

Patient Falls: Zero Tolerance



2 contact hours

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Purpose

The purpose of Patient Falls: Zero Tolerance is to provide you with information about patients at risk for falls, fall risk assessment tools, and methods that will help to reduce the number of falls of patients in your care.

Objectives

After successful completion of this course, you will be able to:

- Identify risk factors for falls
- Describe fall assessment tools that identify patients who are at risk for falling
- Document and communicate information about fall risks
- Identify individualized interventions that will decrease patients' risk for falls
- Identify appropriate interventions following a patient fall based on individual history and assessment

Introduction

A patient fall is an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient (ANA, 2009).

In the past, many healthcare professionals considered patient falls to be unavoidable. Patients with obvious fall risk were managed, but there was no comprehensive assessment of or communication about a patient's risk for falling.

In addition, organizations had no systematic way to measure the true rate of falls. And lastly, research showing true fall risk factors was not widely disseminated.

We now know that we can reduce the risk of falling by conducting comprehensive fall risk assessments. By identifying hazards and putting preventive measures into place, we can reduce the incidence of falls across all healthcare settings.

Past history of a fall is the single best predictor of future falls. In fact, 30-40% of those who fall will do so again (AHRQ, 2014b).

Falls Definitions

Defining and categorizing falls helps healthcare professionals better understand the cause of patient falls.

Many healthcare facilities often categorize falls based on environmental and physiologic factors.

Nationally recognized falls researcher Janice Morse (2002), suggests that falls are best understood and identified when they are classified as accidental, anticipated physiologic, or unanticipated physiologic.

Accidental Falls: Unintentional falls that occur due to environmental factors such as equipment failure, loose floor coverings or ice on the ground.

Anticipated Physiologic Falls: Falls that occur in patients whose score on a risk assessment scale indicates that they are at risk of falling due to an anticipated risk.

Falls/Patient Days: This statistic accounts for organizations of different sizes and/or time frames when census is higher or lower.

Incidence of Falls: The number of falls that occur over a given time frame (usually one year).

Unanticipated Physiologic Falls: Falls that are not linked to patients' known risk factors for falls but rather are caused by unanticipated medical events such as fainting, seizures, or pathological fractures of the hip.

Scope of the Problem

In order to understand the seriousness of falls, consider this:

- Falls are one of the leading causes of unintentional injuries in the United States, accounting for approximately 8.9 million visits to the emergency department annually (NSC Injury Facts 2011).
- Each year, one in every three adults ages 65 or older falls (CDC, 2014b).
- The risk of falling increases with each decade of life (CDC, 2014b).
- The long-term consequences of fall injuries, such as hip fractures and traumatic brain injuries (TBI), can impact the health and independence of older adults (CDC, 2014b).

Test Yourself:

Who is most at risk for falls?

- A. A 92 year old woman with frequent fainting spells
- B. A 55 year old man post coronary artery bypass surgery
- C. A 19 year old student with a fractured femur
- D. A 5 year old leukemia patient

Assessing Risk

Fall-risk assessment, or the health assessment of the older adult patient “at risk,” is an essential component to a comprehensive fall reduction and prevention program (NICHE, 2014).

The purpose of a fall-risk assessment is to identify a patient’s risk for falling before an injury occurs, so that risk factors can be minimized and falls avoided. Fall-risk assessment can take the form of a simple screening of all older adults admitted to a medical facility, or the completion of a more comprehensive assessment for those at high risk for falls. Ideally, fall risk assessment should be completed on admission, when transferred to a new unit, or when level of care changes, if a change in condition occurs, and after a fall (Gray-Miceli, 2008 in NICHE, 2014).

Using a fall risk assessment tool will help you to identify not only who is at risk but the degree of danger they face.

In this course we will review a number of risk assessment tools. But first, let’s take a look at some ways of thinking about risk.



Risk Factors Associated with Falls

While falls can happen to almost anyone at any time, certain risk factors make falling more likely.

There are two main types of factors that contribute to risk: intrinsic risk factors and extrinsic risk factors.

Intrinsic factors are inherent to each patient and result from changes related to aging, disease or medication.

Extrinsic factors include environmental hazards as well as activity-related factors.

Note: Patients with more than one risk factor have a greater risk of falling.

