Fall Prevention Protocol

I. Assessment
Each patient should be assessed for fall risk:

- On admission to the facility
- On any transfer from one unit to another within the facility
- Following any change of status
- Following a fall
- On a regular interval, such as monthly, biweekly or daily

Assessment should be done with a standard tool or tools—the Morse Fall Risk Assessment, the Hendrich Fall Risk Assessment, the Tinetti Gait and Balance Scale, or the RISK Assessment Tool for Falls.

II. Environment
Nursing and other staff should perform regular rounds to make sure that the environment does not cause or increase fall risk. Confirm that:

- Patient areas including hallways are well lit, uncluttered, and free of spills
- Locked doors are kept locked when unattended
- Handrails and grab bars are secure
- Furniture is sturdy
- All assistive devices are functioning correctly
- Patient rooms are set up to minimize the risk of falling
- Unsafe situations are dealt with immediately

III. Interventions
Patients should have interventions tailored to their level and area of fall risk.

<table>
<thead>
<tr>
<th>Intervention Strateegies</th>
<th>Level of Risk</th>
<th>Area of Risk</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Low beds</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-slip grip footwear</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Assign patient to bed that allows patient to exit</td>
<td>X</td>
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</table>
In addition, the following should be implemented for patients assessed as at high risk for falls as appropriate.

- Orient patient to surroundings and assigned staff.
- Instruct to call for help before getting out of bed.
- Demonstrate nurses’ call system.
- Call bell within reach, visible and patient informed of the location and use.
- Light cord within reach, visible and patient informed of the location and use.
- Consider use of sitter for cognitively impaired
- Personal care items within arm length.
- Bed in lowest position with wheels locked.
- Ambulate as frequently as appropriate for the patient’s condition.
- Educate and supply patient and family with fall prevention information.
- Identify patient with a colored wrist band.
- Place a colored star outside of patient’s room.
- Place a colored star over patient’s bed.
- Every 3-hour comfort and toileting rounds.
- Every 2-hour comfort and toileting rounds.
- Every 1-hour comfort and toileting rounds.
- Comfort rounds include positioning as indicated; offering fluids, snacks when appropriate and ensuring patient is warm and dry.
- PT consult is suggested to PCP.
- Consult with the falls workgroup and pharmacy.
- Bed alarm
- Wheelchair alarm
- Room placement closer to nurses’ station.
- Bedside mat.
- Hill-rom low bed.
- Evaluation by the interdisciplinary team.
- For risk of head injury consider consult for PT for consideration of a helmet (those at risk of head injury are patients on anticoagulants, patients with severe seizure disorder and patient mechanism of fall is by history to fall hitting head).
- Elevated toilet seat.
- Relaxation tapes/music.
- Diversional activities.
- Exercise program.
- Transfer towards stronger side.
- Actively engage patient and family in all aspects of the fall prevention program.
- Instruct patient in all activities prior to initiating.
- Minimize distractions.
- Instruct patient in use of grab bars.

IV. Areas of Responsibility

A. Medical Center Director

The Medical Center Director is responsible for ensuring that falls and fall-related injury prevention is:

1. A high priority at the facility
2. Promoted across the facility through direct care, administrative and logistical staff
3. Adequately funded to provide a safe environment for patients and staff

B. Associate Chief Nursing Service/Chief Nurse Executive:

The Associate Chief Nursing Service/Chief Nurse Executive/Designee is responsible for:

1. Establishing population-based fall risk levels/units/programs
2. Deploying evidence-based standards of practice
3. Overseeing the policy within the facility

C. Nurse Managers

The Nurse Managers are responsible for:
1. Making fall and fall-related injury prevention a standard of care
2. Enforcing the responsibilities of the staff nurses to comply with interventions
3. Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with facility equipment experts
4. Ensuring that all nursing staff receive education about the falls prevention program at the facility and understand the importance of complying with the interventions

D. Admissions Nurses
The admissions nurses are responsible for:
1. Completing the fall-risk assessment on admission
2. Notifying the unit of any patients assessed as high-risk
3. Following any procedure for high fall-risk admissions, such as a specific color armband, ensuring the bed assigned is close to the nursing station, ensuring there is a high fall-risk magnet by bed, etc.

E. Staff and Contract Nurses Including RNs, LPNs and CNAs
Staff Nurses including RNs, LPNs and CNAs are responsible for:
1. Ensuring compliance of fall and fall-related injury interventions
2. Completing fall-risk assessments on transfers, following a change in status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use
3. Ensuring that rooms with high fall-risk patients are assessed and corrected if necessary

F. Physicians, Physician Assistants and APNs
Physicians, physician assistants and APNs are responsible for:
1. Identifying and implementing medical interventions to reduce fall and fall-related injury risk
2. Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls
3. Ensuring all patients are screened for risk factors for osteoporosis and tested if necessary
4. Screening patients for fall-risk using the patient's self-report and the Timed Up & Go test (Outpatient Areas)
5. Referring patients who are screened high-risk to a pharmacist to review the medication and to physical or occupational therapy to conduct a more thorough assessment of fall risk (Outpatient Areas)

G. Pharmacists
Pharmacists are responsible for:
1. Reviewing medications and supplements to ensure that the risk of falls is reduced
2. Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls
3. Asking outpatients to list their medications and supplements again and verify the medications and supplements with the list provided by the physician and against the patient record

V. Post-Fall Procedures
There are two key elements of the post fall procedures/management: initial post-fall assessment and documentation and follow-up.

A. Initial Post Fall Assessment
First priority is to assess the patient for any obvious injuries and find out what happened. The information needed is:

1. Date/time of fall
2. Patient's description of fall (if possible)
   a. What was patient trying to accomplish at the time of the fall?
   b. Where was the patient at the time of the fall (patient room, bathroom, common room, hallway etc.)?
3. Family/guardian and provider notification
4. Vital signs (temperature, pulse, respiration, blood pressure, orthostatic pulse and blood pressure — lying, sitting and standing)
5. Current medications (were all medications given, was a medication given twice?)
6. Patient assessment
   a. Injury
   b. Probable cause of fall
   c. Comorbid conditions (e.g., dementia, heart disease, neuropathy, etc.)
   d. Risk factors (e.g., gait/balance disorders, weakness)
   e. Morse/Hendrich Risk Assessment
7. Other factors:
   a. Patient using a mobility aid? If so, what was it?
   b. Wearing correct footwear?
   c. Clothing dragging on floor?
   d. Sensory aids (glasses, hearing aids, was veteran using at the time?)
e. Environment
   
i. Bed in high or low position?
   
ii. Bed wheels locked?
   
iii. Wheelchair locked?
   
iv. Floor wet?
   
v. Lighting appropriate?
   
vi. Call light within reach?
   

vii. Bedside table within reach?
   

viii. Area clear of clutter and other items?
   
ix. Siderails in use? If so, how many? How many are on the bed?
   

f. Was the treatment intervention plan being followed? If not, why not?
   
g. Were the falls team and other nurses on the unit notified?

B. Documentation and Follow-up

Following the post-fall assessment and any immediate measure to protect the patient:

   1. An incident report should be completed (see the example fall prevention policy attachment G, p. 51-54)
   
   2. A detailed progress note should be entered into the patient’s record including the results of the post-fall assessment
   
   3. Refer the patient for further evaluation by physician to ensure other serious injuries have not occurred
   
   4. Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate
   
   5. Communicate to all shifts that the patient has fallen and is at risk to fall again