

Preventing Patient Falls

Patient Falls are the #1 cause of ALL sentinel events.

All patients at Doctors Community Hospital are assessed for fall risk and, as appropriate, the Fall Risk Protocol is implemented.

Patient falls are all too common in the healthcare setting. Falls can cause injury and even death.

You will learn about:

- How balance normally keeps us from falling
- Risk factors for falls
- Strategies for preventing falls

Definitions

- **Fall** - An unplanned movement of the patient to the ground or from one plane to another.
- **Near Miss** - Could have happened, but did not, either by chance or through timely intervention.
- **Sentinel Event** - An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Prevalence of Falls

- Patient falls make up a large number of all sentinel events.
 - Falls account for 42% of sentinel events in long-term care settings.
 - Falls account for almost 5% of all sentinel events.
 - Thus, patients are at risk for falls in:
 - The long-term care setting
 - Other healthcare settings, including acute care hospitals and outpatient areas.
- In the healthcare setting,
1 out of every 20 sentinel events is a patient fall!

Why is Fall Prevention So Important?

- Every year between 33% and 50% of people over 65 suffer a fall.
- Falls can lead to a long stay in the hospital.
- Falls can result in people experiencing a loss of confidence, self esteem and reduced independence.

Prevalence of Falls Among the Elderly

Falls are especially common among the elderly.

In a Joint Commission review of 22 fatal falls in various healthcare settings:

Most of the fall victims were elderly.

Half of the victims were over the age of 80.

Falls Outcomes

Falls can be devastating.

Potential outcomes when a patient falls include:

- Head trauma
- Fracture, including hip fracture
- Soft tissue injury

Falls Outcomes: Fatal and Non-Fatal

The injuries that happen in a fall can be fatal, especially among the elderly.

In non-fatal falls, injuries may lead to:

- Permanent disability
- Decrease in physical function
- Reduced quality of life

In addition, patients who fall may lose confidence or develop a fear of falling. This can result in:

- Further functional decline
- Depression
- Feelings of helplessness
- Social isolation

Where and When Falls Occur

Most falls occur from or near the bed.

Falls also may occur when the patient is:

Walking

Transferring (for example, from chair to toilet)

Sitting on the toilet or in a chair or wheelchair

Some falls are dramatic. Examples include:

- When a patient falls down a staircase
- When a patient falls from a window, roof, or balcony

Balance

Balance is the ability to keep a center over a base of support.

In the human body, balance comes from several different systems. If any one of these systems is impaired, balance may be impaired.

This impairment increases the likelihood of falls.

Risk Factors: Aging

Aging causes changes in every system of the body.

These changes can:

Affect balance

Increase the risk of falls

Internal Risk Factors

Cardiovascular:

- Heart rhythm problems
- Low blood pressure
- In some patients, sitting or standing up can cause sudden low blood pressure. This can result in sudden:
 - Dizziness
 - Faintness
 - Lightheadedness

Neuromuscular:

- Leg weakness
- Other muscle weakness
- Impaired mobility or loss of movement
- Poor coordination
- Unsteady gait or other difficulties with walking
- Functional decline
- Parkinson's disease
- History of stroke

Musculoskeletal:

- Joint pain
- Arthritis

Sensory:

- Poor Vision (Cataracts, Diabetic retinopathy)
- Poor Hearing

Cognitive:

- Confusion
- Disorientation
- Impaired memory
- Inability to understand
- Delirium
- Alzheimer's disease or other dementia
- Stroke

External Risk Factors: Medications

Medication is a major risk factor for falls.

Psychoactive drugs are especially likely to increase fall risk.

These drugs include:

- Sedatives
- Tranquilizers
- Anti-anxiety drugs
- Antidepressants
- Other drugs that may increase risk of falls are:
- Anticoagulant drugs
- Diuretics
- Beta-blockers

Other drugs with a side effect of dizziness, unsteadiness, or low blood pressure

Patients also are at risk if they take:

- More than four prescription drugs
- Certain combinations of drugs
- External Risk Factors: Environmental
- Environmental risk factors for falling include:
- Recent environmental change
- Wet or otherwise slippery floors
- Uneven surfaces
- Inadequate lighting or glare
- Clutter
- Incorrect bed height
- Poorly maintained or fitted wheelchairs

DCH has a Falls Prevention Committee that is responsible for reviewing all patient falls.