Intrinsic risk factors include:

- Advancing age
- Change in cognition
- Vision impairment
- Unsteady gait
- Balance impairment
- High risk medications or taking more than four medications at one time
- Certain physical conditions or specific acute or chronic disorders (post stroke, musculoskeletal, neurologic, cardiac issues)
- A previous fall or history of falls
- Specific co-morbidities such as Parkinson's, arthritis, dementia
- Urge incontinence
- Use of physical restraints (NICHE, 2014)

Extrinsic risk factors include:

- Wearing shoes with thick soft soles
- Poor lighting
- Slick or irregular floor surfaces
- Slippery throw rugs
- Furnishings that are too low or too high
- Unsafe stairways
- Bathroom fixtures that are too low or too high or do not have arm supports
- Excessive clutter
- Unlocked wheelchairs (Eldredge, C. 2009)

Tracking Falls

In order to understand patient risk, the Joint Commission (TJC) and other organizations have been tracking patient falls and outcomes related to patient falls for many years. The standards for acute care contain a provision to both measure falls and have in place a plan to reduce the number of falls in the organization (The Joint Commission, 2014).

Key tracking indicators for falls include:

- Incidence of Falls – The number of falls in a given time frame (e.g. annually).
- # of Falls/Patient Days – This statistic accounts for organizations of different sizes and/or time frames when census is higher or lower.
- Falls with Injury – The incidence and number of falls per patient day.
- Fall that Cause Death or Major Loss of Function – A sentinel event that is reportable to the Joint Commission or other accrediting organization.

Case Studies: Assessing Risk

Review the following scenarios. Identify the intrinsic and extrinsic risk factors associated with each patient for falls.

Case 1: Sandy

Sandy is an 11-year-old, African-American female in sickle cell crisis. She is in acute pain and has numerous cards & gifts scattered around the floor in her hospital room. She had a PCA pump and is wearing socks from home.

What are Sandy's intrinsic and extrinsic risk factors for falls?

Answer

Sandy's intrinsic risk factor is her acute pain, which may interfere with mental alertness. Her extrinsic risk factors are clutter in her room, having a PCA and inappropriate footwear.

Case 2: Michael

Michael is a 52-year-old, Greek immigrant who is blind and being treated for an infected knee. He is on multiple IV antibiotics and is on bed rest. He also takes a diuretic and beta-blocker for hypertension.

What are Michael's intrinsic and extrinsic risk factors for falls?

Answer

Michael's intrinsic risk factors are his blindness, being on multiple intravenous antibiotics, having limited mobility and increased need for urination. Language barrier may also be an issue. No extrinsic risk factors were mentioned in the report

Case 3: John

John is a 70-year-old, white male with left side hemiparesis from a CVA fifteen years prior. He is being worked up for potential MI. He is alert & oriented and can transfer from bed to a wheelchair unassisted.

What are John's intrinsic and extrinsic risk factors for falls?

Answer

John's intrinsic risk factors are his secondary diagnoses, his age, and his hemiparesis. No extrinsic risk factors were mentioned in the report.

Fall Risk Assessment Tools

There are many assessment tools available for fall risk assessment. Only tools that have been empirically tested for reliability and validity should be used (NICHE, 2014).

One common falls assessment tool is the Morse Falls Scale (Morse, 1997).

The Morse Falls Scale (MFS) is a valid and reliable tool used in many inpatient healthcare settings to predict the likelihood of a patient falling. The total score may also be used to predict future falls, but the

scale is more important to use to identify risk factors and planning care to address those risk factors (AHRQ, 2014a).

Note! Tools should not replace, but complement the judgment of the nurse performing fall assessments.

Morse Falls Scale

According to the AHRQ (2014a), the Morse Falls Scale should be done at least once per day and with any change in patient status.

An important goal of the MFS is to identify WHY a patient is at risk for falls. Focusing on the areas of risk identified by the MFS will help to recognize specific interventions to prevent patient falls.

Variables		Score
History of Falling	No	0
	Yes	25
Secondary Diagnosis	No	0
	Yes	15
Ambulatory Aid	None/bed rest/nurse assist	0
	Crutches/cane/walker	15
	Furniture	30
IV or IV Access	No	0
	Yes	20
Gait	Normal/bed rest/wheelchair	0
	Weak	10
	Impaired	20
Mental status	Oriented to own ability	0
	Overestimates or forgets limitations	15
Total		

Morse Falls Score	
High Risk	45 or higher
Moderate Risk	25 - 44
Low Risk	0 - 24

A training module on how to use the Morse Fall Scale can be accessed here:

http://www.brighamandwomens.org/Patients_Visitors/pcs/nursing/nursinged/Medical/FALLS/Fall_TIPS_Toolkit_MFS%20Training%20Module.pdf

Get Up and Go Test

The “Get Up and Go Test” is an assessment that should be conducted as part of a routine evaluation when dealing with older persons. Its purpose is to detect “fallers” and to identify those who need evaluation (AAN, 2014).

