Subject: Fall Prevention

Rationale: Staff will incorporate appropriate safety interventions, in the least restrictive environment, to help reduce the incidence of falls.

Scope: All clinical staff, Medical Staff

Definitions: Fall: any unplanned descent to the floor or next lower surface.

Assisted Fall: when a staff member minimizes the impact of the fall by easing the patient’s descent, or in some manner attempts to break the patient’s fall.

Near miss - a patient is in a situation at risk for fall, but fall did not occur, such as a bed rail left down, patient without safety belt, anti-tipper bars left up, safekeeper bed left unlocked. Patient transferring or ambulating without required assistance.

Equipment: None

POLICY: On admission, all traumatic brain injury and spinal cord injury patients are considered high risk for falls secondary to their diagnosis and injury level. Risk factors exhibited by patients may include: cognitive impairment including confusion/disorientation, impulsivity, and poor judgment, poor mobility/generalized weakness, medications, dizziness/vertigo, depression, and altered elimination. The Interdisciplinary Clinical Team will use their initial assessment to determine how to provide the safest environment for each patient. Safety interventions will be initiated as
needed for each patient. Continued assessment and monitoring will occur until the patient is no longer considered at increased risk for falls. Safety education is provided to patients, family and staff.

PROCEDURE:

I. Fall Prevention Assessment
   A. Nursing, Physical Therapy, Occupational Therapy, and Speech Pathology complete their portion of the Interdisciplinary assessment on admission.
      1. Nursing assessment is completed within 24 hours of admission and then every shift.
      2. Physical Therapy, Occupational Therapy, and Speech Pathology Interdisciplinary assessment is completed within 72 hours of admission.
   B. Physical Therapy assesses each patient for mobility/safety and completes the individualized transfer/mobility sheet within 72 hours of admission and updates weekly, or as needed. This transfer sheet is displayed in a prominent position in the patient’s room and bathroom.
   C. Brain injured patients are at risk for falls based on assessment of motor impairment, sensory impairment, cognitive status, history of falls, and/or use of ambulatory devices. Nursing assesses the need for safety devices/restraints per policy RI 40.
   D. All newly admitted patients utilize safety belts unless deemed safe for ambulation by initial physical therapy mobility/safety assessment. Staff or families should not remove the safety belt unless approved by the team and documented on the restraint form.
   E. All newly admitted patients using wheelchairs must have their anti-tip bars in the down position until cleared by their physical therapist.
   F. Patient ambulation is not permitted until cleared by the physical therapist.
   G. Ongoing assessments by nursing and therapies document changes in patient condition that could increase fall risk. Physical therapy updates the transfer status as needed. Updates print out on nurses’ Kardex and are posted in the room and bathroom.

II. Fall risk interventions include:
   A. Educate staff, patient, and family to increase awareness of patients at risk for falling during hospitalization and provide possible strategies to minimize the risks.
   B. RNs and techs will include specific information regarding patient safety for mobility and transfers in shift to shift handoff communication.
   C. For all patients, staff will be trained to prepare the environment prior to a transfer or mobility activity, and specifically, prior to removing a safety device/restraint from a wheelchair or a bed. Thus, staff will not need to take their hands or eyes from the patient to locate a needed item.
   D. If a restraint is ordered (per policy RI 40), nursing staff will have 2 people present for transfers.
E. On any shift, if the caregiver finds the patient needs more assistance than the transfer sheet indicates; the caregiver has the authority to alter the type of transfer to maintain safety and communicate this information on shift to shift report, document in Meditech under transfers, and communicate with the therapists.

F. Reduce environmental hazards.
   1. Beds shall be left in the low position, with side rails up, call light and bedside table within reach. After the bed is raised for nursing care or change of linens, it is returned to the low position/side rails up, unless patient status indicates otherwise.

G. Implement patient targeted interventions to reduce risk.

III. Immediate Post-Fall Actions
   A. After a fall, the RN should assess the patient.
   B. If the fall was unwitnessed or patient hit their head, a scoop board and collar should be used to transfer the patient to a stretcher.
   C. A call to the MD should always be made, regardless of whether the RN feels as though an MD assessment is warranted.
   D. Documentation related to assessment and monitoring that occurs after the fall should be completed in Meditech by the RN.

IV. Quality Improvement
   A. Any fall within the hospital is reported on the event report form per policy/procedure RI 24. Each fall incident is followed up with an action plan determined by the details of the fall.
   B. Falls and near falls are monitored on a continuous basis and tracked monthly as number of falls per thousand patient days. Inpatient fall data is submitted quarterly to the National Database of Nursing Quality Indicators (NDNQI) for benchmarking. Unassisted inpatient falls are reported to a Patient Safety Organization.
   C. All falls and near miss falls are reviewed monthly by the Environment of Care Committee to monitor fall rate and determine any trends requiring an action plan.

Reference:
