<table>
<tr><td rowspan="2">Crenshaw Community Hospital
Policies and Procedures</td><td>Policy Number
AHW.400.0050</td><td>Effective Date
7/7/14</td></tr>
<tr><td>Revision Date
1/272021</td><td>Review Date
1/27/2021</td></tr>
<tr><td>Manual: Administrative House Wide

Title: Fall Prevention</td><td colspan="2">
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Chief Of Staff

____
Administrator</td></tr>
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FALL PREVENTION

PURPOSE

A. To protect and promote patient safety.
B. To effectively identify and intervene with patients who are at risk for falling.
C. To educate patients, families, and staff members on measures to prevent falls and promote safety.

POLICY

All inpatients will be assessed for risk of falling upon admission using the Morse Fall Scale, with reassessments routinely performed to determine ongoing need for fall prevention precautions. Any patients determined to be at risk for a fall will be placed on fall prevention precautions immediately. All outpatients will be assessed within the outpatient and/or pre-op areas using the Morse Fall Scale on admission to this patient care area and reassessed routinely throughout their procedure. The Special Services Unit (Psychiatric Unit) will use the Morse Fall Scale to assess the psychiatric patient on admission to the Special Services Unit. All inpatients will be reassessed at least every shift to ensure that the patient's fall risk prevention measures meet their needs and provide the safest possible environment during their stay at Crenshaw Community Hospital (CCH).

RESPONSIBILITY

All staff members are responsible for implementing the intent and directives contained with this policy, and for creating a safe environment of care for all patients at Crenshaw Community Hospital. Any staff member, physician, or family member may request that a patient be placed on Fall Precautions to ensure the safety of the patient.

PROCEDURE

MEDICAL SURGICAL UNIT

A. Inpatient Fall Prevention

1. Inpatients will be assessed on admission, after a fall/when con and every 24 hours thereafter.
2. Fall risk screening will be completed by an RN using the Morse Fall Scale on admission to CCH. The RN is responsible for establishing and updating the individual's plan of care related to safety and fall prevention.
3. All interventions will be documented in the patient's medical record.
4. Family, if available, will be consulted for individualizing fall interventions.

B. Upon Admission

1. Complete the Morse Fall Scale, provided within the Initial Nursing Assessment tool.
2. If the patient's score is 45 or higher they are at High Risk for falls and all prevention measures should be initiated immediately to include:
   a. Circle the Yellow Star Picture on the patient whiteboard and place a check mark beside the FALL under the Safety Precaution yellow box.
   b. Apply a Yellow Fall Precaution bracelet to the patients arm.
   c. Place the yellow Falling Stars sign on the outside of the patient's door.
   d. Place a yellow Fall Precaution sticker on the front of the patient's chart and Kardex.
   e. Place yellow non-skid socks on the patient.
   f. If the patient is confused and does not follow commands appropriately initiate the bed alarm system and if available, have the family member sit with the patient at bedside.
   g. Identify appropriate interventions within the plan of care for the patient.
3. If the patient's score is 25-44 the patient is considered a Moderate risk for falls and all interventions listed above should be implemented by the nursing staff if appropriate for the patient.
4. If the patient's score is 0-24 the patient is considered to be a low risk for falls and no prevention measures shall be initiated at that time.

C. Ongoing Risk Assessment

1. Reassess the patient every shift for the risk for falls and document the Fall Prevention Standards being used each shift.
2. If the patient's condition or score changes the nurse should discontinue or initiate the Fall Prevention Process according to the patient's needs.

D. If a patient experiences a fall:

1) Document what occurred in the nurse's progress notes including: patient appearance at the time of discovery, patient response to the event, evidence of injury, location, medical provider notification, medical/nursing actions
2) Monitor the patient's room or environment for any hazards or unsafe equipment.
3) Notify the patient's physician of the fall.
4) Notify the patient's family member, if applicable.
5) Initiate or Update interventions if changes are noted in the patient's condition.