Staff should be trained to perform the “Get Up and Go Test” at check-in and query those with gait or balance problems for falls.

This test should be used as an initial check for any older people who report a single fall. Using this test, a patient should be observed as he or she:

- Stands up from a sitting position, without using their arms for support.
- Walks several paces, turns, and returns to the chair.
- Sits back in the chair without using their arms for support.
- Individuals who have difficulty or demonstrate unsteadiness performing this test require further assessment (AAN, 2014).

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Follow-Up Assessment

In the follow-up assessment, ask the person to:

- Sit.
- Stand without using their arms for support.
- Close their eyes for a few seconds, while standing in place.
- Stand with eyes closed, while you push gently on his or her sternum.
- Walk a short distance and come to a complete stop.
- Turn around and return to the chair.
- Sit in the chair without using their arms for support (AAN, 2014).

<p>Instructions: Tell the patient to wear their normal shoes and use whatever device he normally uses when ambulating (e.g. cane, walker).</p>
<p>Patient Instructions:</p> <ol style="list-style-type: none"> 1. Stand from a sitting position, without using your arms for support. 2. Walk approximately 10 feet, turn, and return to the chair. 3. Sit back in the chair without using the arms for support.
<p>Scoring: Grade the patient on a scale of 1 to 5 with 1 being normal and 5 being severely abnormal. A patient who scores 3 or higher is considered at risk for falls, and interventions should be put in place.</p> <p>(Nayak & Isaacs, 1986, Shumway-Cook & Woollacott, 2001)</p>

The Get Up and Go test is an assessment you can conduct as part of a routine evaluation, especially with older adults. This test is often used in conjunction with other tests or done as a timed test.

Timed Get Up and Go Test

<p>Instructions: Tell the patient to wear their normal shoes and use whatever device he normally uses when ambulating (e.g. cane, walker).</p>
<p>Patient Instructions:</p> <ol style="list-style-type: none"> 1. Stand from a sitting position, without using your arms for support. 2. Walk approximately 10 feet, turn, and return to the chair. 3. Sit back in the chair without using the arms for support.
<p>Scoring: A person who takes longer than 13.5 seconds to complete the task considered at risk for falling.</p> <p>(Shumway-Cooke, et al., 2000)</p>

The Timed Up and Go Test (TUG) is a timed version of the Get Up and Go Test. The same standards apply, but the time it takes the patient to complete the task is critical in the scoring (Podsiadlo & Richardson, 1991)

The Functional Reach Test

Instructions: Ask the patient to stand next to a wall.
Patient Instructions: <ol style="list-style-type: none">1. Make a fist.2. Hold out your arm at shoulder height.3. Reach as far forward as possible without taking a step.
Scoring: A reach of less than 7" indicates limited functional balance.

The Functional Reach is often used in combination with other tools to measure how steady a patient is when reaching away from the body. It is often used in home settings where a patient's risk for falling may increase as he performs activities such as reaching for items in cabinets.

Hendrich II Fall Risk Model™

Another common tool for assessing fall risk is the Hendrich II Fall Risk Model™. This assessment is quick to administer and provides a determination of risk for falling based on gender, mental and emotional status, symptoms of dizziness, and categories of medications known to increase fall risk (Hendrich et al., 2003 in Gray-Miceli, 2013).

The Hendrich II Fall Risk Model™ is intended to be used in the acute care setting to identify adults at risk for falls. The Model is currently being validated for further application of the specific risk factors in pediatrics and obstetrical populations (Gray-Miceli, 2013). Like the Morse Fall Scale, this is a numeric tool that can quickly assess your patient's risk for falling.

This tool screens for primary prevention of falls and is integral in a post-fall assessment for the secondary prevention of falls.

Hendrich II Fall Risk Model™

In addition to other factors, the Hendrich II Model also includes two specific types of medications (benzodiazepines and anti-epileptics) that place patients at risk for falling. The updated Heindrich II model includes the Get Up and Go Test as part of the scoring system.

The Hendrich II Fall Risk Model™ can be viewed online at the Hartford Institute for Geriatric Nursing.

With permission, the Hendrich II Fall Risk Model™ can be inserted into existing electronic health records, documentation forms or used as a single document (Gray-Miceli, 2013).

