The University of Chicago Medical Center
Policy and Procedure Manual

FALLS PREVENTION

PC 149 Falls Prevention
Issue Date: January 1998
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PURPOSE:

To minimize the risk of falls among all patients.
To increase awareness of risk factors for falls among health care providers and patients. To protect the patient's right to autonomy, dignity, and security.

DEFINITION:

Patient 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). (NDNQI 2016)

Universal Safety Precautions: Safety precautions that may be applied to any patients during any admission to UCMC. These include but are not limited to the following:
1. Obstacles Removed from Room
2. Bed Low & Locked
3. Side Rails Up
4 Call light within reach
5. Non-Skid Footwear

High Risk Fall Precautions: Precaution put in place for patients identified as "high risk for fall". These include but are not limited to the following:

1. Universal Safety Precautions
2. Yellow ID Band
3. Fall Risk Signage (Inside/Outside of Patient Room)
4. Bed Alarm On
5. Staff assist with ambulation
6. Encourage Family to Stay

POLICY:

All adult patients will be assessed for fall risk upon admission to the emergency department, inpatient units, labor & delivery or peri-operative units. Pediatric patients will be assessed for fall risk upon admission to an inpatient unit and peri-op units. Fall precautions will be implemented as appropriate and documented in the electronic medical record (EMR).

Outpatients >65 years of age will be assessed annually and as needed as outlined in this policy.

All staff members are responsible for implementing the intent and directives contained within this

policy, and for creating a safe environment of care. Any staff member, physician, or family member may request that a patient be placed on Fall Precautions regardless of Fall Risk score.

All falls must be reported to Risk Management. The Fall Prevention Committee will review all incidences of falls and evaluate the effectiveness of fall activities including assessment, intervention and education.

PROCEDURE:

Recognizing that every patient's safety status may potentially be compromised by the nature of their illness or by their treatment, basic safety issues will be addressed for all patients, and for those patients identified as a higher level of risk, more in-depth prevention interventions will be implemented.

Universal Safety Precautions are implemented and documented for all patients at the point of entry to the Medical Center.

Adult (ER, Inpatient, L&D, Peri-Operative) Fall Assessment & Interventions

Assessment & Documentation: The nurse assesses and documents all adult inpatient's risk factors relating to falling, upon
admission, at the beginning of every shift, at transfer, post-procedure, and whenever there is a change in the patient's condition.

The Fall Risk Scale is used to assess risk factors in adult inpatients. The categories include:

a. History of Falling
b. Medications and contributing physiological factors
c. Ambulatory Aid
d. Medical Devices
e. Gait/Balance/Transferring/Mobility
f. Mental Status

Fall Interventions: Patient care interventions that may reduce the risk of falling must be examined in the context of larger goal of maximizing function and minimizing disability. Interventions should be linked to individual risk factors.

Universal Safety Precautions are interventions initiated for all adult patients and documented each shift. Documentation occurs in the Safety Section of the Daily Care Flowsheet as well as in the Care Plan. The following are Universal Safety Precautions used to minimize the risk for fall:

- Patient/Family education on Universal Fall Safety Interventions
- Provide patient and family orientation to environment and routine.
- Bed Low,& Locked
- Call light within Reach
- Use of Non-slip footwear
- Side rails up as appropriate for patient condition
- Remove Obstacles- Arrange furniture and objects so they are not obstacles and remove unnecessary furniture in rooms.

- Purposeful Rounding: 5 P's- Pain, Positioning, Personal Needs, Placement, and Presence
- Keep all assistive devices (glasses, walker, etc.) available to patients.

