Cleveland Clinic

Euclid Hospital | Hillcrest Hospital | Lakewood Hospital | Main Campus | Medina Hospital
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NURSING INSTITUTE
NURSING PROTOCOL

Policy and Procedure Manual

Fall Minimization and Post Fall Care, Adult

Target Group:	**Policy Number:**	**Date of Issue:**	**Date of Review:**
All Clinical Staff	F 100	Main 3/01/2010 Euclid, Huron 3/23/2010 Fairview, Hillcrest 4/27/2010 Lakewood, Lutheran 5/11/2010 Marymount, South Pointe 5/11/2010	03/10
Approved by:	**Date Approved:**	**Prepared by:**	**Date of Revision:**
Nursing Institute Council Shared Governance Practice Council	2/19/2010	Falls Minimization Committee of Enterprise, Policy & Procedure Committee, Anne Vanderbilt	03/10

PURPOSE

To define Nursing's role in the management of patients at risk for falls and post fall care.

POLICY

1. RNs and LPNs in inpatient units complete the Morse Fall Scale (MFS) (Appendix I) on admission, upon intra-hospital transfer, and at least once every day after admission. Nurses also complete the MFS after any significant change in condition and post fall.
2. If the patient is deemed to be at a higher risk than identified by the scale score, reclassification to a higher risk category may be done. The RN **may not** classify the patient to a lower risk category than measured by the scale.
3. Universal precautions are used for all inpatients. Moderate and high-risk interventions should be selected based on individual patient needs. Document interventions in medical record. Falls risk should be noted on the plan of care.
4. Include fall prevention and intervention in the hand-off communication to the assistive nursing personnel (i.e., PCNA, STNA, CT) caring for the patient.
5. After an inpatient fall, a patient is classified as high fall risk for the remainder of the hospitalization.
6. The RN notifies the family spokesperson for the cognitively impaired patient in the event of a non-injurious fall.
7. The RN asks the cognitively intact patient if he/she would like their family spokesperson to be notified in the event of a non-injurious fall.
8. The Physician or licensed independent practitioner (LIP) notifies the family spokesperson in the event of a fall with an injury.

SUPPORTIVE DATA

Nurses in the Cleveland Clinic Health System provide individualized care that addresses each patient's unique abilities, healthcare needs, values, and beliefs while promoting dignity, personal freedom, functional status, and safety. Promotion of the highest level of physical functioning carries an inherent risk for patient falls. A fall is defined as an unplanned descent to a lower level either with or without injury to the patient. Cleveland Clinic recognizes that while every patient fall cannot be prevented, use of the least restrictive interventions to minimize fall occurrences is the preferred course.

ASSESSMENT Universal 0-35 Low Risk 40-50 High Risk >50	Complete the Morse Fall Scale screening tool (attached Appendix I) to determine fall risk level and select appropriate interventions based on patient's total score. Variables • History of falls • Secondary diagnosis • Ambulatory aid • IV/IV access • Gait • Mental status
INTERVENTIONS Interventions in this document are not exhaustive and nurses may use others per unit practice.	Universal Interventions Used for all Inpatients Patient Orientation: • Orient patient and family to room, unit and call system. • Instruct patient on use of bedside commode and/or bathroom. Environmental Interventions: • Keep bed wheels locked and bed in lowest position when not providing direct care. • Use two top siderails as appropriate to facilitate mobility and transfers. Consider the use of three side rails. • Place call light, telephone and bedside stand within patient's reach. • Provide assistive devices as needed, including glasses, hearing aids, cane and walker. • Lock bedside commode wheels. • Encourage use of night light or bathroom light to enhance night-time vision. • Maintain an uncluttered environment. • Provide nonskid footwear (have family bring in patient's own footwear if possible). • Answer call light in a timely manner. • Make rounds hourly.
LOW-RISK INTERVENTIONS FOR CONSIDERATION Score 40-50 Select appropriate interventions	• Cue, redirect, or reorient patient, as necessary. • Consider consultation to Social Work, Psychiatric CNS, Pastoral Care, Psychiatric OT or Behavioral Health for depression (if available). • Offer and encourage frequent voiding, especially during first 24 hours of hospitalization. • Postpone ambulation until one (1) hour after meals. • Supervise transfers and ambulation. • Allow patient to rest in sitting position one (1) minute before rising. • Discuss medication regimen and fall risk with LIP. • Consult pharmacist for possible drug interactions. • Consider smallest possible dose of sedative or hypnotic drugs.

