Title: Fall Prevention Program
Date Effective: 9/02
Date Revised: 3/05, 7/08, 12/08, 2/11/10, 2/14/11, 5/14/13
Date Reviewed: 4/05
Joint Commission Chapter: Provision of Care, Treatment, and Services

I. Purpose
To assist the nurse in assessing patients for fall risk and to define interventions that may assist in fall prevention.

II. Policy or General Principles
A. All patients are assessed/risked for their fall risk at the time of admission, each shift thereafter and when there is a change in condition and upon transfer in/out of unit. Based on these assessments, the patient will be classified as Safety Level 1, 2, 3 or 4.
   1. A risk assessment will be conducted in Pre-admission Testing on all adult patients who are expected to stay overnight after surgery
   2. Intensive Care Unit and Critical Care Unit patients will be assessed with the Morse Fall Scale upon admission and when ready for transfer to a medical-surgical unit
   3. Outpatient areas may assess patients for fall risks where RN is supervising procedure/visit. Safety screens may occur in appropriate outpatient locations where care is provided. Public areas where patients visit are reviewed for environmental safety through the management of the environment of care process.
B. Each patient’s safety level will be communicated during change of shift report and transfer report.
C. Each patient’s plan of care will be individualized, utilizing nursing judgment and evidenced-based practice. Appropriate interventions for each Safety Level are listed under "Safety Level Definitions”.
   1. Units may develop specific fall prevention strategies based on their unit’s resources, patient population, and falls history.

III. Definition(s)
A fall is a time when a person unexpectedly lands on the ground, assisted or unassisted.

Types of Falls
Accidental fall: Caused by slipping, tripping, or other mishap. Often due to environmental factors. Not considered as a fall on the Morse Fall Scale.
Anticipated physiological fall: Identified as fall-prone on the Morse Fall Scale. By identifying patients who are at risk for falls, prevention strategies can be initiated.
Unanticipated physiological fall: Created by conditions that can’t be predicted, for example, seizures or fainting. Once this type of fall has occurred, it’s likely to happen again. Nursing actions should target preventing a second fall or preventing injury from another fall.
IV. Applies to: RN, CA

V. This policy and procedure is to be used in conjunction with “Post-Fall Patient Assessment and Care”

VI. Procedure

A. Communication of Level 2, 3 and High Injury Risk Level 4 is done
   1. When placing yellow fall risk bracelet on patient by RN who completes fall assessment (IF LEVEL 3 RISK)
   2. Verbally during shift report and transfer off the unit
   3. By writing level 2, 3 or High Injury Risk in the safety section of the treatment kardex
   4. Verbally during report to the CA and prints on CA report sheet in areas where one is used
   5. On Patient Passport

B. Safety Level Definitions

1. **Safety Level 1 (Low Risk):** All adult patients are at least a Safety Level 1 and require the following interventions
   a. Orient patient to surroundings: use of telephone, television, call light
   b. While unattended in bed, the patient's bed is kept in the lowest position, with the brakes locked and one head rail up to assist the patient when they move in bed
   c. The nurse call bell, telephone, glasses, walker/assistive device and other essential items will be placed within patient’s reach
   d. Assess patient footwear, providing for skid-proof footwear
   e. Insure adequate night lighting
   f. Patient/family teaching: IV pole and overbed table have wheels and are not adequate support for ambulating
   g. Ensure clear pathways to the bathroom, remove excess furniture

2. **Safety Level 2 (Moderate Risk):** All adult patients who meet the specific assessment criteria (a score of 30 - 40 on the Morse Fall Scale) for Safety Level 2 require the following interventions: All of the Safety Level 1 interventions, plus
   a. Identify patient as a fall risk in kardex, chart, and during report
   b. Teach patient/family to call for assistance for any activities and describe safety interventions to patient and family
   c. Assess patient’s eating habits, including the need and frequency for meals and/or snacks
   d. Assess need for toileting schedule every 2 hours
   e. Be aware of which medications the patient is taking that may affect BP, level of consciousness, and elimination
   f. Consider moving closer to nurses’ station
   g. Consider setting bed alarm to “out of bed” mode based on patient assessment; consider chair alarm if bed alarm is utilized
   h. Update plan of care to reflect interventions. Communicate using white board in patient's room. "Fall Alarms being used."

