Falls Policy

Overview

The following is a suggested falls prevention policy. It is not required to be implemented. There are several areas that need to be covered in a falls prevention policy:

I. Definition of a Fall

II. Fall Risk Assessment for Inpatients

III. Fall Risk Assessment for Outpatients

IV. Environmental Rounds

V. Responsibilities of Staff

VI. Intervention Strategies

VII. Post Fall Procedures/Management

VIII. Example Fall Prevention and Management Program Core Policy

I. Definition of a Fall

A **fall** is defined as 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.

A **near fall** is a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling.

An **un-witnessed fall** occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she got there.

II. Fall Risk Assessment for Inpatients

Patients should be assessed for their fall risk:

- On admission to the facility
- On any transfer from one unit to another within the facility
- Following any change of status
- Following a fall
- On a regular interval, such as monthly, biweekly or daily

Although there are many risk assessment tools available, NCPS recommends that you use either:

A. Morse Fall Risk Assessment *or*
B. Hendrich Fall Risk Assessment

A. Morse Fall Risk Assessment

This is one of the most widely used fall risk assessment scales available. It is a *reliable* and *valid* measure of fall risk.

Morse Fall Risk Assessment		
Risk Factor	**Scale**	**Score**
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / Walker	15
	None / Bed Rest / Wheel Chair / Nurse	0
IV / Heparin Lock	Yes	20
	No	0
Gait / Transferring	Impaired	20
	Weak	10
	Normal / Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

To obtain the Morse Fall Score add the score from each category.

Morse Fall Score*	
High Risk	45 and higher
Moderate Risk	25 - 44
Low Risk	0 - 24

* Based on most common scores used in VA

Note: Janice Morse recommends calibrating this high-risk score based on the patient population and acceptable fall rate. For more information see Janice Morse's book: *Preventing Patient Falls.*

The major advantages to this assessment are:

1. Research driven

2. Interventions are standardized by level of risk

The major disadvantages:

Not designed for the long term care setting, consequently nearly all patients will be at high risk

B. Hendrich Fall Risk Assessment

Some long-term and geriatric wards are using this scale.

Hendrich Fall Risk Assessment		
Risk Factor	**Scale**	**Score**
Recent History of Falls	Yes	7
	No	0
Altered Elimination (incontinence, nocturia, frequency)	Yes	3
	No	0
Confusion / Disorientation	Yes	3
	No	0
Depression	Yes	4
	No	0
Dizziness / Vertigo	Yes	3
	No	0
Poor Mobility / Generalized Weakness	Yes	2
	No	0
Poor Judgment (if not confused)	Yes	3
	No	0

The main advantages of this assessment are:

1. *Focuses interventions on specific areas of risk rather than general risk score.*
2. *Easy to determine if someone is high-risk because nearly every risk factor categorizes a patient as high-risk.*
3. *There are only two categories of patients: high-risk and low-risk.*

The main disadvantages of this assessment are:

1. *Not as researched as the Morse Fall Risk Assessment*
2. *Nearly every patient will be put into the high-risk category*

C. Comparing Morse and Hendrich Assessment

Some of the factors are the same between the Morse and Hendrich assessment.

Comparing the Morse & Hendrich Assessment			
Morse Fall Risk Assessment		**Hendrich Fall Risk Assessment**	
Risk Factor	**Score**	**Risk Factor**	**Score**
History of Falls	25	Recent History of Falls	7
Secondary Diagnosis	15	No Similar Risk Factor	
Ambulatory Aid	30 *or* 15	No Similar Risk Factor	
IV / Heparin Lock	20	No Similar Risk Factor	
Gait / Transferring	20 or 10	Poor Mobility / Generalized Weakness	3
Mental Status	15	Confusion / Disorientation or Poor Judgment	3
No Similar Risk Factor		Altered Elimination	3
No Similar Risk Factor		Dizziness / Vertigo	3

Both are good assessments depending on how you structure your program.

1. *Use the Morse Fall Risk Assessment if interventions are based on level of risk*
2. *Use the Hendrich Fall Risk Assessment if the interventions are based on area of risk*

Currently Janice Morse is working on interventions that will be tied to the areas of risks highlighted by her risk assessment scale.

Cautionary Notes

There are risks not captured by either risk assessment scale. For instance, although the Morse Fall Risk Assessment scale has a rating of 0 for patients who use wheel chairs, some facilities have found that these patients are at risk for falling. Wheelchairs can tip over backwards or can slide out from under a patient while transferring. Although these events can be easily addressed with the use of wheel chair anti-tip devices and self-locking brakes, it is important to keep track of data that could highlight other potential environmental risks at your facility which can be dealt with easily.

III. Fall Risk Assessment for Outpatients

Outpatient fall risk assessments can be done on two levels. The primary care provider can do an initial screening, then refer patients that are at risk to either physical or occupational therapy to perform a more in-depth balance assessment.

