Fall Prevention for Clinical Staff - 2018 Dignity Health

Patient Safety

- Patient safety is the responsibility of **ALL STAFF** throughout the hospital and outpatient areas
- Preventing patient falls requires a team effort and good communication

Fall Prevention and Management Policy

The organization will provide a safe environment and minimize the risk of falls to patients by using standardized fall risk and injury risk assessments and implementation of appropriate evidence-based fall precaution interventions.

All Dignity Health facilities, including inpatient, outpatient, and ambulatory care centers focus on fall prevention and safety

A Fall is defined as an "unplanned descent to the floor, whether the patient was assisted to the floor or not, and whether injury occurred or not"

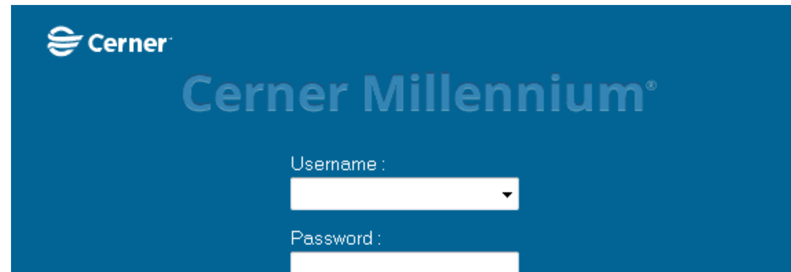
How does nursing assess a patient's risk for falling/injury?

- Physical assessment, critical thinking, and communication with other departments (i.e. therapies)
- Assessment tools in Cerner:
  - John Hopkins Fall Risk Assessment Tool (JHFRAT) for Adults
  - Fall Injury Screen (ABCs)
  - Bedside Mobility Assessment Tool Level (BMAT) Dignity Health Administrative Policy #100.5.013, *Safe Patient Handling and Mobility*.

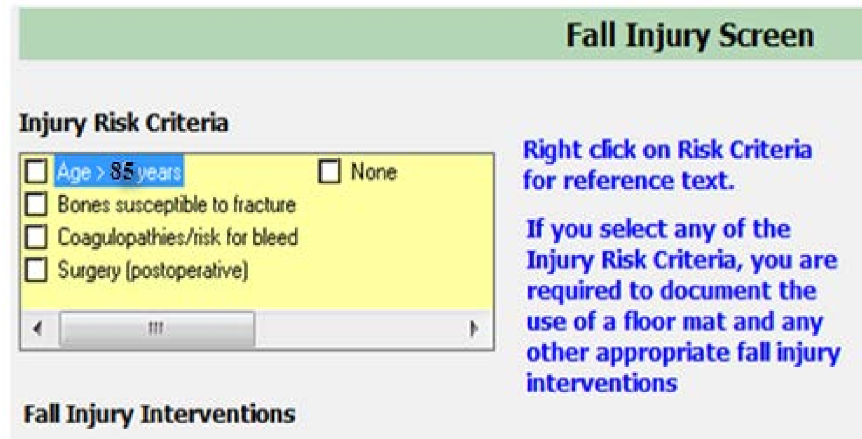
Risk Factors Assessed:

- **JHFRAT**
  - History of falls
  - Age
  - Elimination
  - Medications
  - Patient care equipment
  - Mobility
  - Cognition
- **Fall Injury Screen (ABCs)**
  - A: Age (greater than 85)
  - B: Bones (fracture risk/history)
  - C: antiCoagulation
  - S: recent Surgery (during current episode of care)

Cerner Changes in Documentation



Changes to Fall Documentation and Fall Injury Prevention Strategies coming soon in Cerner… watch for the Tip Sheets!



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Specialty Populations Require Special Consideration

- Newborns: Education and Interventions about: infant placed in bassinet when mother is sleepy, never leave on bed unattended, no co-sleeping
- Obstetrics: higher risk with preeclampsia, hemorrhage, or epidural/ narcotic or magnesium use
- Rehabilitation units/ facilities: higher risk if cognitive, motor, or problem solving issues. Use appropriate Safe Patient Handling and Mobility technology and equipment, gait belts, seatbelts, and consider increased measures for Ultra high risk (closed circuit monitors, enclosure beds)

Outpatient and Ambulatory Care

Appendix D: CDC STEADI Fall Risk Screening Tool

CDC STEADI FALL RISK SELF SCREENING TOOL

We are concerned about our patient's safety while visiting our Dignity Health facility, and want to ensure that we provide the highest level of care.

Please complete the following questions so that the health care provider may better serve you.

Yes	No	
☐(2)	☐	I have fallen in the past year.
☐(2)	☐	I use or have been advised to use a cane or walker to get around safely.
☐(1)	☐	Sometimes I feel unsteady when I am standing or walking.
☐(1)	☐	I steady myself by holding onto furniture when walking at home.
☐(1)	☐	I am worried about falling.
☐(1)	☐	I need to push with my hands to stand up from a chair.
☐(1)	☐	I have some trouble stepping up onto a curb.
☐(1)	☐	I often have to rush to the toilet.
☐(1)	☐	I have lost some feeling in my feet.
☐(1)	☐	I take medicine that sometimes makes me feel light-headed or more tired than usual.
☐(1)	☐	I take medicine to help me sleep or improve my mood.
☐(1)	☐	I often feel sad or depressed.