Berg Functional Mobility Test

The Berg Functional Mobility Test, or Berg Balance Test, assesses the patient's ability to perform several common activities of daily living that may increase the likelihood of falls in high-risk patients. As the score decreases, the patient's risk for falls increases. Scores less than 36 indicate the patient's falls risk is almost 100%.

The test takes 15–20 minutes and comprises a set of 14 simple balance related tasks, ranging from standing up from a sitting position, to standing on one foot. The degree of success in achieving each task is given a score of zero (unable) to four (independent), and the final measure is the sum of all of the scores (The Chartered Society of Physiotherapy, 2014).

Items within the test include the ability to:

- Sit unsupported
- Move from sit to stand
- Stand unsupported
- Stand with eyes closed
- Stand with feet together
- Forward reach
- Retrieve object from floor
- Turn left and right
- Turn 360 degrees

Scoring: A score of less than < 36 (out of a possible 56) indicate the patient's is at a very high risk for falling (The Chartered Society of Physiotherapy, 2014).

Clinical Judgment

Regardless of a patient's fall score, remember to rely on your clinical judgment. If a patient's score does NOT meet the criteria for a fall risk, use your judgment and your organization's P&Ps to start fall risk precautions.

Conversely, if a patient's score indicates he is at risk and your judgment tells you he is not, it is critical to implement the appropriate fall risk measures based on your organization's P&Ps.

The Joint Commission's National Patient Safety Goals (NPSGs)

The Joint Commission's 9th NPSG (Goal 09.02.01) requires all acute care facilities to implement a fall reduction program. Consideration of a patient's medication regimen is very important (NPSG.08.01.01 which require organizations to obtain a list of the patient's current medications); and staff must be competent to consider medication effect in relation to falls (TJC, 2014).

It is helpful to identify some of the drugs/drug classes that are most frequently associated with increased risk of falling. Some suggested medication classifications are:

- Hypnotics
- Sedatives
- Analgesics
- Psychotropics
- Antihypertensives
- Laxatives
- Diuretics

Note! Consider not only the class of drug, but the number of drugs (polypharmacy) and the potential for additive effects when they accumulate in the body that also increases risk (TJC, 2014).

(The Joint Commission, 2014).

Four Steps for Preventing Falls

There are four basic steps you can take to prevent patient falls:

- Assess the patient's falling risk
- Document this risk and communicate it to your colleagues
- Reduce risk by improving the safety of the patient's environment
- Reduce risk by promoting the strength and balance of the patient

Always follow your facility policies and procedures. All information and recommendations in this course are intended for use as guidelines only.

Case Study 1: Ms. C

Initial Assessment

Ms. C is a confused, 89-year-old, 125 pound patient under your care. She is being treated in your facility for a diabetic foot ulcer, which requires intravenous antibiotics.

She has a history of Type II diabetes (diet-controlled), peripheral neuropathy, renal insufficiency, and osteoporosis. Her daily medications include docusate sodium and aspirin. Her family reports that to their knowledge she has had no past history of falls.

When transferring from the wheelchair to bed, you notice she is weak and cannot place any weight on her affected foot. She was unable to complete the Get Up and Go test due to inability to bear weight on her affected foot.

Some of her personal belongings upon admission included a cane, eyeglasses, and dentures. What risk level for falls would you assign to her using the Morse Falls Scale?

Answer

Ms. C would be assigned a score of 85 using the Morse Falls Scale. She is at high risk for falling.

- Secondary Diagnosis: 15 points (More than 1 medical diagnosis for current admission)
- Ambulatory Aid: 15 points (Uses a cane)
- IV Lock (for antibiotics): 20 points
- Gait: 20 points (impaired gait as unable to weight-bear on affected foot)
- Mental Status: 15 points (She is confused)

Total: 85 points. Ms. C. is at high risk for falling.

Reassessment

Now Consider This!

Ms. C's foot ulcer resolves. She is still confused but mainly at night. She follows instructions and seems to realize her limitations. Her antibiotics have been changed to oral dosing. She is awaiting transfer to her assisted living facility. She is no longer weak, but still needs her cane for ambulation.

Using her cane, she is able to complete the "Get Up and Go" test with slight instability when getting up and sitting back down in her chair. What risk level for falls would you now assign to her using the Morse Falls Assessment? The Get Up and Go test?

Answer

On the Morse Fall Scale, Ms. C would be assigned a score of 30 during the daytime, but a score of 45 at night due to her nightly confusion. She would receive a score of 2 using the Get Up and Go test. She is still at risk for falling, although not as significant as upon admission.

