MANUAL/DEPARTMENT	CLINICAL POLICY AND PROCEDURE MANUAL
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APPROVED BY	for [signature] Linda Flowers

PURPOSE
To define the expectations for identifying a patient's risk for falling and implementing interventions to minimize the risk of falling.

PERSONNEL
All direct care providers

GUIDELINES FOR INPATIENTS

1. The patient's risk for falling is scored once per shift using the criteria in the following table:

Fall Risk Score Criteria (I'M SAFE)	Score if Present	Score if Not Present	Score Assigned to Patient
Impairment (OT/PT service involved, orthostatic / dizzy)	1	0	
Medications (seizure medications, narcotics, epidurals)	2	0	
Sedation/anesthesia within the previous 24 hours	2	0	
Admitting diagnosis (neuro or ortho diagnosis)	1	0	
Fall History	1	0	
Environment of care (restraints, oxygen, IV tubing, Foley catheter, other per RN judgment)	1	0	
Fall Risk Score (sum of the scores assigned for each criteria)			

> 2. The RN should use the Fall Risk Score as a guideline for identifying the patient's level of risk. Based upon his/her judgment the RN may assign a different level of risk than indicated by the Fall Risk Score, if the score obtained places the patient in a risk category the RN deems inappropriate. For example, a Behavioral Sciences patient may have a total score of a '1' (a PRN given), which indicates a low risk for falling. However, depending on the medication and route, this can be deemed as a high risk for falling.

3. The RN will document the patient's Fall Risk Score on the Nursing Shift Flowsheet in Epic. The RN will verify this score is appropriate to the level of risk for their specific patient.

> 4. All patients and families will be educated on fall prevention on admission. The RN will document Fall Prevention Education on the Nursing Shift Flowsheet in Epic.

5. If the patient is considered at risk for falls, the RN will document fall prevention interventions on the Nursing Shift Flowsheet in Epic once per shift.

6. Fall prevention interventions for TCH inpatients (see # 7, 8 and 9 below for exceptions / modifications):
   a. Fall prevention interventions regardless of Fall Risk Score, usually include the following:
      1) Patient/family education regarding fall prevention.
      2) No activity/mobility restrictions.
      3) Bed in low position.

4) Side rails up.
5) Bed/crib brakes on.
6) Clutter in room minimized.

b. If the patient's Fall Risk Score is 1, the patient is considered to be at moderate risk for falling. Fall prevention interventions for these patients usually include:
1) Some assisting with activity/mobility per the patient's individualized care plan.
2) Reinforcing patient/family education regarding fall prevention and individualized care plan.
3) Communication of fall risk status to the next provider of care.
4) Periodic assessing of elimination needs.
5) Periodic orientating to call light.
6) Orient patient/family to request help with ambulation.

c. If the patient's Fall Risk Score is 2 or greater, the patient is considered to be at high risk for falling. Fall prevention interventions for these patients usually include:
1) Assistance with activity/mobility.
2) Placement in a bed designed to prevent falls (Posey Canopy Bed, Craig Bed, Bubble Top Crib).
> 3) Yellow High Risk for Fall arm band on patient.

4) Communication of fall risk status to the next provider of care.
5) Close observation particularly when in a wheel chair or out of bed.
6) Assessing need for 1:1 observation.
7) Accompanying patient with ambulation and transfers especially when related to elimination needs.
8) Educating on risk factors and the related care plan.
9) Restraints (refer to Restraints: Medical and Surgical Restraint procedure).

7. **Infants and toddlers less than two years old** are developmentally at risk for falling. Fall prevention interventions for these patients may include the following as appropriate:
> a. A Fall Risk Score does not need to be assigned/documented.
> b. These patients do not need a yellow arm band.

c. Crib rails in the up position at all times.
d. Infants in an incubator will have incubator doors secure at all times.
e. Infants cared for in warmers in the Intensive Care Units will have the sides to the warmer secured in the raised position.
f. Use of a safety belt in an infant seat and infant swing.
g. Continuous observation during weighing, bathing and procedures.
h. Toddlers will be placed in a bubble top crib if the top half of the child's body is above the crib rails when the child is in a standing position.
i. The side rails, warmer sides and incubator doors may be down/open when the nurse or family is with the infant delivering care directly at the bedside.
j. Parents will be oriented to fall prevention interventions upon admission.

> 8. All patients receiving care in the **PICU and CICU** are considered at high risk for falls based on their medical condition necessitating an intensive care unit admission.

a. A Fall Risk Score does not need to be assigned/documented.
> b. These patients do not need a yellow arm band.

c. Care of all PICU patients will include fall prevention interventions outlined under 6c. above.
d. As required by the patient's needs for care, their bed may need to be in an elevated position and/or the side rails may remain down. This is acceptable only if the patient is the only patient the RN is responsible to provide care for during that shift.
e. The High Risk for Falls sign is posted at all entrances to the PICU.
f. Parents and patients as appropriate will be oriented to fall prevention interventions upon admission to the PICU.
g. When the patient is transferred to "Ward" status, care will be provided as described in #1 through 6 above.