6) Communicate the fall risk to all shifts in order to heighten the oncoming staff's awareness of the potential for additional falls and the need to monitor the patient closely.

E. Emergency Department Fall Prevention

1. All Emergency Department patients will be assessed for fall risk by the triage nurse.
2. The criteria assessed:
   a. Altered Mobility
   b. Altered Level of consciousness
   c. Current seizure activity
   d. Dizziness
   e. Multiple medications that can alter the patient's level of consciousness.
   f. Age: >70 or <3 years of age.
   g. Recent falls (Within 30 days)
3. Fall Precautions are initiated in the ED if the patient meets 2 or more of the criteria listed above. The nursing staff may place a patient on Fall Prevention if he/she deems it necessary if the patient only meets 1 of the criteria components listed above.
4. If the patient is deemed to be a High Risk for fall the ER staff will initiate the Fall Prevention Process immediately.

F. ER Fall Prevention Process

1. Maintain the bed in the lowest position
2. All side rails placed in the upright position.
3. Place a yellow fall bracelet on the patient.
4. If the patient is ambulatory allow the patient to have access to his/her shoes at bedside or provide the patient with a pair of yellow non-skid socks.
5. Ensure that the floor is free of clutter and equipment or equipment wires.
6. If available, allow a family member to remain at bedside if the patient is confused or has a decrease in his/her level of consciousness.

G. Special Services Unit Fall Prevention Process

1. All inpatient psychiatric patients will be assessed on admission to the Special Services Unit during the initial assessment using the same Morse Fall Scale.
2. If the patient's score is 45 or higher they are at High Risk and 25-44 is considered a Moderate Risk for falls and all prevention measures should be initiated immediately to include:
   a. Apply a Yellow Fall Precaution bracelet to the patients arm.
   b. Place a yellow Fall Precaution sticker on the front of the patient's chart .
   c. Place yellow non-skid socks on the patient.
   d. Provide one-on-one or close observation, within arm's reach. Document appropriately.
   e. Orient or reorient the patient to his/her environment.

f. Evaluate effects of medications that predispose the patient to falls in collaboration with the Pharmacist or Physician
g. Inform patient about fall risk and provide written education to him/her and encourage their participation in reducing fall risk.
h. Relocate the patient to a room closer to the nursing station if possible.
i. Assess and implement the need to assist with ADLs and toileting. Develop a close routine schedule with the patient in order to meet the needs of the patient.
j. Assess and inform the patient to rise slowly from a sitting or lying position and assess for orthostatic hypotension.
k. Consider other etiologies for behavior such as, pain, or agitation, etc.
l. Identify appropriate interventions within the plan of care for the patient.

3. If the patient's score is 0-24 the patient is considered to be a low risk for falls and no prevention measures shall be initiated at that time.

H. Ongoing Risk Assessment

1. Reassess the patient every 24 hours and whenever there is a significant change in the patient's condition, which may include: cognition, mobility, a fall in a patient with no previous risk identified or any other situation in which the nurse determines an assessment to be indicated. Document the risk in the nurse's progress notes.
2. If the patient's condition or score changes the nurse should discontinue or initiate the Fall Prevention Process according to the patient's needs.

I. Post Fall Evaluation and Care

1. Document what occurred in the nurse's progress notes including: patient appearance at the time of discovery, patient response to the event, evidence of injury, location, medical provider notification, medical/nursing actions.
2. Monitor the patient's room or environment or any hazards.
3. Notify the patient's physician of the fall.
4. Notify the patient's family member, if applicable.
5. Initiate or Update interventions if changes are noted in the patient's condition.
6. Communicate the fall risk to all shifts in order to heighten the oncoming shifts awareness of the potential for additional falls and the need to monitor the patient closely.

J. Surgery Department Fall Prevention – All surgical patients are considered to be at risk for fall due to the effects of surgical preparation, medications received, and the surgical procedure performed. Fall risk is mitigated through continuous/frequent monitoring and observation of the patient during pre, intra and post-operative procedures.

