University of Colorado Hospital Policy and Procedure
Fall Prevention

Related Policies and Procedures:
Patient Occurrence Reporting Process
Restraint Use: Acute Medical Surgical (Non-Violent, Non-Self Destructive Patients) and
Restraint and Seclusion: Behavior Management for the Violent, Self-Destructive (Suicidal)
Patient
Constant Observation for Patient Safety

Approved by: Professional Practice, Policy, and Procedure Committee
Effective: 06/99
Revised: 05/13

Accountability: Preventing patient falls is a UCH Critical Success Factor. All healthcare
providers are expected to prevent patient falls.

In the Ambulatory/Procedural Setting:
Ambulatory/Procedural staff is responsible for initial screening of fall risk and thereafter according
to clinic/procedural area guidelines.

In the Inpatient Setting, including the Rehabilitation Unit, the RN or LPN is accountable for:
- The RN or LPN must assess and calculate patient level of fall risk upon admission, at the start of
each shift, and as needed with changes in patient condition using the Fall Risk Assessment Tool.
- Implementing strategies to prevent falls.
- Reassessing patient fall risk if the patient condition changes.
- Implementing post-fall procedures if a patient fall occurs, including:
  - Notifying the MD.
  - Perform a Fall Huddle/Debriefing, including completion of Fall Huddle Form.
  - Reporting falls via Patient Safety Net (PSN), to Professional Risk Management by
  faxing the Fall Huddle Form, and to Pharmacy by RN order for medication review.

Definitions:
Patient Fall: An unplanned descent to the floor with or without injury. Assisting the patient to the
floor is a fall.
Near Miss fall: Patient does not reach the floor; is assisted to chair or bed. Near miss falls are not
calculated into fall rates.
Anticipated Physiological Fall: Fall related to a patient’s age, functional ability, disease (s),
previous fall (s), weak or impaired gait, lack of realistic assessment of patient’s own ability, or
patient making errors of judgment.
Unanticipated Physiological Fall: Fall that may be attributed to a physiological cause but created
by conditions that cannot be predicted. As in: Pattern Falls: disorder of balance in older elderly;
Premonitory Falls: such as acute illnesses i.e. MI, CVA, GIB; Intentional Falls: whereas a patient
throws himself on the floor.

**Accidental Fall:** Slip or trip.

**Intentional Fall:** Patient falls on purpose or falsely claims to have fallen.

**Gait Ataxia:** Patient is unsteady, stumbles 1 or more times, shuffles, reaches for assist (wall, person, etc.), sways, or knees buckle.

**Medication Naïve:** A patient who has not been taking the medication in question (opioid, hypnotic, sedative, tranquilizer) regularly and therefore is at higher risk for side effects. The highest risk is the first dose and the first 24 hours.

**Minor Injury:** Results in an application of dressing, ice, cleaning of wound, limb elevation or topical medication.

**Moderate Injury:** Results in suturing, steri-strips, splinting.

**Major Injury:** Results in fracture, surgery, casting or traction, intracranial injury requiring neurological consultation, consultation for internal injury such as crushing, burns, electric shock, or death as a result of the fall (CMS Definitions of fall ‘never events’).

**Death:** Patient Death directly related to a fall while under care at UCH.

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**Fall Prevention**

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**Points of Interest**

- **Accidental Fall:** Slip or trip.
- **Intentional Fall:** Patient falls on purpose or falsely claims to have fallen.
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- **Minor Injury:** Results in an application of dressing, ice, cleaning of wound, limb elevation or topical medication.
- **Moderate Injury:** Results in suturing, steri-strips, splinting.
- **Major Injury:** Results in fracture, surgery, casting or traction, intracranial injury requiring neurological consultation, consultation for internal injury such as crushing, burns, electric shock, or death as a result of the fall (CMS Definitions of fall ‘never events’).
- **Death:** Patient Death directly related to a fall while under care at UCH.
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II. It is expected that if a clinical service has pediatric admissions, the service will use age-specific guidelines to manage fall prevention in pediatric patients.

III. **Inpatient Services** including Rehabilitation Unit:
The RN or LPN must assess and calculate patient level of fall risk upon admission, at the start of each shift, and as needed with changes in patient condition using the Fall Risk Assessment Tool.

A. All patients must receive low risk interventions (green): non-skid footwear, side rails raised x2 or x3 (x1 for beds with 2 long rails), bed in low position, brakes on, call light/personal items in reach, removal of obstacles. Patients with a low risk level are observed at least once per shift.

B. Patients with moderate risk (yellow) or high risk (red) levels must have appropriate color fall star sticker placed by door, in front of medical chart, and on the assignment board, when appropriate. The assignment board stars need to be either vendor purchased or by use of UCH fall stickers applied to a magnet.

C. Interventions to prevent falls are initiated based on risk assessment level. Fall risk assessment must be re-initiated with any change in patient condition. All clinical providers must secure the environment using safety procedures. The RN may delegate fall risk monitoring to unlicensed personnel, including observations/rounding. Toileting regimens are a structured part of this rounding procedure.

D. Moderate fall risk interventions include all low fall risk interventions and observing the patient every two hours, offer/encourage toileting every 1-2 hours as appropriate, and assessing for the use of standing/transfer devices.

E. High fall risk interventions include all low and moderate fall risk interventions and placing red fall-alert socks on patient (unless contraindicated), all side rails raised with bed alarm on, chair alarm when up in chair, remain within reach of the patient when in chair or bed without alarm, observe patient every hour, standby assist with or without use of gait belt, and additional fall risk interventions as appropriate (See Point G).

