**PREVENTION OF PATIENT FALLS**

**POLICY:**

Falls can be a source of serious injuries to patients in an ambulatory setting. The patient fall risk assessment and accompanying measures are designed to prevent and /or reduce the number and severity of falls. The Center will take steps to reduce the number and severity of patient falls by assessing all patients upon admission and reassessing after a change in condition. Patients determined to be at risk for a fall will be placed on prevention precautions and those patients that do fall will be appropriately managed. All falls will be reported in the Risk Management incident reporting system.

**PURPOSE:**

* Establish a framework for assessing risk factors for patient falls and implementing intervention for reducing the risk for falling.
* Establish guidelines for the prevention of patient falls through assessment, ongoing communication, patient and family education, and appropriate interventions.
* Establish guidelines for staff to retain responsibility for patient safety at all times even if family is present.
* Establish guidelines to define action in the event of a fall and complete the required follow-up assessments and documentation.

**DEFINITION:**

**Fall** - a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

* **Unassisted Fall**: a fall during which the patient is **not** assisted down by a center employee or healthcare provider.
* **Assisted Fall**: a fall during which the patient **is** assisted down by a center employee or healthcare provider. (i.e. Physician, CRNA.)

**PROCEDURE:**

1. **Pre-Op Fall Risk Assessment**
   * Upon admission to the Center, a registered nurse will complete the pre-operative fall risk assessment and document risk level and related interventions, if any, in the medical record.
   * Fall prevention education will be conducted with patient and family/caregiver, if available and documented in the medical record.

The fall risk assessment tool is utilized to determine the patient’s fall risk as follows:

a. Patients who score 0-5 are considered Low Risk for falls

b. Patients who score 6-8 are considered Moderate Risk for falls

c. Patients who score 8-10 are considered High Risk for falls

The risk assessment includes such factors as fall history, impaired mobility, assistance device use, cognitive dysfunction, medication use, and sedation. Interventions are undertaken based of the risk assessment.

* Pre-operative Low to Moderate Risk Interventions:

1. Maintain unobstructed and clean pathways
2. Familiarize the patient to the environment
3. Keep floor surfaces clean and dry, with all spills cleaned up promptly
4. Ensure sturdy bathroom handrails are in place
5. Have the patient demonstrate call light use and maintain call light within reach
6. Keep bed in low position with the side rails up
7. Maintain stretcher brakes in the locked position
8. Provide adequate lighting
9. A registered nurse or center employee designee is available to assist the patient with transfers, toileting, ambulation, and changing

* Pre-Operative High-Risk Interventions:

1. Implement low and moderate risk Interventions with the exception of patient assistance
2. High-Risk patients scoring ≥ 8, or at the nurse’s discretion, have fall precautions initiated
3. A fall risk sticker is placed on the front of the patient's chart. Electronic medical records have an electronic notification entered into the patient’s chart (Center to Specify).
4. A yellow *Fall Precautions* armband is placed on the patient’s wrist
5. A registered nurse or designee **assists** the patient with transfers, toileting, ambulation, and changing
6. **Post-op Fall Risk Re-Assessment**
   * A registered nurse completes a post-op fall risk re-assessment to determine if a patient’s risk for a fall has increased due to changes in condition that include, but are not limited to sedation administration, general anesthesia, pain management procedure, or extremity procedure. The registered nurse documents the risk level and related interventions, if any, in the medical record.

* If a patient’s risk for fall has **increased,** then post-operative high-risk Interventions are implemented.
* If a patient’s risk for fall has not increased, then post-operative low to moderate risk Interventions are implemented.
  + Fall prevention education is conducted with patient and family/caregiver, if available, and documented in the medical record.
* Post-operative Low to Moderate Risk Interventions:

1. Maintaining unobstructed and clean pathways.
2. Familiarize the patient to the environment.
3. Floor surfaces clean and dry, with all spills cleaned up promptly.
4. Sturdy handrails in place in bathrooms.
5. Have the patient demonstrate call light use and maintain call light within reach.
6. Keeping bed in low position with the side rails up.
7. Stretcher brakes in the locked position.
8. Adequate lighting.
9. A registered nurse or center employee designee is available to assist the patient with transfers, toileting, ambulation, dressing, and discharge assistance.

* Post-Operative High-Risk Interventions:

1. Implement all clinically appropriate low and moderate risk interventions
2. A registered nurse or center employee designee assists the patient with transfers, toileting, ambulation, dressing, and discharge assistance
3. A registered nurse or center employee designee assists the patient upon discharge to their vehicle using a wheelchair or walking with the patient
4. **Ongoing Risk Assessment**

In additional to pre-op and post-op assessments, additional fall precautions may be added or discontinued based on patient condition

**D. Fall Risk Factor Communication**

1. Educate staff on fall prevention
2. Communicate patient’s fall risk during handoff
3. Communicate to patients and families:
4. Notify the patient and family that fall prevention measures are taken to maintain patient safety
5. Describe and educate the patient and family on the fall prevention program
6. Discuss patient home fall prevention and provide fall safety brochure to patient and family

**E. Post Fall Management**

1. Assess patient for signs of injury
2. Notify the physician for patient evaluation to determine extent of injury, if any
3. Re-establish safe conditions, if applicable (i.e. wet floor)
4. Document what occurred in the nurse’s progress notes including: patient appearance at time of discovery, patient response to event, evidence of injury, location, medical provider notification, medical/nursing actions
5. Notify the patient’s family
6. Complete Incident Report as soon as possible or at a minimum within three business days
7. For a fall with significant harm, immediately notify Center Leadership and Risk Management

**FALL PREVENTION PROGRAM EVALUATION:**

1. The QAPI Committee reviews incident report data related to falls on a quarterly basis, identifies trends, and approves/recommends any corrective action or prevention strategies to address the findings. In addition, the Committee makes recommendations for improvement of the falls prevention program.

**STAFF EDUCATION:**

1. Center employees are educated about the Fall Prevention Program during New Employee Orientation, annually, and with any policy changes or revisions.