St. Joseph Health
Santa Rosa Memorial

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Owner:	*Kevin Craven: Dir, Nursing*
Area:	*Administrative*
References:	

Fall Prevention –Northern California Regional

Values Context:

Practicing within the context of our core values of Compassion, Dignity, Justice, Excellence and Integrity ensures the provision of respect for each person, accountability, commitment to quality, opportunities to serve each other, and a sense of community among all persons.

Purpose:

It is recognized that everyone is at risk of falling; however the purpose of this policy is to identify patient's level of risk for falling and institute measuress to prevent falls and/or to reduce injuries from falls. This policy will define the different types of falls, outline fall prevention protocols, and the expected post fall actions.

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Definitions:

A. A fall is "an unintentional event in which a patient comes to rest on the floor and can involve assistance by another". (Morse, JM; 1987). A fall is any unplanned descent to the floor, or extension of floor (i.e. trash can or other equipment including bedside mat) regardless of whether assisted, or unassisted by staff, with or without injury. During an assisted fall, any member of the staff may have physical contact with the patient and attempt to minimize the patient's injury. All types of falls are to be included, whether they result from physiologic reasons (fainting/syncope) or environmental reasons (slippery floor). The fall may be witnessed or unwitnessed.

1. There are four types of falls:

   a. **Accidental Falls** – Includes patient slipping, tripping or have some mishap that results in a fall. They may not have been identified as a fall risk, utilizing the tool. Environmental factors and errors in patient judgment cause these kinds of falls. Prevention of these types of falls is geared at keeping the environment free from hazards and proper education for the patient regarding the environment and use of various devices.

   b. **Unanticipated Physiological Falls** – These falls are attributed to physiological causes that cannot be identified or predicted by any prior assessment, such as a seizure. There is no real way to prevent this type of fall the first time, but if it does occur, then interventions are taken to

prevent injury if the event should happen again.

c. **Anticipated Physiological Falls** – These are the types of falls identified by using a fall risk assessment tool. Fall prevention programs are geared to decreasing the numbers & severity of these types of falls. Predictable factors include: more than one diagnosis; a previous fall; a weak or impaired gait; the lack of a realistic assessment of his or her own abilities to go to the bathroom unassisted; an IV or saline lock; catheter or tethering-type device which can impair movement; poly-pharmacy; and an ambulatory aid.

d. **Intentional Fall** - When a patient purposely descends to the ground or falsely claims to have fallen.

B. **Morse Fall Scale:** Standardized measurement tool comprised of six factors utilized to evaluate risk of fall for adults and pediatric patients over the age of 13 years.(Appendix A)

C. **Humpty Dumpty Falls Scale:** A seven item assessment scale used to assess the fall risk in pediatric patients.

D. **Intentional Rounding:** Routine, standardized patient rounding is performed regularly by clinical staff. Purposes of the rounds include, but are not limited to, meeting patient's physical needs (i.e. toileting, positioning and pain management), assuring call light and personal items (i.e. eyeglasses, hearing aids, water) are within patient's reach, and completing a visual safety check.

Scope/Responsible Person(s):

All caregivers within their respective scopes of practice are responsible for understanding and actively participating in fall prevention and awareness, and to include the patient/family in identified fall prevention interventions.

All caregivers should be aware of environmental fall risk factors and will work collaboratively to eliminate hazards.

Policy:

All patients including newborns, will be considered at risk for falls, and will be assessed, and receive interventions to minimize their risk of falling. Evidence-based tools will be used to assess each patient’s risk for falls. Patient Falls must be reported through the event reporting process which is available to throughout the facility.

Procedure:

A. **Environmental and Hospital Safety**

1. All staff are responsible for reducing fall risks and ensuring a safe environment free from hazards. All clinical and non-clinical staff are aware of high fall risk patients, and will work within their scope of practice to prevent patient falls. Staff works as a cohesive team to eliminate environmental hazards, by involving Environmental Services and Engineering as appropriate.
2. This includes, however is not limited to:
    a. Monitor cords, equipment, and uneven surfaces to eliminate trip hazards.
    b. Immediately clean up spills and place caution signs if floors are wet.
    c. Ensure patients immediate physical safety while notifying appropriate clinical staff if unsafe

patient activity is observed.

