OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 5306
VERSION: 5

SUBJECT/TITLE: **FALL PREVENTION PROGRAM**

PURPOSE To provide guidelines for:

1. Identifying patients at risk for falls
2. Implementation of fall prevention/reduction strategies
3. Post Fall evaluation and management.

DEPARTMENTS **ALL**

DEFINITIONS **Fall:**

- A witnessed or un-witnessed unplanned descent to the floor (or extension of the floor such as a trash can or other equipment) with or without injury to the patient (National Database of Nursing Quality Indicators; NDNQI).

- All types of falls are to be included whether they result from physiological reasons (e.g., fainting) or environmental reasons (e.g., 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/extension of the floor or by breaking the patient's fall.

Intentional Falls:

- Are when patients throw themselves on the floor/extension of the floor.
  - Should be categorized in the event reporting system as a *Behavioral event*.
- May either be witnessed by a staff or viewed in the camera.
  - This is not considered a fall, but like with any other fall events, patient assessments and/or interventions are required.

Rehabilitation Fall:

- A fall that results from a purposeful action during a rehabilitation session that is performed with the intent of challenging a patient's balance or to attempt a functional activity the patient is unable to perform without assistance.
  - Rehabilitation staff have prepared, in advance, mechanisms to minimize the impact of a potential fall by using a gait belt, assistive device, wheelchair, extra staff and/or placement of padded mats on the floor.

POLICY

HOSPITAL BASED OUTPATIENT CLINICS
Shall screen patients and mitigate risks for falls and harm based on the patient population, setting, and environment.
Documentation, as applicable, will include:

- Fall Screening
- Fall Risk
- Fall prevention measures implemented and patient education provided.

INPATIENT SETTING
All hospitalized inpatients, one (1) year of age and older will be assessed on admission and reassessed every shift, on transfer to another unit, and with condition change for their risk of falls.
Documentation will include:

- Initial assessment and ongoing reassessments using the appropriate Fall Risk Assessment Tool
  - Adults: Morse Fall Scale (Attachment A)
  - Pediatrics: Humpty Dumpty (Attachment B)
- Patient/family education
- Ongoing safety precautions and fall prevention measures
- Any fall incident, related assessment, and notification of physician/family.

EMERGENCY DEPARTMENT
Patients will be screened for fall risk using specific assessment screening elements.
Appropriate fall prevention measures will be implemented for all patients identified as at risk for falls.
Documentation, as applicable, will include:

- Fall Screening
- Fall Risk
- Fall prevention measures implemented and patient education provided.

Post Fall Evaluation and Management (applicable to all areas; see *Post Fall Algorithm*, Attachment E):

- Appropriate actions and interventions will be taken to assess the patient for injury.
- The nurse and physician will take prompt actions and interventions to treat any injury and prevent further injury.
- The nurse will evaluate and revise the plan of care for the patient (as applicable).

Performance Improvement, Quality Control Monitoring, Reporting and Bench-marking:
Will be performed on a quarterly basis utilizing the identified DHS fall database.

FALL PROGRAM COMPONENTS

Fall Prevention Program	Inpatient	Outpatient
Policy	✓	✓
Procedure	✓	✓
• Screening • Assessment • Reassessment	NA* ✓ ✓	✓ NA NA
Plan of Care	✓	NA
Fall Prevention Measures • Interventions implemented • Education (Patient/Family)	 ✓ ✓	 ✓ ✓
Post Fall Evaluation and Management	✓	✓
Documentation	✓	✓
Performance Improvement, Quality Control Monitoring, Reporting and Bench-marking	✓	✓

*NA: Not applicable

PROCEDURES

I. HOSPITAL BASED OUTPATIENTS

A. Screening for fall risk may be applied across a clinic, or patient-specific:
- Certain patient populations, settings, and environments pose an equivocal increased risk for falls. Risk may be based on factors including, but not limited to, patient demographics, diagnoses, medical condition, clinical situation, mobility, and ambulatory/mobility equipment needs.
- Clinic-wide screening may include:
  - Periodic Environmental Rounds
  - Validation of clinic-wide safeguards (e.g., hand rails, level flooring/surfaces, wheelchair/walker access, grab bars)
  - Patient education.

B. Screen all adult and pediatric patients over 1 year of age for fall risk using the age appropriate screening tool.
  - *Adult:* Ambulatory Care Fall Screening Criteria
  - *Pediatric:* Ambulatory Care Fall Screening Criteria (patients > 1 year of age). (Attachment C.)