The goal of the committee is to reduce patient falls and improve patient safety.

Falls Prevention Committee

The Falls Prevention Committee has representation from these departments:

- V.P. Patient Care Services
- Education
- Director, Clinical and Support Services
- Nursing Units
- Risk Management
- Pharmacy
- Director, Environment of Care
- Rehabilitation

Multidisciplinary Approach: Communication

To succeed, any multidisciplinary approach must include regular communication between disciplines.

This includes:

- Physicians
- Pharmacists
- Physical and occupational therapists
- Nurses
- Other staff

In other words:

To prevent falls, the healthcare team must discuss at-risk patients regularly.

Fall Reduction Program

Joint Commission National Patient Safety Goal 9 requires the hospital to have a Fall Reduction Program that:

- Evaluates the patient's risk for falling
- Takes action to reduce the risk of falling and reduce the risk of injury should a fall occur
- Includes inpatient *and* outpatient settings
- Fall Reduction Program
- Inpatients *and* outpatients are screened to determine their fall risk
- When a patient is identified as being at risk for falls, the Fall Risk Protocol is implemented
- Staff are educated about the Fall Reduction Program
- Patients/families are educated about the Fall Reduction Program
- The effectiveness of the Fall Reduction Program is evaluated by the Fall Reduction Team and revised, as appropriate

Fall Risk Assessment

- A multidisciplinary approach first requires a patient assessment.
- Assessment of a patient's fall risk:
- Alerts staff to at-risk patients
- Provides information so that providers can use the multidisciplinary interventions most likely to be effective for a given patient

DCH Key Point:

Upon admission, all inpatients are assessed for fall risk by a nurse using the computerized Inpatient orientation tool. Patients are reassessed for falls every shift not to exceed every 12 hours.

Outpatient Fall Risk Screening

- Outpatients are screened for fall risk at the time of each visit using the Outpatient Fall Risk Screening Tool
- The screening is performed at the point of Registration or at triage in the Emergency Department
- If the patient is identified as being at risk for a fall, this status will be communicated to the Clinical and/or Technical staff in the department providing care, treatment or services
- The Outpatient Fall Risk Screening Tool consists of the following questions:
 - Have you had a fall in the past 3 months?
 - Do you use an assistive device (walkers, canes, braces, etc.)
 - or have difficulty walking?

Outpatient Falls

If the patient answers Yes, to either question *OR* on observation the patient appears to have difficulty walking or requires assistance, the patient will be considered to be at risk for a fall

- A wheelchair will be provided for any patient who presents with an unsteady gait or has difficulty in walking
- Any patient identified as being at risk for a fall will have a yellow wrist bracelet applied and a yellow fall risk sticker will be placed on the chart, if applicable the Fall Risk Protocol will be implemented

Outpatient Fall Risk Screening

- The screening process must be documented on the Outpatient Fall Risk Screening Tool. The individual performing the screening must sign, date and time the Tool upon completion of the screening. (Done in Allscripts in the ED)
- Clinical and technical staff will educate the Patient/family about the DCH Fall Reduction Program and provide a copy of the Outpatient Fall Prevention handout.

- The education process must be documented on the Outpatient Fall Risk Screening Tool. The individual conducting the education must sign, date and time the Tool upon completion of the education.

The Fall Risk Protocol

- Place a yellow wrist band on the patient's wrist and a yellow fall risk sticker on the chart, if applicable
- Educate the patient/family about the Fall Reduction Program
- Orient the patient to surroundings, call device and bathroom locations
- Instruct the patient/family to ask for assistance from staff for any patient activity
- Respond promptly to any request for assistance. Responding to call lights promptly may prevent a patient from getting out of bed unassisted.
- Supervise and/or assist with toileting and personal hygiene, as appropriate
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The Fall Risk Protocol

