BEEBE HEALTHCARE

Patient Care Manual

Fall Prevention and Management	Date Issued: 3/92
Issued By: Dareth Penuel BSN RN, Nurse Manager MedSurg/Oncology, H@H & Virtual Nurse Approved By: Loretta Ostroski MSN RN, VP of Inpatient Nursing & Emergency Services, Interim CNO	Revised: 5/00, 10/01, 3/02, 6/03, 3/06, 4/06, 2/07, 8/08, 2/09, 7/09; 3/11, 4/11, 8/12, 3/14, 5/14, 8/14, 4/19, 9/19, 4/22
[X] Condition of Participation [X] Joint Commission Standard [ ] Department Specific Regulation	Reviewed:

PURPOSE

To address fall prevention and management at Beebe Healthcare

SCOPE

To include inpatient, outpatient, and visitor fall prevention and management at Beebe Healthcare that occurs on our property or at our facilities.

DEFINITIONS

Definition of a 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).

- When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall.
- If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only considered as a fall *if the patient is injured.*

Note: NDNQI (National Database for Nursing Quality Indicators), which is a Database Beebe utilizes for trending patient fall data, counts only falls that occur on an eligible inpatient or ambulatory unit that reports falls.

POLICY

Beebe Healthcare should create a safe physical environment for our community and healthcare patients, both inpatient and outpatient. When identified as a risk for falls, fall interventions appropriate to the care setting should be implemented to reduce the incidence of falls and to reduce the risk of harm resulting from falls. Data is reviewed regularly with interdisciplinary team.

PROCEDURE

I. INPATIENT

A. Assessment

1. On admission, the nurse is to assess a patient's risk for falling utilizing the Morse Fall Risk Assessment in the medical record.

2. Interventions should be implemented based on the "Fall Prevention Guidelines" which are located in **Appendix A** of this policy.

3. Family/caregiver involvement in fall prevention may be utilized when appropriate.

Morse Fall Risk Assessment Scoring:

History of Falls: Immediate or within 3 months	Yes=25 No=0
Presence of Secondary Diagnosis (More than one medical diagnosis is listed on the patient's chart)	Yes=15 No=0
Use of Ambulatory Aid	Furniture=30 Crutches, Cane, Walker=15 None, Bed rest (does not get OOB at all), Wheelchair, Nurse=0
IV or Heparin Lock Fall Risk	Yes=20 No=0
Gait Weak or Impaired Fall Risk	Impaired=20 Weak=10 Normal, Bedrest, Immobile=0
Mental Status Fall Risk	Forgets Limitations=15 Oriented to Own Ability=0

B. Reassessment

1. The nurse should reassess the patient's fall risk every 12-hour shift and as needed as condition warrants, such as a change in mental status or within 24 hours post-procedure.

C. Interventions/Precautions:

1. Interventions and education should be implemented as necessary based on fall risk assessment. "Fall Prevention Guidelines" located in **Appendix A** to this policy.
2. Based on nursing judgement, precautions /interventions may be increased. Consider use of an alternative method for toileting based on patient condition/diagnosis/medications.
3. Beds equipped with safety features (top side rails, low position and bed alarm) should be engaged for patients according to their fall risk score.

D. To improve patient safety, please educate family as follows:
"If assistance is needed or you need to speak with the staff for any reason, please use the call bell or pull the bathroom cord."

II. OUTPATIENT

A. Beebe Home Care

(See *Admission to Skilled Services* Policy in Home Health Manual. Patients will be reassessed per Home Health Policy.)

B. Emergency Department

Patients should be assessed per unit. Fall Assessment tool on arrival for fall risk. If at risk for fall, patient specific interventions should be initiated (e.g. assistance with elimination and mobility, family involvement, patient safety attendant, tele-monitor equipment), Located in Appendix A to the policy.

C. Tunnell Cancer Center

Risk for fall should be assessed at the first visit and as the patient's condition changes. Interventionsappropriate to the setting are implemented. (See also Tunnell Cancer Center Policy Manual).

D. Wound Care Services

(See Wound Care Services Policy and Procedure Manual)

E. Physical Rehabilitation Services

Risk for fall should be assessed at the first visit and as the patient's condition changes. Interventionsappropriate to the setting are implemented.

F. Other Outpatient Settings

Patients should be observed as they enter the outpatient settings and upon leaving and assistance will begiven as necessary.

G. Visitors

Staff is encouraged to assist visitors to their destination if needed.