High Risk Fall Precautions are interventions used for patients are classified as being at high risk for falling. Patients with a score of ≥ 45 must have a yellow ID band and signage placed inside and outside their room. Additionally, these patients require the implementation of High Risk Fall Precautions. The following are High Risk Fall Precautions used to minimize the risk for fall:

- Universal Safety Precautions
- Yellow Falls identification bracelet applied
- Yellow Falls sign placed inside and outside patient room
- Use of Bed Alarm
- Remain within arms' reach of patient while in bathroom/on bedside commode
- Educate patient and family when there is a risk of falling and reinforce as much as possible to call for assistance with ambulating/toileting
- Encourage family to stay with high-risk or confused patient, when possible
- Door to room open, unless isolation or privacy required
- Communicate fall risk to ancillary departments
- Consider placing high risk patients near nursing station

Educations: Patients and their families are educated on the patient's risk for falls and the Falls Prevention interventions.

Pediatrics (Inpatient & Peri-Operative) Fall Assessment & Interventions

1. The nurse assesses and documents risk factors for all pediatric inpatients greater than 12 months of age, or patients able to pull to a stand, upon admission, every shift, upon transfer and whenever there is a change in patient condition.

2. The General Risk Assessment for Pediatric In-patient falls (GRAF-PIF) (Attachment 2) is used to assess fall risk factors in pediatric patients.

3. Universal Fall Prevention interventions are initiated for all pediatric patients and documented every shift. See attachment for a list of Universal Fall interventions recommended for children.

4. A Graf-PIF Score of ≥ 2 indicates that a patient has been identified at "high risk" for falling and a a Falls Prevention Plan of Care initiated. Once a pediatric patient is identified as "high risk" by the GRAF-PIF, he/she remains at high risk for the remainder of hospitalization. These patients do not need future GRAF-PIF assessment; the nurse documents once per shift the patient's high risk status. Interventions are documented every shift. See attachment two for a list of High Risk Fall interventions recommended for children.

5. Pediatric patients and their families are educated on the patient's risk for falls utilizing the "Children Are at Risk of Falling While Hospitalized" document in the admission packet.

Out-Patients

1. Out-patients age 65 years and over, under the care of and having an appointment with a Physician, Nurse Practitioner and/or Physician's Assistant, are screened annually for fall risk.

2. The University of Chicago Medicine's Fall Risk Assessment (Attachment 2) is used to screen out-patients for fall risk factors.

3. Out-patients identified as "high-risk" for falling, are provided the UCMC "Out-Patient Fall Prevention Education Guidelines".

4. Physical Therapy consultation and treatment is considered for out-patients identified as "high risk" for falling as deemed appropriate and feasible by the patient's provider.

Attachments:

1. Adult Fall Risk Assessment Tool & Interventions
2. Pediatric Fall GRAF-PIF Assessment Tool
3. Pediatric Fall Risk Interventions
4. Out Patient Fall Guidelines and Risk Assessment
5. Inpatient Adult Fall Prevention Pamphlet.

Interpretation, Implementation, and Revision:

The Department of Patient Safety/Risk Management and Department of Nursing are responsible for the interpretation, implementation and revision of this policy.

References:

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CROSS REFERENCE
PC 128 Documentation of Patient Care

Associated Elsevier Skills
Fall Prevention
Fall Prevention (Pediatric)

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Attachment 1 Adult Fall Risk Assessment Tool and Interventions

Patient care interventions that may reduce the risk of falling must be examined in the context of larger goal of maximizing function and minimizing disability. Interventions should be linked to individual risk factors. The following are interventions used to minimize the risk for fall:

Universal Safety Precautions may include but are not limited to the following:

Patient/Family education on Universal Fall Safety Interventions
Provide patient and family orientation to environment and routine.
Bed Low,& Locked
Call light within Reach
Use of Non-slip footwear
Side rails up as appropriate for patient condition
Remove Obstacles- Arrange furniture and objects so they are not obstacles and remove unnecessary furniture in rooms.
Purposeful Rounding: 5 P's- Pain, Positioning, Personal Needs, Placement, and Presence
Keep all assistive devices (glasses, walker, etc.) available to patients.

