do so can put any patient at risk. For example, virtually any patient could slip and fall if there is a spill on the floor. Standard fall precautions include:

- Orient patient to surroundings and assigned staff;
- Lighting adequate to provide safe ambulation;
- Instruct to call for help before getting out of bed;
- Demonstrate nurses' call system;
- Call light within reach, visible and patient informed of the location and use;
- Light cord within reach, visible and patient informed of the location and use;

- Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unneeded equipment);
- Personal care items within arm length;
- Bed in lowest position with wheels locked;
- Instruct patient in all activities prior to initiating;
- Assign bed that enables patient to exit towards stronger side whenever possible.

E. Hourly rounding can be carried out by clinical staff (i.e., nurse, nursing assistant, respiratory) alternating with a nursing assistant (such as a certified nurse assistant, patients are not disturbed if sleeping, except as needed to provide care. Benefits of hourly rounding is that it is proactive; it reduces patients‘ need to use the call light to ask for help and therefore decreases the number of unscheduled call lights that require response. These regular rounds allow many needs like toileting and access to drinking water to be met by staff who are scheduled to visit the patient‘s room. When rounding staff can utilize the 5 P’s when rounding on the patient:

1) *Pain:* Assess the patient‘s pain level. Provide pain medicine if needed.
2) Personal Needs: Offer help using the toilet; offer hydration, offer nutrition, empty commodes/urinals.
3) *Position:* Help the patient get into a comfortable position or turn immobile patients to maintain skin integrity.
4) *Placement:* Make sure patient‘s essential needs (call light, phone, reading material, toileting equipment, etc.) are within easy reach.
5) *Prevent Falls:* Ask patient/family to put on call light if patient needs to get out of bed.

F. Additional strategies for preventing falls in hospitalized patients involves engaging patients and families in a three-step prevention process to reduce the risk of falls:

1) Fall risk screening/assessment;
2) Tailored/personalized care planning;
3) Consistent preventative interventions:
    a) Universal precautions
    b) Tailored interventions to address patient-specific areas of risk

Involving the patient and family in completing the fall risk assessment helps them understand their personal risk factors and including patients in developing a personalized prevention plan makes them more likely to accept and follow it. In addition, informing patients of their risk for injury if they fall increases the likelihood that they will follow their plan.

Interventions should be tailored to identified risk factors, not risk level, and work collaboratively with the patient and family to help ensure understanding of the prevention plan.

Consistent implementation of the fall prevention plan requires communicating the patient’s risk factors and plan to the healthcare team (including the patient and family). Direct-care team members, such as nurses and patient care assistants should reinforce the plan with the patient. If the patient’s risk status changes, the patient should be reassessed, and the plan updated to prevent a fall.

G. Post Fall Procedures and Management-The hospital will use a comprehensive post-fall tool to analyze the fall event. The Quality Manager will retain the post-fall assessment tool.

Note: There are two (2) key elements of the post fall procedures/management: Initial post-fall assessment and documentation and follow-up

Initial Post Fall Assessment

1. **First priority** is to assess the patient for any obvious injuries and find out what happened.
2. **Second priority** is family/patient representative and physician notification.
3. **Third priority** is to find out what happened.
4. **Environmental Assessment**
5. **Contributing Factors**
6. **Treatment Plan**

H. Pediatric Patients

a) Neonates and infants are by definition at risk for falls due to their developmental age. Such patients are maintained in bassinets for their safety. No assessment/reassessment of fall risk is required for these patients.

b) Children under 10 have the greatest risk for fall related death and injury. At name of hospital, the Humpty Dumpty Pediatric Fall Assessment Scale is utilized in the care of Pediatric patients.

I. Documentation and Follow-up

1. Following the post-fall assessment and any immediate measures to protect the patient:
   a. An incident report should be completed. All incident reports must be forwarded to the Director of Quality Management.
   b. A progress note should be entered into the patient's record including the results of the post-fall nursing assessment and fall precautions.
   c. Notify the medical provider that a patient fall event has occurred.
   d. Notify the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate.
   e. Communicate to all shifts that the patient has fallen and is at risk to fall again. Place a falling star fall indicator outside the room and place the appropriate wristband on the patient, and appropriate colored socks on the patient, if not already in place.

