Falls Prevention

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Falls Prevention

Your company recognizes the patient’s right to a safe environment. It is the policy of your company to implement an interdisciplinary approach to fall precautions. By reducing the risk factors and implementing appropriate interventions, staff can impact the prevention of patient falls.

1. Definitions

A fall is an unexpected event, which results in the patient coming to rest unintentionally on the ground or other lower surface.

**Observed fall** – Occurs when a staff member sees a patient experience a loss of balance during walking or transferring and lands on the floor or another object such as a bed, chair or wheelchair, or when patient comes to rest on the ground (lower plane) without intending to do so.

**Assisted fall** – Occurs when a staff member or a non-staff member lowers the patient to the floor (lower plane) or when a patient lowers him or herself to the floor (lower plane) because they feel dizzy or weak.

**Unobserved fall** – Occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she came to be on the floor or the patient reports that they have fallen. Until proven otherwise this is considered a fall. This type of fall is often referred to as being “found down” or “found on the floor.”

**Near fall** – Occurs when a patient experiences and unexpected sudden loss of balance that does not result in a fall or other injury. For example, a patient may slip, stumble, or trip but is able to regain balance control, thereby avoiding a fall to a lower plane. Episodes where the patient loses his or her balance and would have fallen were it not for staff intervention, is a near fall. Intercepted falls are near falls.

The presence or absence of a resultant injury is not a factor in the definition of a fall. The distance to the next lower surface is not a factor in determining whether a fall has occurred.

2. General Information

At the point of entry into the hospital, i.e. Admission or Registration, Inpatient, Outpatient Departments, Emergency Departments and Labor and Delivery, all patients that come to the hospital are placed in standard fall precautions and are assessed or screened for the potential to fall.
3. Standard Fall Precautions

All patients that are in the hospital environment have the potential to fall. Standard precautions apply to each patient. Interventions for Standard Precautions may include:

- Orientation to surroundings, room, department, bathrooms.
- Instruction on how/when to call for help, use of call lights and placing them within reach.
- Keeping side rails raised on stretchers, two upper side rails on patient beds.
- Keeping wheels locked on stretchers, wheel chairs, and patient beds.
- Keeping beds in lowest position.
- Providing assistance climbing on and off stretchers, exam tables, x-ray equipment, and beds.
- Providing non-skid footwear.
- Maintaining a clutter free environment.
- Appropriate use of lighting including night lighting for patients who stay overnight.
- Assistance with keeping the telephone and personal items within reach (i.e., water, eyeglasses, hearing aid, dentures).
- Providing wheelchair assistance as appropriate
- Discontinuing the use of IV’s/catheters as soon as possible.
- Education and encouragement of the patient family regarding the prevention of falls in the hospital environment.
- Non-Clinical Staff screening for fall

Non-clinical staff, such as Admissions or Registration staff, who screen patients at points of entry do so by showing a list or asking the following indicated below:

- Have you fallen in the last 6 months?
- Do you have any difficulty walking? (i.e. use of assisted device, cane, walker, or wheelchair)
- Are you experiencing and dizziness or weakness?

4. Nursing Staff Assessment for Falls

The high risk potential assessment criteria used by clinical staff is listed below:

Previous fall in the past 6 months

- If the answer is “NO”, the patient has not fallen in the past 6 months proceed to the next nursing assessment component.
- If the answer is “YES” perform the “Get up and go test”.

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• If the patient passes the get up and go test proceed to the next nursing assessment component.

• If the patient fails, is unwilling, or is unable to complete the “Get up and go test” place the patient in the High Risk Falls Precautions and consult/investigate with physician regarding PT/OT options as appropriate.

**Proceed to the nursing assessment component**

*One “YES” answer places the patient in the high risk fall potential category and the patient is placed on High Risk Fall Precautions*

**Impaired mobility**

• Assess that patient for the following, unsteady or altered gait, balance impairment, inability to ambulate without assistance of person or equipment, weakness, deformity of feet

• Consult/investigate with physician regarding PT/OT options as appropriate.

**Altered Mental Status**

• Assess the patient for the following: memory or cognitive impairment, confusion, non-compliance with instructions.

**Medication Effects**

• Assess the patient for medication effects such as sedation, light-headedness, bowel/bladder changes, impaired balance, and orthostatic hypotension.

• Consult Pharmacy as appropriate.

**Visually impaired**

• Assess the patient for blindness, cataracts, uncorrected blurred vision, loss of visual field

*Two “YES” answers to any of the contributing factors below places the patient on High Risk Fall Precaution*

**New onset of Sensory Impairment**

• Assess the patient for auditory and tactile impairment

**Impaired Elimination**

• Assess the patient for incontinence, urgency, frequency, and diarrhea

**Environmental/Medical Device concerns**

• Assess the environment for items in this environment that may increase the risk for falls.

• Assess the use of medical devices such as IV poles, pumps, chest tubes, catheters and bedside commodes.
5. Instructions for the Timed Get up and Go Test

The Timed Get Up and Go Test is performed during the Admission Assessment when a patient has fallen during the past 6 months and as part of the reassessment on all patients every shift, when there is an acute change in the patient’s physical and/or mental status and post procedure.