High Risk Fall Precautions may include but are not limited to the following:

Universal Safety Precautions
Yellow Falls identification bracelet applied
Yellow Falls sign placed inside and outside patient room
Use of Bed Alarm
Remain within arms' reach of patient while in bathroom/on bedside commode
Educate patient and family when there is a risk of falling and reinforce as much as possible to call for assistance with ambulating/toileting
Encourage family to stay with high-risk or confused patient, when possible
Door to room open, unless isolation or privacy required
Communicate fall risk to ancillary departments
Consider placing high risk patients near nursing station

Fall Risk Factors	Score	Row Information
History of Falling	25	Score 25: Patient has fallen within the last 6 months or during current or previous hospitalization
	0	Score: 0: Patient does not have a history of falling.
Medications & Physiologic Risk Factors	15	Score 15 if patient has more than one medical diagnosis, any physiologic risk factor or is on any medication listed below: *Does the patient have any of the following conditions:* · Alcohol/substance abuse · Altered elimination · Altered oxygenation · Cardiac arrhythmia · Electrolyte imbalance · Neurologic deficit/stroke · Orthostatic hypotension · Seizure disorder · Severe anemia · Vasovagal syncope *Is the patient on any of these medications:* · Antiarrhythmic · Antidepressant · Antihypertensive · Benzodiazepines · New Chemotherapy · Diuretics · Laxatives · Opioids · Sedatives hypnotics *Additionally: Consider the addition of any new medications.*
	0	Score 0: Patient does not have any medical diagnosis, physiological risk or not on any high risk medications as noted above.
Ambulatory Aid	30	Score 30: if patient uses furniture to assist with ambulation
	15	Score 15: if patient uses crutches, cane or walker
	0	Score 0: if patient walks without a walking aid
Medical Devices	20	Score 20: if the patient has any medical device: ALPs, chest tubes, drains, feeding tubes, infusion/PCA/epidural pump, NGT to suction, oxygen therapy, urinary catheter, wound-vac, L- VAD cords
	0	Score 0: if patient doesn't have any medical devices
Gait- Balance- Transferring- Mobility	20	Score 20 (impaired gait): patient walks with head down, poor balance, grasps onto furniture, a support person, or a walking aid and cannot walk without assistance. AM-PAC score <18
	10	Score 10 (weak gait): characterized by a stooped posture, but can lift head without losing balance. Steps are short and may shuffle. AM-PAC Score 19 – 23.
	0	Score 0 (normal gait): characterized by the patient walking with head erect, arms swinging freely at side and striding without hesitation. AM-PAC Score 24.
		Note: Check patient's ability to accurately assess his/her own ability to walk alone.
Mental Status	15	Score 15: if patient is forgetful or unrealistic related to ability to walk. Patient with confusion, short-term memory loss, delirium, dementia, impulsiveness, A & O <4, developmental delays, GCS <14, CIWA score >8.
	0	Score 0: if patient assessment and demonstrated ability match.

Attachment 2 Pediatric Fall Assessment Tool

General Risk Assessment for Pediatric In-patient Falls (GRAF-PIF)

- Use with any child 12 months or older or any child able to pull to a stand
- **A GRAF-PIF Score ≥ 2 Indicates a Child is at High Risk for Fall**

			Score
Length of Hospital Stay	**1-4 days**	**0**	
	5-9 days	**1**	
	10 or greater	**2**	
IV / Heparin Lock	**No**	**1**	
	Yes	**0**	
PT / OT	**No**	**0**	
(recent past, current or expected in near future)	**Yes**	**1**	
Anti-seizure medication, given for any reason	**No**	**0**	
	Yes	**1**	
Acute or chronic orthopedic, musculoskeletal diagnoses	**No**	**0**	
	Yes	**1**	
History of fall within past 1 month	**No**	**0**	
	Yes	**2**	
Fell During this Hospitalization	**No**	**0**	
	Yes	**2**	
	Total Score		

Used with permission of Dr. Elaine Graf, RN egraf@childrensmemorial.org

Attachment 3: Pediatric Fall Risk Interventions

Pediatric Universal Fall Precautions: The following interventions (Universal Fall Precautions) are initiated for all pediatric inpatients (as appropriate) and documented every shift:

- Select safest sleeping arrangement for patient. All patients under three years of age are placed in a crib with a climber-hood. Should a parent request a full-sized bed, the parent must sign a Patient Safety Release Form (Form 76.05) and be educated regarding risk of injury or falls related to bed choice.
- Provide patient and family orientation to environment and routine.
- Educate families regarding fall risk and fall prevention, and reinforce as much as possible to call for assistance with ambulating and toileting.
- Per unit standards and patient condition, offer patient assistance to bathroom every 2-4 hours while awake, and monitor every four hours at night; answer calls for assistance promptly.
- Assist with age appropriate ambulation
- Ensure caregiver is able to operate crib or bed.
- Keep bed in lowest position.
- Lock wheels of beds, wheelchairs, strollers, etc.
- Determine safest side rail position (2-4 side rails up based upon diagnosis); ensure side rails are up and climber-hood down, as appropriate.
- Do not leave side of bed if side rails are in down position.
- Maintain direct supervision of children on elevated surfaces such as infant scales.
- Use safety straps on swings, infant seats, wheelchairs and PT devices.
- Remove objects that provide young children with climbing access to elevated areas; do not allow child to lay or play on furniture.
- Set behavioral activity limits; monitor patient/parents ability to comply and re- emphasize limits as needed.
- Ensure patient is able to reach call light, bedside table, telephone, and personal items.
- Keep all assistive devices available to patient.
- Review medications that can place the patient at risk for falling, and communicate concerns to physician.
  Reduce environmental hazards:
    i. Eliminate spills, wet areas, and dragging cords.
    ii. Maintain tubes and monitor wires as not to obstruct patient mobility.
    iii. Arrange furniture and objects so they are not obstacles.
    iv. Provide and encourage use of non-skid footwear for all patients able to ambulate or cruise.
    v. Ensure clothing is appropriate for child's size and not dragging or inhibiting movement.
    vi. Provide adequate lighting.

Pediatric High Risk Fall Interventions GRAF-PIF ≥ 2: In addition to above universal fall risk interventions, the following interventions are initiated (as indicated and when possible) for pediatric inpatients at "high risk", and documented every shift:

- Identify patients as high risk for falls (ID band, door sign, sticker).
- Include Fall Risk as element of nurse to nurse SBAR communication.
- Communicate with ancillary departments that patient is at high risk for falls.
- Use a dim light at night.
- Assess patient coordination and balance before transfer and mobility activities.
- Instruct parents to inform RN or MD if the patient seems less coordinated, dizzy or weak.
- Instruct parents to walk alongside of child to provide support and protection.
- Reinforce activity limitations as appropriate.
- Elimination needs assessed and assistance offered every two hours while awake.
- Remain in bathroom with patient as warranted by physical activities.
- Request referral for physical therapy if patient's gait or balance is impaired; provide assistive devices to steady gait.
- Monitor medications for side effects that may add to the patient's risk of falling.
  Educate patient and caregivers regarding high risk for falls and review fall prevention strategies.

Attachment 4: Out Patient Fall Guidelines and Risk Assessment

Step 1:
If 65yrs or over ask the following questions:
Y N Do you have a fear of falling?
Y N Have you had 2 or more falls in the past year?
Y N Have you had any fall with injury in the past year?
If answered yes to any of the above questions patient is "High Risk" please complete step 2.

Step 2:
Y N Would the patient like to be referred for an evaluation of fall risk?
If no, why? _____
Patient is already being evaluated by Physical Therapy
For all referrals please complete Step 3a and 3b then sign

Step 3a /Diagnosis:
Weakness- 780.79 /evaluate and treat for Fall Risk
Gait disturbance/abnormality- 781.2 /evaluate and treat for Fall Risk
Other_____/evaluate and treat for Fall Risk

Step 3b/ Referral
Patient is being referred to Physical Therapy for evaluation and treatment
Physical Evaluation / Therapy
Home Evaluation/ Home Physical Therapy (Refer to Social Work)
Other

_____
Physician signature MD Print Name Office phone
Referring service: _____

Fax order to the Physical Therapy Department Ext: 2-5340

Patient Fall Prevention and PrecautionInformation for Patients and Families

Who is at a higher risk for falling?
Studies have shown that the odds of falling increase each year after the age of 65. Other leading causes of falls include: surgery, added stress from illness, physical changes and multiple medications.