J. Responsibilities of Staff

Responsible Party	Actions
Medical Director	The Medical Director is responsible for ensuring that falls and fall-related injury prevention is: *1. A high priority at the hospital* *2. Promoted across the hospital through direct care, administrative and logistical staff*
Chief Clinical Officer	The Chief Nursing Officer is responsible for: *1. Establishing population-based fall risk levels/units/programs* *2. Deploying evidence-based standards of practice* 3. *Overseeing the policy within the hospital*

	4. Developing competencies for nursing staff about the falls prevention program
House Supervisors/Charge Nurses	The House Supervisors/Charge Nurses are responsible for: *1. Making fall and fall-related injury prevention a standard of care* *2. Enforcing the responsibilities of the clinical staff to comply with interventions* *3. Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with hospital equipment experts* *4. Ensuring that all nursing staff receive education about the falls prevention program at the hospital and understand the importance of complying with the interventions* *5. Providing education to patients and/or families regarding fall prevention.* *6. Assuring Fall Prevention is incorporated in the patient's plan of care.*
Staff and Contract Nurses Including RNs, LPNs and CNAs	Staff Nurses including RNs, LPNs and CNAs are responsible for: *1. RNs: Completing the fall-risk assessment on admission* *2. Notifying the care team of any patients assessed as high-risk* *3. Following the identification procedure for high fall-risk admissions (i.e. specific color armband, ensuring the bed assigned is close to the nursing station, ensuring there is visual cue outside of patient's room and over patient's bed, and applying the appropriate colored socks.* 4. *Ensuring compliance of fall and fall-related injury interventions* 5. *Completing fall-risk assessments on transfers, following a change in status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use* 6. *Ensuring that rooms with high fall-risk patients are assessed and corrected as necessary depending on the patient's current fall risks*
Medical Providers (MD/DO, ARNP, PA)	Medical Providers are responsible for: *1. Identifying and implementing medical interventions to reduce fall and fall-related injury risk* *2. Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls*
Pharmacists	Pharmacists are responsible for: *1. Reviewing medications and supplements to ensure that the risk of falls is reduced* *2. Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls*
Rehab Therapists	Physical and occupational therapists are responsible for: *1. Conducting balance assessments for all high fall-risk patient referrals* *2. Developing an intervention program for patients to reduce their fall-risk*

	3. Assistive equipment, such as wheelchairs, walkers and canes are checked regularly and equipped with devices to prevent falls
Quality Management	The Quality Management is responsible for: *1. Collecting data to ensure that fall and fall-related injury prevention strategies are effective* *2. Conducting case-by-case reviews for all falls to ensure that medications are reviewed, and prevention measures are recommended* *3. Providing assistance to interdisciplinary treatment teams when requested to recommend prevention strategies for a patient*
Hospital Management Staff	The hospital management staff are responsible for: *Ensuring a safe environment of care by conducting environmental assessments*

K. Evaluation of Program Effectiveness

- Measurements

1. **Rates:** The most commonly used statistic to measure and track falls is the "fall rate," which is calculated as follows:

$$\frac{\text{Number of patient falls x 1000}}{\text{Number of patient days}}$$

The fall rate for a specified time period is defined as the total number of eligible falls divided by the total number of eligible patient days, multiplied by a constant or "k" of 100 to create a rate per 1000 patient days. Note that all falls are included in the formula, so that repeated falls experienced by the same patient are included in the numerator.

2. **Other rates** found in the literature are also used to track and trend fall data and include:

a. The number of patients at risk;
b. The number of patients who fell;
c. The number of falls per bed.

L. Tracking and Reporting

1. All falls should be reported to the House Supervisor/Charge Nurse immediately following the event. Quality management should be notified within 24 hours of the event.
2. Each fall incident is investigated and summarized in the Incident Log.
3. All falls are reviewed by the Environment of Care Committee (EOC) as they pertain to the environment, the Quality Committee (QC), the Medical Staff Committee (MS), and the Governing Board (GB).
4. Quality Management reviews and analyzes fall data to ensure that fall and fall-related injury prevention strategies are effective. A fall review or Root Cause analysis is used to evaluate and understand what problems contributed to the fall or undesired outcomes. The data collection will obtain information that may help prevent the next fall in this patient or future patients. The post-fall assessment analysis captures information from the patient, staff, and other witnesses about how the fall occurred.

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ATTACHMENTS

PTR-023A Morse Fall Scale Interventions Visual Management Tool
PTR-023B Humpty Dumpty Fall Risk Assessment Scale
PTR-023C Pediatric Fall Interventions Visual Management Tool
PTR-023D Mobility Fall Precautions Poster
PTR-023E Fall Incident Update Poster
PTR-023F Post Fall Assessment

REVISIONS/UPDATES

Date	Brief Description of Revision/Change