

Providence Alaska Learning Institute HealthStream Course

PAMC: Fall Prevention for Clinical Staff

14575

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Providence Alaska Learning Institute

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Course Description:

This course is designed for clinical healthcare professionals and will define falls, address the prevalence of falls in the hospital setting, identify fall prevention strategies, and how to manage falls when they occur in the hospital.

Learning Objectives:

- **Discuss the importance of a fall prevention program**
- **Define a fall**
- **Describe causes of falls**
- **Identify prevention strategies**

What is a Fall?

- **Fall: Unplanned descent to floor (or extension of the floor; trash can, or other equipment) with or without injury including falls that result from physiological reasons (fainting) or environmental reasons (slippery floors.)**
- **Unassisted Fall: Occurs without the presence or assistance of a staff member.**
- **Assisted Fall: Staff was present & attempted to minimize impact by easing descent to floor.**

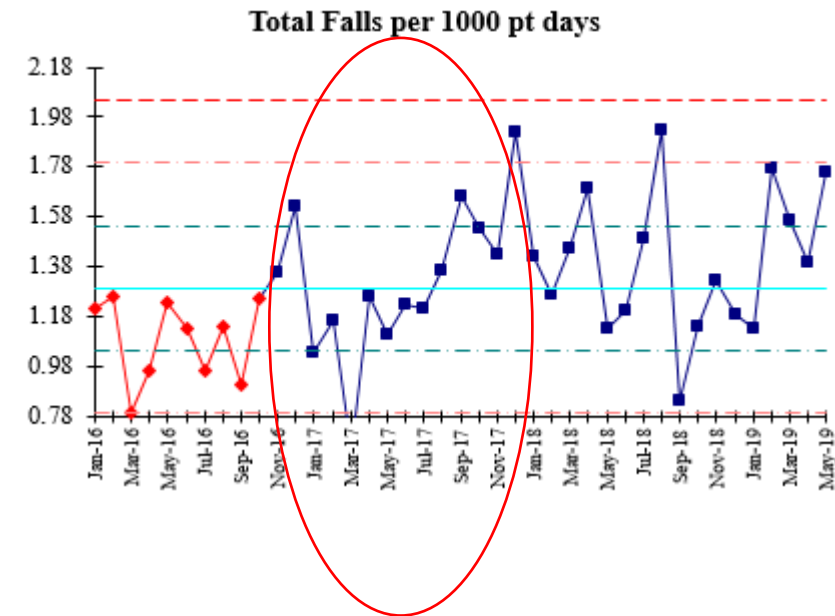
***PAMC uses the fall definitions set by the National Database for Nursing Quality Indicators (NDNQI.)**

Impact of Falls on Healthcare

- **Agency for Healthcare Research & Quality (AHRQ) reports close to 1 million falls are recorded in U.S. hospitals every year. The care that is needed due to these falls (x-rays, splinting, surgery, extended hospital stay, etc.) is not reimbursed by the Centers for Medicare and Medicaid Services.**
- **As many as half of all reported hospital falls result in injury. In addition to the effects of falls on the patient, the annual total cost of fall-related injuries could increase to \$34.4 billion by the year 2020**

Impact of Falls at Providence











- Falls have a very real impact on our own patients.
- In 2017, PAMC had:
 - 326 total inpatient falls
 - 5 falls that resulted in injury to the patient categorized as moderate to severe (requiring sutures, blood transfusions, surgical treatment, or fractured bones)
- According to the AHRQ cost estimates for falls are between \$2680 and \$15,491



Assess Risk

- Assess fall risk on admission, every shift, after transfer from another unit, & for change in condition
- When patient identified “At Risk to Fall” develop individualized plan to prevent falls & minimize injury if fall occurs and includes:
 - Consult physicians and/or pharmacy for medications that increase risk for falls (i.e., diuretics, benzodiazepines, sleep meds, etc.)
 - Assessing environment – cords off floor, lighting adequate, appropriate equipment in place (low bed if needed, floor mats)
- Mobility Assessment – use lift equipment (Sara Steady etc.) for pts that cannot stand and balance for 10 seconds

Quick Mobility Screen: PHS Alaska Date: _____ Shift: AM / PM
 Patient's preferred name: _____ Caregiver name: _____