C. Patients identified as high risk during either screening methods, will have a licensed professional further determine, implement, and document appropriate prevention measures including patient/family education.

D. ***Outpatient Fall Prevention Measures***:
- Maintain a safe, hazard free environment (remove any obstacles from patient pathway).
- Place "at-risk" patients who are identified as needing assistance on exam table only at the time of examination, with staff present.
- Aid with toileting, when appropriate, for safety reasons (ensuring privacy when doing so).
- Ensure adequate lighting.
- Use wheelchair locks, when indicated.
- Keep procedure beds, stretchers, and/or gurneys in lowest, locked position with side rails up, as appropriate.
- Keep call light, as applicable, within reach.
- Identify and manage areas of concern during Environmental/Safety Rounds.
- Inform patient/family to not leave children unattended when using equipment such as strollers, walkers, infant seats or swings.
- Notify appropriate professional for focused fall reduction interventions and patient/family education.
- Provide patient/family education regarding:
  - Fall risk determination.
  - Safety measures for prevention of falls.
  - Rising slowly from a sitting or lying position.
- Offer wheelchair, if appropriate.
- Ensure that assistive devices (e.g., cane, crutches, walker, and wheelchair) are within reach of the patient.
- Assist patients walking with medical equipment as appropriate (e.g., wound vacuum devices, IV poles, oxygen tubing, and tanks etc.).
- Alert subsequent providers that patient is a fall risk (e.g., during transfers or hand-off to another clinical area/service).

E. After a patient fall, initiate the Post-Fall Algorithm (Attachment E) and complete all post fall documentation in the medical record. Reference OVMC Policy # 5378- Text Paging Providers to communicate patient information and requested response time.

II. INPATIENT SETTING

A. All patients admitted to the inpatient setting will be assessed on admission for fall-related risk factors using the appropriate falls risk assessment tool.
- Adults: Morse Fall Assessment Scale (Attachment A)
- Pediatrics: Humpty Dumpty Scale (Attachment B).

B. Patients are to be assessed/reassessed every shift as part of the assessment

process after admission or with change of status (e.g., procedure, surgery, etc.).

C. Risk Determination

Adult Inpatients

- ***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.

Pediatric Inpatients

- ***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 High Risk for the duration of his/her hospitalization.

D. When an adult patient is identified as ***MODERATE (score 25 - 50)*** or ***HIGH RISK (score ≥ 51)*** 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.

E. Reference OVMC Policy # 5378- Text Paging Providers to communicate patient information and requested response time.

Inpatient Intervention Strategies:

The registered nurse will implement the fall prevention and management interventions specific to the determined fall risk level.

ADULT Fall Prevention Measures and Interventions

- **Level 1 Interventions** for patients assessed with ***low risk*** **(0-24),** as applicable:
    a. The patient's risk for falls will be discussed with interdisciplinary

team members.

b. Provide patient/family education related to fall management and document education in patient's medical record:
   - Purpose and importance of fall/injury prevention measures.
   - Use of call light.
   - Maintain 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).

c. 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 attendance).

d. Perform purposeful rounds.

e. Orient patient to surroundings and hospital routines.

f. During exchange of patients between staff (e.g. shift report, break relief and patient transport/transfer), hand-off communication will include fall risk level, supervision provided, and observation of unsafe behavior.

g. Set the bed in the lowest position with brakes locked. For patients with indwelling catheters, the bed height may be raised minimally (not more than two inches) to keep drainage bag (e.g., Foley bag) from touching the floor.

h. Place personal belongings within reach on the bedside stand/table.

i. Reduce room clutter (e.g. remove unnecessary equipment and furniture).

j. Provide non-skid (non-slip) footwear.

- **Level 2 Interventions** for patients assessed as ***moderate risk*** **(25-50)** as applicable; includes Level 1 interventions:

  a. Place armband and a sign at the entrance to the patient's room and/or head of the patient's bed.
  b. Offer toileting, minimally, every two hours.
  c. Activate the bed alarm, if appropriate.

- **Level 3 Interventions** for patients assessed as ***high risk*** **(51 and higher)** as applicable; includes Level 1 and Level 2 interventions:

  a. Activate bed alarm.
  b. Increase purposeful rounds based on patient needs.
  c. Collaborate with interdisciplinary team for therapy schedule/activities.
  d. Cohort patients, when possible.

e. Provide continuous in-person observation with a trained staff member as needed for safety reasons.
f. Place the patient in a room or area where they can be easily observed.
g. Always stay with the patient while toileting out of bed.
   - Refusal by patient for direct observation during toileting must be documented in the patient's medical record, as applicable. (Further assessment may be necessary if the patient exhibits conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.).
   - Notify the appropriate licensed professional of patient's refusal.
h. Restraints are discouraged, however, if needed, apply per hospital specific restraint policy/procedure.

