LOS ANGELES GENERAL MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject:		Original Issue Date: 1992	Policy # 802
FALL PREVENTION		Supersedes: 11/20	Effective Date: 08/23
Departments Consulted:	Reviewed & Approved by: Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	Approved by: (signature on file) Nancy Blake Chief Nursing Officer	

I. PURPOSE

To provide guidelines for:

- Identification of patients at risk for falls.
- Implementation of fall reduction strategies.
- Post fall evaluation and management.

II. POLICY

All inpatients, 1 year of age and older, will be assessed upon admission, reassessed daily, upon transfer, and as condition changes (i.e. surgery, invasive procedure, and actual fall, a change in mental status, or change in medication) utilizing the appropriate fall assessment tool.

- Adult inpatients- Morse Fall Assessment Tool
- Pediatric inpatients – Humpty Dumpty Fall Assessment Tool

All patients presenting to the Adult and Pediatric Ambulatory Care Areas will be screened for fall risk using a hospital-based outpatient screening tool. If any screening criteria are positive, a licensed health care professional will document interventions implemented and patient education provided to reduce outpatient fall risk.

- Outpatient Adult and Pediatric patients - Fall Risk Screening Tool

Appropriate fall prevention measures will be implemented for all patients identified as moderate risk or high risk for adults or high risk for pediatrics. Any patient adult and pediatric identified at moderate to high risk will have a yellow “Fall Risk” alert arm band placed.

Emergency Department (Adult and Pediatric patients):

All adult and pediatric patients, regardless of age, will be screened for fall risk using specific assessment screening elements. The staff will document all fall reduction interventions and patient/family education in the electronic medical record (EHR). Appropriate fall prevention measures will be implemented for all patients identified as “at risk for falls”. If any of the screening criteria element is positive, a license healthcare professional will implement and document interventions to reduce the “risk of falls” to include patient/ family education.

- ED Adult and Pediatric patients - Fall Risk Screening Tool

Definition per The Joint Commission

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

III. PROCEDURE

A. Hospital Based Outpatients:

1. Screen all adult and pediatric patients over 1 year of age for fall risk using the age appropriate screening tool.
   - Adult Ambulatory Care Fall Risk Screening Criteria (refer to Nursing Policy #802 Addendum - A)
   - Pediatric Ambulatory Care Fall Risk Screening Criteria (patients greater than 1 year of age) (refer to Nursing Policy #802 Addendum 802-A)
2. Patients identified at risk for falls, will have a licensed professional implement and document appropriate fall prevention intervention measures including patient/family education.
3. Place a yellow "Fall Risk" alert arm band on all patients identified at risk.

B. Outpatient Fall Prevention Measures

1. Implement the General safety measures to prevent falls for all face to face outpatient visits (Adult and pediatric):
   - Maintain a safe, hazard free environment (remove any obstacles from patient pathway)
   - For patients on gurneys, maintain gurney in lowest position with side rails up
   - Ensure adequate lighting
   - Use wheel locks when indicated
   - Keep beds, stretchers, gurneys in lowest, locked position
   - Keep call light (as applicable) within reach
   - Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
   - Notify licensed professional for focused fall reduction interventions and patient/family education, including, but not limited to:
     - ➢ Diagnosis and treatment underlying etiology of fall risk
     - ➢ Ensure "fall risk "alert armband is in place based on patient condition and determination of fall risk

2. Implement the following fall prevention intervention measures if the outpatient has been identified at risk for falls:
   - Ensure “Fall Risk” alert arm band is in place
   - Provide education to patient/family regarding
     - Fall risk determination
     - Safety measures for prevention of falls during their outpatient visit
     - Rising slowly from a sitting or lying position
   - If possible, consider having patients relocate to an area that allows closer nursing observation
   - Offer wheelchair if appropriate
   - Keep assistive devices (cane, crutches, etc.) within reach of the patient
   - Assist patients walking with medical equipment (wound vac, IV, etc.)
   - Alert next provider that patient is a fall risk (e.g., during transfers or hand – off to another clinical area/service).

C. Emergency Department:

Patients identified at risk for falls will have a licensed professional implement and document appropriate fall prevention intervention measures including patient/family education.

1). Implement the following falls risk Interventions for all ED adult and pediatric patients:
   - Place yellow arm band on patient
   - Provide assistance with ambulation
   - Move to allow closer nursing observation
   - Place “fall risk” sign at bedside
   - Place the patient directly to bed/gurney, place bed/gurney in lowest locked position
   - Provide patient/family education on fall prevention measures, to include environment
   - Provide observation with a trained staff member, as needed,
   - Assess and anticipate elimination needs every 2 hours
   - Provide in- person observation for patients requiring assistance with toileting, as needed
   - Provide privacy when patient is toileting,
   - If requested, encourage family to stay at patient’s bedside

D. Inpatients:

At risk for fall screening in the outpatient area does not replace the requirement to complete an initial fall risk assessment upon admission into the unit by the RN.

1. Assessment / Reassessment

a. Upon admission, the RN will assess all adult in-patients and children greater than 1 year of age for their risk for falls utilizing the appropriate Fall Risk Assessment Tool.