Initial Screening for Fall Risk

1. *Send the patient a "Self Report" and review at the appointment*
   a. If patient does not have a self report then go over it with them (be sure to annotate this in the notes section of the appointment)
   b. If several medications and supplements are listed, have a pharmacist review the medications and supplements for any drug interactions or side effects which could increase the likelihood of falls.
2. *Perform the* Timed Up & Go *test*[1]
   a. Place a chair against the wall or another sturdy object. Set up a cone or other visible marker 8 feet away for the patient to walk around. Tell the patient to get up and walk as quickly as they can around the object and sit back down.
   b. If the patient takes longer than 8.5 seconds they should be considered high risk and be referred to PT/OT for further evaluation.

   Note: Allow the patient to practice one time.

IV. Environmental Rounds

The facility management, nursing and biotech staff should perform environmental rounds.

A. Facility management staff confirm:

1. *Hallways and patient areas are well lit*
2. *Hallways and patient areas are uncluttered and free of spills*
3. *Locked doors are kept locked when unattended*
4. *Handrails are secure and unobstructed*
5. *Tables and chairs are sturdy*

B. Biotech staff confirm:

1. *All assistive devices are working properly by inspecting them on a regular basis*

C. Nursing Staff confirm:

1. Locked doors are kept locked when unattended

2. Patient rooms are set up in a way that minimizes the risk of falling (see High Fall-Risk Room Set-up in Intervention section)

D. Everyone confirms:

1. Unsafe situations are dealt with immediately either by dealing with the situation or notifying the appropriate staff and ensuring that they arrive and correct the situation.

V. Responsibilities of Staff

In this section, the responsibilities of the following staff are delineated:

A. Medical Center Director

B. Associate Chief Nursing Service/Chief Nurse Executive

C. Nurse Managers

D. Admissions Nurses

E. Staff and Contract Nurses Including RNs, LPNs and NAs

F. Physicians, Physician Assistants and APNs

G. Pharmacists

H. Physical and Occupational Therapists

I. Audiologists and Optometrists

J. Biomedical Technologists

K. Interdisciplinary Falls Team

L. Facility Management Staff

M. Education Service

A. Medical Center Director

The **Medical Center Director** is responsible for ensuring that falls and fall-related injury prevention is:

1. A high priority at the facility

2. Promoted across the facility through direct care, administrative and logistical staff

3. Adequately funded to provide a safe environment for patients and staff

B. Associate Chief Nursing Service/Chief Nurse Executive:

The **Associate Chief Nursing Service/Chief Nurse Executive/Designee** is responsible for:

1. Establishing population-based fall risk levels/units/programs

2. Deploying evidence-based standards of practice

3. Overseeing the policy within the VAMC

C. Nurse Managers

The **Nurse Managers** are responsible for:

1. Making fall and fall-related injury prevention a standard of care

2. Enforcing the responsibilities of the staff nurses to comply with interventions

3. Ensuring equipment on the unit is working properly and receiving scheduled maintenance. This is done in collaboration with facility equipment experts

4. Ensuring that all nursing staff receive education about the falls prevention program at the facility and understand the importance of complying with the interventions

D. Admissions Nurses

The **admissions nurses** are responsible for:

1. Completing the fall-risk assessment on admission

2. Notifying the unit of any patients assessed as high-risk

3. Following any procedure for high fall-risk admissions, such as a specific color arm band, ensuring the bed assigned is close to the nursing station, ensuring there is a high fall-risk magnet by bed, etc.

E. Staff and Contract Nurses Including RNs, LPNs and NAs

Staff Nurses including **RNs**, **LPNs** and **NAs** are responsible for:

1. Ensuring compliance of fall and fall-related injury interventions

2. Completing fall-risk assessments on transfers, following a change in

status, following a fall and at a regular interval and ensuring procedures for high fall-risk patients are in use

3. *Ensuring that rooms with high fall-risk patients are assessed and corrected if necessary*

F. Physicians, Physician Assistants and APNs

Physicians, **physician assistants** and **APNs** are responsible for:

1. *Identifying and implementing medical interventions to reduce fall and fall-related injury risk*
2. *Taking into consideration the recommendations of pharmacists regarding medications that increase the likelihood of falls*
3. *Ensuring all patients are screened for risk factors for osteoporosis and tested if necessary*
4. *Screening patients for fall-risk using the patient's self-report and the* Timed Up & Go *test (Outpatient Areas)*
5. *Referring patients who are screened high-risk to a pharmacist to review the medication and to physical or occupational therapy to conduct a more thorough assessment of fall risk (Outpatient Areas)*

G. Pharmacists

Pharmacists are responsible for:

1. *Reviewing medications and supplements to ensure that the risk of falls is reduced*
2. *Notifying the physician and clearing medications with the physician if a drug interaction or medication level increases the likelihood of falls*
3. *Asking outpatients to list their medications and supplements again and verify the medications and supplements with the list provided by the physician and against the patient record*

H. Physical and Occupational Therapists

Physical and **occupational therapists** are responsible for:

1. *Conducting balance assessments for all high fall-risk patient referrals*
2. *Developing an intervention program for patients to reduce their fall-risk*

I. Audiologists and Optometrists

Audiologists and **optometrists** are responsible for performing annual assessments on patient's vision and hearing to reduce the risk of falls.