Will Ms. C ever be free from the risk of falling? It is unlikely. Her advanced age and medical history will always be factors that predispose her to falls. Ms. C's and other patient's falls risk may increase or decrease depending upon their physical status, mental status and progression of care. Assessing falls must be ongoing and occur at admission or transfer, with every shift and with change in status.

Now what if...

Ms. C has no confusion at night and does not need the cane for ambulation? What would her scores be now?

Answer

Her Morse Falls Scale score would be 15, considered at no risk for falls. The Get Up and Go test in this scenario, would be completely normal.

How do you feel about this?

Given Ms. C's history of Type II diabetes, peripheral neuropathy, renal insufficiency, and osteoporosis, and that she is on aspirin therapy, placing her in a no risk category may be too optimistic.

If she did fall, given her advanced age, brittle bones, and medication regimen, a fall could be devastating and even life threatening. Thus, CLINICAL JUDGEMENT must always guide the nurse in her assessments and interventions.

Case Study 2: Mr. J

Initial Assessment

Mr. J is a 42-year-old man who works in the construction industry. He has a history of unstable angina and his cardiac catheterization revealed coronary artery disease in 3 vessels. He is admitted for bypass surgery which will occur in the morning. Mr. Jones has no other medical history. He does take atorvastatin for high cholesterol. He is alert and oriented, ambulates without difficulty, and has no IV at this time.

What score would you give Mr. J based on the Morse Falls Scale?

Answer

Mr. J's score would be 0 based on his current status. He is not at risk for falls based on this score.

Reassessment

Now Consider This!

Mr. J has bypass surgery the following day. He remains in the ICU for 1 day and then returns to your unit. He is alert and oriented, but is experiencing incisional pain in both his chest and left leg. He has an IV in place, and is quite weak when moving from the bed to the chair. His medications include IV antibiotics, morphine or codeine for pain. He is having difficulty sleeping, but does not want any medication for sleep.

What score would you now give Mr. J based on his current status?

Answer

Mr. J's score would be 30, showing he is at low risk for falls. Depending on your organization's P&Ps, some fall risk prevention strategies may be put in place.

Now what if...

Mr. J develops an incisional infection at his left leg graft site. He has a heparin lock to administer IV antibiotics, although the rest of his medications are given by mouth. His left leg remains somewhat weak due to the incisional pain and the infection. Mr. J attempted to go to the bathroom without assistance and slipped to the floor on the previous shift. He is evaluated by his physician and a neurologist and he suffered no apparent injuries.

What is Mr. J's score now?

Answer

Mr. J's score is 45: at the lower end of "High Risk for Falls."

Using your clinical judgement, however, would you consider Mr. Jones's risk to be low or high?

Or perhaps you gave Mr. J a score of 60, adding in that he doesn't realize his own limitations. In this case his score would be in the "High Risk" category.

Document & Communicate

Now that you have identified your patient's level of risk, it's time to document your findings and communicate them to all of the relevant parties: your colleagues, the patient's family, and most of all, the patient herself.

Note! Repeated fall risk assessments, performed annually and with any patient status changes, will increase the reliability of assessment and help predict a change in condition that signals a fall risk (Gray-Miceli, 2013).

Documentation

Following a fall, you must document the circumstances surrounding the fall in the medical record. These circumstances include:

- Patient appearance at the time they are discovered
- Patient response to the fall
- Any evidence of injury
- Location of the fall
- Physician notification
- Medical and nursing actions taken (AHRQ, 2014b)

Documentation for your patient at risk for falling should also include:

- Fall risk status
- Factors that place him at risk (may be on initial nursing admission assessment form)
- Interventions employed to reduce risk
- Patient and family education
- Environmental precautions being taken (i.e. patient placed close to nursing station, call bell in reach, elimination needs assessed every two hours)

Documentation

If your patient falls make sure that your documentation is complete, factual, and consistent with your facility standards. Which of the two examples above gives the most accurate and factual information about a patient fall?

The patient was found alert and oriented, beside her bed, crying. She did not complain of pain, just stated she was “scared because her left leg gave out on her.” No evidence of injury – no bruising, redness, swelling noted on the left lower extremity. Active & passive range of motion were not impaired. Patient helped back to bed and comforted. Dr. Collins was notified by phone of above circumstances and patient response regarding the fall.

Loud thud heard from patient room. Patient on floor, upset. No evidence of injury. Patient stated, “left leg gave out on her”. Physician notified.

Communication

The Joint Commission NPSGs require healthcare professionals to improve communication among caregivers. Your plan of care to reduce your patient’s risk for falling must be communicated to all members of the healthcare team that are involved in the patient’s care.