NOTE: If patient refuses activation of bed alarm, registered nurse will document refusal in the patient's medical record

PEDIATRIC Fall Prevention Measures and Interventions

- **General Fall Prevention Interventions for *All Children*:**
  Children can fall because of developmental, environmental, and situational risks. The following strategies shall be implemented for all children:

  a. Do not leave unattended when using equipment such as strollers, walkers, infant seats or swings.
  b. Always leave crib side rails up unless an adult is at the bedside.
  c. Determine bed type and size based on child's developmental and clinical needs.
  d. Instruct patient/family on how to prevent falls in the hospital setting by:
     - Maintaining side rails in appropriate position.
     - Maintaining crib rails up.
     - Not allowing the child to jump on the bed.
     - Not allowing the child to run in the room or hallway.
     - Not allowing the child to climb on hospital furniture or equipment.
     - Explaining importance of wearing non-skid footwear.
     - Notifying the nurse if the child complains of dizziness, feeling weak or seems less coordinated than usual.
     - Notifying nursing staff of environmental hazards (e.g., spills cluttered passages).
     - Supervising the child's activities (e.g. walk next to the child and provide support as strength and balance are regained).

- **Fall Prevention Measures for *High Risk* children**:
  a. Consider locating the child closer to nursing station for closer observation.
  b. Assess and anticipate the reasons the child gets out of bed such as elimination needs, restlessness, confusion, and pain
  c. Offer assistance with toileting, minimally, every 2 hours while awake.
  d. Always stay with child while toileting out of bed.
     - Refusal by the child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
     - Notify the appropriate licensed professional of child's parent/guardian's refusal.
  e. Provide calming interventions and pain relief.
  f. Accompany with ambulation.
  g. Monitor medication profiles for children receiving medications that may increase their risk for falls (e.g., narcotics, sedatives, anti-seizure medications).
  h. Set bed alarms, as appropriate, to alert when child is exiting the bed.
  i. Evaluate need and encourage family to remain at the child's bedside.
  j. Assess need for continuous in-person observation with a trained staff member, as needed, for safety reasons.
  k. Provide patient/family education related to fall prevention:
     - Purpose and importance of fall/injury prevention measures
     - Use of call light.
     - Maintaining bed rails in appropriate position.
     - Safe ambulation/transfer techniques.
  l. Instruct family of pediatric patients to inform the nurse and/or physician if the child seems to be less coordinated from baseline or complains of dizziness or feeling weak.
  m. Instruct family of pediatric patients that until the child regains his/her strength, someone should walk alongside him/her to provide support and protection in case he/she loses his/her balance.

<u>For all inpatient areas:</u>

- After a patient fall, initiate the Post-Fall Algorithm (Attachment E) and complete all post fall documentation in the medical record.
- Reference OVMC Policy # 5379- Text Paging Providers to communicate patient information and requested response time.

III. EMERGENCY DEPARTMENT

A. Screening (adult, pediatric, psychiatric, and all other ED areas) will take place at the time of triage assessment using age appropriate *fall risk screening criteria*:

Adult

- History of previous fall
- Use of assistive device for ambulation/mobility
- History of seizure or syncope
- Alcohol/drug withdrawal/intoxication symptoms
- Altered mental status/confusion
- Sensory deficit – sight/hearing/speech impairment
- Unsteady gait/weakness

Pediatrics

- History of previous fall
- Use of assistive device for ambulation/mobility
- History of seizure in last 6 months
- Alcohol/drug withdrawal/intoxication symptoms
- Altered mental status/confusion
- Sensory deficit-sight/hearing/speech impairment
- Developmental problems causing difficulty walking
- Neurologic diagnosis/condition causing difficulty walking (e.g., Muscular Dystrophy)

B. Identify all patients who meet any one of the criteria as a possible falls risk.

C. All patients who are identified as a falls risk will have a falls risk arm band placed.

D. Additional interventions will be implemented as applicable for the individual patient.

Adult Interventions

1. Provide assistance with ambulation
2. Move to allow closer nursing observation
3. Place the patient directly to bed (or on gurney):
   - Bed or gurney in lowest, locked position
   - Side rails up
4. Provide patient /family education on fall prevention measures
   - Environmental orientation
   - Call light
   - Call for assistance, as needed
5. Place fall sign at bedside (or on gurney)
6. Provide continuous in-person observation with a trained staff member,

as needed, for safety reasons.