K. Fall Prevention Procedure within the Surgical Department

1. Place a yellow fall bracelet on all of your surgical patients on admissions to the surgical unit. Always communicate with the patient

and explain the risk for falls during transfers from one unit to the other.

2. The staff member should always stay with the patient during episodes of transfers.
3. At the time of discharge:
   a. Assess the patient's ability to dress independently and safely.
   b. Instruct the patient to remain seated while dressing.
   c. All Same Day Surgical patients will discharge via wheelchair.
   d. Based on mobility and transfer ability, accompany the patient with 1-2 staffs members during ambulation transfer is necessary.
4. Patient Education
   a. Provide patient fall prevention education at admission.
   b. Provide family education on fall prevention at discharge with instructions on how to assist the patient in their recovery process.

NOTE:
REPORT ALL FALLS [PATIENT AND VISITOR] REGARDLESS OF LOCATION TO THE DEPARTMENT MANAGER AND TO QUALITY/RISK MANAGEMENT. QUALITY/RISK MANAGEMENT WILL ENTER THE INFORMATION INTO ECRI'S REPORTING SYSTEM WHERE IT REMAINS AS A PROTECTED DOCUMENT.

DO NOT MAKE COPIES OF THE REPORT.

HOURLY ROUNDING

CRENSHAW
COMMUNITY HOSPITAL

PAIN
"How is your pain?"

POTTY
"Do you need to use the bathroom?"

POSITION
"Are you Comfortable?"

POSSESSIONS
Everything should be within reach

Introductions: Use opening Key Words to introduce yourself or your co-worker, your skill set, and your experience.

For example:

"Mr. smith, this is Sarah. She will be your nurse today. Sarah has been a nurse for 8 years and she will take very good care of you. I have discussed your care with Sarah and she knows what our plan is for the day."

Describe Hourly Rounding

"Because we want you to receive excellent care, we are going to round EVERY HOUR from 6am to 10pm and EVERY 2 HOURS from 10pm to 6am. We will not wake you if you are sleeping, unless your physician has asked us to do so. During this time, we will check on your pain, your comfort, and ask you if you need to use the bathroom."

Use White Boards

Write your name on the white board. Note the plan or goals for the day.

Address the 4 P's

Pain "How is your pain?"

Medicate patient or schedule during upcoming rounds

Position "Are you Comfortable?"

Move up in bed. Re-arrange the pillows. Offer extra blankets. Turn patients at high risk for skin break down.

Potty "Do you need to use the bathroom?"

Assist patient to the bathroom.

Possessions Move phone, call light, trashcan, and Kleenex within reach. Arrange over-bed table. Fill water pitcher.

In Addition:

- Perform scheduled tasks. M.D. ordered procedures. Give scheduled medication.
- Communicate when you will return.
  "I will be back in about an hour"
- Close with Key Words
  Is there anything else I can do for you?
  I have time.
- Document your round.

Rounding Results

Reduces call lights | saves steps for nursing staff | increases patient satisfaction | improves clinical outcomes | decreases patient anxiety | builds patients confidence and trust

At Crenshaw Community Hospital, Our Goals Are:

VERY GOOD CARE.

EVERY PATIENT.

EVERY DAY.

An important part of providing you with Very Good care and service is hourly rounding. You will be visited by one of your caregivers.

EVERY HOUR from 6 a.m. to 10 p.m.
And
EVERY 2 HOURS from 10 p.m. to 6 a.m.

During this time we will be:

- Checking on you and your well being
- Monitoring your comfort and pain
- Helping you move and change position
- Assisting with trips to the bathroom

Your caregivers also will make sure that you have easy access to the:

- Telephone
- Bedside Table
- Water or other beverages
- Glasses
- Call light for assistance
- Urinal and/or bedpan
- Waste Basket

What does this mean to **YOU**, your family and visitors?

It means that we are anticipating your personal needs and monitoring your well-being on an active, hourly basis so that your family and visitors can focus on your recovery.

