



# FALL PREVENTION RESOURCE GUIDE

*Let us help you create an effective fall prevention program with this comprehensive guide.*



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## ABOUT THE GUIDE



Falls have been a concern in healthcare for years, and for good reason.

Falls are the leading cause of injury for adults over the age of 65. Although few falls actually result in death, many falls result in serious injury for the elderly, including hip fractures and head trauma.

In addition to the physical toll that falls cause for the elderly population, they also result in a reduced quality of life. Often elderly who have a history of falls will limit their own activity and interaction with others due to a fear of future falls, chronic pain from injuries, and debility resulting in depression and decline in their physical health. (NCOA, 2021) Falls during a hospital stay can increase the length of stay of a patient by up to 6.3 days and may not be covered by insurance since they are seen as preventable, hospital-acquired injuries (TJC 2015).

The Agency for Healthcare Research and Quality (2019) reports that falls in healthcare occur at a rate of 3-5 falls per 1000 patient care days, depending upon the department, with an injury occurring in approximately one-third of all patient falls. Gero-psychiatric departments tend to have the highest rates of falls. The Joint Commission (2015) reports that falls with injury are among the top 10 reported sentinel events.

Falls and falls with injury are also a concern of hospitals in the LHATF. In a three-year period, the LHATF had 33 patient fall claims costing more than \$1,330,955.

The purpose of this information is to present an overview for developing a fall prevention program and policy that will help reduce falls, reduce professional liability exposure and improve patient safety.

## DISCLAIMER

*The information provided in this Fall Prevention Resource Guide is intended to be modified by the end-user in order to meet facility or site-specific requirements. Without such modifications, the guide might not be appropriate.*

*Although the information provided has been compiled and assembled with industry knowledge of patient falls in healthcare facilities, users of this information must customize the program to fit the unique needs of the facility and related patient population and should not implement policies that cannot or will not be enforced.*

*If your facility is a restraint-free facility, the policy should so state, family members should be informed accordingly and encouraged to stay with the patient or provide sitters.*

*This guide is not meant to be fully adopted in its present form. The documents contained herein are exactly what the name implies, a "Guide", and are to be used (in conjunction with existing fall prevention techniques and procedures) in the development of a fall prevention program if such is deemed necessary in your facility.*

# EVALUATING THE CURRENT STATE



## Risk Assessment

Healthcare facilities are expected to have a safe environment to provide care to patients. In order to provide care in a safe environment, it is necessary to understand what is being done to promote or impede the provision of care in a safe environment. One good way to achieve this understanding is through a risk assessment of the current fall prevention processes in place to determine the current state and identify opportunities for improvement.

This risk assessment of the current fall prevention processes can be done in a few ways, but the ultimate goal is for a thorough evaluation of the hospital's current process in order to identify areas where improvements can be made.

Risk assessment tools can be obtained from various organizations, developed internally or your LHA Trust Funds Patient Safety Consultant can assist you. The risk assessment is a series of questions representing expectations and best practices of the fall prevention process at the hospital that you use to compare the hospital's current process against.

A team from the hospital is typically led by the risk manager and includes a multi-disciplinary composition of the nursing department managers, staff nurses, physical therapy, and medical staff that should work together to do the comparative analysis of current practices against best practices. By using this method to evaluate the hospital's current fall prevention process, a gap analysis is actually being conducted whereby the hospital should be able to identify gaps in the current process, and those gaps can be targeted for improvement.

## Performance Improvement Tools to Reduce Patient Falls

Another example of how a risk assessment of the current fall prevention process can be done is through a Failure Mode Effects Analysis (FMEA). Although not everyone is formally trained in the process, it is not a difficult process to follow. An FMEA can also be conducted by a multi-disciplinary team that maps out the process of fall prevention at the hospital step by step. Then the team applies a risk scoring technique to identify areas of risk that are of the highest concern. The areas of highest priority are addressed as opportunities for improvement.

The Lean Six Sigma methodology, DMAIC stands for define, measure, analyze, improve and control, and can also be used as a performance improvement (PI) tool to reduce patient falls. The process is very similar to other PI tools where the process of fall prevention is mapped out and root causes are identified, but also includes a research step to help better understand the problems with patient falls in order to develop more informed strategies for prevention. For example, research may be conducted related to the financial impact of patient falls, length of stay for patients, time spent by staff caring for a patient after a fall, variations in practice from unit to unit, and trends with falls on a very granular level.

## Adverse Event Reporting of Falls Data

Collections of data surrounding actual falls that occur within the hospital are an excellent source of information for a risk manager. Inclusion of falls in the adverse event reporting program is essential. It is important that staff is aware of the expectation to report falls promptly via the hospital's established adverse event reporting system.