**Direct the patient to do the following as you time him/her:**

- Rise from a sitting position in a chair or bed
- Walk 10 feet
- Turn Around
- Return to chair or bed and sit down

**Use the following as assessment and interpretation guidelines for the test:**

- Did the patient take 20 seconds or less to complete the test?
- Is the patient steady and balanced when sitting upright?
- Is the patient steady and balanced when walking?
- When walking, does each foot clear the floor well?
- Does the patient take symmetrical, continuous steps?
- Is the patient able to sit down safely?

If the answer to any of these questions is “NO,” place the patient in High Risk Falls Precautions.

If your patient fails, is unable, unwilling to do or complete the “Get Up and Go Test”, place the patient in High Risk Falls Precautions.

The “Get Up and Go” is a tool used to assess the functional status of the patient. It is important for the nurse to utilize all their assessment abilities and critical thinking when deciding the use of this tool. Falls reassessment is required every shift, post procedure and when there is a change in the status of the patient. Get up and go is the only one component of the fall reassessment the other components include impaired mobility, altered mental status, medication effects, visually impaired, sensory impairment, impaired elimination, environment and medical concerns.

6. High Risk Fall Precautions

In addition to Standard Fall Precautions, implement the following High Risk Fall Precautions interventions.

- Assign a room near the nurse’s desk, as needed and if possible.
- Instruct the patient not to get up without assistance.
- Activate electronic bed alarm/alert device when appropriate.
- Consult appropriate members of the interdisciplinary team as indicated.
- Identify the patient as High Risk Fall Precaution patient as indicated on the record, on the door, on the armband and on interdisciplinary and/or interdepartmental communications.
- Observe the patient hourly and document in the medical record.
The High Risk Fall Precaution hourly observations include:

- The patient is in the correct position, place, without safety concerns and in no distress
- The bed is in the low position
- Call light is within reach
- Telephone and personal items are within reach
- Two side rails are up on the bed
- Non-skid footwear is in use
- Lighting is appropriate
- Glasses are on for corrected vision as appropriate
- Alarm devices are activated when appropriate
- Personal needs are met
- Reassessment Every Shift

All patients are reassessed utilizing all the High Risk for fall assessment criteria every shift, when there is an acute change of patient’s physical and/or mental status and post-procedure.

What does unwilling, unable or not applicable for “get up and go” mean:

The following are some examples that could be a component that would influence the nurses’ decision making regarding this assessment tool.

Unwilling *(This list is not all inclusive – critical thinking and nursing judgment is required)*

- The patient says no, I don’t want to, don’t make me.

Not Applicable at this time *(This list is not all inclusive – critical thinking and nursing judgment is required)*

- The patient has an order for bed rest or an activity order that negates or limits the performing of this test.
- The patient is not in the room for whatever reason – smoking, they have gone to x-ray, cafeteria, surgery etc.
- The patient may be having a procedure in the room.

Unable *(This list is not all inclusive – critical thinking and nursing judgment is required)*

- Paralyzed
- Amputee of the leg
- Patient is unable to sit themselves up in the bed or on the side of the bed
• You have to lift the patient into the chair
• Patient is unable to get out of bed
• Patient maybe terminal, contractured
• The functional status of the patient is such that this test would be a safety risk for the patient
• Post-cath – leg is immobilized
  • Patient is in a CPM machine, traction
  • Patient has a halo
  • Patient is and ICU patient
  • Patient is ventilated
  • Patient is retrained
  • Any of the fall assessment criteria may influence where the patient is unable – i.e. mental status, functional status, effects of medication etc.

Ways to identify high-risk patients:
  • Place falls precaution stickers on armbands or use fall precaution armbands
  • Place fall stickers or other methodologies on patient charts
  • Place signs on doors
  • Encourage and participate in communication between staff and departments

Removal of patient from high-risk category:
  • Remove patients from high-risk category if on reassessment the patient does not meet high-risk criteria and/or demonstrate high-risk behavior.
  • Document removal in patient care record.

REMEMBER…..Standard Fall Precautions remain in effect

7. Problem / Goal / Intervention / Outcome
Based on the patient’s assessment and specific needs, individualize the plan of care to include High Risk Fall Precautions and interventions to address this patient’s problem.

  • PROBLEM: Potential for Falls due to immobility, medication effects, etc.
  • GOAL: Patient will not experience a fall.
  • INTERVENTIONS: Standard Fall Precautions, bed alarm, tether alarm, education of patient/family, hourly checks, etc.
  • OUTCOME: Goal met, un-met
8. Patient and Family Education

Education is documented in the Medical Record

**Things to be considered for education include:**

- Receipt of Fall Brochure – Partners in Care – Fall Precautions
- Standard and High Risk Fall Precautions
- Safety Interventions Used
- Understanding and compliance with instructions
- Incorporate fall status into discharge planning when appropriate
- Identify and define interdisciplinary roles and responsibilities

**Education to consider for discharge planning:**

- Nutrition
- Exercise – Tai Chi
- Reporting to physician weakness, dizziness, medications and “almost falls”
- Assessment and modification of home
- Instructions following a fall in the home

YOU ARE THE MOST IMPORTANT TOOL IN FALL PREVENTION!