CRENSHAW
COMMUNITY HOSPITAL

Patient Label

HOURLY ROUNDING LOG

Date: ____________ **RM#** ___________ **Bed#**__________ **Day:** _________________________

Time Period	Initials	Time Rounding	Pain	Position	Potty	Possessions	Comments (In chart by exception, per need)
EVERY1 HOUR ROUNDS 6AM – 10 PM							
6 AM							
7AM							
8AM							
9AM							
10AM							
11 AM							
12 PM							
1 PM							
2 PM							
3 PM							
4 PM							
5 PM							
6 PM							
7 PM							
8 PM							
9 PM							
EVERY 2 HOUR ROUNDS 10 PM – 6 AM							
10 PM							
12 AM							
2 AM							
4 AM							

_______________________________________ Employee Signature/Initials

_______________________________________ Employee Signature/Initials

_______________________________________ Employee Signature/Initials

_______________________________________ Employee Signature/Initials

This is not a part of the permanent medical record.

Morse Fall Scale

(Adapted with permission, SAGE Publications)

The Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling. A large majority of nurses (82.9%) rate the scale as "quick and easy to use," and 54% estimated that it took less than 3 minutes to rate a patient. It consists of six variables that are quick and easy to score, and it has been shown to have predictive validity and interrater reliability. The MFS is used widely in acute care settings, both in the hospital and long term care inpatient settings.

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/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.

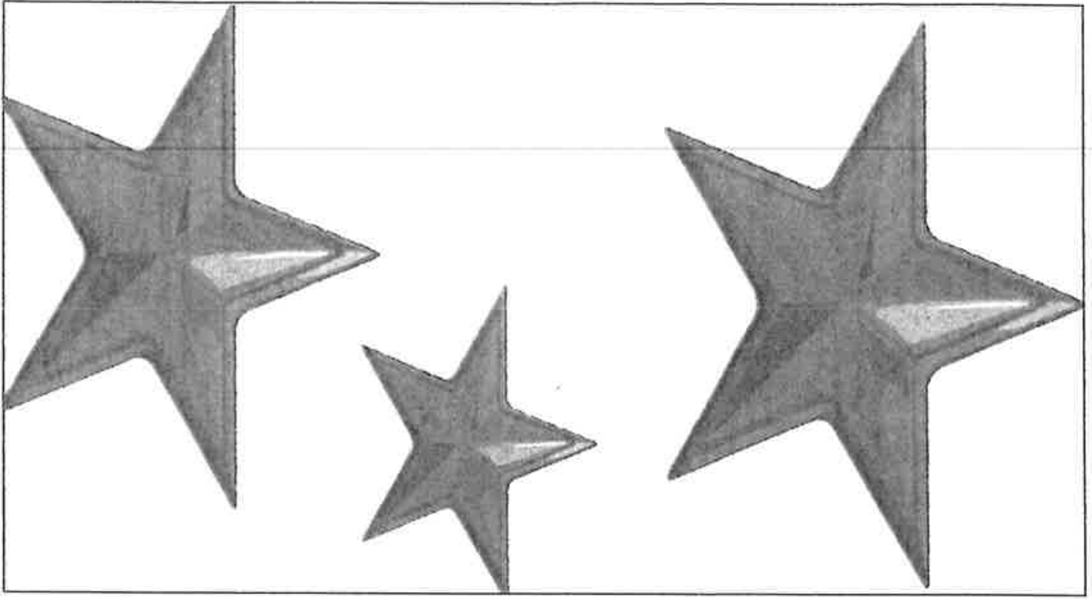
Mental status: When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the ambulatory order on the Kardex®, 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.

