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Owner	Brenda Houston: Director Clinical Nurse
Area	Adult General Nursing
Applicability	Logan Health & LHMC

Fall Prevention and Management, AGN469

PURPOSE

This policy establishes the guidelines for the assessment of patient's fall risk and the implementation of fall prevention interventions, and it establishes the guidelines for the assessment and management of patients who have fallen.

POLICY

1. Adult Patients, 18 years and older and minor aged obstetric patients are evaluated for increased fall potential upon admission, each shift, and as needed, as condition changes.
2. All reasonable attempts to safely support the patient's right to independence and self-determination by using the least restrictive safe method for fall prevention will be made.
3. For those at increased risk, additional safety measures individualized to the patient and situation will be identified on the plan of care, and implemented by the health care team.

PROCEDURE

1. Fall Risk Assessment
    A. Calculation of fall risk is not required for patients who are comatose, completely immobile or completely paralyzed. Implement basic safety precautions per low risk interventions.
    B. All patients in the following areas are considered high risk and the fall risk assessment tool may not be completed or documented for these patients; implement high fall risk interventions as indicated.
        1. Peri-Operative
        2. Post- Operative

3. Hospital based ambulatory care

C. Patients receiving procedural sedation are considered high risk for falls; implement high fall risk interventions as indicated.

D. High fall risk interventions are implemented for patients with a history of more than one (1) fall in six months prior to admission, experience a fall during his/her hospitalization, or are deemed to be a high fall risk per risk assessment tool.

2. Fall Prevention (See appendix A)

A. Use standard interventions for all patients.

1. Implement additional fall prevention interventions as appropriate for the patient's fall risk assessment.

B. Document specific interventions used for each patient.

C. Purposefully round hourly on patients using the 5 P's (position, personal needs, pathways, possessions and pain).

D. Use teach-back to verify that patient understands use of the call light system.

E. Update fall risk level on patient white board in room each shift and as needed.

F. Patient and family are educated appropriately to fall prevention.

3. Discharge Planning.

A. Teach patient and family about creating a safe home environment as appropriate

4. Communicate during hand offs and upon transfer to another unit

A. History of falls during this hospital stay or greater than one (1) fall 6 months prior to hospitalization.

B. Fall prevention interventions in place.

C. Fall Risk Assessment score.

5. Post Fall Event (see appendix B for Guidelines for post fall huddle and post fall review processes, appendix C for Decision Tree for Fall Type and Preventability, appendix D for post fall huddle form)

A. Assess and provide immediate care to the patient as needed.

B. Notify the patient's provider of fall and assessment findings.

C. Notify the following as appropriate with the intent to have a multidisciplinary post fall huddle: Provider, House Supervisor, Shift Unit Supervisor, Manager, or Charge Nurse, and Physical Therapist.

1. Convene with-in 15 minutes, or as soon as possible after the fall.

2. Keep huddle brief.

3. Involve staff present at time of fall.

4. Utilize a spirit of inquiry to discover what happened.

5. Identify actions to prevent re-occurrence.

6. Modify the fall prevention plan of care to include KRH and any unit specific interventions to prevent repeat fall.

D. Complete documentation in electronic medical record
    1. Reassessment using Fall Risk Assessment tool.
    2. Specific fall prevention interventions implemented post fall.
    3. Complete Post Fall Assessment documentation.
    4. Complete Post Fall note in EMR.

E. Utilizing post fall note, complete documentation in incident reporting system

F. Notify family as appropriate.

DEFINITIONS

1. **Fall** - 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 on an object (e.g., a trash can). When a patient rolls off a low bed or on 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 on to a bed, chair or commode, this is only counted as a fall if the patient is injured.
2. **Physiological Fall** - A fall attributed to one or more intrinsic, physiological factors. Physiological falls include:
    A. Falls caused by a sudden physiological event such as hypotension, dysrhythmia, seizure, transient ischemic attack (TIA), or stroke.
    B. Falls occurring due to side effect of known "culprit drugs" (e.g., CNS-active drugs and certain cardiovascular drugs).
    C. Falls attributed to some aspect of the patient's physical condition such as delirium, intoxication, dementia, gait instability, or visual impairment.
3. **Non-Physiological Fall** - A fall attributed to an external cause (e.g., wet floor) and cannot be attributed to a physiological factor.
4. **Assisted Fall** - A fall in which any staff member (whether a nursing service employee or not) was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent.
5. **Unassisted Fall** - Any fall/slip in which a person comes to rest unintentionally on the floor or some object and no one intervenes during the fall.
6. **Suspected Intentional Fall** - An intentional fall event occurs when patient age 5 years or older falls on purpose of falsely claims to have fallen. Patients may fall intentionally or falsely claim to have fallen for various reasons, including seeking attention or obtaining pain medication.
7. **Completely Immobile** - A state in which the patient's motor strength is so diminished that the patient is incapable of moving the body to change position.
8. **Complete Paralysis** - Loss of motor function due to lesion of the neural or muscular mechanism, or administration of paralytic medications, such that the patient is incapable of

moving.

REFERENCES

1. American Nurses Association. (2022). National database of nursing quality indicators. *The National Databases.*
2. Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D, & Rita S. How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012.
3. Institute for Healthcare Improvement. (2017). Retrieved from http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx

Attachments

- A: Adult Fall Prevention Interventions by Fall Risk Factor Category
- B: Guidelines for post fall huddle and post fall review process
- C: Decision Tree for Fall Type and Preventability
- D: Post Fall Huddle Form.pdf
- Image 02

Approval Signatures

Step Description	Approver	Date
Final Admin Approval	Amy Vanterpool: Vice President (VP), Chief Nursing Officer (CNO)	02/2024
Manager Approval	Jennifer Clark: Executive Director Service Line	10/2023
Policy Committee	Kelly Stimpson: Associate General Counsel	09/2023
Reviewer	Brenda Houston: Director Clinical Nurse	09/2023
Owner	Brenda Houston: Director Clinical Nurse	09/2023

Applicability

Logan Health (locations excluding LHMC), Logan Health Medical Center