B. **Adult Assessment using Morse Fall Scale (Appendix A)**

1. All adult inpatients will be assessed for fall risk using the Morse Fall Scale by the nurse as follows:
    a. On admission to an inpatient unit or to the Emergency Department
    b. Every shift
    c. Post fall during hospitalization
    d. Anytime where changes in the patient's assessment including medication changes warrant re-evaluation of fall risk.
2. Morse Fall Scale (See Appendix A for description)
   Scoring:
    a. Low Risk - Less than 25
    b. Moderate Risk - (25-45)
    c. High Risk - (>45)
    d. Scoring

C. **Fall Prevention Program**

1. Standard Fall Prevention Interventions for all patients include but are not limited to:
    a. Orient patient/family to their room.
    b. Place call light within reach at all times.
    c. Instruct patient to call for assistance.
    d. Place phone and other personal items within reach.
    e. Ensure that patient bed/gurney is in lowest position and the brakes are on.
    f. Nonskid footwear as needed
    g. Consider additional lighting
    h. Room free of clutter
    i. Patient/family fall risk education including handout and teach back
    j. Frequent rounding for patient safety and comfort)
    k. Patient mobility signage at bedside is encouraged
2. **Moderate /High Fall Risk Interventions. In addition to the standard precautions listed above, the following interventions will be implemented for patients who are at Moderate/High Fall risk:**
    a. Visually identifying the patient by placing Yellow Fall Risk armband on patient wrist. Yellow skid proof socks are strongly encouraged but not mandatory.
    b. Use Gait belt for all transfers and ambulation
    c. Place close proximity to nursing station
    d. Activate bed alarm when patient is in bed. Ensure that the bed is connected to the call light system where available:

e. Activate chair alarm while in chair/wheelchair

f. Supervise patient directly (with direct visual observation and within arms length) while on commode or in bathroom. **Do not leave patient unattended in these situations.**

g. Proactive toileting recommended at least every 2 hours

h. Consider Medication Review by pharmacy

i. Assist/supervise with ambulation

j. Assist/supervise with transfers

k. Request family to stay with patient

l. If patient is impulsive, and/or has experienced a previous fall, a specialty low bed is advised if available to reduce harm secondary to a fall. Specialty low beds may also be implemented based on nursing clinical judgment and availability to provide a safer environment for the patient. A physician order is not required for a specialty low bed.

m. Initiate Fall Risk Care Plan

n. Educate patient/family

o. Consider sitter

p. If patient is on a specialty low volume air mattress, it is recommended to have all four side rails are up for patient safety, and consider placing protective seizure pads on the bed to prevent the patient from sliding through the side rails. This is not considered a restraint.

D. **Pediatric Patients**

1. Neonates and infants are by definition at risk for falls due to their developmental age. Such patients are maintained in age an appropriate isolette, bassinet or open crib. Document safety checklist on age appropriate intervention in the electronic medical record.
2. The Humpty Dumpty Pediatric Fall Assessment Scale is utilized in the care of Pediatric patients. Specific details regarding the Pediatric fall risk interventions are available in the Pediatric Department.
3. Co sleeping is not encouraged for infants and children of any age. Safe sleep and fall prevention education is documented in the patient's medical record.

E. **Obstetric Patients**

1. Complete Fall risk assessment in the electronic medical record on admission to labor and delivery
   Complete Fall risk assessment when patient is transferred to post-partum care
   The following patients should NOT be left unattended without a support person in the room.
   a. Women in labor using a birthing ball
   b. Women in labor who are in the shower
   c. New mothers getting out of bed for the first time after birth
   d. New mothers taking a shower for the first time
   e. Babies of new mothers recovering from cesarean birth who are receiving pain meds for the first 24 hours
   f. Babies of new mothers who have been given medication for sleep
   g. Babies of new mothers who do not feel well enough to care for their baby

h. Patient and family education should include placing the baby in the open crib/bassinet if the mother, family member, or support person holding the baby is feeling drowsy

F. Communicating Fall Risk Status for Inpatients

1. The following interventions are utilized to communicate the patient's fall risk status and appropriate interventions to nursing and other licensed ancillary staff:
   a. "High Fall Risk" is identified on Status Board in the electronic health record.
   b. Utilize "Ticket to Ride" to communicate fall risk status when patient is going off the unit for a procedure. (Note: not every ministry has this process in place)
   c. Review patient's Fall Risk status at all handoffs for transfers between levels of care and utilize this information for safe patient placement.