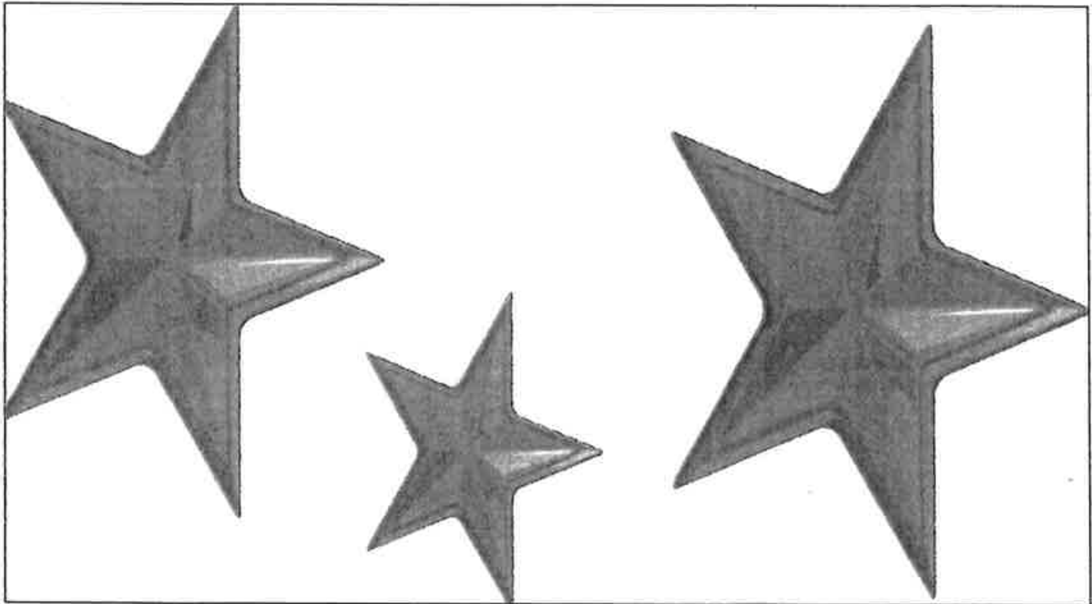
Scoring and Risk Level: The score is then tallied and recorded on the patient's chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

Important Note: The Morse Fall Scale should be calibrated for each particular healthcare setting or unit so that fall prevention strategies are targeted to those most at risk. In other words, risk cut off scores may be different depending on if you are using it in an acute care hospital, nursing home or rehabilitation facility. In addition, scales may be set differently between particular units within a given facility.

Sample Risk Level

Risk Level	MFS Score	Action
No Risk	0 - 24	Good Basic Nursing Care
Low Risk	25 - 50	Implement Standard Fall Prevention Interventions
High Risk	≥ 51	Implement High Risk Fall Prevention Interventions





Crenshaw Community Hospital
Event Reporting Form [DO NOT COPY]

COMPLETE FORM AND SEND TO QUALITY/RISK MANAGEMENT DEPARTMENT

Report date: Time of Event:
Patient Name: Account Number:
Department/Location:
Describe briefly what happened:
Physician Notified: Date and time
Type of Event: Medication: [describe briefly] – omission, dosage, wrong med, wrong route, transcription error, etc. Adverse drug reaction: What drug? Describe what happened:
Fall: Inpatient Outpatient Visitor [circle one] Was fall observed? Yes or No Was patient assessment done prior to fall, if applicable: Yes ___ No ____ N/A _____ Injuries noted: [Check] • None ___ • Minor [skin tear, contusion/bruise, laceration] ____ • Moderate [Sprain, Deep laceration] __ • Major [Fracture, dislocation, Loss of consciousness] ___ • Death ___ • Other: Please describe
Equipment failure [please describe]
Elopement: AMA ___ Left without being seen [LWBS] ____
Security/Life Safety Issues: Patient lost articles ___ Hospital property damage ___ Assault ____ Fire __
Other: Blood Transfusion reaction ___ IV complication ____ **NOTE: FOR EMPLOYEE INJURY OR EXPOSURE GO TO ER AND COMPLETE THIS FORM WITH HAVE A COPY THE INJURY FORM SENT TO QUALITY/RISK MANAGER.**