J. Biomedical Technologists

Biomedical technologists are responsible for ensuring that:

Assistive equipment, such as wheelchairs, walkers and canes are checked regularly and equipped with devices to prevent falls

K. Interdisciplinary Falls Team

The **interdisciplinary falls team** is responsible for:

1. *Collecting data to ensure that fall and fall-related injury prevention strategies are effective*
2. *Conducting case-by-case reviews for all falls to ensure that medications are reviewed and prevention measures are recommended*
3. *Providing assistance to interdisciplinary treatment teams when requested to recommend prevention strategies for a patient*
4. *Participating in the Quarterly Falls Aggregate Review*

L. Facility Management Staff

The **facility management staff** are responsible for:

Ensuring a safe environment of care by conducting environmental assessments

M. Education Service

The **education service** is responsible for:

1. *Developing an education program about falls for* ***all*** *staff*
2. *Developing competencies for nursing staff about the falls prevention program*

VI. Intervention Strategies

Intervention strategies can be based on level of risk and/or area of risk. It is helpful to provide the available strategies in the policy. To get more information on the strategies see the section entitled Interventions.

Intervention Strategies									
Intervention	Level of Risk			Area of Risk					
	High	Med	Low	Frequent Falls	Altered Elimination	Muscle Weakness	Mobility Problems	Multiple Medications	Depression
Low beds	X	X	X	X	X	X	X	X	X
Non-slip grip footwear	X	X	X	X	X	X	X	X	X
Assign patient to bed that allows patient to exit toward stronger side	X	X	X	X	X	X	X	X	X
Lock movable transfer equip-ment prior to transfer	X	X	X	X	X	X	X	X	X
Individualize equipment to patient needs	X	X	X	X	X	X	X	X	X
High risk fall room setup	X	X		X	X	X	X	X	X
Non-skid floor mat	X	X		X	X	X	X	X	X
Medication review	X	X		X	X	X	X	X	X
Exercise program	X	X		X	X	X	X	X	X
Toileting worksheet	X	X			X				
Color armband / Falling Star etc	X			X	X	X	X	X	X
Perimeter mattress	X			X	X	X	X		
Hip protectors	X			X		X	X		
Bed/chair alarms	X			X		X	X		
Note: this list is not all-inclusive, nor is it required to be used. Facilities should use their best judgement in implementing recommendations.									

VII. Post Fall Procedures/Management

There are two key elements of the post fall procedures/management:

A. Initial post-fall assessment

B. Documentation and follow-up

A. Initial Post Fall Assessment

First priority is to assess the patient for any obvious injuries and find out what happened. The information needed is:

1. Date/time of fall

2. Patient's description of fall (if possible)

a. What was patient trying to accomplish at the time of the fall?

b. Where was the patient at the time of the fall (patient room, bathroom, common room, hallway etc.)?

3. Family/guardian and provider notification

4. Vital signs (temperature, pulse, respiration, blood pressure, orthostatic pulse and blood pressure — lying, sitting and standing)

5. Current medications (were all medications given, was a medication given twice?)

6. Patient assessment

a. Injury

b. Probable cause of fall

c. Comorbid conditions (e.g., dementia, heart disease, neuropathy, etc.)

d. Risk factors (e.g., gait/balance disorders, weakness)

e. Morse/Hendrich Risk Assessment

7. Other factors:

a. Patient using a mobility aid? If so, what was it?

b. Wearing correct footwear?

c. Clothing dragging on floor?

d. Sensory aids (glasses, hearing aids, was veteran using at the time?)

e. Environment

i. Bed in high or low position?

ii. Bed wheels locked?

iii. Wheelchair locked?

iv. Floor wet?

v. Lighting appropriate?

vi. Call light within reach?

vii. Bedside table within reach?

viii. Area clear of clutter and other items?

ix. Siderails in use? If so, how many? How many are on the bed?

f. Was the treatment intervention plan being followed? If not, why not?

g. Were the falls team and other nurses on the unit notified?

B. Documentation and Follow-up

Following the post-fall assessment and any immediate measure to protect the patient:

1. *An incident report should be completed (see the Example Fall Prevention Policy, Attachment G, p. 51-54)*
2. *A detailed progress note should be entered into the patient's record including the results of the post-fall assessment*
3. *Refer the patient for further evaluation by physician to ensure other serious injuries have not occurred*
4. *Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate*
5. *Communicate to all shifts that the patient has fallen and is at risk to fall again*

[1] Rikli, RZ, Jones, CH. Senior Fitness Test Manual. Human Kinetics Publishers: Champaign, IL; 2001. *http://www.humankinetics.com*

Note: This is only an example policy. This policy should be modified as appropriate to your clinical setting and available resources.

VIII. Example Fall Prevention and Management Program Core Policy

A. Purpose: To establish national policy, assign responsibility and provide procedure for residents/clients at risk for falls; to systematically assess fall risk factors; provide guidelines for fall and repeat fall preventive interventions; and outline procedures for documentation and communication procedures.

B. Policy: Upon admission residents/clients are assured of assessment of their risk for falls; manipulation of the environment to prevent falls; and appropriate management of those who experience a fall.

Suggested Definition of a 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.

