

PARKLAND HEALTH & HOSPITAL SYSTEM
Nursing Services

Section: Safety/Comfort
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Page 1 of 4
Distribution: Nursing Procedure Manual

FALL PROTOCOL

PRACTICE

STATEMENT: Patients and/or families shall receive fall prevention education on admission to inpatient units.

Patients shall be assessed for fall risk upon admission to inpatient units.

Patients at risk for fall shall be placed on a fall protocol.

PURPOSE: To educate patients and families about fall risk.

To identify those patients who are at risk of falling.

To institute measures to prevent or reduce falls.

ATTACHMENTS: IH-IV-198 & S “Tips to Keep You From Falling” English & Spanish

Related

Procedures: Nursing [25-06](#), Behavioral and Clinical Restraints in the Acute Medical Surgical Settings

PROCEDURE:

A. Patient/family Education

1. Patients/families will receive basic fall prevention education on admission to inpatient units.
2. “Tips to Keep You from Falling” located inside the Patient Information Packet and other unit-specific teaching plans may be utilized for educating patients/families.
3. Education will be documented by checking the fall section of the “Interdisciplinary Discharge Planning and Education Record.”

B. Identification of Patients at Risk for Falling

Morse Fall Scale

Item	Scale	Scoring
1. History of falling; immediate or within 3 months	No 0 Yes 25	-----
2. Secondary diagnosis	No 0 Yes 15	-----
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/bed rest/immobile Weak Impaired	0 10 20	-----
6. Mental status Oriented to own ability Forgets limitations	0 15	-----

Definitions:

Secondary diagnosis: any additional diagnosis for which the patient is receiving treatment or medication.

Furniture: Any furnishing in the room such as bed, chair, bedside table, bedside commode etc that the patient may use to lean on to move from place to place.

Weak Gait: any impairment to strength.

Impaired Gait: any impairment to balance or mechanics

1. The RN shall assess the patient for the above risk factors on admission & every 8-12 hrs, total the points and document the score in the "Fall Risk" section of the "Patient Observation and Flow Sheet."
2. The RN shall indicate the completion of the assessment by initialing beside the identified risk factors in the "Fall Risk" section of the "Patient Observation and Flow Sheet" and signing in the required signature section on page 4.
3. If the patient has a risk score of 51 or greater and is not placed on the fall protocol, the RN will document the rational in the nurses' notes.
4. All ICU patients are considered as high risk for fall. See unit specific manual.

C. Initiation of "Fall Protocol"

1. When the Fall Protocol is initiated, the RN will enter a nursing diagnosis on the "Plan of Care Needs & Referral List."
2. A "Fall Precautions" armband will be placed on the patient, "Fall Precautions" sign mounted on the wall at the head of the bed, outside the door and a sticker on the front of the chart.
3. Patients on fall protocol will have rounds every hour to confirm:
 - a) Bed is in low position
 - b) Call light/Bell are in reach
 - c) Personal effects are in reach
 - d) Toileting offered if awake and allowed by treatment plan/condition
 - e) Fluids offered if awake and allowed by treatment plan/condition
 - f) Side rails are elevated as appropriate
4. Rounds will be documented by initialing the appropriate section of the "Daily Patient Care Record/Flow Sheet."
5. Patients on Fall Protocol will be reassessed by the RN a minimum of every 8 -12 hours to determine the need to remain on the Fall Protocol.
6. Fall reassessment will be documented by initialing beside the identified risk factors in the "Fall Risk" section of the "Patient Observation and Flow Sheet" and signing in the required signature section on page 4.
7. If a patient is on the Fall Protocol when transferred to another unit, the sending nurse will notify the receiving nurse of the Fall Protocol and rationale for use as part of "hand off communication."

D. Discontinuation of Fall Protocol

1. The fall protocol shall be discontinued when the patient's risk for fall score is less than 51 for more than 24 hours.
2. The discontinuation shall be indicated as follows:
 - Initial and date the "Date Resolved and Initial" box on the "Plan of Care/Patient Needs and Referral List."
 - Inform the Patient Care Assistant to discontinue the frequent observations of the patient and documentation on "Patient Care Record and Flow Sheet."

E. Fall Occurrence

1. If fall occurs, the following shall be initiated:
 - Assess patient and take actions to sustain and stabilize as indicated
 - Determine the reason for the fall and take action to prevent a reoccurrence
 - Notify the provider
 - Complete an online risk report through the Patient Safety Net. Include all known information about the reasons for the fall and indicate if the patient was on the fall protocol before falling and/or placed on the fall protocol after the fall.
 - Fall interview tool will be completed by the manager or designee if actual harm has occurred to the patient [Harm score of E and above]. The tool will be sent to the Performance Improvement department within 48hrs or next business day.
 - All events should be notified to the unit manager/designee. If injury occurs [Harm score E and above] Nursing Supervisor/ Director of Nursing should be notified.
 - Notify family of the fall.

Note: If the patient falls during the night and isn't injured, family notification may wait until morning.

F. Additional Safety Considerations

1. Orient patients and significant others thoroughly to the room, use of side rails, call lights, etc.
2. Reinforce with the patient/family the need to call for help before getting up.
3. Do not leave non co-operative high risk patients unattended. Enlist the aid of the patient's family when possible.
4. Consider moving fall protocol patients near the Nurses Station.
5. Keep patient's personal effect (fluids, telephone, call lights, etc.) within reach.
6. Ask patient for his or her need during hourly fall protocol rounds, when patient is awake.
7. Lock bed and wheelchair brakes.
8. Utilize the bed exit alarm if present.
9. Sit the patient on the side of the bed for few minutes before standing.
10. Allow the patient to use their walker or cane for ambulation and transfer.
11. Use proper body mechanics to protect yourself and the patient.
12. Get help if needed.