7. Assess for elimination needs every 2 hours.
8. Provide in-person observation for patients requiring assistance with toileting, as needed, for safety reasons.
    - Provide privacy when patient is toileting, if requested.
    - Refusal by patient for direct observation during toileting must be documented in the patient's medical record. (Further assessment may be necessary should patient exhibit conditions such as dementia, confusion, altered gait, combative, withdrawals, etc.).
    - Notify the appropriate licensed professional of patient's refusal.

Pediatrics Interventions

1. Assist with ambulation
2. Move to allow closer nursing observation
3. Place the patient directly to bed (or on gurney):
4. Bed or gurney in lowest locked position
    - Side rails up
    - Crib with side rails up
5. Provide patient /family education on fall prevention measures:
    - Environmental orientation
    - Call light
    - Call for assistance, as needed
6. Place falls sign at bedside (or on gurney)
7. Provide continuous in-person observation with a trained staff member, as needed, for safety reasons.
8. Assess for elimination needs every 2 hours
9. Provide in-person observation for patients requiring assistance with toileting as needed for safety reasons.
    - Provide privacy when patient is toileting, if requested
    - Refusal by child's parent/guardian for direct observation during toileting must be documented in the patient's medical record.
    - Notify the appropriate licensed professional of child's parent/guardian's refusal.
    - Encourage family to stay at patient's bedside.

E. Post-Fall Procedure: After a patient fall, initiate the Post-Fall Algorithm (Attachment E) and complete required post fall documentation in the medical record. Reference OVMC Policy # 5379- Text Paging Providers to communicate patient information and requested response time.

IV. POST ANESTHESIA CARE UNIT (PACU)

- All patients are presumed at risk for fall and the following interventions will be implemented:
  - Place call light within patient's reach.
  - Verify side rails on gurney are in the up position.
  - Lock all wheelchairs, beds, and stretchers before ambulation.
  - Offer a bedpan, urinal, or assistance to the bathroom.
  - Ensure the patient has a physically safe environment (e.g., eliminate spills, clutter, electrical cords, and unnecessary equipment).
  - Ensure appropriate footwear, including treaded socks, is used when patient ambulates.
  - Place patient's care and personal items within reach.
- Post Fall Procedure: After a patient fall, initiate the Post-Fall procedure Algorithm (Attachment E) and complete required post fall documentation in the medical records. Reference OVMC Policy # 5379- Text Paging Providers to communicate patient information and requested response time.

DOCUMENTATION

Document in the medical record:

- Screening or Assessment/ Reassessment(s)
- Fall prevention measures and interventions implemented
- Patient education
- Plan of care (if applicable)
- Communication to provider (if applicable)
- Post fall evaluation/management (if applicable)

References:

Austin, D. (2017) Predicting and Preventing Pediatric Falls in the Hospital. Science of Caring, University of California San Francisco. Retrieved from: https://scienceofcaring.ucsf.edu/research/predicting-and-preventing-pediatric-falls-hospital

Agency for Healthcare Research and Quality. (2017). Fall Prevention Program. Retrieved from https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/implguide-overview.html

Agency for Healthcare Research and Quality. (2018). Preventing Falls in Hospitals. Retrieved from https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

DHS System-Wide Fall Prevention Program. Policy # 311.101. July 17, 2017

OVMC Policy No. 5378 – Text Paging Providers

The Joint Commission (2015). Sentinel Event Alert: Preventing falls and fall-related injuries in health care facilities. Retrieved from: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_55_falls_4_26_16.pdf

Morse,J.M. (2008). Preventing patient falls (2nd ed.). New York: Springer. published

Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. Canadian Journal on Aging, 8,366-377.

Poe, S. S., Cvach, M. M., Gartrell, D. G., Radzik, B. R. & Joy, T. L. (2005). Evidence-based Approach to Fall Risk Assessment, Prevention, and Management. Journal of Nursing Care Quality, 20 (2), 107-116.

Approved by: Bonnie Bilitch (Chief Nursing Officer), Judith Maass (Chief Executive Officer), Rima Matevosian (Chief Medical Officer)	Date: 04/30/2020
Review Date: 04/09/2015, 07/09/2018	Revision Date: 11/08/2019
Next Review Date: 04/30/2023	
Distribution: Olive View Hospital-Wide Policies	
Original Date: 01/07/2008	