Patient Action	Patient Instruction	Mobility Classification	Equipment	Check Box
Bed Mobility:  Scoot  Roll	Can you move yourself up / scoot sideways or roll over to the side?	No → Needs Assistance with Bed Mobility Continue to seated balance with either yes or no answer.	Ceiling Lift with Repositioning Sling Slide tube or sheets < 250 lbs. Air Assisted Transfer Device HoverMatt >250lbs.	
Seated Balance:  Good Balance  Failed Balance	Can you sit on the edge of the bed by yourself, hands in lap - Hold for 10 seconds.	No → Max Assistance / Dependant Yes	Ceiling Lift / Seated Sling Floor Lift / Seated Sling	
Must have gait belt on.	Sit to Stand:  Bears weight	Gait belt on; stand to side of patient. Can you stand up? Nose over toes. Caregiver uses less than 35 lbs. of force to assist. May use assistive device: Walker Cane other	Can weight bear on at least one leg and can use arms. Moderate Assistance	 Sit to Stand Device (Sara Plus)
	Standing Balance:  Standing Balance	Gait belt on; stand to side of patient. Can you stand and balance? 10 seconds. Caregiver uses less than 35 lbs. of force to assist. May use assistive device: Walker Cane other	No → Minimum Assistance Yes	 Stand and Raise Aids (Steady)
	March In Place:  March In Place	Gait belt on; stand to side of patient. Can you march in place? 10 steps. May use assistive device. Caregiver assistance required Caregiver assistance NOT required	Supervision / Independent	 Consider Gait Belt

Revision 1 - 8/2015

Falls Interventions

Risk Factors	Recommended Interventions
General Risk Factors	<ul style="list-style-type: none"> • Purposeful rounding every 1-2 hours • Patient/Family education; Age appropriate bed with alarms
Cognitive Impairment	<ul style="list-style-type: none"> • Anticipate & meet physical needs; Low stimulus environment; bed/chair alarms
Altered Elimination	<ul style="list-style-type: none"> • Toilet every 2-4 hours around the clock; never leave high fall risk patient alone on toilet or bedside commode; Assess for presence of urinary tract infection
History of Previous Falls or Unlikely to Call for Help	<ul style="list-style-type: none"> • Consider contract to NOT get up without assistance; Bed alarms; Low bed; Use of assistive devices; Use of gait belt as appropriate
Fall Risk Medication	<ul style="list-style-type: none"> • Consult with pharmacist if needed; Evaluate responses to new meds especially opioid therapy
Anticoagulation Therapy	<ul style="list-style-type: none"> • Protect from injury; Consider family presence • Consider sitter; work with Provider to ensure correct therapy levels

Bed Alarms – Available & Working

- **Set at appropriate sensitivity**
- **Plugged in to nurse call system**
- **Bed must be zeroed before, for alarm to work properly**
- **Check alarm set during Purposeful Rounding**
- **All disciplines responsible for resetting alarms before leaving patient**
- **Specialty beds & rental beds may have different alarm settings – ask Rep or refer to the bed's manual or Clinical Toolbox**



Chair Alarms

- Patient out of bed in recliner, wheelchair, toilet, etc.
- Plugged in to nurse call system (where applicable)
- Use in the bathroom to alert if patient trying to get off the toilet without assistance
- Pads available include:
 - Chair pad; Stretcher pad; Toilet seat pad



Toileting & Purposeful Rounding

- **Create a toileting plan:**
 - Can reduce urgency that causes pts to try getting up without help
 - Pts taking diuretics may need more frequent toileting
- **Prompt patient to use bathroom every 2 hours (part of Purposeful Rounding)**
- **Do not assume pt is safe on toilet with family or visitors. Patients at risk to fall are not left alone on toilet or commode**
- **If pt refuses caregiver attendance in the bathroom, document refusal in EMR (see Falls Program policy for more info)**

Engage Everyone; Communicate Risk

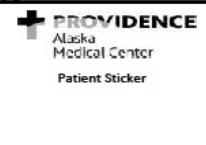
- Visibly identify patients at risk by placing “Prevent a Fall” magnet on door jamb of room
- Include fall risk & interventions in all handoffs (shift change, transfers, Ticket to Ride)
- Adopt the “Not on My Watch!” attitude
- Use white boards for current safety & mobility needs
- No Pass Zone = All staff responds to bed/chair alarms to maintain patient safety
- Non-clinical staff calls for assistance and stays with the patient until help arrives



Debrief Every Fall

- Complete a UOR by the end of the shift
- All staff involved with the fall (therapies, TLC, etc.) and primary RN & PCT will do an immediate Post-Fall Huddle
- The purpose of the fall debriefings are to make immediate changes to the patient's plan of care to prevent further falls & to share findings with other staff caring for pt

