Nursing Policy: Fall Prevention & Post-Fall Actions

Nursing Policy Statements: (designates what MUST be done)

1. The RN assesses Fall Risk within 8 hours of admission and reassesses every shift, with any major clinical change, and after a fall event. Doc'n Stds
    a. The RN uses the Johns Hopkins Fall Risk Assessment Tool (JHFRAT) for admitted inpatient adult patients.
    b. The RN uses the Humpty Dumpty for non-NICU admitted inpatient pediatric patients (1-17 years old).
2. The RN communicates fall risk status (high, low) and necessary fall prevention interventions to assigned PCA/PCT.
3. The RN implements Fall Prevention measures per Standard Work for Adult Inpatient Fall Prevention (Acute, ICU, and IMU areas) for HIGH Fall Risk Patients to reduce fall occurrence & injury.
    a. For ordering/replacing signage/gowns, see Product Information below
    b. NOTE: Routine use of low beds is not clinically indicated.
4. The use of restraints is not considered part of routine fall prevention. Restraints may be used only once routine fall prevention measures have been ineffective. MCP 0159;
    a. If restraints are used, consult unit leadership within 24 hours to discuss alternative strategies.
5. For cognitively-intact patients who refuse fall prevention interventions, document refusal each shift under Daily Interventions comment section.
6. Complete the Standing Spine Films Screening Tool for patients who have Standing Spine Films ordered.
7. If a fall occurs: Guideline 2.090
    a. Assess patient head-to-toe where patient has fallen.
    b. Provide immediate treatment, including spinal immobilization if needed.
    c. Return patient to safe environment.
    d. Notify LIP/interdisciplinary team, Shift Manager and Manager/Nursing Supervisor.
    e. Perform post-fall huddle and/or provide perishable information to Shift Manager/Manager.
    f. Document as a Shift Event / Event Note, reassess fall risk score, and update prevention strategies.
    g. File a Be Safe Event by midnight on the day the event occurred.

Interprofessional Policies (designates what MUST be done)

- Medical Center Policy 0159: Restraint and Seclusion of Patients
- Medical Center Policy 0254: Clinical Alarm Systems
- Patient Care Services Policy 00.02: Initiating, Documenting, and Resolving the Nursing Care Plan
- Nursing Policy: Beds and Support Surfaces
- Nursing Policy: Restraint and Seclusion

Protocols (pre-determined criteria & actions that MUST be implemented)

- Continuum Home Health - Fall Prevention Protocol

Guidelines (provides RECOMMENDATIONS)

- 2.090: Fall Assessment And Prevention Guideline
- Guideline A07 : SRO Patient Companion Guidelines

Standard Work (best known how-to steps to optimize outcomes, minimize waste and variation)

- **Adult Inpatient Fall Prevention (Acute, ICU, and IMU areas) for HIGH Fall Risk Patients**
- Beds – Algorithm for Adult Inpatient Bed Type Selection, Traction, and Side Rail Use
- Chair Alarm Use and Panduit Cord Containment for Chair Alarms
- Out of Bed Plan (OOB) Completion
    - NOTE: contact Michelle Longley for additional OOB Plans (PIC 3819, mcl5n@virginia.edu)
- Standing Spine Films Screening Tool

Procedures (how-to steps):

Lippincott:

- Fall prevention
- Fall prevention, pediatric
- Fall management
- Ambulation, progressive
- Cane use training
- Crutches use training
- Gait belt use
- Walker
- Transfer from bed to chair
- Transfer with a hydraulic lift
- Transfer with an air-assisted transfer device
- Transferring to and from the OR table
- Net or canopy bed use

Staff Education

None

Products Information & Manufacturer's Instructions:

- To order more Out of Bed Plans (OOB Plans): Order item "171601 Out of Bed Plan" from uvaprint.virginia.edu
- To order more flippable yellow HIGH/LOW Fall Risk Signs: email mcl5n@virginia.edu
- To increase unit yellow gown pars or order bariatric yellow gowns: call linen room at 924-5825
- Fall Prevention Equipment and Devices (3/2015)
- Bed Selection Algorithm and Bed/Support Surface Safety & Ordering Reference (3/2017)
- Posey "Sitter Elite" Chair Alarms - Guide and Video (8/13).

Primary Contact:	Version information:	Date & Approval Body:
Michelle Longley & Shelley Knewstep-Watkins	Version 1.0: Initial version	2/14/17 Nursing Policy Program 3/3/17 CNO & Nursing Executive Committee
Michelle Longley	Version 1.2: low bed removal, new bed preparation	9/8/17
	1.3: SW link update; bed/side rail algorithm update	12/5/17
	1.4: SW link High Fall Risk prevention	12/13/17
	1.5: removed duplicate content for SW link, keywords, ordering information	1/15/18

Keywords: falls, fall, low bed, side rails, bed alarm, chair alarm, OOB, OOB Plan, Out of Bed Plan, restraint, Johns Hopkins, JHFRAT, Humpty Dumpty, floor pads, Patient Companion, sitters, fell, enclosure bed, low bed, flappable signs, magnet signs, HIGH fall risk, low fall risk, yellow gowns