C. Delegation of Authority and Responsibility:

1. *The Associate Chief Nursing Service/Chief Nurse Executive/Designee is responsible for establishing population-based fall risk levels/units/programs, deploying evidenced-based standards of practice, and oversight of this policy within VAMCs.*
2. *The Nurse Manager or First Line Nursing Supervisor is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with facility equipment experts to aid in fall prevention (**See Attachment A, Equipment Safety Checklist**)*
3. *Registered Nurses are responsible for implementation and oversight of individualized residents/clients fall prevention care as follows:*
    a. Assessing fall risk upon admission using a valid/reliable assessment tool, such as the Morse Fall Scale, **Attachment B, "Morse Fall Scale"**;

    b. Determining risk for fall and establishing appropriate prioritized patient need / nursing diagnosis related to fall risk in the patient plan of care;

    c. Reassessing residents/clients for change in fall risks when the patient is transferred, a change in condition occurs or following a fall episode using the Morse Fall Scale;

    d. Implementing the **Fall Prevention and Management Interventions (Attachment C)** specific to determine fall risk level; and implementing the **Core Fall Prevention Standard (Attachment D)** for residents assessed at risk for falls;

    e. Supervising ancillary personnel in delivering safe and personalized care;

    f. Evaluating residents/clients to the plan of care;

g. Collaborating with the interdisciplinary team in the prevention of falls;

h. Appropriately managing residents/clients who experience a fall by completing **Post-Fall Management, Attachment E**.

4. Members of the interdisciplinary team are responsible for assessing, treating, and implementing strategies for the prevention of resident/client falls. Rehabilitation staff will provide assessment for assistive devices and need for gait training.

5. Environmental Management Service and Engineering staff will assure environment is safe according to EMS standards.

6. All staff are responsible for implementing the intent and directives contained within this policy, and creating a safe environment of care.

7. Residents/clients and/or significant others are responsible for actively participating in their fall prevention and management program.

D. **Procedure**:

1. Fall Risk - Individual Patient:

a. Upon admission, a registered nurse will assess each resident/client for risk for falls using a valid and reliable instrument, such as the Morse Fall Scale (or Hendrich's Fall Scale). If determined to be at risk for falling, the resident's interim and/or interdisciplinary care plan will identify him/her as at risk for fall based on level of risk, and all members of the interdisciplinary team will be notified.

b. Each resident/client will be assessed by physician/nurse practitioner/ physician assistant/ and/or clinical pharmacist for medications that contribute to fall risk.

c. PM and RS staff will complete further assessment of fall risk factors for residents/clients determined at risk for falls or repeat fall.

2. Fall Risk - Unit Level:

a. Each unit will determine their fall risk scores to set parameters for low, moderate and high fall-risk scores / ranges.

b. These levels will guide correct selection and implementation of fall risk reduction interventions.

c. Unit level risk scores will be re-evaluated / validated / modified annually.

3. Prevention Interventions/Strategies:

a. Environmental Safety — All staff will implement interventions to create a safe environment. **(Environmental Rounds Attachment F)**

b. **Nursing Service Fall Prevention Standard** will be implemented by the Registered Nurse. **(Attachment D)**

c. Medication adjustments will be implemented to reduce medication-related fall-risk factors.

d. Interim and/or interdisciplinary care plans will initiate the **Fall Prevention and Management Interventions (Attachment C)**.

4. Post Fall Management:

a. The Registered Nurse will complete resident/client post fall assessment and notify the physician **(Section B. of the Fall Incident Report Form, Attachment G).**

b. Residents/Clients experiencing a fall will be managed according to protocol **(Post-Fall Management, Attachment E)**.

c. If fall-related injury is suspected or occurs, the physician will complete post fall assessment and initiate further diagnostic orders.

d. The registered nurse will initiate referral to the Fall Response /Interdisciplinary Team if appropriate (**Suggested Membership for Fall Response Team, Attachment H**).

i. Fall Response Team will:

- Assess all factors contributing to the fall event such as environment, equipment, medication factors and which interventions were in place at the time of the fall using Fall Prevention and Management Interventions (**Attachment C**) as a guideline.
- Recommend interventions and changes to plan of care to prevent repeat falls.
- Communicate and document results of referral.
- Meet on a regular basis to evaluate the fall prevention program and recommend improvements to the program.

5. Communication/Documentation:

a. A Fall Incident Report Form (**Attachment G**) will be completed for each resident/client fall episode.

b. The medical record will be completed to include: patient appearance at time of discovery, patient response to event, evidence of injury, location, medical provider notification, medical/nursing actions.*

c. Staff will complete a Fall Hazard/Near Miss Report Form (**Attachment I**) when they identify and take corrective action to prevent falls. Staff will be recognized for contributions to fall hazard prevention.

6. Program Evaluation:

a. The facility will complete a fall aggregated review every 6 months according to the National Center for Patient Safety (NCPS) Handbook**and related updates.

b. An individual Root Cause Analysis (RCA) will be completed for any falls that are an actual Safety Assessment Code (SAC) 3.**

c. Reported falls will be entered into the SPOT database as indicated by NCPS guidelines.