Post-Fall Huddle Form

Completed by: _____ Classification of Patient: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out Patient <input type="checkbox"/> Other		
Injury Occurred: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Age: _____ Gender: <u>M/F</u> Date of Incident: _____		
Time of Incident: _____ Department of Incident: _____ Date: _____		
Unit where the event occurred _____ Date: _____		
Morse/GRAF PIF Score: _____ Fall Risk Level: _____		
Type of Fall (check all that apply)		Injury Level (check one)
From Bed /Crib/Exam table/OR table (circle one) <input type="checkbox"/>	<input type="checkbox"/> None (no injuries)	<input type="checkbox"/>
From Chair <input type="checkbox"/>	<input type="checkbox"/> Minor (bruise, abrasion, ice, cleaning, elevation)	<input type="checkbox"/>
During Transfer <input type="checkbox"/>	<input type="checkbox"/> Moderate (suturing, steri-strips/skin glue, splinting)	<input type="checkbox"/>
While Ambulating <input type="checkbox"/>	<input type="checkbox"/> Major (surgery, casting, required consult, neuro/internal injury, fracture)	<input type="checkbox"/>
From Commode/Toilet <input type="checkbox"/>	<input type="checkbox"/> Death	<input type="checkbox"/>
Baby/Child Drop <input type="checkbox"/>		
Developmental (pt age 8 or less) <input type="checkbox"/>	*Note any follow up procedures or tests as a result of injury: _____	
Check One:		Interventions in Place
Physiological Fall? (syncopal event, fainting, etc) <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Non-skid slippers
Was fall intentional? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bed locked and in low position
Was fall assisted? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side rails up: x 1 2 3 4 Topper (circle)
Was pt under supervision of PT/DT? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Call light accessible
Was Fall Risk assessment done on admission? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bed Alarm/Chair Alarm in place
Was Fall Risk reassessment done per protocol? (Q shift) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Omni belt
Was pt assessed as at risk to fall before the fall occurred? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Age-appropriate bed/ crib
Time Since last patient rounding <input type="checkbox"/> <15 min <input type="checkbox"/> 15-30 min <input type="checkbox"/> 30-45 min <input type="checkbox"/> > 45 min		<input type="checkbox"/> Family or Sitter at bedside
Medication Usage? Circle those used (Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/ Diuretics, Narcotics, Opioids) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Purposeful Rounding
Restraint in use at time of fall? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mobility Assessed in last 24 hours
If yes, specify type of restraint: _____		<input type="checkbox"/> Fall prevention education documented
Was fall related to toileting? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Removal of environmental hazards
Time since last toilet <input type="checkbox"/> <30 min <input type="checkbox"/> < 1 hour <input type="checkbox"/> < 2 hours <input type="checkbox"/> >2 hours		<input type="checkbox"/> Escort to the bathroom at all times
		<input type="checkbox"/> Gait Belt
Patient Related Risk Factors (check all that apply)		Family/ caregiver behavior
Current Diagnosis/Condition (falls, a caregiver, psych/behavioral disorder) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Developmental Fall (ft <8yo in play area, unobstructed by medical equipment)
Mental status/capacity (Not aware of/unsafe limitations, unable to follow instructions) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Environmental risk factors (poor lighting, bed type inappropriate, etc)
Impaired mobility/gait or limited movement (Patient uses assistive device) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Unsecured medical device (i.e. IV tubing, Foley, etc)
Dizziness, Vertigo, conditions that affect balance <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other Factors: _____
Altered elimination/ Toileting <input type="checkbox"/>	<input type="checkbox"/>	
History of prior falls <input type="checkbox"/>	<input type="checkbox"/>	
Event Description - Include as much detail as you can. If you need more space for writing, you can attach a blank piece of paper with written description.		
Make sure to notify MD & Family document this in EMR. Notify & Forward this document to Charge Nurse/ Manager. For Mod to Severe Injury call PEAT Team 88-7328 Adult 88-7378 Peds		

Revised: 3/7/2018

Summary

- **Know your resources; ask manager/clinical educator/CNS who represents your area or someone on the Fall Prevention Taskforce**
- **Be familiar with PAMC “Falls Program” policy**
 - **Assess the risk; Turn on alarms**
 - **Toileting & Purposeful Rounding**
 - **Engage everyone; Debrief every fall**
- **Adopt the “not on my watch” attitude**



Resources

- **“Preventing Falls in Hospitals: A toolkit for improving quality of care.” (2018, July) Agency for Healthcare Research and Quality. Retrieved from <http://www.ahrq.gov/professionals/systems/long-termcare/Resources/injuries/fallpxtoolkit/fallpxtkover.html#Problem>**
- **Christopher, D., Trotta, R., Yoho, M., Strong, J., & Debendorf, P. (2014). Using Process Improvement Methodology to Address the Complex Issue of Falls in the Inpatient Setting. J Nurs Care Qual, 29(3), pp. 204-214.**
- **PAMC Falls Program Policy 951.110**