9. **Behavioral Sciences Patients**
   a. Fall prevention interventions for Behavioral Sciences patients regardless of their Fall Risk Score, usually include the following:
      1) Some assisting with activity/mobility per the patient's individualized care plan.
      2) Patient/family education regarding fall prevention.
      3) No activity/mobility restrictions.
      4) Bed in low position (if applicable).
      5) Side rails up (if applicable).
      6) Clutter in the patient's room and/or activity areas is minimized.
   b. If the patient's Fall Risk Score is 1 or 2, the patient is considered to be at moderate risk for falling. Fall prevention interventions for these patients usually include:
      1) Some assisting with activity/mobility per the patient's individualized care plan.
      2) Reinforcing patient/family education regarding fall prevention and individualized care plan.
      3) Communication of fall risk status to the next provider of care.
      4) Orient patient/family to request help with ambulation.
   c. If the patient's Fall Risk Score is 3 or greater, the patient is considered to be at high risk for falling. Fall prevention interventions for these patients usually include:
      1) Assistance with activity/mobility.
      2) Reinforcing patient/family education regarding fall prevention and individualized care plan.
      3) Periodic assessing of elimination needs.
      4) Close observation particularly when in a wheel chair or out of bed; this includes not allowing the patient to ambulate without assistance.
      5) Assessing need for 1:1 observation.
      6) Accompanying patient with ambulation and transfers especially when related to elimination needs.
      7) Educating on risk factors and the related care plan.
      8) Communication of fall risk status to the next provider of care.

GUIDELINES FOR PERIOPERATIVE SERVICES

All patients in Perioperative Services are considered to be high risk for falls. Precautions are taken in accordance with the Patient Care Guidelines for each of the clinical areas within Perioperative Services.

GUIDELINES FOR AMBULATORY AND EMERGENT/URGENT CARE DEPARTMENTS

1. Sedated patients in Ambulatory and Emergent/Urgent Care Departments, the Dental Clinic and Medical Day Treatment are all considered at increased risk for falls. Care for these patients includes:
   a. Per care provider judgment, application of a device that secures the patient to the stretcher/exam table after the sedating medication has been administered.
   > b. Placing a yellow arm band on the patient until recovered from Phase II Sedation. If the patient is going to be discharged post-sedation, a "Sedation" sticker is placed on the patient instead of a fall risk arm band.
   c. One-to-one observation/care of the patient while in Phase I Sedation.
   d. Close observation of the patient while in Phase II Sedation.
   e. Education to parents/caregivers regarding fall prevention, including the use of stretcher side rails.
   f. Communication of fall risk status to the next provider of care.
   g. Written discharge instructions related to fall prevention.

2. All patients receiving care in the Emergent/Urgent Care Departments, Infusion Center, KidStreet, Kidney Center Dialysis, Neurology Clinic, Orthopedic Clinic, Rehabilitation Clinic, Special Care Clinic, and Therapeutic Apheresis may be considered at increased risk for falls based on their medical condition. Care for these patients includes:
   a. Risk for Fall signs will be placed in appropriate areas of departments.

b. Risk for Fall signs will be placed by all exam tables/prams/beds.
c. As appropriate, the following interventions will be implemented:
    1) Assistance with activity/mobility. Accompanying patient with ambulation and transfers especially when related to elimination needs. Once patient has demonstrated ability to maneuver equipment (i.e. IV pole), patient may ambulate by themselves.
    2) Placement in a bed/chair designed to prevent falls.
> 3) Seat belts, belly bands or other protective devices applied to secure patient.
    4) No split side rail beds.
    5) As required by the patient’s needs for care, their bed may need to be in an elevated position and/or have the side rails in the down position. This is acceptable only if a caregiver is able to remain at the bedside to implement interventions to prevent the patient from falling.
    6) If patient is using medical equipment at the time they are transferred to another department, the receiving department will be notified of the patient's fall risk status.
    7) Close observation particularly when in a chair, wheel chair or out of bed.
    8) Assessing need for 1:1 observation.
    9) Parents and patients, as appropriate, will be educated on risk factors and oriented to fall prevention interventions.

3. All patients receiving care in other Ambulatory Clinics are screened for increased risk for falls using the I’M SAFE criteria. Any one documented positive response to I’M SAFE criteria places a patient at increased risk for falls, excluding normal growth and developmental risks. Standard fall risk interventions listed above (2c.) will be implemented as appropriate in addition to the following:
> a. Patients identified at increased risk for falls will have yellow arm bands placed that indicate the patient is at increased risk.
    b. Parents will be educated on risk factors and oriented to fall prevention interventions, as identified above.
    c. Risk for Fall signs will be placed by all exam tables/prams.

RELATED DOCUMENT
Restraints: Medical and Surgical Restraint
Sedation Guidelines

REVIEWED BY
Clinical Policy and Procedure Committee