



Risktopics

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Patient fall prevention program

Introduction

Falls are the leading cause of accidents for people over the age of 65 and a leading cause of serious injury in hospitals and long-term care facilities. In the United States, one of every three adults 65 years old or older falls each year. Falls are the leading cause of injury deaths among people 65 years and older and are the most common cause of injuries and hospital admissions for trauma among the elderly.

The pressure to accelerate fall prevention measures intensified when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began adding National Patient Safety Goals (NPSG) and requirements for hospitals and other settings that touched on preventing falls. In 2005, the NPSG stated: "Reduce the risk of patient harm resulting from falls and the specific requirement: Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks."

Fall risk assessment

Patients should be assessed for their fall risk:

- On admission to the facility
- On any transfer from one unit to another within the facility
- Following any change of status
- Following a fall
- On a regular interval such as monthly, biweekly or daily

There are several risk assessment tools available. Two of them are the Morse Fall Risk Assessment and the Heindrich Fall Risk Assessment.

Morse Fall Risk Assessment

This is one of the most widely used fall risk assessment scales available.

Morse Fall Risk Assessment		
Risk factor	Scale	Score
History of falls	Yes	25
	No	0
Secondary diagnosis	Yes	15
	No	0
Ambulatory aid	Furniture	30
	Crutches/cane/walker	15
	None/bed rest/wheelchair/nurse	0
IV/Heparin lock	Yes	20
	No	0
Gait/transferring	Impaired	20
	Weak	10
	Normal/bed rest/immobile	0
Mental status	Forgets limitations	15
	Oriented to own ability	0

To obtain the Morse Fall score, add the score from each category.

Morse Fall score
High risk = 45 and higher
Moderate risk = 25 - 44
Low risk = 0 - 24

Note: Janice Morse recommends calibrating this high-risk score based on the patient population and acceptable fall rate. For more information, see Janice Morse's book, *Preventing Patient Falls*.

The major advantages to this assessment are:

- Research driven
- Interventions are standardized by level of risk

The major disadvantages:

- Not designed for the long-term care setting, consequently nearly all patients will be at high risk

Hendrich Fall Risk Assessment

Some long-term and geriatric wards are using this scale.

Hendrich Fall Risk Assessment		
Risk factor	Scale	Score
Recent history of falls	Yes	7
	No	0
Altered elimination (incontinence, nocturia, frequency)	Yes	3
	No	0
Confusion/disorientation	Yes	3
	No	0
Depression	Yes	4
	No	0
Dizziness/vertigo	Yes	3
	No	0
Poor mobility/generalized weakness	Yes	2
	No	0
Poor judgment (if not confused)	Yes	3
	No	0

The main advantages of this assessment are:

- Focuses interventions on specific areas of risk rather than general risk score
- Easy to determine if someone is high-risk, because nearly every risk factor categorizes a patient as high-risk
- There are only two categories of patients: high-risk and low-risk

The main disadvantages of this assessment are:

- Not as researched as the Morse Fall Risk Assessment
- Nearly every patient will be put into the high-risk category

Intervention strategies

Intervention strategies can be based on level of risk and/or area of risk.

Intervention strategies									
Intervention	Level of risk			Area of risk					
	High	Med	Low	Frequent falls	Altered elimination	Muscle weakness	Mobility problems	Multiple medications	Depression
Low beds	X	X	X	X	X	X	X	X	X
Non-slip grip footwear	X	X	X	X	X	X	X	X	X
Assign patient to bed that allows patient to exit toward stronger side	X	X	X	X	X	X	X	X	X
Lock movable transfer equipment prior to transfer	X	X	X	X	X	X	X	X	X
Individualize equipment to patient needs	X	X	X	X	X	X	X	X	X
High-risk fall room setup	X	X		X	X	X	X	X	X
Nonskid floor mat	X	X		X	X	X	X	X	X
Medication review	X	X		X	X	X	X	X	X
Exercise program	X	X		X	X	X	X	X	X
Toileting worksheet	X	X			X				
Color armband/falling star, etc.	X			X	X	X	X	X	X
Perimeter mattress	X			X	X	X	X		
Hip protectors	X			X		X	X		
Bed/chair alarms	X			X		X	X		

Note: this list is not all-inclusive.
Facilities should use their best judgment in implementing recommendations.

Post-fall procedures/management

The two key elements of the post-fall procedures/management:

- Initial post-fall assessment
- Documentation and follow-up

Initial post-fall assessment

After a fall, the first priority is to determine if the patient has any injuries and to find out what happened. This information is needed to identify the root cause(s) of the fall so appropriate corrective actions can be implemented.

Documentation and follow-up

Following the post-fall assessment:

- An incident report should be completed.
- A detailed progress note should be entered into the patient's records including the results of the post-fall assessment.
- The patient should be seen by a physician for further evaluation.
- Fall prevention interventions should be reviewed and care plans should be modified as appropriate.
- Communicate to all staff that the patient has fallen and is at risk for additional falls.

Summary

The implementation of a Patient Fall Prevention Program should result in a reduction in the number of patient falls, and it will satisfy JCAHO requirements. A key component of the program is the fall risk assessment piece. When completed properly, at-risk patients will be identified and appropriate preventive measures will be implemented to reduce the risk of falls.

References

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