Fall risks and interventions to reduce falls should be communicated at every shift report.

Communications should include factual observations of the patient. In addition, if your facility uses color coded bracelets to indicate a risk for falls or other forms of falls communication about the patient, ensure they are being used appropriately.

1. When reporting your patient is at high risk for falls, follow up by explaining your patient’s intrinsic risk factors and the interventions you implemented to decrease these risk factors.
2. Report interventions aimed to minimize external risk factors.
3. Report patient and family education and their response to the education.

Create a Safe Environment

Since statistical information indicates that about half of all falls happen at home, patient and family teaching prior to discharge is essential for your patient’s well-being.

When discussing fall prevention and patient safety in the home, encourage patients to ask questions.

Involving patients and their families in all aspects of their care is mandated across all healthcare settings.

Safety in the Home

To Create a Safe Environment

- Remove items the patient can trip over (the less clutter the better)
- Remove small throw rugs or use double-sided tape to keep rugs from slipping
- Move items that are used frequently in lower cabinets to avoid reaching or climbing up on stools
- Keep the path from the bedroom to the bathroom well lit
- Install grab bars next to the toilet, bathtub and shower
- Use non-slip mats in the bathtub and on shower floors
- Improve lighting around the home
 - Use lampshades or frosted bulbs to reduce glare

- Put handrails and lights on all staircases
- Place a light at the bedside to use in the middle of the night before getting out of bed
- Wear shoes that give good support and have thin non-slip soles
- Avoid wearing slippers and athletic shoes with deep treads

Patient and Family Education

Falls are not just the result of getting older. Many younger individuals may have a risk for falls related to a particular medical condition. Healthcare professionals can help reduce the risk of falls by taking time to teach patients and their significant others about basic falls prevention.

Develop Your Plan of Care

Each organization identifies fall prevention interventions for patients who score at risk for falls. Depending on the tool used and the particular score different interventions may be applicable.

Standard Fall Intervention

- Use standard system to notify other staff of a patient's risk for falls (colored wristband, colored tag on door, other notification)
- Communicate with patient and family about the risk for falling
- Assess at admission, change in status, transfer to another unit, and upon discharge
- Assess coordination and balance before implementing transfer and mobility devices
- Obtain any patient assistive device (cane, walker, or wheelchair) the patient had been using prior to hospitalization
- Offer a bedpan, urinal, or assistance to the bathroom before mealtime, at bedtime, upon awakening, and every two hours while awake
- Lock all wheelchairs, beds, and stretchers
- Make sure the patient uses appropriate footwear, including treaded socks
- Place your patient's care and personal items within reach
- Ensure your patient has a physically safe environment (eliminate spills, clutter, electrical cords, and unnecessary equipment)
- Ensure lighting is adequate
- Work with physical therapy to treat gait changes, postural instability, and spasticity
- Encourage your patient to wear his glasses and hearing aids
- Assess and treat pain
- Monitor for orthostatic hypotension
- Reorient to surroundings as needed

High-Risk Fall Intervention

In addition to the standard precautions, implement high-risk precautions for those patients with multiple risk factors or for those patient who have previously fallen.

- Consider technology (i.e. non-skid floor mats, raised edged mattresses, bed alarms, video surveillance)
- Keep in mind any technology that restricts an individual’s access to his or her body or restricts freedom of movement is considered a restraint, and restraint criteria apply
- Place a “Falls Identifier” such as a color-coded armband on your patient
- Treat underlying medical conditions
- Assess circumstances surrounding past falls for extrinsic and intrinsic risk factors
- Optimize the patient’s nutritional status
- Discuss home safety with the patient and the patient’s family
- Work with the physician to review and adjust medications. Pay particular attention to drugs that may cause orthostatic hypo-tension and urinary frequency such as diuretics, anti-hypertensives and beta blockers
- Ask the physician to initiate a referral to services such as physical therapy and rehabilitation, audiology, ophthalmology and cardiology

Critical Thinking Activity

Let’s take another look at Ms. C

When she was first admitted to your unit, she was a confused, 89-year-old, 125 pound patient with a diabetic foot ulcer requiring intravenous antibiotics. She had a history of Type II diabetes (diet-controlled), peripheral neuropathy, renal insufficiency and osteoporosis. Her daily medications included docusate, sodium and aspirin. Her family reported that to their knowledge, she had no past history of falls.

When transferring Ms. C from her wheelchair to her bed, you noticed that she was weak. She was unable to complete the “Get Up and Go” test due to inability to bear weight on her affected foot. Some of her personal belongings upon admission included a cane, eyeglasses and dentures.

