Patient Fall Prevention

Objectives

- Define the goals of fall prevention
- Define a fall
- Identify patients at risk for falls
- Describe fall protocols
- Identify strategies and interventions to prevent falls
- Describe the process for monitoring patient falls
Commitment to Patient Safety

- Many agencies are involved with setting standards of care and monitoring the incidence of falls such as:
  - State and Federal Regulatory Bodies
  - Center for Medicaid and Medicare Services (CMS)
  - Joint Commission

Commitment to Patient Safety

Every patient has the potential to experience a fall.

Falls represent a serious hazard and pose a threat to quality and longevity of life, especially in older adults.
Goal of Fall Prevention

Maintain patient safety and reduce fall risk and injury.

All education provided to patients and families regarding falls is patient and family-focused.

Defining Falls

Hover over each term to explore definitions related to falls.

- Fall
- Assisted Fall
- Baby/Child Drop
- Developmental Fall
- Anticipated Physiological Falls
- Unanticipated Physiological Falls
- Accidental Falls
- Suspected Intentional Falls
- Witnessed Falls
- Unwitnessed Falls
Defining Falls

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- Fall
- Assisted Fall
- Baby/Child Drop
- Developmental Fall
- Anticipated Physiological Falls
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- Accidental Falls
- Suspected Intentional Falls
- Witnessed Falls
- Unwitnessed Falls

Fall:
A sudden, unintentional descent, with or without injury to the patient, which resulted in the patient coming to rest on the floor, on or against some other surface, another person or an object.

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Assisted Fall:
When a staff member attempts to minimize the impact of a fall.
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Baby/Child Drop:
A fall in which a newborn, infant, or child being held or carried by a healthcare professional, parent, family member, or visitor falls or slips from the person's hands, arms, lap, etc.

This can occur with a child is being transferred from one person to another.

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- Unwitnessed Falls

Developmental Fall:
A fall in which an infant, toddler, or preschooer who is learning to stand, walk, run, or pivot falls as part of the developmental process of acquiring these skills.

These falls are considered a normal part of the learning process.
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Anticipated Physiological Fall:
Falls that we anticipate will occur due to the patient’s existing physiological status, history of falls, decreased mobility, and fall risk screening.

Unanticipated Physiological Fall:
Falls associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale.

Examples: Unexpected orthostasis, extreme hypoglycemia, stroke, heart attack, seizure
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Accidental Falls:
Falls that occur due to extrinsic environmental risk factors and hazards such as spills on the floor, tripping on clutter, tubing/cords on the floor, or errors in judgement (not paying attention or leaning against a curtain or unlocked furniture).

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- Unwitnessed Falls

Suspected Intentional Falls:
Falls in which a patient intentionally drops or throws themselves to the floor or staff suspect this is attention-seeking behavior.
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- Developmental Fall
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- Unanticipated Physiological Fall
- Accidental Falls
- Suspected Intentional Falls
- Witnessed Falls
- Unwitnessed Falls

Witnessed Falls:
Staff or visitor witnesses the patient fall

Unwitnessed Falls:
Staff or visitor does NOT witness the patient fall—patient is found on the floor.
How Can I Maintain Patient Safety?

Practice Purposeful Rounding

- Definition: A pro-active, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs.
- Complete the 5 Ps during Purposeful Rounding

Click on each “P” of Purposeful Rounding to learn more

- Pain
- Position
- Prevention
- Potty
- Personal Environment

Pain: Assess the patient for any signs/symptoms of pain
How Can I Maintain Patient Safety?

Practice Purposeful Rounding
- Definition: A pro-active, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs.
- Complete the 5 Ps during Purposeful Rounding

Click on each “P” of Purposeful Rounding to learn more

- Pain
- Position: Reposition the patient as appropriate to prevent pressure injury
- Prevention
- Potty
- Personal Environment

How Can I Maintain Patient Safety?

Practice Purposeful Rounding
- Definition: A pro-active, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs.
- Complete the 5 Ps during Purposeful Rounding

Click on each “P” of Purposeful Rounding to learn more

- Pain
- Position
- Prevention: Assess the environment and correct any potential safety issues
- Potty
- Personal Environment
How Can I Maintain Patient Safety?

Practice Purposeful Rounding

Definition: A pro-active, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs.

Complete the 5 Ps during Purposeful Rounding

Click on each “P” of Purposeful Rounding to learn more

Pain
Position
Prevention

Potty: Offer to assist the patient with toileting or check the patient for incontinence.