G. **Educating the Patient and Family Regarding the Risk of Falling**

1. Provide Fall Prevention education to patient and family including calling for assistance before getting out of bed
2. Patients benefit from having family at the bedside to provide comfort & reassurance. Review fall risk status with patient and/or family upon initial assessment, and if indicated, discuss the benefits of continuous supervision with family as appropriate.
3. The Patient Falls Agreement should be reviewed with patients/families when the patient exhibits noncompliance with the Falls Protocol.

H. **Post Fall Follow Up (Inpatient or Emergency Department)**

If there is a patient fall, the nursing/therapy staff is responsible for conducting a post fall debriefing including:

1. Assess the patient prior to moving the patient following a fall. If there is concern of injury, consider calling the Rapid Response Team. Provide spinal immobilization before moving patient, if applicable.
2. If there is no anticipated risk of spinal injury a nurse must assist with returning the patient to bed or chair using proper body mechanics and appropriate patient lift equipment
3. Assess patient (vital signs and patient response to fall) and document circumstances of the fall and the patient assessment in the electronic health record.
4. Notify the physician of the fall and obtain orders as needed.
5. Notify the Nurse Manager/Administrative Supervisor of the fall.
6. Notify the family or designee of the fall and any injury.
7. Update safety measures and care plan as needed. .
8. If a patient has fallen, consider implementing a low bed for the patient if available, and discuss with physician the need for a sitter or additional safety measures.
9. Documentation of the fall (shall include date, time and location of fall, notification of physician, family and physical assessment findings) in the Post Fall Debriefing Form, Shift Event in the EMR, and in the event reporting system.

I. **Outpatient Services Fall Risk Screening**

The Fall Risk Reduction program in the outpatient settings will consist of risk screening of the populations served, the services provided, and the environment of care. The outpatient fall reduction program will include risk screening and periodic evaluation of individual patients and/or the environment of care. The

Morse Fall Scale is not used in this setting. Periodic safety inspections will be conducted to comply with the Joint Commission Environment of Care Standards (EC.02.06.01).

1. Outpatient Departments will screen patients based upon the following Fall Prevention strategies.
    a. If a patient presents with obvious risk criteria such as unsteady gait, use of assistive devices, or other obvious need, then staff will take appropriate action to assure patient's safety during the provision of care, treatment and service.
    b. History of previous fall within the past year.
2. If patient is screened to be at risk for falling the following interventions should be implemented:
    a. Observe the patient's coordination and balance and assist with transfer and mobility activities as needed
    b. Orient the patient to the environment especially to the bathroom
    c. Lock all moveable equipment before transferring patients.
    d. Keep all gurneys in lowest position with side rails up.
    e. Individualize equipment specific to patient needs.
    f. Place call bell and patient care articles within reach
    g. Provide a physically safe environment (eliminate spills, clutter, electrical cords and unnecessary equipment)
3. Communicate Fall Risk Status:
   The patient's fall risk status and appropriate interventions are communicated with Nursing and other licensed and ancillary staff at the following times:
    a. During staff report, shift to shift within the department at time of hand off.
    b. Before transfer/discharge to another level of care at time of handoff report.
    c. Prior to movement to another department for diagnostic test/procedure, or surgery utilizing Ticket to Ride if applicable
4. Post Fall Process:
    a. In the event of a patient fall in the outpatient setting, the patient will be assessed for the need to be evaluated in the emergency room and call for emergency assistance if indicated.
    b. Documentation of the patient fall in the patient health record is required.
    c. All falls will be reported through the event reporting system.

J. **Emergency Department**

1. It is required that the patient fall risk assessment will be completed and documented utilizing the Morse Fall Scale. The patient's fall risk score will be included in the handoff for admission and/or prior to movement to another department for diagnostic test/procedure or surgery utilizing Ticket to Ride.
2. The fall risk prevention interventions outlined in the Fall Prevention Protocol for inpatients will be followed in the Emergency Department setting.