Ms. C is confused at night. Her Morse Falls Score is 75, well above the minimum high-risk score of 51. She is definitely in need of high risk fall intervention.

What are three interventions that you would recommend for Ms. C?

1. _____
2. _____
3. _____

Some immediate high-risk interventions would include:

1. Providing Ms. C with a color-coded wristband or other “falls” identifier. Other caregivers need to know she is at risk before trying to get Ms. C out of bed.
2. Consider technology. Setting the bed alarm and placing Ms. C next to the front desk may reduce the likelihood that Ms. C will fall.
3. Treat underlying medical conditions. Ms. C’s foot ulcer may be more than superficial. Confusion in the elderly does not necessarily equate to dementia. She may potentially be developing septicemia, which would account for her confusion.
4. Investigate need for constant observation. Due to her confusion constant observation may be needed until her falls risk decreases. Ms. C is also on aspirin therapy, which predisposed her to a serious injury if she does fall.
5. Optimize patient’s nutritional status. Ms. C is elderly and only weighs 125 pounds. She may need fluids and parenteral nutrition. Ms. C should also be monitored for orthostatic hypotension.

Promote Strength and Balance

We often take balance for granted in our own lives. Our bodies are constantly adjusting our posture, muscle tone and movement to remain upright.

Increasing balance in individuals prone to falling may seem a daunting task but may be accomplished with outpatient physical therapy and a few home exercises.

Lack of exercise leads to weakness and increases your patient’s chances of falling.

Exercises that improve balance and coordination (like Tai Chi) are the most helpful (CDC, 2014) . It makes your patients stronger and helps them feel better.

Work with your patients to develop a home exercise program and give them the resources they need to get started.

Exercise is one of the most important ways to reduce the chances of falling.

What If Your Patient Does Fall

Despite our best efforts, sometimes a patient still falls. In these cases, it is important to perform a rapid and focused post-falls assessment and implement strategies to prevent a fall from happening again in the future.

Immediately following a fall, ensure patient safety and follow your emergency protocol and organization guidelines to care for your patient.

(VA National Center for Patient Safety, 2003; American Medical Directors Association [AMDA], 1998)

Initial Assessment

Check if your patient is breathing.

If your patient's airway, breathing, and circulation are intact when you find the patient, a rapid assessment of level of consciousness, change in cognition, shortness of breath, and vital signs should be some of the first assessments you make.

Assess for any spontaneous movement. If there is any evidence of a head, neck, or spinal cord injury, immediately immobilize the patient.

Assess

If traumatic injuries can be ruled out...

Assess for symmetrical range of motion in the extremities. Also, note any shortening and external rotation of the lower extremities. Observe for swelling, redness, bruising, abrasions, pain on movement, shortness of breath, and impaired balance.

Record Vital Signs

Record vital signs, including blood pressure in lying, sitting, and standing positions (unless limited by possible significant injury).

Ensure Privacy

Ensure that you maintain the patient's privacy by closing the door or pulling the curtain.

Notify Physician and Family

Notify the patient's physician, according to your facility's P&P . Provide him with the details about the fall and the patient's current vital signs.

Notify the patient's family if appropriate.

Document Event

Document the circumstances regarding the fall (e.g. location, time of fall, related activity).

Document Follow-Up

Document what happened after the fall.

Observe Patient

Observe the patient for potential short or long term complications.

After a Fall

After your patient is safely back in bed and physically stable, you should assess the environment to look for clues that may have contributed to the fall. Be sure to assess the following extrinsic factors that may have contributed to the fall:

- Dim lighting or glare
- Uneven flooring wet or slippery floor
- Poor fit or seating device

- Inappropriate footwear
- Inappropriate eye wear
- Use of full length or all four side rails in bed
- Lack of hallway rails in area of fall
- Inappropriate assist devices (fit or condition)
- Lack of grab bars in the bathroom
- Cluttered areas (VA National Center for Patient Safety, 2003)

Reassessment

Reassess your patient's intrinsic factors for falls. Ask yourself the following questions...

- Has your patient's fall risk changed since admission?
- Has a new medication been introduced into your patient's medication regime?
- Has your patient's physical or mental status changed?
- Was your patient in pain?
- What was your patient's nutritional and hydration status?
- Has your patient had any changes in vision or hearing?
- How is your patient's coordination and gait?

Conclusion

Research and clinical practice have led to the development of a number of tools to identify patients who are at risk for falling. Using these tools, organizations can perform successful interventions that reduce the number of patients who fall.