Personal Environment: Ensure the patient’s belongings are within reach.
Assessing for Fall Risk

Fall risk assessment tools are used to identify patients who may be at a high risk for falling.

Patients are assessed for fall risk using an approved Evidence-Based tool
1. Upon admission
2. Daily
3. With patient condition change
4. After a fall

Assessing for Fall Risk

If the patient scores as a High Fall Risk:
- Initiate fall precautions
- Identify patients as a High Fall Risk
- Engage ALL associates and volunteers in fall prevention
- Communicate that the patient is a High Fall Risk during hand-off
- Individualize interventions and the patient Plan of Care
- Always include the patient and family in fall prevention
Evidence-Based Fall Risk Assessment Tools

Click on each Fall Risk Assessment Tool to learn more!

- Adult Inpatient: Morse Fall Risk
- Pediatric Inpatient: Cummings Fall Risk
- Labor and Delivery: PEFRAS
**PEFRAS (Slide Layer)**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Response</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of an epidural and/or fall</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Hours since epidural turned off</td>
<td>Greater than 3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater than 2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater than 1</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Able to lift legs, feet, and bottom off of the bed unassisted</td>
<td>No</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>History of opioid medication administration before or after delivery</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>History of unstable B/P (change in B/P greater than 20 mm Hg)</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Pre-existing illness (e.g. Diabetes, pre-eclampsia)</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>EBL &gt; 500mL for SVD and &gt; 1000mL for C/S</td>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Test Stand: Can bend knees without buckling (use with a walker)</td>
<td>No</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE:**

(Abbreviations: C/S - cesarean section; EBL - estimated blood loss; SVD - spontaneous vaginal delivery)

**Patients with a score of 50 or higher** are instructed to **not** attempt walking or getting out of bed without assistance. Patient will be reassessed every thirty minutes until able to pass the "Test Stand" and able to walk independently without a walker.
Morse Fall Scale

- Patient Has a History of Falling
  - Yes (2 points)
  - No (0 points)

- Patient Has a Secondary Diagnosis
  - Yes (2 points)
  - No (0 points)

- Patient Uses Ambulatory Aid
  - Walking with cane (1 point)
  - Walking with walker (2 points)

- Patient Has IV Therapy/Replacement Stock
  - Yes (2 points)
  - No (0 points)

- Patient's Gait
  - Normal gait: touching with head erect, same swing freely of the side and sitting unsteadiness = 0
  - تهناى: Touching foot withAbility to up the head while walking without being balanced. They are short and may be rubbing. Support in only half height based on requirements, rather than placing to remain upright = 10
  - Impaired Gait: Difficulty doing funerals, attempting to get up by pushing on the arm of the chair while being unsteady, head is down, balance have gone wrong, then the patient with self assistance. Short duration

- Patient's Mental Status
  - Patient is lucid, can answer (1 point)
  - Patient has memory loss (2 points)

Right click in box below for reference text related to fall risk.

Morse Fall Score

Patients are considered high fall risk if the score is 45 or greater.

Symbols

- Yellow ID band
- Yellow patient gown
- High Fall Risk Signage and/or Yellow Dot

Interventions

If a patient scores positive for fall risk:

- Place yellow band on the patient’s wrist.
- Provide a yellow gown for the patient.
- High Fall Risk Sign or Yellow Dot on the door.
- Post the yellow High Fall Risk Intervention sign in the patient room.

Implement and document individualized fall risk interventions in patient’s Plan of Care.

Click here to view fall risk interventions for adult inpatients.
### Outpatient Fall Risk Assessment

#### Symptoms
- Unsteady on feet
- History of falls
- Age >65 years or <3
- Confused or disoriented

#### Fall Scale
- No risk
- Low risk if 1 circled above
- High risk if more than 1 circled above

#### Fall Intervention
(check all that apply):

**Low Risk**
- Side rails up
- Call light within reach
- Child with parent
- Bed in low position
- Non-skid slippers on

**High Risk**
- Side rails up
- Call light within reach
- Yellow band on with sticker on chart
- Child with parent
- Bed in low position
- Non-skid slippers on

#### Symbols

<table>
<thead>
<tr>
<th>??</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete Outpatient Fall Risk Assessment upon admission</td>
</tr>
<tr>
<td></td>
<td>If patient is at risk for a fall, initiate indicated Interventions per risk level</td>
</tr>
<tr>
<td></td>
<td>Document interventions in the nursing narrative notes</td>
</tr>
</tbody>
</table>
Cummings Pediatric Fall Scale