- Adults: Morse Fall Assessment Tool Scale (refer to Nursing Policy #802 Addendum - B)

- Pediatrics: Humpty Dumpty Fall Assessment Tool Scale (refer to Nursing Policy # 802 Addendum - C)

- Patients admitted to a pediatric unit will be assessed with the Humpty Dumpty Fall Assessment Tool Scale.
- Pediatric patients admitted to an adult unit will be assessed with the Humpty Dumpty Fall Assessment Tool Scale.
- Patient will be reassessed every shift, upon inter-unit transfer, upon change of status, or upon fall to determine the need for Fall Prevention Measures (FPM) implementation.

b. Attach yellow" Fall Risk" alert band to patients identified at risk for falls.

2. Risk Determination

a. **Adults**

- **Low risk:** Any adult patient who receives a score of 0-24 on the Morse Fall Scale is considered as low risk. Level 1 interventions will be implemented for these patients
- **Moderate risk:** Any adult patient who receives a score of 25-50 on the Morse Fall Scale is considered as moderate risk. Level 2 interventions will be implemented for these patients in addition to Level 1 interventions
- **High risk:** Any adult patient who receives a score of 51 and higher on the Morse Fall Scale is considered as high risk. Level 3 interventions will be implemented for these patients in addition to Level 1 and 2 interventions

b. **Pediatrics**

- **Low risk:** Any pediatric patient who receives a score of 7-11 on the Humpty Dumpty Scale is considered low risk and "General Fall Prevention Interventions for All Children" will be implemented for these patients
- **High risk:** Any pediatric patient who receives a score of 12 or above on the Humpty Dumpty Scale is considered high risk for falls and will be placed on Fall Prevention Measures for the duration of his/her hospitalization
- If in the judgment of the RN, a child no longer meets the high risk for falls criteria, a falls risk reassessment may be performed and documented to justify the discontinuation of the high risk for falls identification and implementation of Falls Prevention Measures
- If, in the nurse's judgment, any pediatric patient is considered to be at risk for falls, in spite of not meeting the criteria for high risk, the nurse may identify the child as high risk for falls and initiate Fall Prevention Measures

3. Initiation of Plan of care

When a patient is identified as moderate to high risk for falls, the RN will initiate a plan of care related to the patient's identified risk factors. Injury and/or fall prevention strategies, including patient/family education will be incorporated into the plan of care for at risk patients.

4. Fall Prevention Measures

When a patient is identified as moderate to high risk for falls either on admission or during his/her hospitalization, the RN will implement the following Fall Prevention Measures:

a. Identify patient as being high risk for falls and communicate patient fall risk status.

b. Identification and communication strategies could include, but are not limited to, the following:

- ➢ Place a colored "fall risk" alert armband on the patient
- ➢ Place a sign at the entrance to the patient's room and/or head of the patient's bed

A. Fall Prevention Measures (Adults)

Level 1 Interventions for patients assessed as low risk: (0-24)

- The patient's risk for falls will be discussed with interdisciplinary team members
- Provide patient/family education related to fall prevention
  - Purpose and importance of fall/injury prevention measures
  - Use of call light/maintaining bedrails in appropriate position
  - Safe ambulation/transfer techniques
  - Importance of wearing non-skid footwear
  - Reporting environmental hazards to nursing staff, e.g., spills,
  - cluttered passages
- Family/ significant others may assist with fall reduction strategies once fall management training is completed. (Note: staff remains responsible for overall safety of patients even with family in attendance.)
- Perform purposeful nursing rounds
- Orient patient to surroundings and hospital routines
- Communicate the patients "at risk" status during shift report
- Set the bed in the lowest position with brakes locked
- Place personal belongings within reach on the bedside stand/ table
- Reduce room clutter. Remove unnecessary equipment and furniture
- Provide non-skid (non-slip) footwear

Level 2 Interventions for patients assessed as moderate risk: (25 – 50)

- Includes All Level 1 interventions
- Place a yellow "fall risk" alert armband on the patient
- Place a sign at the entrance to the patient's room and/or head of the patient's bed
- Place the patient in a room or area where they can be easily observed
- Offer toileting every 2 hours
  Activate the bed alarm and wheelchair seat belt alarm

Level 3 Interventions for patients assessed as high risk: (51 and higher)

- Includes all Level 1 and Level 2 interventions
- Increase frequency of purposeful nursing rounds based on patient need
- Collaborate with interdisciplinary team for therapy schedule/ activities
- During exchange of patients between staff, hand off communication should include fall risk level, supervision provided, and observation of unsafe behaviors
- Cohort patients, when possible
- Stay with patient at all times while in the bathroom. Refusal by patient for direct observation during toileting must be documented in the patient's EHR.
- Provide continuous observer. Assess for appropriateness of Telesitting® and/or 1:1 care companion, when possible. (Excluding ICU's. Refer to Nursing Policy #726 Telesitting® – Remote Continuous Visual Monitoring)
- Restraints are discouraged however if needed apply, refer to Medical Center Policy #903 Restraints and Seclusion