K. **Education of the Staff**

1. Caregivers are educated on the Fall Risk Prevention Program at new hire orientation and periodically.

2. Education for Fall Risk Prevention Program includes how to identify patients at risk for falls, how to communicate the risk level to the patient, family and other members of the health care team, and the use of fall precautions and interventions to reduce the risk of harm to our patients.

L. **Analysis And Review of Patient Falls Data**
The facility Falls Committee is responsible for analysis and review of patient fall data, and reports through the quality reporting process.

Considerations/Regulations:

The Joint Commission: PC.01.02.08 & EPs 1 & 2

References

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Morse, J.M. (2009. Preventing patient falls. (2nd ed). New York: Springer

Miake-Lye, Isomi et. al. "Inpatient Fall Prevention Programs as a Patient Safety Strategy" Annals of Internal Medicine March 2013 Vol. 158 No. 5

Joint Commission Standards: National Patient Safety Goals
Quigley, P. Falls Prevention *American Nurse Today* V. 7 July 2015
Quigley, P. Best Practices Reducing Falls and Fall Related Injury Presentation 1.9.2013
Reduce the Risk of Patient Harm Resulting from Falls Hourly Rounding AJN Oct. 2006
Morse, J.M. (1993). Nursing research on patient falls in health care institutions. 8/16**Nursing Research**, 11 299-316.

AHRQ Fall Prevention toolkit: https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

IHI Fall Prevention tool kit: http://www.ihi.org/Topics/Falls/Pages/default.aspx

Chapter/Department: Clinical Patient Care		
References: See above		
Reviewed/Revised by:		
Approvals: Policy and Procedure Routing Committee Zero Heros Quality and Safety Council Clinical Practice Council Regional Falls Collaborative 1/28/19, CPC Medical Executive Committee Board of Trustess	(Date) 1/21/19 11/20/19 1/23/19 1/28/19 3/10/20 3/24/20	Distribution: All Entity Departments

APPENDIX A - Morse Fall Scale

The Fall Risk Score is assessed on admission and reassessed each shift and for any change in orientation or level of consciousness.

Factor	Points	Description
History of falling	Yes = 25 No = 0	During present Hospitalization or *Immediately* prior to admit *Ask Patient , Check admit assessment or H & P*
Presence of Secondary diagnosis	Yes = 15 No = 0	Does the patient have 2 or more medical diagnoses? - Examples: diabetes, HTN, seizures, ostomy, sleep apnea, deaf/blind, arthritis, chronic pain, COPD, ostomy, *Check admit assessment or H & P* *Consider the effect of multiple medications when scoring*
IV therapy or peripheral IV lock	Yes = 20 No = 0	
Type of gait	Weak = 10	Normal = head erect, arms swing freely, striding unhesitantly. Weak = stooped but able to lift head without losing balance. If support from furniture needed – only featherweight touch for reassurance. Short steps or shuffle.
	Impaired = 20	Impaired = difficulty rising, pushes off on chair arms. Head down or watches ground. Poor balance, grasps on furniture – white knuckle *Review patient health care record. Consider the effect of multiple medications when scoring*
Use of walking aids	Normal/bedrest/ wheelchair = 0 Cane/crutches/walker = 15 Uses furniture = 30	Normal = no walking aids (even if assisted by a nurse), uses wheelchair, is on bedrest or doesn't get up at all Uses furniture = Clutches onto furniture for support *Review patient health care record.*
Mental status	Overestimates/forgets own limitations = 15	Check patients own self-assessment of his or her own ability to ambulate. "Are you able to go to the bathroom alone or do you need assistance?" or "Do you feel safe getting up by yourself?" If patient's reply is not consistent with MD or RN ambulation orders or if patient's assessment is unrealistic –score as 15.

Factor	Points	Description
		Consider the effect of multiple medications when scoring.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Vicki White: CNO-Chief Nursing Ofcr	04/2020
Policy and Procedure Routing	Dalila Formato: Project Coordinator - NE	03/2020
	Kevin Craven: Dir, Nursing	02/2020