
Fall & Injury Prevention
Fulfilling Our Promise To Keep Patients Safe


Food for Thought...
Can you identify which of your patients are at risk of falling?
Can you identify what puts patients at risk?
Are you doing everything you can to prevent your patient from falling?

Contributing Factors

Inadequate Assessment

A fall risk assessment must be performed every shift and as needed by the nurse. Appropriate interventions need to be implemented based on the fall risk score.

Communication Gaps

Fall risk score and interventions must be discussed during bedside shift report and team huddles.

Practice Gaps

Lack of adherence to safety protocols and safety practices.

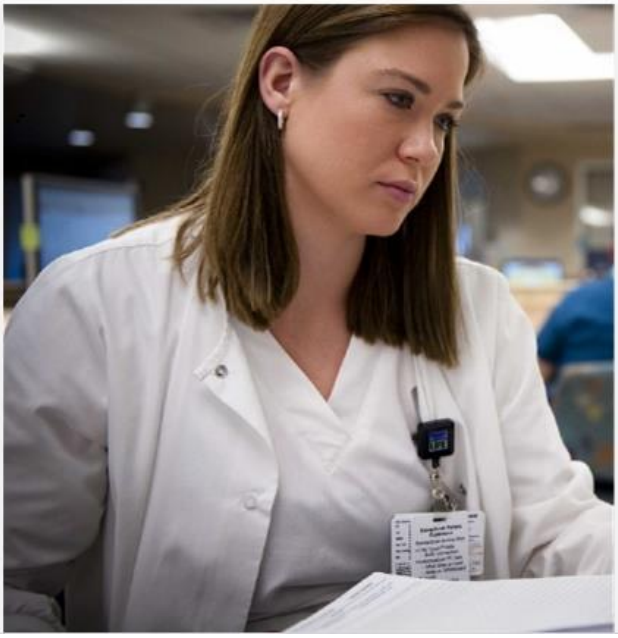
Fall Risk Score

1 **Fall Risk Assessment Tool**
A fall risk score is required by a nurse at the beginning of each shift and upon admission to the unit.

2 **Scoring**
The higher the score, the higher risk your patient is to fall.

3 **Intervention**
Individualized interventions are put in place based on the fall risk score.

Fall Risk Assessment Tool



4 – history of falls within 3 months
3 – polypharmacy
3 – cardiovascular medication
3 – central nervous system/ psychotropic medications
2 – age greater than 65
2 – altered elimination
2 – cognitive deficit
2 – sensory deficit
2 – mobility deficit/weakness
2 – dizziness/vertigo
2 – depression
1 – male
0– no indicators present

Add to determine the patient's Fall Risk Score

Interventions

Discuss the importance of the following interventions frequently with your patients:

Fall Risk Wristband
Explain to patient why they are a fall risk and have them explain back to you using the Teach Back Tool.

Non-Slip Socks
Always utilize non-slip socks when ambulating patients to prevent them from slipping.

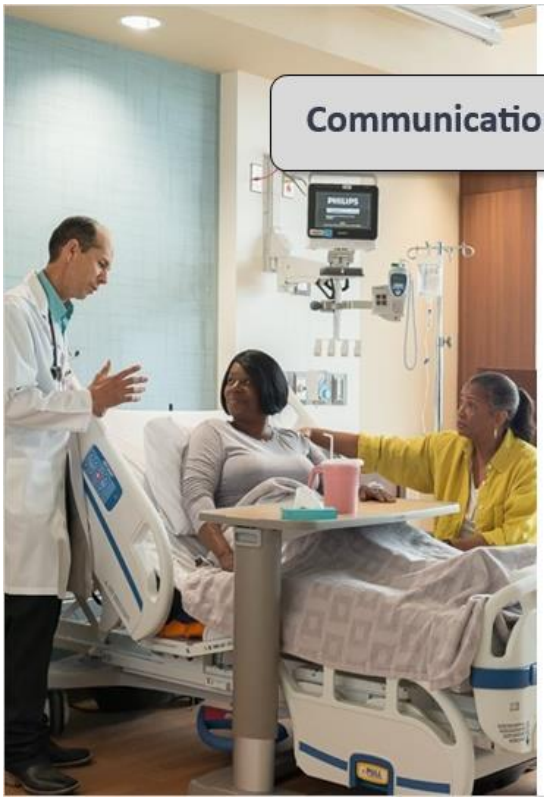
Call Light
The call light should remain within reach of the patient. Don't forget to review how it works & who will respond.

Bed Alarm
Every patient must have a bed alarm activated when in bed. Double check when rounding and after assisting the patient back to bed. (If you have a patient that is refusing the bed alarm, this must be escalated to the charge nurse, management, or nursing supervisor). Document refusal in EPIC.

Interventions

1. Most falls that occur in the bathroom result in serious injury. Always assist your patient to and from the restroom and bedside commode. When your patient is in the bathroom, keep the patient within your sight at all times.

2. The key to success is patient and family involvement. To ensure their understanding of fall prevention, ask the patient to describe their risk for falls and how we are keeping them safe. Do this often throughout your shift.



Communication is Key!

Upon admission, discuss the possible risk factors with your patient and their family. Because these factors may change, discuss the risks often.

Bedside Shift Report and Purposeful Hourly Rounding are optimal times to discuss the risk and interventions with the patient and family.

The 6P's for Purposeful Hourly Rounding are:

- Pain
- Potty
- Position
- Proximity
- Prescriptions
- Plugs

Teach Back Tool

The Teach Back Tool is required for every patient with a fall risk score of 4 or greater.

Individual needs may require additional interventions including but not limited to:

- Reorientation
- Room closer to the nursing station
- Urinal within reach or bathroom rounds
- Chair alarms, bed alarms
- Ambulation with assistance
- Pharmacy consult

Click here to see Teach Back Tool

Summary

Assess the patient early and often.

Discuss the patient's fall risks and interventions with the care team early and often.

Educate the patient and their family early and often.

Utilize the tip sheets within resources.

****************************End of Training***************************