B. Fall Prevention Interventions for the Pediatric inpatient

Children can fall because of developmental, environmental and situational risks. The following strategies shall be implemented for all pediatric children greater than age 1, regardless of their Humpty Dumpy scale and for pediatric patients, who receives a score of 7-11 on the Humpty Dumpty Scale and is considered Low Risk.

a. **Implement the following interventions as indicated for Humpty Dumpty Score 7-11 (Low Risk):**
   - Do not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
   - Leave crib side rails up at all times unless an adult is at the bedside.
   - Bed type and size shall be determined based on child's developmental and clinical needs.
     - Instruct patient/parent on how to prevent falls in the hospital setting:
     - Maintain side rails in appropriate position
     - Maintain crib rails up
     - Do not allow the child to jump on the bed
     - Do not allow the child to run in the room or hallway
     - Do not allow the child to climb on hospital furniture or equipment
     - Importance of wearing non-skid footwear
     - Notify the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual
     - Notify nursing staff of environmental hazards (e.g., spills, cluttered passages)
     - Supervise the child's activities, e.g. walk next to the child and provide support as strength and balance are regained

b. **Implement the following interventions as indicated for Humpty Dumpty Score 12 or greater (High Risk):**
   - Include all "Low Risk" interventions
   - Consider locating the patient closer to nursing station for closer observation
   - Assess and anticipate the reasons patients get out of bed such as elimination needs, restlessness, confusion and pain
     - Offer assistance with toileting every 2 hours while awake
     - Provide calming interventions and pain relief
   - Accompany patient with ambulation
   - Monitor medication profiles for patients receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications)
   - Set bed alarms, as appropriate, to alert when patient is exiting the bed.
   - Evaluate need for and encourage family to remain at the patient's bedside
   - Assess need for continuous observer 1:1 supervision
   - Provide patient/family education related to fall prevention (in addition to education related to general injury prevention above):
     - Purpose and importance of fall/injury prevention measures
     - Use of call light/maintaining bedrails in appropriate position
     - Safe ambulation/transfer techniques

- Instruct parents of the pediatric patient to inform the nurse and/or physician if the child seems to be less coordinated than usual, or complains of dizziness or feeling weak
- Instruct parents of the pediatric patient that until the child regains his/her strength, someone should walk along side him/her to provide support and protection in case he/she loses his/her balance

5. Post-Fall Procedure:

- Stay with the patient. Call for help
- Assess patient for pain or injury and check level of consciousness
- Report fall to licensed personnel
- Provide comfort measures
- Notify the Provider
- Complete Safety Intelligence (SI) report

After a patient fall initiate the Post Fall Evaluation and Management Algorithm (refer to Nursing Policy# 802 Addendum - D)

6. Documentation

a). Outpatient: For patients at risk for falls, staff will document the following in the EHR:

- Fall Risk screening
- Fall Risk assessment
- Fall prevention measures and patient education provided

b). Emergency Department: The licensed professional will assess if the adult or pediatric patient (regardless of age) is at risk for falls in the EHR:

- ED Triage / Intake form under the Risk tab.

c). Inpatient: The RN will document the following in the EHR:

- Using the appropriate Fall Risk Assessment Tool, the RN will document the initial fall risk assessment upon admission.
- The RN will assess patients not initially identified as moderate to high risk of falls using appropriate fall assessment tool daily, upon transfer and when conditions changes (i.e. surgery, invasive procedure, an actual fall, a change in mental status, or change in medication).
- Patient/family education related to falls
- Ongoing safety precautions
- Any fall incident, related assessments, and notification of provider /family
- Implement Injury (Falls), Risk for, Plan of Care

d). Document the following if a fall occur:

- Notification of provider
- Complete Safety Intelligence (SI) report
- Assessment of patient status
- Description of fall
- Falls risk reassessment per assessment tool

- Changes to plan of care

7. Performance Improvement, Quality Control, Monitoring, Reporting And Bench-Marking
Performed on a quarterly basis utilizing the Press Ganey/NDNQI) Fall Data. The Morse Fall Scale will be calibrated to each unit, so that fall prevention strategies are targeted to those most at risk (within the range of 45 to 51).

8. DHS Employee Fall Prevention Program Education
Current DHS nursing staff will be trained on the DHS System Wide Fall Prevention Program. Additionally, the DHS System Wide Fall Prevention Program will be incorporated into the New Employee Orientation Program.

RESPONSIBILITY

Prevention of patient falls is the responsibility of every staff member.

REFERENCES

Los Angeles County Department of Health Services System Wide Fall Prevention Program

Nursing Policy #802 Fall Prevention Addendum A- Outpatient Falls Risk Screening Adult

Nursing Policy #802 Fall Prevention Addendum - B- Inpatient Morse Fall Risk Assessment

Nursing Policy #802 Fall Prevention Addendum - C- Inpatient Humpty Dumpty Scale and Prevention

Nursing Policy #802 Fall Prevention Addendum - D- Post Fall Algorithm

REVISION DATES

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