3. **Safety Level 3 (High Risk):** All adult patients who meet the specific
assessment criteria (a score of 45 or more on the Morse Fall Scale) for Safety Level 3 require all of the Safety Level 1 and 2 interventions, plus

a. Identify patient as high risk for fall by application of yellow fall risk bracelet when Fall Assessment is completed. (Not used in SAU, CCU or ICU where all patients are high risk due to condition or equipment used.)
b. Increase frequency of observations to at least every hour
c. Anticipate physical needs - plan a toileting schedule every 2 hours, plan meals at regularly spaced time intervals, provide snacks as needed; offer fluids every 2 hours when awake
d. Reorient patient to surroundings as gently as possible (avoid trying to change patient’s mind if chronically confused)
e. Review Fall interventions with patient and family and introduce fall brochure for their reference
f. Discuss with patient/family, as appropriate, the use of restraints. Use least restrictive form that minimizes freedom of movement and use for the least possible amount of time
g. Consider setting bed alarm to "out of bed" mode or “exit” mode based on patient assessment. List on white board.
h. Use chair alarm when appropriate. Communicate using nursing care plan, kardex and whiteboard.
i. Never leave a level 3 Fall Risk unattended in bathroom

4. Safety Level 4 (High Risk for Injury): All adult patients who meet the specific assessment criteria (a score of 45 or more on the Morse Fall Scale) for Safety Level 3 and are on anticoagulation therapy, have osteoporosis or clotting abnormalities, or has had a fracture from a fall in the last 12 months require all of the Safety Level 1, 2 and 3 interventions, plus

a. Identify patient as high risk for fall by application of yellow fall risk bracelet when Fall Assessment is completed.
b. Evaluate patient for increased safety check to 30 minutes
c. Evaluate use of floor mat if appropriate for patient
d. Evaluate for 1:1 Constant Companion
C. To assess a patient's risk for falls, the MORSE FALL SCALE is used

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**Morse Fall Scale Definitions**

**History of falling:** During present hospitalization OR a recent history prior to hospitalization—within the past 3 months.

Note: This does not include an accidental fall, slip, trip, or some other mishap resulting in a fall.

**Secondary diagnosis:**
More than one active medical diagnosis. (for example: fractured hip with pneumonia, appendectomy with exacerbation of COPD, etc.) not past medical history
- And/or patients receiving anticoagulation therapy
- And/or any medications new or ongoing that could affect patient’s gait or mental status

**Ambulatory aids:** No device, a cane/walker/crutches, OR furniture (ambulating by reaching for pieces of furniture)

**IV access:** peripheral IV, saline lock (with ordered intermittent infusions), multimed line, port-a-cath, epidural catheter, subcutaneous infusion

Note: The patient is considered to be a fall risk while receiving an infusion. Patient is considered high risk if tubing is attached during any portion of that shift.
**Gait:** how the patient would ambulate if he/she were to get out of bed on your shift. Weak gait: stooped slightly, may shuffle, may hold lightly onto furniture OR Impaired gait: difficulty rising from chair, grasps assistance of furniture and/or people, walks in short steps and shuffles

**Mental status:** patient's self-assessment is unrealistic - overestimates abilities. May be forgetful of limitations. Could be due to a cognitive factor or a side effect of medications.

D. If, despite interventions, a patient does fall
   1. Refer to “Post-Fall Patient Assessment and Care”
   2. Reassess patient using the Morse Fall Scale, and apply appropriate interventions
   3. Document patient care, the circumstances leading up to the fall, outcome, and update care plan.

E. Patient is reassessed each shift and care plan changed if assessment determines a different level of risk.

VII. **Documentation**
Morse Fall Scale, Patient Passport, white board, care plan, progress note, kardex and other, standard means per policy.

VIII. **Orientation/Training**
On hire and when change to policy occurs.

IX. **Monitoring**
Fall Prevention Committee

X. **References**

XI. **Storage, Retention and Destruction**
A. All policies are able to be retrieved upon request. Policies are stored in MCN Policy Manager and in paper format.
B. This policy will be reviewed at least every three years
C. Previous versions of this policy are archived in MCN Policy Manager. Policies in paper format are retained for 7 years, or 9 years if related to obstetric and newborn care.