**VHA National Center for Patient Safety. Patient Personal Freedoms and Security. Fall Prevention and Management. October 2001. http://www.patientsafety.gov/FallPrev/howtostart.html*

***VA National Center for Patient Safety (NCPS) (2002, January 30). VHA National Patient Safety Improvement Handbook (1050.1): Veterans Health Administration. Access at: http://vaww.va.gov/publ/direc/health/handbook/1051-1hk1-30-02.pdf*

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Attachment A

Equipment Safety Checklist

Item	Component	Check	
Wheelchairs			
	Brakes	Secures chair when applied	_____
	Arm Rest	Detaches easily for transfers	_____
	Leg Rest	Adjusts easily	_____
	Foot Pedals	Fold easily so that patient may stand	_____
	Wheels	Are not bent or warped	_____
	Anti-tip devices	Installed, placed in proper position	_____
Electric Wheelchairs/Scooters			
	Speed	Set at the lowest setting	_____
	Horn	Works properly	_____
	Electrical	Wires are not exposed	_____
Beds			
	Side Rails	Raise and lower easily	_____
		Secure when up	_____
		Used for mobility purposes only	_____
	Wheels	Roll/turn easily, do not stick	_____
	Brakes	Secures the bed firmly when applied	_____
	Mechanics	Height adjusts easily (if applicable)	_____
	Transfer Bars	Sturdy, attached properly	_____
	Over-bed Table	Wheels firmly locked	_____
		Positioned on wall-side of bed	_____
IV Poles/Stands			
	Pole	Raises/lowers easily	_____
	Wheels	Rolls easily and turns freely, do not stick	_____
	Stand	Stable, does not tip easily (should be five point base)	_____
Footstools			
	Legs	Rubber skid protectors on all feet	_____
		Steady — does not rock	_____
	Top	Non-skid surface	_____
Call Bells/Lights			
	Operational	Outside door light	_____
		Sounds at nursing station	_____
		Room number appears on the monitor	_____
		Intercom	_____
		Room panel signals	_____
	Accessible	Accessible in bathroom	_____
		Within reach while patient is in bed	_____
Walkers/Canes			
	Secure	Rubber tips in good condition	_____
		Unit is stable	_____
Commode			
	Wheels	Roll/turn easily, do not stick	_____
		Are weighted and not “top heavy” when a patient is sitting on it	_____
	Brakes	Secure commode when applied	_____
Geri/Broda Chairs			
	Chair	Located on level surface to minimize risk of tipping	_____
	Wheels	Roll/turn easily, do not stick	_____
	Breaks	Applied when chair is stationary	_____
		Secure chair firmly when applied	_____
	Footplate	Removed when chair is placed in a non-tilt or non-reclined position	_____
		Removed during transfers	_____
	Positioning	Chair is positioned in proper amount of tilt to prevent sliding or falling forward	_____
	Tray	Secure	_____

References: Morse, J. 1997. Preventing patient falls. Thousand Oaks, CA: Sage
Broda. 1999. Safety Operating Instructions

Attachment B

Morse Fall Scale*

Variables		Score	
History of Falling	no yes	0 25	______
Secondary Diagnosis	no yes	0 15	______
Ambulatory Aid	None/bed rest /nurse assist Crutches/cane/ walker Furniture	0 15 30	______
IV or IV access	no yes	0 20	______
Gait	Normal/bed rest/ wheelchair Weak Impaired	0 10 20	______
Mental status	Knows own limits Overestimates or forgets limits	0 15	______
		Total	______

Immediate or within 3 months.

Patients are designated at risk for fall if the MFS score is greater than _____. (Determine high risk score for your unit. See pages 43-44, Morse, J. M. (1997).

* Morse, J.M. (1997). *Preventing patient falls*. Thousand Oaks, Sage Publications.

Attachment C

Fall Prevention and Management Interventions

Note: Include any interventions that you have available.

1. Orient patient to surroundings and assigned staff.
2. Lighting adequate to provide safe ambulation.
3. Non-slip footwear
4. Instruct to call for help before getting out of bed.
5. Demonstrate nurses' call system.
6. Call bell within reach, visible and patient informed of the location and use
7. Light cord within reach, visible and patient informed of the location and use
8. Consider use of sitters for cognitively impaired
9. Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unnecessary equipment).
10. Personal care items within arm length
11. Bed in lowest position with wheels locked
12. Ambulate as early and frequently as appropriate for the patient's condition.
13. Educate and supply patient and family with fall prevention information.
14. Identify patient with a colored wrist band.
15. Place a colored star outside of patient's room.
16. Place a colored star over patient's bed.
17. Every 3-hour comfort and toileting rounds
18. Every 2-hour comfort and toileting rounds
19. Every 1-hour comfort and toileting rounds
20. Comfort rounds include positioning as indicated; offering fluids, snacks when appropriate and ensuring patient is warm and dry.
21. PT consult is suggested to PCP.
22. Consult with the falls workgroup and pharmacy.
23. Bed alarm
24. Wheelchair alarm
25. Room placement closer to nurses' station
26. Bedside mat
27. Hill-rom low bed
28. Evaluation by the interdisciplinary team.
29. For risk of head injury consider consult for PT for consideration of a helmet (those at risk of head injury are patients on anticoagulants, patients with severe seizure

disorder and patient mechanism of fall is by history to fall hitting head).

30. Elevated toilet seat
31. Assign bed that enables patient to exit towards stronger side whenever possible.
32. Relaxation tapes/music
33. Diversional activities
34. Exercise program
35. Transfer towards stronger side.
36. Actively engage patient and family in all aspects of the fall prevention program.
37. Instruct patient in all activities prior to initiating.
38. Individualize equipment specific to patient needs.
39. Minimize distractions.
40. Check tips of canes, walkers and crutches for non-skid covers.
41. Instruct patient in use of grab bars.
42. Medications reviewed.