Five Ways to reduce your risk for falling

1) Tell the nurse or doctor:
- If you have fallen and injured yourself in the last 12 months
- Provide a complete list of the medications you take at home
- If you feel weak, dizzy or unsteady on your feet
- Ask for help and ask frequently (Request a wheelchair)

2) Keep Moving (*improve your strength*)
- Ask about exercise programs
- Start Regular exercise (walking, water workouts, tai chi)

3) Wear sensible shoes
- Wear and buy sturdy rubber-soled, flat, nonskid, shoes or slippers
- Avoid high heels, floppy slippers and extra thick soles

4) Remove Hazards from home
- Keep your home brightly lit (use night lights and lamps)
- Move and or remove coffee tables, magazine racks, plant stands, boxes, newspapers, phone cords, from high traffic areas and walkways
- Secure or remove loose rugs, repair loose wooden floor boards
- Immediately clean spilled liquids, grease and food

5) Use assistive devises
- Use canes, walkers and crutches provided to you
- Wear your eyeglasses

Anyone can fall, even patients that appear healthy and strong.
Help Us Help You Stay Safe

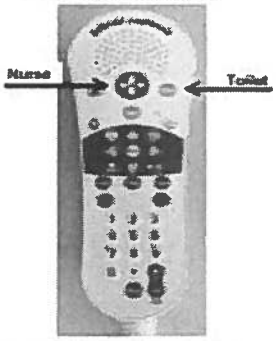
Reference: MayoClinic.com

Attachment 5 Inpatient Adult Fall Prevention Pamphlet

Safety First

Call! Do Not Fall

Use your call light to ask for help to get up



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Prevent Falls in the Hospital

Talk to our Staff

The University of Chicago Medicine
5841 S. Maryland Ave., Chicago, IL 60637

THE UNIVERSITY OF CHICAGO MEDICINE

Talk About Falls

Talk to your hospital staff about how to reduce your risk of falling.

Everyone who is in the hospital is at risk for falls because of weakness, confusion, changes in diet, medications, and being tired.

Falls can be serious. They can lead to longer stays in the hospital from injuries or from not being able to care for yourself.

Our staff expect you to call for help even if you have family in your room.

Stop Falls

What You Can Do

- **Use your call light when you need to get up**
- Do not stand up if you feel weak or dizzy
- Sit on the edge of the bed several minutes before standing
- Wear non-skid slippers
- Do not lean on furniture for support – Call for help
- Ask if your medications increase your risk of falling

What Staff Will Do

- Talk to you and your family about how you can prevent a fall
- Help you get to the bathroom
- Help you get out of bed
- Talk to other staff about keeping you safe
- Make sure you can reach your call light, telephone and personal items
- Give you non-skid slippers

Know Your Fall Risk

You have a higher risk for falling when in the hospital if:

1. You fall or lost your balance in the last 6 months
2. You take any of these medicines
   - water pills
   - sleeping aids
   - pain pills
   - mood changing pills
   - anxiety reducing pills
   - blood pressure pills
   - laxatives
3. You had a procedure, surgery or dialysis
4. You use furniture, crutches, cane, or walker to help you walk.
5. You have weakness or lack of feeling in your legs, feet, or toes
6. You have trouble with your memory or vision

Help Us Keep You Safe

We Care

The University of Chicago Medical Center
ACKNOWLEDGEMENT OF RECEIPT OF FALL PREVENTION POLICY

I acknowledge that I have received, read and understand The University of Chicago Medical Center's Falls Prevention Policy (PC149 Review date: April 2017)

_____

Print Name

_____ _____

Signature Date

_____

Organization Name