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References:	
Applicability:	*WA - Kadlec Regional Medical Center*

Falls Prevention: Risk Assessment and Guidelines, 650.19.00

KADLEC REGIONAL MEDICAL CENTER

HOUSE-WIDE

POLICY AND PROCEDURES

Section: Patient Care Services

TITLE: Falls Prevention: Risk Assessment And Guidelines	**POLICY:** **PROCEDURE:** **GUIDELINE:X** **STANDARD:**	**NO.650.19.00**
Key Words: falls, risk assessment, ABCS	**EFFECTIVE DATE:**4/15	
ADMINISTRATIVE APPROVAL: Signed by Kirk Harper, COO/CNO	**SUPERSEDES:**8/11, 4/09, 3/08, 10/05, 1/03, 8/99	
COMMITTEE APPROVAL/REVIEW: Patient Care Services		
DEVELOPMENT TEAM/AUTHOR(S): Falls Committee		
AUDIT REVIEW: (By and Date)		

PURPOSE:

To identify patients at risk for falls and implement fall prevention measures in order to eliminate preventable injuries and death.

PROCEDURE:

All patients admitted to the hospital and outpatients that require a full admission assessment will have a fall risk and risk of injury assessment completed and documented in the electronic medical record. Outpatients will be observed for risk of falls. Fall Risk Assessment will be completed per department standards as listed in Table 1 and Table 2.

Table 1 – Risk Assessment Frequency

Unit / Department / Division	Frequency – Risk Assessment tools will be completed

Adult Inpatient - KMC IRF - KMC Surgical - KMC Acute Care Floor 6 - KMC Acute Care Floor 7 - KMC Acute Care Floor 8 - KMC Acute Care Floor 9 - KMC ICU - KMC Acute Care Floor 4	• On admission • Every shift • After a fall • Change/decline in condition
KMC MOTHER BABY, KMC LABOR & DELIVERY, KMC PERINATAL SPECIAL UNIT	• On admission for adults (If the patient's condition significantly changes; such as, excessive bleeding, or had a second procedure during their hospital stay ie: Post Partum Tubal Ligation, the fall risk assessment will be redone.)
KMC CDU/OPP	• When a full admission is completed for patients according to department standards.
KMC ED/FSED	• Patients presenting to the ED and FSED will have an appropriate age fall risk assessment completed. If the patient is identified as a medium or high fall risk or risk for injury, this information will be included in any hand off communication.
Pediatric Patients <18	• The Graf-Pif Pediatric Falls Assessment Scale is an evidence-based fall risk tool. It indicates the pediatric patient's (<18 years of age) likelihood of falling with both a numeric score and a risk level of high or low. • On admission • Parent education shall be done on admission.

Table 2 – Department That Do Not Use Risk Assessment Tools to Assess Fall Risk

Unit / Department / Division	**Assessment Methods Used to Assess High Fall Risk**
Outpatients - Lab - Diagnostic Imaging - Outpatient Specialty Clinics - Healthplex Services	All patients will be observed by staff for steadiness. If they appear to be unsteady on their feet or have a difficult time rising from a chair, assistance will be offered such as offering a wheel chair or lending an arm for support. Patients that have received narcotic pain medications, sedatives or anesthetics will be assisted when getting up until they are steady. If the patient is discharged and is still under the effects of medications that can contribute to a risk for a fall, the patient and the significant other will be educated on safety.

Patient's receiving epidural/Intrathecal narcotics or anesthetics.

All patients receiving epidural narcotics and anesthetics are considered at risk to fall because of decreased motor/neuro skills. The following precautions will be taken for any patient that has had an epidural injection or a continuous epidural drip with narcotics and or anesthetics in it.

- A staff member will assist the patient when getting out of bed or ambulating.
- Once an epidural drip is discontinued, a patient will be assisted with ambulation at least two times and until they are steady on their feet.

Post Sedation/Anesthesia

- Post sedation/anesthesia, a patient will be assisted with ambulation at least two times and until they are steady on their feet.

Fall Risk Assessment Scoring Tool:

KMC utilizes the Morse Falls Risk Scale to assess risk of fall. (Appendix A)

KMC utilizes the ABCS criteria to assess fall injury risk. (Appendix B)

INTERVENTIONS

Low Risk (Morse Score 0-24)

- **Basic Nursing Care/Injury Prevention Strategies**

- Maintain bed or gurney in a low, locked position with only the upper two side rails up on the bed
- For patients in treatment chairs, the wheels will be locked
- Orient to surroundings upon admission and as needed
- Monitor patient environment every patient encounter. Safe environment includes the following: room free of clutter, tissues, water, call light and telephone within reach of the patient, no tangled cords, and adequate lighting
- Offer bedpan, urinal, or assistance to the bathroom as needed and during rounding
- Provide non-skid slippers for patients without footwear.
- Rounding per standard
- Provide fall mats as appropriate
- Instruct patient to rise slowly from change of positions to avoid dizziness or loss of balance
- Assist the patient with early and regular ambulation
- Utilize the white board for communication of activity and assistance level.
- Communicate Fall Risk and Injury Risk as part of all hand off communication**.**
- Adequate night lighting

