NURSING SERVICE GUIDELINES
INPATIENT BEHAVIORAL HEALTH

Guideline: **Fall prevention**

Policy Number Superseded:

Responsibility: All patient care personnel

Purpose of Guideline: To prevent patient falls using proactive interventions.

Equipment: Fall ID stickers, bed monitoring devices, patient mobility devices, nursing assessment-fall risk assessment section, Morse fall scale

Effective Date:
June 2023

Initial Effective Date:
May 2008

PROCEDURE	POINTS OF EMPHASIS
(1) Assess for fall risk on admission.	(1) This is the most frequently occurring risk factor on a psychiatric unit were the clinical diagnoses of depression and confusion or disorientation. (a) Patients who are at higher risk include those with a history of falls, generalized weakness, confusion, disorientation, difficulty with mobility or walking, elimination problems and temperature elevation. (b) The majority of falls occured when patients were getting out of bed, walking to the bathroom at night, or changing from a sitting to a standing position. (c) Risk factors may change hospitalization.

(2) The total possible scoring on the Morse fall scale is 125. At UTMC, the patient's potential to fall is considered: Low risk <25 Medium risk 25-44 High risk >45	(2) Morse fall scale looks at six different areas: (a) History of falling: This is scored as 25 if the patient has fallen during the present hospitalization, or if there is an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored as zero. NOTE: if a patient falls for the first time, then his or her score immediately increases by 25. (b) Any secondary diagnosis: This is scored a 15 if more than one medical diagnosis is listed on the patient's chart. If not, score zero. (c) Use of any ambulatory aids: This is scored as zero if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest and doesn't get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15. If the patient ambulates clutching onto the furniture for support, score this item a 30. (d) IV therapy: This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted, if not, score zero. (e) Type of gait: A normal gait is characterized by the patient walking with head erect, arms

	swinging freely at the side, and striding without hesitation. This gait scores a zero. With a weak gait, (score as 10) the patient is stooped but is able to lift the head while walking without losing balance; steps are short and the patient may shuffle. With an impaired gait (score 20) the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e. using several attempts to rise). The patient's head is down, and he or she watches the ground because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance. (f) Mental status: When using this scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient if they are able to go to the bathroom alone or if they need assistance. If the patient's reply judging his or her own ability is consistent with the ambulatory order on the Kardex, the patient is rated as "normal" and scored zero. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be

	forgetful of limitations and scored as a 15.
(3) Initiate fall prevention standard if Morse fall scale score is > 25.	Risk Level / MFS Score / Action No risk 0-24 Good basic nursing care Low Risk 25-50 Implement Fall Prevention Intervention High Risk >51 Implement High Risk Fall Prevention Interventions
(4) Place Fall ID sticker on patient's chart.	
(5) Place patient in close observation or handicap accessible room.	(5) Keep unit and pathways clean and free from clutter.
(6) Provide patient with bell or other means to notify staff of the need for assistance.	(6) Bells located in restraint drawer in exam room.
(7) Implement the following interventions as needed: (a) Put protective mats around bed to reduce potential injury. (b) Place bell or signal device within patient's reach. (c) Put mattress on floor if necessary. (d) Supervise ambulation. (e) Put patient in room close to nurse's station. (f) Monitor patient's ambulatory status hourly, or more if needed. (g) Assess patient's vital signs every shift, or more if necessary. (h) Assess patients for medication side effects and notify physician as needed.	(7) Communicate to all patient care personnel that patient is at risk for falls. Ask physician to consider a physical therapy consult.

(i) Adjust patient's treatment plan to reflect initiation of Fall Prevention Protocols. (j) Reassess fall risk daily if found to be at risk for falls.	
(8) Educate patient regarding fall risk.	(8) Educate patient (a) Safety awareness. (b) Reason for fall risk. (c) Determination. (d) Precipitating factors.

Fall definition:

Untoward/uncontrolled/undirected event in which a patient comes to rest unintentionally on the floor.

Fall types:

(1) Physiologic anticipated.

This type of fall may be anticipated. Admission assessment reveals that patient has a history of falls, displays an unsteady gait, typically uses an assistive device for ambulation or locomotion, has a neurological deficit, has an IV/heparin lock, or scores greater than 25 on the Morse fall scale section of the nursing admission assessment. In these instances, the patient will be placed on fall prevention protocol and monitored accordingly. Physical therapy may be accessed to help patient regain safe ambulation. Staff will attempt to educate and reorient patient as necessary.

(2) Physiologic unanticipated.

This type of fall may not be preventable. This patient is usually oriented, however, he/she may develop unknown medical problems (i.e., syncope, vertigo, and medication side effects) or the patient's psychiatric condition (i.e., impulsivity, age, oppositional behavior) increases the patient's propensity for injury.

(a) Maintain ongoing awareness of fall risk factors and initiate appropriate fall prevention interventions.

(b) Patients will be educated in regard to safety during play and therapeutic activities.

(3) Accidental.

This type of fall is caused by a hazardous condition in the hospital.

(a) Staff should maintain continual unit awareness and correct unsafe conditions whenever possible. Patients should be removed from areas in which the hazardous condition cannot be corrected immediately. Staff will notify maintenance/supervisory staff as soon as possible to correct the hazard.
(b) Patients will be educated in regard to safety during play and therapeutic activities.

References:

Stevens, J. A., Smith, M. L., Parker, E. M., Jiang, L., & Floyd, F. D. (2017). Implementing a clinically based fall prevention program. *American Journal of Lifestyle Medicine,* 1559827617716085.

Kobayashi, K., Imagama, S., Ando, K., et al. (2017). Analysis of falls that caused serious events in hospitalized patients. *Geriatrics and Gerontology International.*

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