Data from falls that have occurred should be used to identify trends and opportunities for improvement. Data should be set up in a format that facilitates tracking and trending of commonalities, as well as when rates are increasing or decreasing. A good format for tracking falls is also important in order to determine if interventions taken to prevent falls are being effective and sustained.

# PREDICTING THE FALL



## Predictive Risk Assessment Tool for Staff

In order to help prevent patient falls and create a safe environment of care, it is important to try to predict which patients are at the highest risk of falling. By identifying which patients are at the highest risk of falling, nursing staff will be able to incorporate fall prevention into the nursing care plan and implement interventions to proactively prevent falls based upon the level of risk. It is important to find a standardized tool for fall risk prediction so that all patients are assessed using the same standard of care.

There are several nationally accepted, evidence-based fall risk assessment tools that have been created, such as the Morse Fall Risk Assessment and the Hendrich Fall Risk Assessment. Whichever fall risk assessment tool the hospital selects should meet the needs of the population served, be used consistently, and be a scoring-type of assessment (NCPS). Then a fall risk score can be obtained on each patient and fall prevention techniques can be implemented according to the specific score.

Using a scoring-type of risk assessment tool reduces the subjectivity of the assessment. Specific scores are assigned depending on answers to specific questions and a total score is obtained, placing the patient in either a high, moderate or low level of fall risk. Each level of fall risk is associated with specific fall prevention interventions that should be taken to prevent falls. Although it is understandable that some variations may need to be made in order to customize care for the patient, the score will serve as a guide to direct the intensity of interventions needed for each patient to prevent a fall.

Another important consideration with predicting fall risk is the current medications the patient is taking. Some of the common fall risk assessment scales do not have medications included, but evaluation of the patient's current medications is critical in prevention of falls. Certain medications may increase the risk of fall, such as diuretics and laxatives, which could cause the patient to go to the restroom more frequently and possibly urgently. Also, medications that alter their level of consciousness or may make them dizzy, such as narcotics, could increase the risk of fall. These types of medications should be factored into the fall risk equation.

The hospital should determine the best way to incorporate a medication review into the fall risk assessment. It is recommended that a medication review be included for each patient regardless of their level of risk and heighten staff awareness of the risk through communication. Another recommendation is to include certain high risk medications in the fall risk assessment and either assign them a point value or declare all patients on certain medications to automatically be at a certain level of risk for falls. Involve the pharmacist in the fall prevention program since he/she would be helpful in the medication review or in the development of a process to incorporate medication review into the fall risk assessment process.

# PREDICTING THE FALL



## Understanding the Risk Assessment Scoring

The fall risk assessment should be completed for all patients upon admission to the patient care area. A registered nurse, typically the admitting nurse, is responsible for completing the risk assessment of the patient, obtaining the fall risk score, and initiating a plan of care based upon the assessment. All nursing staff should be aware of what level of risk each score represents in order to implement appropriate precautions to create a safe environment and prevent the patient from falling.

Unfortunately, this is an area that is often overlooked in importance. Nursing staff should understand that their assessments of the patient are very important and the information they collect has meaning. The fall risk assessment is a good example of how the nursing assessment is meaningful to patient care. Depending upon the risk score obtained, the nursing staff should implement appropriate precautions that are within the realm of nursing.

While some care requires a physician order, like physical therapy and medication, many inventions used to create a safe environment and prevent falls do not require a physician order. Nursing interventions like maintaining clear pathways to restrooms, patient and family education, skid-proof socks, and fall alarms are a few ways to prevent falls.

If the patient is found to be at moderate or high risk for falls, a nursing care plan should be developed to address the risk of falls. The nursing care plan should address patient nursing care needs, not only those directly related to the medical diagnosis. The incorporation of fall prevention into the nursing care plan should help in ensuring that fall prevention is a priority for nursing. It is helpful to post or educate recommendations for nursing staff to make them aware of nursing diagnoses that would be applicable.

## How Often to Assess Fall Risk

Fall risk assessment should be completed upon admission to the hospital and updated upon any change in the level of care, change in condition, once per shift and after a fall—if one occurs.

Since a patient's condition is expected to change throughout their admission, it is expected that the level of fall risk may change depending upon their improvement or debility. Therefore, it is important to periodically reassess the level of risk in order to maintain a safe environment of care for the patient.



# PREVENTING THE FALL



## Interventions

There are a host of actions that can be taken to prevent falls. However, not every intervention is appropriate for every patient.