- **Medium Fall Risk Score (Morse Score 25-44)**

In addition to basic nursing care/injury prevention:

- Remove excess furniture and equipment from patient care area
- Access Exit side of bed and arrange furniture for clear pathway
- Utilize yellow socks and a yellow gown
- Mandatory gait belt when up with assistance
- Level of assistance at minimum STANDBY - (stay with in arms reach)
- Utilization of bed and chair alarms
- Place the patient close to the nurse's station, if possible
- Leave the patient's door open, if possible

- Assure that ambulatory aides are appropriate and utilized

High Fall Risk Score (Morse Score 45 or greater)

In addition to low and medium fall risk interventions:

- High Fall Risk sign posted on door frame and inside the room
- Consider PT evaluation
- Consider patient sitter or video monitoring as appropriate

High Risk for Injury (ABCS)

- High Risk for Injury sign posted on door frame (red border) and inside the room.
- Mandatory gait belt when up with assistance
- Utilize floor mats and other protective equipment when appropriate
- Toileting schedule
- Partial (hands on patient) or maximum assist (two person assist or a lift)
- Bed and chair alarms are on at all times
- If patient is a high falls risk and a high injury risk, increased observation is important. Place patient near the nurse's station, or in a camera room (see policy # 1012)

Use nursing judgment and critical thinking skills to occasionally override the results of the assessment scales. If a nurse believes that a patient is at risk for falling, appropriate interventions should be implemented regardless of the assessment results.

Consider increasing assessment level if two or more of the following medications are prescribed:

- Antihypertensives
- Diuretics
- Laxatives
- Narcotics
- Nitrates
- Sedatives
- Sleep Aids

Education

Education for patients and family.

- All patient/families receive fall prevention education on admission and document in the EMR.
- High Risk Falls/Injury including information on their Fall Risk, Risk of Injury, interventions and signage
- Instruct patient/family to call for assistance prior to patient getting up. Have patient/family return demonstration of call light use
- Instruct family about fall prevention and safe patient handling methods and alternatives. Instruct family, formal training is required before assisting with transfers/ambulation
- Instruct family to inform staff prior to leaving the patient bedside

Patient Falls Definition

A patient fall is a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or an object (e.g., trash can). NDNQI® counts only falls that occur on an eligible inpatient or ambulatory unit that reports falls. * When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to

find a patient, this is considered a fall. If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured.

When a fall occurs:

Follow post fall decision guidelines (Attachment 1)

Appendix A

Morse Fall Scale

Item	***Scale***	***Scoring***
1. History of falling	No/Non Ambulatory 0 Yes25	
2. Secondary diagnosis (More than one diagnosis)	No 0 Yes15	
3. Ambulatory aid Bed rest/nurse assist Crutches/cane/walker Furniture	 0 15 30	
4. IV/Heparin Lock	No 0 Yes 20	
5. Gait/Transferring: Normal/bedrest/immobile Weak Impaired	 0 10 20	
6. Mental status Oriented to own ability Forgets limitations	 0 15	

The items in the scale are scored as follows:

History of falling: This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

Secondary diagnosis: This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.

Ambulatory aids: This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.

Intravenous therapy: This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.

Gait: A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side,

and striding without hesitant. This gait scores 0. With a weak gait (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.

Mental status: When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the ambulatory order in the electronic medical record, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.

Scoring and Risk Level: The score is then tallied and recorded on the patient's chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

Sample Risk Level

Risk Level	MFS Score	Action
Low Risk	0 – 24	Basic Nursing Care
Medium Risk	25 – 44	Basic Nursing and Medium Risk Interventions
High Risk	≥ 45	Implement High Risk Fall Prevention Interventions

Appendix B

ABCS: Fall Injury Assessment Tool

A = Age > 80

B = Bone:

History of fractures- Hips (multiple fractures could be a sign)

Diagnosis of Bone Disease (osteoporosis, bone metastasis)

Treatment or medication that causes bone weakness (i.e. steroids)

C = Coagulation:

Blood Thinners (Coumadin, Pradaxa, Xarelto, Angiomax, Arixtra, Fragmin, Heparin gtt, assess lab results). (Elevated INR will increase risk of injury if a fall occurs).

Coagulopathy (Diagnosis of sickle cell, liver failure, low platelets, and etc. Assess diagnosis and use nursing judgment to score as appropriate if patient's labs may increase their risk for injury from a fall).

S - Risk of post-surgical complications:

If the patient had recent abdominal or thoracic surgery, lower limb amputation, and hip replacement. Assess diagnosis and use nursing judgment to assess their risk of injury from a fall.

Attachments

 Image 01

Approval Signatures

Approver	Date
Kirk Harper: CNO	11/2020
Heather Shipman: Executive Assistant	11/2020
Gretchen Eslick: Mgr Inpat Therapy Svcs	11/2020

Applicability

WA - Kadlec Regional Medical Center