Pediatric Level of Mobility
- Not Mobile
- Ambulance
- Rolling or crawling
- Impaired mobility

History of Fall
- (0) No
- (1) Yes

Physical Alteration/Impairment
- (0) No
- (1) Yes

Functional Status
- (0) None, age appropriate
- (1) Weak
- (2) Injured
- (3) Devices or Orthostatic Hypotension

Equipment
- (0) No equipment
- (1) Yes

Cognitive/Psychological
- (0) None
- (1) Limited

Medications That Alter Equilibrium
- (0) None
- (1) Yes

Cummings Score

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Click here to view fall risk interventions for pediatric inpatients

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Patients are considered high fall risk if the score is 8 or greater

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Symbols

Humpty Dumpty

Interventions

If a patient has been identified as a High Fall Risk:
- Place yellow band on the patient
- Place Humpty Dumpty sticker on patient chart
- Post High Fall Risk Sign above patient bed

Complete Pediatric Fall Risk Assessment upon admission and daily.

Implement interventions that correspond to the identified risk factors.

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<table>
<thead>
<tr>
<th>Risk Level</th>
<th>PFAS Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Risk</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>Low Risk</td>
<td>1-7</td>
<td>Use treads, teach parents to raise side rails, or close isoles, when away from the patient's side. Implement frequent toileting and monitoring by staff, and clear patient environment of hazards/obstacles.</td>
</tr>
<tr>
<td>High Risk</td>
<td>8</td>
<td>All of the above plus apply &quot;fall risk&quot; band on the same limb as the name band, and family or staff to accompany patient with ambulation.</td>
</tr>
</tbody>
</table>

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Fall Prevention: Possible Interventions

Provide interventions based on patient’s specific fall risk factors.

Some interventions may include:
- Bed or chair alarm
- Room patient in high traffic area
- Educate patient and family
- Provide adequate lighting and sensory aids such as glasses
- Use assistive devices as needed during transfers and ambulation
- Encourage patient to rise slowly from sitting to standing position
- Use non-skid footwear

Patient safety and fall prevention depends on collaboration of ALL associates. It takes a team!

Click here to learn more!

It Takes a Team

- **If you hear an alarm:** Stop, look, and respond. Go to the room if necessary. If you are not a clinical person you will need to attempt to verbally redirect the patient to sit down or stay in bed. Push the nurse call button for help.

- **If you see someone in a yellow gown walking alone:** Stay with the patient and alert someone else to find help or clinical staff to assist the patient. Attempt to redirect the patient to their room.
It Takes a Team

- If you see someone in a yellow gown up in their room alone: Knock on door—avoid startling patient. Attempt to redirect them to sit or lay down. If you need help, raise your voice to get attention of the staff or turn on the call light. Stay with the patient until you get help.

- If you see a crib (pediatrics) with side rail down: push call light down to alert clinical staff—stay with the patient.

It Takes a Team

“I heard an alarm buzzing and didn’t see anyone around. I didn’t know what it was and was just passing through. My coworker told me later that it was probably a safety alarm for someone who might fall or be falling. I felt bad. I could have tried to help and will next time I hear an alarm”

Don’t wait until it is too late...
- Respond to alarms whether you are clinical or non-clinical staff
- Do not be afraid to approach a patient to help or redirect them
- Stay alert and aware of signs/gowns that indicate a patient is considered a fall risk
Monitoring Patient Falls

- Despite our best efforts, sometimes patients do fall
- It is important to identify the cause of these occurrences, adjust the plan of care, and take action to prevent them from occurring again.

So what do I do if my patient falls?

Monitoring Patient Falls

- Complete a Post-Fall Huddle
- Notify your immediate supervisor
- Complete an occurrence report using MIDAS Event Report system
- Occurrences are reviewed by Quality Services and the Fall Team for process improvement
  - You may be approached for further information regarding the patient fall
Summary

Remember...

Falls are very costly to the health and well-being of staff, patients, and visitors.
Falls can cause the need for extra services such as radiology or other needed medical assistance related to the injury.
This can affect the organizational cost related to time needed for staff to evaluate and treat the patient appropriately.

Our mission discusses the importance of promoting the well-being and dignity of the patients that entrust us with their care.

Be aware of your departmental goals and interventions to prevent falls.