A core of basic interventions should be developed for all patients and set forth in the policy. In addition, risk level-specific interventions should also be developed. In this way, fall prevention interventions will become consistent among various levels of risk. Some examples of basic interventions are patient/family education regarding fall prevention, use of non-skid shoes, color-coded armbands to communicate the level of risk, locked movable equipment, and a room with clear paths to the restroom and free from fall hazards. Other more specialized interventions include toileting schedules, low beds, bed or personal alarms, and sitters.

It is important to include patients and families in efforts to prevent falls. Education of the patient and family is an essential step in order to make them aware of the level of risk and what is being done to prevent falls for the patient. In this way, the patient and family will be able to participate in fall prevention. The use of whiteboards, brochures, and posters might be helpful forms of education. All documentation of education and responses to education should be included in the medical record.

## How to Communicate Fall Risk

Hand-off of patient care is a critical time in which the fall risk of a patient should be communicated. Each patient's level of fall risk, as well as whether or not the patient has experienced a fall during the hospital stay, should be communicated between nursing shifts. Therefore, it is important to include fall risks and precautions that are in place in the hand-off nursing report.

In addition, it is important to realize that hand-off between nursing at shift change is not the only hand-off that typically occurs during patient admission. Occasionally, patients must leave the patient care area for testing, such as x-rays, lab tests, stress tests, etc. In these situations, it is important to ensure that the patient's fall risk is communicated to the ancillary staff member who is taking the patient from the patient care area. Often times when tests are ordered, transport staff arrives and takes the patient from the room without nursing staff knowledge. It is recommended that the ancillary staff members be educated to communicate with the nursing staff before taking the patient from the room for testing in another part of the hospital. In order to provide a safe environment throughout the hospital stay, hospital staff must communicate to keep the patient safe.

Don't forget other members of the staff who are involved in patient care and need to know the patient's fall risk. It is important not to forget to communicate fall risk to healthcare providers on the team who may not be present in shift reports, such as nursing assistants. These staff members are involved with patients regularly, and it is important that they know and are able to participate in fall prevention.

Developing a formal Safe Patient Handling and Mobility (SPHM) program, including a bedside mobility assessment, in your organization can also be a component of a fall prevention program. Use of a patient assessment, such as the BMAT (Bedside Mobility Assessment Tool), to determine the type of mobility aids a patient needs for ambulation can be beneficial. View and download the LHA Trust Funds BMAT tool [here](#).

# PREVENTING THE FALL



## Staff Education on Fall Risk and the Fall Prevention Program

All patient care staff should be educated on the fall prevention program in detail. All hospital employees should have some knowledge of the program basics so they can be aware and involved as necessary.

Clinical patient care staff should be educated on the hospital program upon hire, annually, and as needed. Other staff should also be trained upon hire and annually but may not require as detailed training as clinical staff. Stratify education on fall prevention to deliver the type and intensity of education depending upon the department. Generally, everyone should be aware of the fall prevention program though.

In addition, to education on fall assessment, reassessment, prevention, documentation, and patient/family education, clinical patient care staff should be educated on factors that can increase fall risks, such as medications, disease processes, mental condition, and other situations like being a hospital room at night.

## Documentation

The importance of documentation cannot be underestimated. Accurate and complete documentation of the fall risk assessment and the efforts taken to prevent a fall should be well documented and easy to find in the medical record. It is recommended that the policy specify where this documentation should be located in the medical record, such as the initial assessments, reassessments, patient/family education, and preventive measures taken to prevent falls. It is easier to find if the staff is consistently putting this information in the same consistent location.

## Monitoring of Prevention Techniques

Anytime a new program is put into place or revisions are made, it is important to monitor the components and overall impact that the program is having on patient care.

The overall goal for fall prevention would be a reduction in the number of patient falls, repeat falls, and falls with injury. It is also important to monitor process-types of goals to ensure that the program is being implemented appropriately by staff, such as are the proper preventive techniques in place depending upon the patient fall risk score.



# COMPONENTS OF A FALL PREVENTION POLICY



## In-Patients

### **Purpose:**

- What the policy was intended to accomplish overall.

### **Definition:**

- Definition of a “fall”.

### **Assessment:**

- A tool used to assess the risk of falls for each patient.
- Description of how the tool is to be used.
- Description of how the risk assessment information is to be used and scores interpreted.
- The expectation of when/how often the risk assessment is to be completed.
- The expectation of who is responsible for completing the risk assessment.
- Description of how the results of the risk assessment are to be used.

### **Care Plan:**

- Incorporate fall risk into the care plan.
- Incorporate applicable fall risk precautions on the care plan.
- Indicate the frequency that this care plan must be reviewed/revised.