- Place personal and frequently needed objects within reach of the patient (eyeglasses, telephone, water, shoes, assistive devices)
- Assure adequate lighting
- Assess for and provide properly fitting non-skid footwear
- Lock all beds, stretchers, wheelchairs
- Keep beds/stretchers/chairs in lowest position during use, keep side rails elevated
- Check to be sure side rails are locked appropriately and clicked into place!!!
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Strategies to Prevent Falls

- Re-orient patients if they show signs of confusion, encourage family to sit with/accompany patients who become confused or disoriented
- Knowledge and awareness is prevention:
- Let other caregivers know that a patient may be at risk for falling. If you notice potential or actual problems, let all the caregivers know.
- Preventing Falls Starts with Awareness
- Being aware of our Patients state of mind and physical limitations helps prevent falls
- Everyone is a part of the Team!
- Keeping your eyes and ears open to potential problems can help prevent a fall.

Falls occur in all age groups and all types of patients!

Fall Risk Protocol at DCH

- If a patient is assessed as a fall risk, the Fall Risk Protocol is implemented.
- Place a yellow "Fall" sign as well as a yellow "Do Not Get Up" sign on the bulletin board next to the patient identified as a fall risk.
- Place a yellow wrist band on the patient and a yellow Falls Sticker on the patient's chart.
- Follow the toileting protocol by having the patient use toilet facilities by bedtime (10:00 p.m.) and again when walking (around 5:00 - 6:00 a.m.)

Assistive Alarm Devices

DCH has two bed alarm systems to aid in detecting when a patient is getting out of bed.

- The Chaperone system
- The Tabs System.

TABS Alarm System

Use TABS Alarm system on the bed or chair for patients who may not remember to call for help before getting up.

This alarm system will alert nursing staff to immediately come to the patient's bedside.

- Complete Requisition Form
- Obtain Alarm
- Record Statement
- Plug in pad to monitor
- Apply pad to bed or chair

TAB Instructions

- Place pad across the width of the mattress
- Position the pad under the patients buttocks-cover with sheet (thick pad may be too heavy to allow alarm to work properly)
- Plug pad into monitor
- Mount the TABS monitor at the headboard
- Monitor will beep when weight is applied
- Reset monitor by pressing reset button on front
- The alarm will sound when the patient's body is lifted off the pad
- Reset alarm by pushing RESET button on front of the monitor or by placing pt back on pad

Chaperone System

- Fall Prevention: 4 P's
Round every 1-2 hours
- Pain: Does the patient have pain?
- Potty: Does the patient need to use the bathroom?
- Position: Turn your patient, or reposition for comfort
- Possessions: Be sure water, call light, tissues, glasses and other items are within reach
- When an Inpatient Falls
- The House Officer and charge nurse must be called to come and evaluate the patient
- A "Post Falls Standing Orders Sheet" must be completed by the H.O
- It needs to be placed in the Doctors Order Section in the chart
- Near Misses are to be treated like a regular fall and need to be reported too!

When an Inpatient Falls

- They must have a CT of the brain .
- This includes witnessed and unwitnessed falls!!
- There is a presumption that they may have hit their head.
- Sometimes there are other injuries that require an x-ray to be done.
- THE IMAGING DEPARTMENT needs to be called and notified that that there is a patient that needs Radiology Services post fall!!!!!!
- There is a time limit for post-fall tests. They have to be done within a certain time period and Radiology needs to know so they can re-arrange their schedule!

Who Must Be Notified?

- Clinical Coordinator or charge nurse
- House Officer
- Patient's PMD (notify as soon as reasonably practical)
- Unit manager
- Patient's family
- Rapid Response Nurse (the fall may be a result of a serious problem not seen immediately)

When an Outpatient Falls

- There is an ITR called "OUTPATIENT FALLS". Please use this ITR if and when an outpatient has sustained a fall in an outpatient area.
- Notify the Department Manager
- Notify the Administrative Nursing Supervisor
- Suggest/Recommend the person go to the Emergency Department for follow up
- For Visitors (not outpatients) who may have sustained a fall while on campus, please use the VISITOR ITR.
- Inpatient Falls should be reported on the INPATIENT FALLS ITR.
- Remember Call 8513 to notify Radiology of any STAT Post FALL ORDERS