Attachment D

Nursing Service Fall Prevention Standard

STANDARD: Patients are designated at risk for fall if the MFS score is greater than ___ (Determine high risk score for your unit, See pages 43-44, Morse, J. M. [1997]. Preventing Patient Falls. Thousand Oaks, Sage Publications.)

A. All Patients/Residents

1. Assess and document patient's fall risk upon admission, change in status or transfer to another unit.
2. Assign the patient to a bed that enables the patient to exit towards his/her stronger side when ever possible.
3. Assess the patient's coordination and balance before assisting with transfer and mobility activities.
4. Implement bowel and bladder programs to decrease urgency and incontinence.
5. Use treaded socks and/or non-skid footwear.
6. Approach patient toward unaffected side to maximize participation in care.
7. Transfer patient towards stronger side.
8. Actively engage patient and family in all aspects of fall prevention program.
9. Instruct patient in all activities prior to initiating.
10. Teach patient use of grab bars.
11. Instruct patient in medication time/dose, side effects, and interactions with food/medications.
12. Instruct the patient to call for help before getting out of bed. Demonstrate nurse's call system.
13. Orient the patient to the environment, especially the location of the bathroom.
14. Lock all movable equipment before transferring patients.
15. Individualize equipment specific to patient's needs.
16. Place an "at risk" indicator on the chart, outside the room and at the bedside.
17. Place patient care articles within reach.
18. Provide physically safe environment (eliminate spills, clutter, electrical cords, and unnecessary equipment).
19. Provide adequate lighting.

B. Patients/Residents using Ambulatory Aids

1. Assist the patient with ambulating with assistive device.
2. Check tip of canes, crutches and walkers for non-skid covers.
3. Instruct the patient to request assistance with ambulation.

C. Patients/Residents with Gait and Transferring Difficulty

1. The patient is to ambulate with assistive devices (if applicable).

2. Rehab team (PT and OT) is to make recommendations for the safest type of transfer, i.e., toward the stronger side, use transfer belt, etc.

D. Patients/ Residents with Mental Status Changes

1. Instruct the patient not to get up without help, reinforce every shift and with each transfer.
2. Minimize distractions.
3. Observe activity every hour, or more often if indicated.
4. Use bed and wheelchair alarms when indicated.
5. Repeatedly reinforce activity limits and safety needs to the patient and family.

E. Patients with a History of a Fall During this Admission

1. Assess etiology of the fall.
2. Increase frequency of observation to every hour.
3. Initiate corrective action(s).
4. Consider referral to Falls Clinic or Falls Workgroup.

Attachment E

Post-Fall Management

Residents/Clients Experiencing a Fall with
- No loss of consciousness
- No injuries to exceed minor hematomas and lacerations

A. **No Head Trauma**
1. Determine vital signs to include sitting/standing blood pressure (manual cuff) and pulse.
2. If diabetic, check blood glucose.
3. Determine circumstances leading to the fall with corrections.
4. For the 48 hours following the fall:
    a. Obtain vital signs every 8 hours
    b. Observe for possible injuries not evident at the time of the fall (limb reflex, joint range of motion, weight bearing, etc.)
    c. Mental status changes
    d. If restrictions in mobility appear warranted due to the fall
5. All falls will be reported to the attending physician or nurse practitioner on the day of the fall.

B. **Minor Head Trauma**
1. Use the same protocol outlined above and, in addition, perform neuro checks every two hours for the first 12 hours, every three hours for the next 24 hours, and every four hours for the following 24 hours. Alert the attending physician for any changes.
2. Alert attending physician for all falls with head trauma in residents receiving anticoagulants.

Additional Measures:

- Complete incident report
- Detailed progress note
- Review fall prevention interventions and modify plan of care as indicated
- Communicate to all shifts that patient has fallen and is at risk to fall
- Consult Fall Response Team for additional suggestions for changes to plan of care

Attachment F

Environmental Rounds

Area:

Location:

Date:

Reviewer:

	YES	No*	NA
Exit signs exist and are visible			
Are hallways and corridors clear of obstacles			
Furniture and equipment is sturdy and wheels are locked			
Furniture and equipment is suitable for the specific needs of the unit			
Chairs, gerichair, wheelchairs are suitable			
Commode/seat lifts are properly installed (not loose)			
Door handles are secure			
Handrails in halls present, accessible and properly secured to wall			
All lights are working properly and areas are well lit			
Floor is clean and dry			
Floor is clear of personal items			
Flooring is level and free of tripping hazards, such as broken tiles or thresholds that are above the level of the floor			
Call bell/light within reach			
Bed in low position			
Bedside table within reach			
Water within reach			
Light within reach			
Room furniture arranged to allow patient space when walking and grab bars/hand rails are accessible			
Is there a 2 foot wide path for the patient to walk in or use w/c			
Door to bed			
Bed to commode			
Bed to chair			
Chair to commode			
Does patient have footwear present			
Patients clothing does not drag on the floor			
Do slippers have non-slip soles			
Are there grab bars next to the toilet			
Is the toilet seat at a height that allows easy transfer			
Is there a night light in the bathroom			
Other			