### **Interventions:**

- List fall prevention strategies per each level of risk.
- List other optional strategies that may be helpful.

### **Documentation:**

- Indicate where fall prevention documentation is expected to be done. *For example, in the nurse’s notes.*
- Indicate who is responsible for the documentation in the medical record.
- Specify the depth of information that is expected to be documented related to fall prevention and fall prevention interventions.
- Reiterate the frequency of documentation of the risk assessment and re-assessments.
- Reiterate review/revisions to the care plan.
- Indicate the frequency of which routine fall prevention entries are expected to be made.

### **Hand-off:**

- Indicate that hand-off communication of fall risk is expected.
- Set forth examples of types of hand-off communications that might require communication of this type of information.

# DRUGS/EFFECTS CONTRIBUTING TO FALL RISK



## Analgesics, Opioids

Drug	Effects
Codeine	Orthostatic hypotension, dizziness and syncope
Hydrocodone	Orthostatic hypotension, dizziness and syncope
Hydromorphone	Orthostatic hypotension, dizziness and syncope
Methadone	Orthostatic hypotension, dizziness and syncope
Morphine	Orthostatic hypotension, dizziness and syncope
Oxycodone	Orthostatic hypotension, dizziness and syncope
Oxymorphone	Orthostatic hypotension, dizziness and syncope
Propoxyphene	Orthostatic hypotension, dizziness and syncope

## Anticonvulsants

Drug	Effects
Carbamazepine	Ataxia, sedation, dizziness and syncope
Divalproex	Dizziness and weakness
Ethosuximide	Ataxia and dizziness
Felbamate	Ataxia, sedation, dizziness and syncope
Gabapentin	Ataxia, sedation, dizziness and syncope
Levetiracetam	Ataxia, sedation, dizziness and syncope
Methsuximide	Ataxia and dizziness
Oxcarbazepine	Ataxia, sedation, dizziness and syncope
Phenytoin	Ataxia and dizziness
Pregabalin	Ataxia, sedation, dizziness and syncope
Primidone	Ataxia, sedation, dizziness and syncope
Tiagabine	Ataxia, sedation, dizziness and syncope
Topiramate	Ataxia, sedation, dizziness and syncope
Zonisamide	Ataxia, sedation, dizziness and syncope

## Antidepressants, Monoamine Oxidase Inhibitors

Drug	Effects
Isocarboxazid	Orthostatic hypotension, ataxia, weakness and dizziness
Phenelzine	Orthostatic hypotension, ataxia, weakness and dizziness
Tranylcypromine	Orthostatic hypotension, ataxia, weakness and dizziness

# FALL PREVENTION CHECKLIST



	Yes	No	N/A
Fall risk has been assessed.			
Medications have been reviewed for likelihood of contributing to a fall.			
Fall risk has been included in the care plan, if applicable.			
Patient is in a room as close to the nurse's station as possible.			
"High fall risk" signage/indicator is in place.			
Fall risk armband is in place.			
Toileting schedule in place, if applicable.			
Patient/family has received education of the patient's level of fall risk and how to prevent a fall.			
Patient has non-skid footwear.			
Patient's clothing does not drag along the floor.			
Bedside table is on the side of the bed in which the patient does NOT exit.			
Bedside table is within reach of the patient.			
A clear path to the restroom has been established.			
The bed is in the low position.			
Call bell is within reach for the patient.			
Bed wheels are locked.			
Room lights and night lights are working properly.			
IV pole is on the side of the bed in which the patient will exit.			
Bedside commode is on exiting side of bed.			
Bed alarm is enabled.			
Floor is clean and dry.			
Handrails in restroom are intact.			
Walking aid is within patient's reach on exit side of bed, if applicable.			
Walking aids are in good repair and stable for use.			



## REFERENCES

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## CONTACT US



**Stacie Jenkins, RN, MSN, CPSO**  
**Vice President of Patient Safety and Risk**

225.368.3823  
[staciejenkins@lhatrustfunds.com](mailto:staciejenkins@lhatrustfunds.com)



**Caroline Stegeman, RN, BSN, MJ, ONC, CPHRM, CPSO**  
**Director of Patient Safety**

225.368.3836  
[carolinestegeman@lhatrustfunds.com](mailto:carolinestegeman@lhatrustfunds.com)



**Allison Rachal, RN-BC, CPSO**  
**Senior Patient Safety Consultant**

318.227.7207  
[allisonrachal@lhatrustfunds.com](mailto:allisonrachal@lhatrustfunds.com)