III. FACILITY WIDE

A. Staff Education

All team members, clinical and non-clinical are to receive education about fall prevention and management upon hire and annually.

B. Fall Monitoring

Fall occurrence data is reviewed as part of the *Organizational Improvement and Patient Safety Plan.* The Fall Prevention Team is Interdisciplinary. The Fall Prevention Team works together to developaction plans to reduce falls and injuries associated with falls.

C. Interventions

Staff should keep walkways free from clutter; provide assistance to any patients and visitors that ask orin their clinical judgment require assistance with ambulating, toileting, or assistance up or down from exam areas or any other assistance. Staff should also provide wheelchair assistance for any patient thatrequests it or in their clinical judgment may need assistance, including to and from vehicles.

D. Procedure to Follow if a Fall Occurs

1. Clinical staff should:

a) Remain calm, call for help, and stay with the patient until additional assistance arrives.
b) Assess the patient for airway, breathing, circulation, level of consciousness, and extent ofinjuries including spinal injuries, if any.
c) Assess the patient and initiate appropriate interventions for suspected injuries. SpecialConsideration for injury potential should be utilized in patients with bleeding risk, advanced age (85 or >), history of falls.
d) Notify the Nursing Supervisor at time of fall.
e) Notify physician at time of fall.
f) Notify family as soon as practicable of fall.
g) Assure completion of physician ordered treatments and diagnostic studies.
h) Document the Post Fall Assessment, the Plan of Care, Falls Education in the medicalrecord.
i) Conduct a debriefing after each fall with any members present at the time of the fall and/ornursing staff assigned to caring for the patient and the charge nurse to determine what could have been done differently to prevent future similar falls and use this information to educate staff, patient, and disseminate lessons learned to staff.
j) Fill out an STT (Safety Tracking Tool).
k) Reassess the Fall Score, document in the medical record, and apply appropriateinterventions.

REFERENCES

1. NDNQI – National Database for Nursing Quality Indicators (used for definition of a fall.)

2. Press Ganey. (2022). *National Database for Nursing Quality Indicators* (*fall definition*). https://www.pressganey.com/products/clinical-excellence (secured log in required) http://www.nursingquality.org/Content/Documents/NQF-Data-Collection-Guidelines.pdf

3. Agency for Healthcare Research and Quality. (2021, March). *Preventing falls in hospitals.* AHRQ. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

4. Morse Fall Risk Assessment Scoring: https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html

5. Staggs, V.S., Davidson, J., Dunton, N., & Crosser, B. (2015, April). Challenges in Defining and Categorizing Falls on Diverse Unit Types: Lessons from Expansion of the NDNQI Falls Indicator. *Journal of Nursing Care Quality*, 30(2), 106-112. https://doi.org/10.1097/NCQ.0000000000000085

Appendix A: Clinical Staff: Guidelines for Fall Prevention Interventions

	Interventions/Precautions	Low Risk for Fall (0-24)	Medium Risk for Fall (25-45)	High Risk for Fall (>45)
1	Educate the Patient and Family: • Fall Risk • Purposeful Rounding • White Boards (include updated Fall Risk Score and Activity Level)	**X**	**X**	**X**
2	Keep frequently used items within reach	**X**	**X**	**X**
3	Maintain adequate lighting	**X**	**X**	**X**
4	Maintain area free of clutter	**X**	**X**	**X**
5	Use non-skid footwear	**X**	**X**	**X**
6	Maintain bed in lowest position with wheels locked • Utilize bed/personal alarms		**X**	**X**
7	Provide toileting opportunities during purposeful rounding • Accompany patient to and from bathroom		**X**	**X**
8	Provide toileting opportunities during purposeful rounding • Accompany patient to and from bathroom **AND** • **Remain with the patient**			**X**
9	Educate Patient to Rise Slowly to Avoid Dizziness	**X**	**X**	**X**
10	Apply fall risk band		**X**	**X**
11	Accompany patient while ambulating • Use gait belt when appropriate		**X**	**X**
12	Obtain order for physical therapy evaluation		**X**	**X**
13	When mental status is compromised, utilize resources for patient observation (Refer to *Close Observation Policy* for appropriate intervention)			**X**
14	Document in the EMR: • Fall Risk • Toileting • Interventions • Education	**X**	**X**	**X**
ALSO	Pharmacy Consult: Using general criteria, such as patients who are 80 years old and older AND who have a Morse Score of 80 or greater, consider a medication consult to Pharmacy, or as deemed necessary by clinical staff.			