	• Request family members to increase visitation. • Post bedside reminder and/or verbally inform patient to call for help prior to getting out of bed. • Educate/inform patient/family of patient's fall risk and request their cooperation in keeping patient safe. • Obtain order to consult Physical Therapist. • Provide walker at bedside.
HIGH-RISK INTERVENTIONS FOR CONSIDERATION (IN ADDITION TO LOW-RISK INTERVENTIONS) SCORE >50 Select appropriate interventions	Increase patient observation: a. Place patient in a room near nurse's station if increased stimulation is not contraindicated. b. Place patient in a chair in the hallway. c. Request the family to stay with the patient during known times of confusion (e.g., night or mealtime). d. Round every 30 minutes or more frequently per unit practice (i.e., some behavioral health areas) e. Consider bed or personal alarm. f. Stay with patient while on toilet/commode. g. Consider constant observation care. h. Consider use of diversional activities. Institute toileting schedule: a. Maintain targeted toileting schedule to include toileting before bedtime, upon awakening, after all meals, before change of shift, after diuretics or laxatives are administered. b. Accompany patient to and from the bathroom; stay with patient while on commode (including bedside commode). Consider use of a personal alarm device when the patient is out of bed and use of the bed zone alarm if available. Consider q 2 hour ambulation.
MANDATORY INTERVENTIONS FOR HIGH-RISK PATIENTS	• Place a yellow Fall Risk wristband on same extremity as patient's ID band. • Place "Falling Leaf" symbol on doorframe outside patient's room. Ensure that the falling leaf is removed upon discharge.
OTHER INTERVENTIONS TO CONSIDER FOR PREVENTION OF FALLS INJURY	• Program call light system to indicate patient is at high risk of falling (if available). • Use bed zone alarm or personal alarm device for first 24 hours following discontinuation of patient care companion or after prolonged ICU stay (>3 days). Communicate to other nursing staff when patient has recently had a patient care companion discontinued to alert other members of the healthcare team to patient's increased risk status.
RESOURCES AVAILABLE	Consult resources as needed: a. Clinical Nurse Specialist b. Nurse Managers c. Pharmacist d. Physical Therapist e. Occupational Therapist f. Case Manager g. Social Worker h. Pastoral Care
DOCUMENTATION	Document risk level and interventions in appropriate medical record.

PATIENT/ SIGNIFICANT OTHER EDUCATION	• Inform patient and significant other if patient is high fall risk prior to discharge. • Instruct patient and significant other about fall risk factors and home safety measures to minimize falls.
DISCHARGE PLANNING	Notify Case Manager/Social Work for appropriate discharge referral.
POST FALL CARE	
ASSESSMENT	1. Assess for head or other injury at the location that the patient landed. Do not move patient until assessment complete. Keep patient comfortable and warm. a. Ask patient if head was hit during fall b. Assess for signs of head trauma c. Assess for a change in level of consciousness (LOC) or orientation d. Assess for skin abrasions or bleeding e. Ask patient about pain or tenderness, especially head, hip, leg or arm f. Palpate neck for tenderness g. Assess range of motion h. Measure vital signs 2. Do not move patient if an injury is suspected until assessed by physician. 3. Maintain head in neutral position until assistance arrives. If head or neck injury is suspected, do not allow patient to move head or sit up. Contact Rapid Response Team to assist with immobilization. 4. Assist patient to bed and continue to monitor if injury is not suspected. 5. Monitor patient for delayed signs or symptoms of injury (i.e., persistent or unexplained pain, swelling, or bleeding). 6. If the patient reports head or neck injury or unable to determine if patient struck head: neuro checks q 1 hour x 4, then q 4 hours x 24. Neuro checks include coma scale, motor response and pupil response.
SAFETY	• Identify patients who have fallen during this hospital admission by checking *"Patient Fallen This Admission*" box within Nursing Progress Record. Also record date of fall. • Communicate patient fall event and high fall risk status in nursing report for remainder of hospitalization.
ENVIRONMENT/ CAUSE ANALYSIS	• Ask patient to describe fall. • Ask staff or other witnesses to describe fall. • Inspect area for contributing factors (i.e., lighting, floor, equipment in room, bed or chair locks, side rails, restraints). • Review medications given to patient in previous 24 hours that may have contributed to the event (i.e., narcotics, anesthesia, hypnotic, diuretics, laxatives).
PATIENT/ SIGNIFICANT OTHER EDUCATION	• Instruct patient and family in fall risk factors and safety interventions (i.e., arrange objects that patient needs near bedside, call light in reach, call for nurse before rising).

PHYSICIAN NOTIFICATION	• Notify physician of the fall at time of event. (Describe fall, circumstances of fall; inform physician if patient on anticoagulants). • Notify nurse manager or designee • Notify physician of significant change in patient condition post fall including but not limited to: o Changes in level of consciousness o Change in orientation o Pain o Neck tenderness
FAMILY NOTIFICATION	• RN notifies family spokesperson for a cognitively impaired patient in the event of a non-injurious fall. • RN asks the cognitively intact patient if he/she would like the family to be notified in the event of non-injurious fall. • Physician notifies appropriate person in the event of fall with an injury.
DOCUMENTATION	1) Document patient fall and post assessment in appropriate medical record. 2) Document change in risk factors and high fall risk status. 3) Document nursing interventions in appropriate medical record.