F. Unlicensed personnel must report emergent situations or changes in patient condition immediately to RN.

G. The use of siderails is not a fall prevention strategy per evidence. Three siderails up can offer patient security in an unfamiliar environment and be used to help patients sit upright and exit bed safely. The 4th side rail is considered a restraint and requires a restraint order and documentation under restraints. In some circumstances, such as when a specialty bed surface elevates the patient and is slippery, the 4th side rail may be necessary to protect the patient and is not considered a restraint. In the ICUs, a sedated or unconscious patient, in addition to those patients on bed surfaces, may need a 4th side rail for safety. In these cases, document the 4th side rail use as a safety precaution, and restraint orders are not applicable.

H. Bed and chair alarms are a safety device to alert providers that the patient is exiting the bed/chair. When a bed or chair alarm device is activated for a high fall risk patient, a bell sticker must be applied to door and cover of chart to indicate alarm is on. Bed alarms are only excluded on patients in the ICUs with a RASS Score of -4 or -5 with appropriate sedation, bed alarms are required during awakening trials weans.
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I. Transport orders, including the Ticket to Ride, in the electronic medical record must include fall risk information.

J. If a patient falls, assess need for a constant observer for patient safety, or activity limitations. Continue to reassess patient’s physical, mental and treatment changes.

K. RN must assess patient fall risk as it relates to prescribed medications. An RN can order a pharmacy consult for pharmacy staff medication review at any time and is required to order one after any patient fall.

L. Accompanying the patient to and remaining with the patient during toileting is not considered a Fall Prevention Intervention; it is a nursing protocol and refusal should be highly discouraged. If the patient is rated as at risk for falling, has appropriate capacity, and refuses any of the interventions to prevent a patient fall despite instruction on these interventions, the RN must respect patient preferences. Documentation of refusal must include the interaction, instruction, patient refusal, MD consultation and continued potential risk for falling. If patient lacks appropriate capacity, i.e. Alzheimers, dementia, or any other condition where patient would not be able to sign his/her own consent, they are NOT to be allowed to refuse Fall Risk Safety Interventions.

IV. Procedural Areas
   A. Radiology: Fall prevention procedures will adhere to the University of Colorado Hospital Radiology Guideline on Fall Prevention.
   B. Cardiovascular Pre/Post: Fall prevention procedures will adhere to the University of Colorado Cardiovascular Pre/Post Guideline on Fall Prevention.
   C. In and Outpatient Pre-Op/PACU: Fall prevention procedures will adhere to the University of Colorado Hospital Pre-Op/PACU Guideline on Fall Prevention (Pending).
   D. GI Lab: Fall prevention procedures will adhere to the University of Colorado Hospital GI Lab Guideline on Fall Prevention (Pending).
   E. Acute Dialysis: Fall prevention procedures will adhere to the University of Colorado Hospital Policy and Procedure for Fall Prevention.

V. Emergency Department
   A. ED RNs will use the ED Fall Assessment Tool.
   B. All ED patients will be assessed for fall risk upon arrival to a main ED bed and as condition changes.
   C. Patient will be rated either low risk or moderate/high risk for falls:
      1. Interventions for patients rated as low risk will include:
         a. sign outside door
         b. non-skid socks
         c. 1 hour rounding,
         d. bed in low position
         e. call light within reach
      2. Interventions for patients rated as moderate-high risk will include
         a. sign outside door
         b. non-skid socks
         c. bed alarm
         d. 1 hour rounding
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e. bed in low position
f. call light within reach
g. assistance with toileting
h. move to in view of nurses station (as needed)

D. ED documentation will include fall risk score and any interventions implemented to prevent patient falls.

E. If the patient is rated as at risk for falling, has appropriate capacity, and refuses any of the interventions to prevent a patient fall despite instruction on these interventions, the RN must respect patient preferences. Documentation must include the interaction, instruction, patient refusal, MD consultation and continued potential risk for falling. If patient lacks appropriate capacity, i.e. Alzheimers, dementia, or any other condition where patient would not be able to sign his/her own consent, they are NOT to be allowed to refuse Fall Risk Safety Interventions.

VI. Center for Dependency, Addiction and Rehabilitation (CeDAR)
CeDAR RNs will use the inpatient Fall Risk Assessment Tool and interventions will adhere to the University of Colorado Hospital CeDAR Guideline on Fall Prevention (Pending).

VII. Ambulatory Services
All members of the ambulatory healthcare team contribute to initial clinic admission screening, implementing prevention strategies and reporting falls in addition to ongoing screening per clinic rooming guidelines. The patient is screened during the initial visit, every 3 months, and as indicated by their condition. Areas such as Ophthalmology and Neurology will consider all their patients as potential fall risks. Any type screening must include a minimum of the following fall assessment questions:

a. If they have experienced any falls in the past 3 months.
b. Have a fear of falling.
c. Have difficulty ambulating.

A patient reporting falls or fears of falling related to the above questions are considered at risk for falling. Staff will implement and document appropriate interventions, especially during the visit, such as assisting patient to exam room, not leaving patient unattended, escorting patient to transportation post visit, and checking devices such as canes, crutches or walkers for non-skid surfaces. Unlicensed staff will notify the risk to the MD/RN. The RN/MD can do a more in depth fall assessment using the MACH 10 fall risk assessment tool used with permission of the Missouri Alliance for Home Care, 2013. Staff may use the Ambulatory Home Patient Checklist to instruct patients in fall risks.

VIII. Documentation
A. Complete inpatient documentation in the electronic medical record, using the Fall Prevention NIC, recording all prevention activities and patient education
C. Ambulatory Clinics/Procedural Areas document fall risk and patient teaching on appropriate visit form or electronically. CeDAR documentation is completed per CeDAR procedures.

References