- **Use the CDC STEADI checklist Self Screening Tool on first contact and update as needed**
- **Environmental risk assessment**
- **Supervise/ assist with mobility and toileting after a procedure**
- **Fall Prevention education to all outpatients**

ER and Pediatrics Special Considerations

- Use the Memorial ED Fall Risk Assessment
- Keep gurney/ bed in low position and room obstacle free
- Move confused patients closer to nurses station
- Yellow wristband and booties
- Toilet every hour
- Consider fall mat
- Encourage family members to sit when confusion present

- Use Little Schmidy Fall Risk Assessment
- Use age specific bed/ crib with railing
- Provide fall prevention education to patient and family
- Apply floor mats, yellow wristband
- Individualize activity/ mobility restrictions

How do I know if a patient has been identified as a fall risk?

These indicators help staff to quickly identify patients who are at risk for falling.

What fall interventions are required for patients who are at risk for falling?

FALL BUNDLE:

- Yellow fall sign
- Yellow arm band and socks
- Bed alarm and chair alarm activated; yellow flag above door in outward position
- Fall mat in place while patient is resting in bed or in chair
- Door and curtain open
- Bed locked and in lowest position
- Scheduled toileting
- Supervised and/or assist bedside sitting and toileting
- Mobilize based on BMAT recommendations

Policy 27051

THE FALL BUNDLE IS ALL OR NONE… MEDIUM OR HIGH FALL RISK 6 or higher= ALL INTERVENTIONS!

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What is my role in preventing falls?

IDENTIFY AND INTERVENE

- Be able to **identify** patients at risk for falling based on the fall alert indicators.
- If a patient has any of these alerts…
  - **Do not let them ambulate alone and mobilize based on BMAT assessment**
  - **Do not leave them in the bathroom alone**
  - **Do not close the door/curtain to their room**

SAFETY ABOVE PRIVACY

What is my role in preventing falls?

COMMUNICATE

- If the patient does not have any fall indicators present, **but you have concerns** about them falling (ex: they report dizziness, a recent fall, or they seem unsteady as they walk)– **treat them as a fall risk** and inform the patient's primary nurse.
- Fall risk is included in hand-off communication/report between caregivers at shift change and transfer of patient between units/departments.
- Non-clinical staff have a role as well to be aware of high risk patients and report if they are out of bed or attempting to ambulate on their own

What is my role in preventing falls?

EDUCATE

- Remind patients and families that our goal is to keep them safe while they are under our care.
- If you have questions or concerns about a patient, please bring it to the attention of the patient’s primary nurse.

Post Fall Management

- **Assessment** by nursing to immediately perform and document head to toe assessment, neuro checks and vital signs. Monitor and reassess patient as appropriate
- **Contact** practitioner of any changes in status, suspected injury or if on anti-coagulation medication to obtain orders for diagnostic procedures
- **Notify** family or patient representative if patient is unable, and the Patient Safety Officer if there has been any injury
- **Document** assessment of patient condition, who notified and interventions, update plan of care, and reassessment of patient
- **Complete** event report and post-fall debrief

Appendix E: Post Fall Debrief Tool

Post Fall Debriefing Tool –page 1/2
(This document is NOT TO BE PLACED IN THE MEDICAL RECORD)

Patient Label

Completed by:____________ Fall Location(Facility/Unit) :______________
Date of Fall:________ Time:______ Time of Last Rounding:______ Assisted Descent ___Yes ____ No
Pre-Fall Risk Screen/Assessment Completed ☐ Yes ☐ No Time: __________ Score:__________
Pre-Fall Injury Risk Assessment Completed ☐ Yes ☐ No Time: __________ Result:__________
Bedside Mobility Assessment Tool (BMAT) Completed __ Yes __ No Result:______________
Safe Patient Handling Equipment used to Assist Patient Back to Bed ☐ Yes ☐ No Name of Device ____________ Care Plan includes Fall Prevention Interventions ☐ Yes ☐ No
Type of bed (i.e. Versacare, Linette, Bariatric)______________

Circle or Check Patient Risk Factors	
History of Falls	Yes ☐ No ☐
Altered level of consciousness (LOC)	
Mobility assessment:	
Altered elimination:	Time of last toileting:
Unable to follow / refuses Fall Prevention strategies	
Multiple lines / drains	
Sensory impairment (hearing / vision loss)	

Pre-Fall	Pre-Fall interventions	Post - Fall
Yes ☐ No ☐	Yellow armband in place	Yes ☐ No ☐
Yes ☐ No ☐	Fall risk indicator visible (door/room)	Yes ☐ No ☐
Yes ☐ No ☐	Yellow non-skid slippers on patient/gown	Yes ☐ No ☐
Yes ☐ No ☐	Bed in low position	Yes ☐ No ☐
Yes ☐ No ☐	Restraint	Yes ☐ No ☐
Yes ☐ No ☐	Sitter / family at beside	Yes ☐ No ☐
Yes ☐ No ☐	Fall mat	Yes ☐ No ☐
Yes ☐ No ☐	Bed alarm / chair alarm	Yes ☐ No ☐
Yes ☐ No ☐	Patient educated regarding fall risk including teach back	Yes ☐ No ☐

Final Thoughts

- **<u>Communication</u>** between nursing, ancillary staff, and patients/families is **<u>KEY</u>** to preventing falls and keeping our patients safe!

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Thank You!

Our patients thank you!

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