REFERENCES:

Morse J. Enhancing the safety of hospitalization by reducing patient falls. Am J Infect Control 2002; 30(6):376-80.

Morse J. Preventing Patient Falls: Establishing a Fall Intervention Program, 2nd edition. New York, NY: Springer Publishing Co. LLC, 2008.

Quigley PA, Hahm B, Collazzo S, et al. Reducing serious injury from falls in two veterans' hospital medical-surgical units. J Nurs Care Qual 2009; 24(1):33-41.

APPENDIX I

Patient ID Label

MORSE FALL SCALE

VARIABLE		SCORE
History of falling within 12 months	No = 0 Yes = 25	
Secondary Diagnosis:	No = 0 Yes = 15	
Ambulatory aid:	None/bed rest/nurse assist = 0 Crutches/cane/walker = 15 Furniture = 30	
Intravenous Therapy:	No = 0 Yes = 20	
Gait:	Normal/bed rest/wheelchair =0 Weak = 10 Impaired = 20	
Mental Status:	Oriented to own ability = 0 Overestimates/forgets limitations = 15	
Total Score Universal Risk = 0-35 Low Risk = 40-50 High Risk = > 50	**Mandatory High Risk Interventions** □ Place yellow Fall Risk wristband on same extremity as patient's ID band □ Place a "falling leaf" symbol on the doorframe outside of the patient's room.	

Interventions:

Toileting	□ Provide a bedside commode □ Offer and encourage frequent voiding, especially during first 24 hours of hospitalization □ Maintain targeted toileting schedule to include toileting patient: before bedtime, upon awakening, after all meals, before change of shift, after diuretics or laxatives are administered □ *Accompany patient to and from the bathroom (high risk patients)* □ *Stay with patient while on commode/ bedside commode (high risk patients)*
Observation/ Alarms	□ Use bed or personal alarm □ Place patient in a room near nurse's station if increased stimulation is not contraindicated □ Request family members to increase visitation □ *Place patient in a chair in the hallway (high risk patients)* □ *Request family to stay with patient during known times of confusion (e.g., night)* □ *Round every 30 minutes (high risk patients)* □ Constant observation by nursing staff (high risk patients)
Mobility / Ambulation	□ Postpone ambulation until l hour after meals □ Provide walker at bedside □ Allow patient to rest in sitting position one (1) minute before rising □ Obtain order to consult Physical Therapist □ *Supervise transfers and ambulation (high risk patients)* □ *Every 2 hour ambulation (high risk patients)*
Education/ Communication	□ Cue, redirect, or reorient patient, as necessary □ Verbally inform patient to call for help prior to getting out of bed □ Post written bedside note reminding patient to call for assistance prior to getting out of bed □ Educate/inform patient/family of patient's fall risk and request their cooperation in keeping patient safe
Medication	□ Discuss medication regimen and fall risk with Licensed Independent Practitioner (LIP) □ Consult pharmacist for possible drug interactions □ Use smallest possible dose of sedative or hypnotic drugs
Consults	Consult: □ Social work □ Pastoral Care □ Clinical Nurse Specialist □ Case Manager Obtain an order for consult to: □ Occupational Therapist □ Physical Therapist □ Psychiatric Occupational Therapist □ Behavioral Health

APPENDIX I

HOW TO USE THE MORSE FALL SCALE RISK SCREENING TOOL

History of Falling

If the patient has fallen during the present admission or there was an immediate history of physiological falls, such as syncope or impaired gait, score 25.
If the patient has not fallen, score 0.

Secondary Diagnosis

If the patient has more than one medical diagnosis identified, score 15;
if not, score 0.

Ambulatory aid

If the patient is clutching on the furniture for support, score 30.
If the patient uses crutches, cane or walker, score 15.
If the patient walks without walking aid, score 0.

Intravenous Therapy

If the patient has intravenous therapy, score 20;
if not, score 0.

Gait

If the patient has an impaired gait; has difficulty rising from a chair, uses the arms of the chair to push off, head is down, eyes focus on the floor, uses moderate to heavy assistance for balance through use of furniture, persons or walking aids and steps are short or shuffled, score 20.

If the patient has a weak gait; patient is stooped; unable to lift head without losing balance or support is required with limited assistance and steps are short and shuffles, score 10.

If the patient walks with a normal gait, score 0.

Mental Status

Identifying patient's self-assessment of his/her ability to walk.
If the patient overestimates physical ability, score 15.
If the patient's assessment is consistent with his/her ability, score 0.