Preventing patient falls is an ongoing practice. By performing regular fall risk assessments, communicating and documenting our findings, monitoring the safety of the patient's environment and working to improve strength and balance, we can decrease the overall number of patient falls along with their devastating consequences.

Yet, even the most well-designed fall prevention interventions will be ineffective if they are not selected and implemented appropriately. For a fall reduction program to succeed, there must be staff engagement and continuous feedback. The bedside nurse must recognize that he or she is the first line of defense for patients against a fall injury. When the nurse is vigilant in assessment and intervention, the risks to the patient are decreased (ANA, 2009).

References

- Agency for Healthcare Research and Quality [AHRQ], (2014a). Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care. Retrieved January 29, 2014 from: <http://www.ahrq.gov/legacy/research/lrc/fallpxtoolkit/fallpxtool3h.htm>
- Agency for Healthcare Research & Quality [AHRQ], (2014b). Chapter 2: Falls Response. Retrieved January 31, 2014 from: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspix/fallspixman2.html>

American Academy of Neurology [AAN], (2014). Get Up & Go Test. Retrieved January 29, 2014 from: <https://www.aan.com/Guidelines/home/GetGuidelineContent/273>

American Medical Directors Association. (1998). Falls and fall risk. Columbia, MD: Author.

American Nurses Association [ANA], (2009). Patient Falls. Retrieved January 29, 2014 from: <http://ana.nursingworld.org/qualitynetwork/patientfallsreduction.pdf>

Centers for Disease Control (2014a) STEADI (Stopping Elderly Accidents, Death & Injuries). Tool Kit for Health Care Providers. Retrieved January 29, 2014 from: <http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html>

Centers for Disease Control and Prevention (2014b). Older Adult Falls Data & Statistics, 2005. Retrieved January 28, 2014 from: <http://www.cdc.gov/homeandrecreationalafety/Falls/data.html>

Centers for Disease Control and Prevention (2014c). Check for Safety: A Home Fall Prevention Checklist for Older Adults, National Center for Injury Prevention & Control. Falls At Home. Retrieved January 31, 2014 from: <http://www.cdc.gov/ncipc/pub-res/toolkit/checklistforsafety.htm>

Eldredge, C. 2009. Expert spotlight: Prevent falls by identifying extrinsic risk factors. Nurse Manager Weekly, July 20, 2009. Retrieved on November 1, 2010 from <http://www.hcpro.com/NRS-236083-868/Expert-spotlight-Prevent-falls-by-identifying-extrinsic-risk-factors.html>.

Gray-Micelli, D. (2013) A. Fall Risk Assessment for the Older Adult: The Hendrich II Fall Risk Model. Try This: Best Practices in Nursing Care to Older Adults. Issue #8, Revised 2013. Retrieved January 29, 2014 from http://consultgerirn.org/uploads/File/trythis/try_this_8.pdf.

Gray-Micelli, D. (2008) Nursing Standard of Practice Protocol: Fall Prevention. The Hartford Institute of Geriatric Nursing. Retrieved September 17, 2010 from http://consultgerirn.org/topics/falls/want_to_know_more.

Hendrich, A. (2007). Predicting Patient Falls. American Journal of Nursing, 107 (7), 50-58.

Morse, J. (1997). Preventing patient falls. Thousand Oaks, CA: Sage

Morse, J. (2002). Enhancing the safety of hospitalization by reducing patient falls. American Journal of Infection Control; 30: 376-80

National Safety Council [NSC], (2011). Falls. Retrieved January 30, 2014 from: http://www.nsc.org/safety_home/HomeandRecreationalSafety/Falls/Pages/Falls.aspx

Nurses Improving Care for Healthsystem Elders [NICHE], (2014). Fall Risk Assessment. Retrieved January 30, 2014 from:

Podsiadlo, D., & Richardson, S. (1991). The timed "up & go": A test of basic functional mobility for frail elderly persons. Journal of the American Geriatrics Society, 39, 142-

The Chartered Society of Physiotherapy, (2014). "Berg Balance Scale (BBS)". Retrieved January 31, 2014.

The Joint Commission (2014). Standards FAQ Details. Fall Reduction Program NPSG 09.02.01. Retrieved January 2014 from:

http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=201&ProgramId=47

Web-Based Injury Statistics Query & Reporting System [(WISQARS)], (2014). Injury Prevention & Control: Data & Statistics, CDC, 2014. Retrieved January 29, 2014 from: <http://www.cdc.gov/injury/wisqars/>

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