ANY IMMEDIATE SAFETY ISSUES NOTIFY PROPER SERVICE IMMEDIATELY

Notes:

Attachment G:

FALL INCIDENT REPORT

(Confidential in accordance with Title 38 U.S.C. 5705) ***DO NOT INCLUDE THIS FORM IN THE PATIENT'S MEDICAL RECORD***

SECTION A: To be completed by clinical staff

Location at time of fall (ward, clinic, service, etc.): ______________ ☐ Inpatient ☐ Outpatient

Date of fall: Time of fall(military):

Name of Physician/ARNP/PA notified:

For inpatients, Date admitted/transferred to this ward:

Description of the event, including any obvious fall-related injuries (e.g., head trauma, change in ROM, pain, bruises, lacerations) and describe what was patient doing or trying to do that may have contributed to the fall:

☐ Found on floor ☐ Staff lowered patient to floor ☐ Patient lowered self to floor

Was next of kin notified? ☐ Yes ☐ No (If no why not?)

Contributory Factors (check all that apply):

Mobility:
- ☐ Up ad lib
- ☐ Wheelchair
- ☐ Ambulate with assistance
- ☐ Restraints
- ☐ Bed rest
- ☐ Ambulate with wheelchair
- ☐ Ambulate with walker
- ☐ Other ______________

Cognitive & Functional factors:
- ☐ Incontinent (circle appropriate choice(s): bowel or bladder)
- ☐ Confused/memory impaired
- ☐ Altered gait/balance
- ☐ Altered ADL

Environmental/Equipment (check all that apply):
- ☐ Floor wet ☐ Lighting poor ☐ Needed item out of reach ☐ Cluttered area ☐ Foot wear
- ☐ Bed side rails (circle appropriate choice(s): all up or down 1 up (left right) top half up (left right) bottom half up (left right)
- ☐ Equipment faulty:
  - ☐ Shower chair/commode chair ☐ Cane ☐ Walker ☐ Wheelchair ☐ Unavailable grab bars
  - ☐ Stretcher ☐ Bed ☐ Other, please specify ______________

Assistive Devices:
- ☐ Assistive Devices involved in fall? ☐ No ☐ Yes

If Yes, please complete the following:
- ☐ Assistive device(s) not appropriate?
- ☐ Needed transfer/mobility equipment NOT within reach?
- ☐ Other, please specify: ______________
- ☐ No documentation of patient education in proper use?
- ☐ Equipment not correctly or safely used by patient?

Preventive Measures prior to incident (check all that apply):
- ☐ Interdisciplinary Fall Prevention Care Plan implemented & communicated to entire team
- ☐ Increase level of observation
- ☐ Patient close to nurses' station
- ☐ Call light/bell in reach
- ☐ Patient/family involved in care plan
- ☐ Fall Alert Identifier (e.g., green armband, signage, computer alert)
- ☐ Motion alarm
- ☐ Gait/Safety training

Witnessed/Reported by: Name: **Position/Title:**

Report prepared by: **Title:**

ADDRESSOGRAPH

SECTION B: To be completed by nurse

MORSE FALL SCALE *CHOOSE HIGHEST APPLICABLE SCORE FROM EACH CATEGORY*		**Circle all that apply at the time of this fall**
HISTORY OF FALLING	**NO**	0
	YES	25
SECONDARY DIAGNOSIS (more than one diagnosis)	No	0
	Yes	15
AMBULATORY AID	None, on bedrest, uses W/C, or nurse assists	0
	Crutches, cane(s), walker	15
	Furniture	30
IV/HEPARIN LOCK OR SALINE PIID	No	0
	Yes	20
GAIT/TRANSFERRING	Normal, on bedrest, immobile	0
	Weak (uses touch for balance)	10
	Impaired (unsteady, difficulty rising to stand)	20
MENTAL STATUS	Oriented to own ability	0
	Forgets limitation	15
Total Morse Fall Scale score at the time of fall (High Risk >50)		

Date of last fall assessment: **Morse Fall Scale score at last assessment:**

Nursing physical assessment and examination findings (if not completed in Section A):

Date: **Signature and Title:**

SECTION C: To be completed by Nurse Manager/Supervisor (check all that apply)

- ☐ Patient was not assessed for fall risk prior to falling
- ☐ Equipment was used incorrectly by: ☐ Patient ☐ Staff
- ☐ Staff needs education on the fall prevention protocol
- ☐ Restraints use was not monitored and documented
- ☐ Staff lack or misinterpreted information regarding patient care needs
- ☐ Staff distracted/interrupted
- ☐ Patient condition was not documented and communicated to staff
- ☐ Patient care environment/equipment unsafe or contributory to fall
- ☐ Maintenance program for involved equipment was not current
- ☐ Workload was a factor If yes, complete the following:
  - ☐ Unit/area extremely busy
  - ☐ Some staff worked overtime
  - ☐ Float staff
  - ☐ Change of shift
  - ☐ Actual staff/patient ratio at time of fall ______

Corrective/Preventive measures taken to reduce risk of reoccurrence post fall:

- ☐ Patient/family education
- ☐ Nursing Care Plan revised
- ☐ Rehab Consultation
- ☐ Patient placed in rehab program. Specify type ______
- ☐ Staff education
- ☐ Staffing adjusted
- ☐ Biomedical Engineering notified
- ☐ Equipment replaced/repaired
- ☐ Enhanced safety observation
- ☐ SPD notified
- ☐ Fall prevention team notified

Date: **Signature and Title:**

SECTION D: To be completed by physician or individual, e.g. ARNP or PA with appropriate credentials

Physical Assessment and Examination findings:

- ☐ Rash/erythemia
- ☐ ROM impairment
- ☐ Change in LOC
- ☐ Change in mental status:
- ☐ Bruise(s) ____________________
- ☐ Pain ____________________
- ☐ Minor abrasion (s)____________________
- ☐ Bleeding ____________________
- ☐ Laceration (s) ____________________
- ☐ Fracture (s)____________________

Injury from fall:

☐ **No Injury** ☐ **Minor Injury** ☐ **Major Injury** ☐ **Death**

Post Fall Plan of Care:

- ☐ No follow-up indicated
- ☐ Keep under observation
- ☐ First aid given
- ☐ Pain Management
- ☐ Other____________________
- ☐ Lab ordered
- ☐ X-ray
- ☐ PM&RS consultation
- ☐ Sutures____________________

Date of exam: **Time:** **Signature/Title:**

SECTION E: To be completed by Attending Physician (Review and Comment)

Attending Physician Review/Comments:

Corrective/Preventive measures taken to reduce risk of reoccurrence:

- ☐ No change in treatment indicated
- ☐ Treatment Plan modified (How?)
- ☐ Medication adjusted ____________________

Date: **Signature and Title:**

SECTION E: Service Chief/SHG Leader: Please review the information regarding this incident and provide your comments, e.g. current status of patient, recommendations/action taken or no further action

☐ No further action indicated

Date: **Signature and Title:**

Chief of Staff:

☐ No further action

Investigation indicated: (check type)

☐ Physician Peer Review
☐ Mortality & Morbidity Review
☐ Root Cause Analysis
☐ Administrative Board of Investigation
☐ Other (see comments)

Comments and recommendations:

This event is reportable to: (check all that applies) ☐ VISN ☐ VA Headquarters ☐ JCAHO
Date reported: ______________________________

Date: **Signature:**

Director:

☐ No further action required

☐ Investigate incident and submit report and recommendations to me by (date) __________________.

Comments:

Date: **Signature of Director:**

Risk Manager:

☐ Forwarded for ABI ☐ Mortality & Morbidity Review ☐ Root Cause Analysis ☐ Physician Peer Review

☐ Case closed ☐ Other (please specify)

Date: **Signature:**

Attachment H

Suggested Membership for Fall Response Team

1. Senior leader
2. Technical leader
3. Clinical leader
4. Day-to-day leader
5. Recreation
6. PM & RS
7. Social work
8. EMS
9. Dietary
10. Pharmacy
11. Nurse manager(s)
12. Staff nurse or nursing assistant from ward 1
13. Alternate nurse or nursing assistant from ward 1
14. Nurse or nursing assistant from ward 2
15. Alternate nurse or nursing assistant from ward 2
16. Nurse or nursing assistant from ward 3
17. Alternate nurse or nursing assistant from ward 3

Attachment I

Fall Hazard/Near Miss Report Form

Employee Name: **__Enter employee name_(Please Print)**______________________

Hazard Being Reported: _Identify the actual hazard in detail__________________

Date of Discovery: _Enter actual date hazard was first discovered_______________

Location of Hazard: (bldg., unit, room) - Enter detailed location of the hazard, example: Bldg. 78, NH2, Rm 242, bathroom, broken handrail.

Immediate Corrective Action Taken: Enter exactly what corrective action you took to eliminate the hazard, to prevent a fall. Example: Placed a STAT work order to have handrail repaired, advised patients and staff of the hazard, removed the hazard until it is repaired.

Was a work order initiated? Yes___ No___ N/A___ Check one
If yes, describe the requested correction. Loose handrail in bathroom of room 242 needs immediate repair.

Please explain the measures taken to prevent future reoccurrence of the hazard. Explain any measures put in place for prevention. Example: Loose floor tiles, if they can be removed, do so, and then place a STAT work order. Alert staff and patients of the hazard. Block the area where the loose tiles were found.

Please identify Lessons Learned from the Near Miss. Example: Communication among staff on all shifts gives a better total understanding of the day-to-day happenings on each unit.
Information/Lessons Learned shared with staff via:

Staff meeting: Date(s) ____

Shift Reports: Date(s) ____

Postings on bulletin boards: Date(s)/Location(s) ___________________________

Storyboards: Date(s)/Location(s) _____________________________________

Other (Please describe): ____
____

Patient Safety Manager Response: ____________________________________

This report is what submission for this employee?
1st___ 2nd ____ 3rd ____ 4th ____ 5th ____
Pin Pen/pencil Popcorn Drink Time Off Award

Please submit this form to your Nurse Manager upon completion.
Each submission will earn one entry into a quarterly drawing for a special surprise!
THANKS for putting the SAFETY of our Patients FIRST!