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. ASSISTED FALL – when a staff member minimizes the impact of the fall by easing the patient’s descent to the floor or in some manner attempting 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.

POLICY: On admission, all traumatic brain injury and spinal cord injury patients are considered at a high risk for falls secondary to their diagnosis and injury level. Risk factors exhibited by patients may include: cognitive impairment including confusion/disorientation and poor judgment, poor mobility/generalized weakness, medications, dizziness/vertigo, depression, and altered elimination. The Interdisciplinary 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 will 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.

B. Physical Therapy will assess each patient for mobility/safety and complete the individualized transfer/mobility sheet within 72 hours of admission and update weekly, or as needed. This transfer sheet will be 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. Need for safety devices/restraints will be assessed and implemented by nursing, per policy RI 40.

D. All newly admitted patients will 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 this has been approved by the team and documented on the restraint form.

E. All newly admitted patients using wheelchairs will have their anti-tip bars in the down position until cleared by physical therapist.

F. Patient ambulation is not permitted until cleared by the physical therapist.

G. Ongoing assessments by nursing and therapies will be completed with documentation of changes in patient condition or if a patient has fallen. As needed, the transfer status will be updated in Meditech by physical therapy, will print out on the Kardex, and be re-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 would not need to take their hands or eyes from the patient to locate a needed item.

D. If a restraint is order (per policy RI40), nursing staff will have 2 people present for transfers.

E. On any shift, if the caregiver finds that the patient needs more assistance than the transfer sheet indicates; the caregiver has 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. Beds shall be left in the low position, with side rails ups, call light and bedside table within reach. After the bed is raised for nursing care or change of linens, it should be returned to the low position/side rails up, unless patient status indicates otherwise.

G. Implement methods to compensate for functional limitations.

H. Implement patient targeted interventions to reduce risk.

III. Quality Improvement

A. Any fall within the hospital is reported on the Incident 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.

C. All falls and near falls are reviewed monthly by the Safety Committee to monitor fall rate and determine any trends requiring an action plan.

Reference: