I. PURPOSE

To provide guidelines for routine fall risk assessment and fall precaution strategies.

II. POLICY

A. All patients will be assessed for Fall Risk by the RN as follows:
   1. upon admission
   2. with each shift assessment
   3. upon transfer to another level of care
   4. upon change in condition/post-procedure/post-fall during hospitalization
   5. upon discharge
   Exceptions:
   a. Patients who are brain dead and/or comatose will not need to be assessed. Patients who are appropriately sedated and/or are on paralytics will not need to be assessed, unless breakthrough agitation is noted.
   b. All critical care and burn center patients are high risk for falls.

B. Radiology and Rehabilitative Services will use a service specific plan for fall/injury prevention.

C. All assessments are to be properly documented and patient or service specific precautions are to be taken as appropriate.

III. PROCEDURE

A. Assess patient for Fall Risk Precautions using Morse Fall Assessment Scale Tool. (see attached.)

B. Determine the patient's Morse Scale Score
   1. 0-24 = no risk/prevention (Green Light)
   2. 25-40 = low risk (Yellow Light)
   3. 41+ = high risk (Red Light)

C. Place corresponding color of stoplight in a highly visible location in the patient's room. Place corresponding sticker on patient ID band.
   1. Department specific practices:
      a. In the Critical Care department at CRMC, the corresponding color is placed outside the door.
b. At CBHC, patients designated as fall risk will be identified with a purple arm band and the communication board will also note fall risk.
c. Ambulatory care place appropriate color on the patient's chart.
d. Inpatient care areas place stoplight/appropriate color signs or magnets at each bedside.

D. Implement patient or Service specific (i.e. Radiology, Critical Care, Rehabilitation) fall prevention strategies.
1. Basic Fall Risk Prevention Strategies - (Morse Score 0-24)
   a. Place green stoplight in a highly visible location in the patient's room and green dot on armband and implement all the above prevention strategies:
      i. Bed in low position, brakes locked, call light within reach, upper side rails elevated.
      ii. Belongings/equipment within reach
      iii. Eliminate clutter in room/clear passage to bathroom
      iv. Answer call light promptly
      v. Educate patient/family about fall prevention
   b. Implement on all patients and on patients who are brain dead, comatose, appropriately sedated, and/or are on paralytics.
      Note: If the patients are not appropriately sedated and/or on paralytics, they cannot be on this level of prevention.

2. Low Risk Prevention Strategies - (Morse Score 25-40)
   a. Place yellow stoplight in a highly visible location in the patient's room and yellow sticker on armband and implement all basic (see above) and appropriate low risk prevention strategies:
      i. Elimination Issues
      ii. Mobility Issues
      iii. Mental Status Issues

3. High Risk Prevention Strategies - (Morse Score 41+)
   a. Place red stoplight in patient's room and red sticker on armband. Implement all basic and appropriate low risk strategies (see above) and high risk strategies.
      i. Medication Issues
      ii. Mobility Issues
      iii. Mental Status Issues

E. Instruct the patient/family on the Fall Prevention Program and document in the chart.
F. Identify a nursing diagnosis for potential for injury/falls, interventions and outcomes on Care Plan. Individualization of interventions may differ from routine strategies listed above, i.e. Radiology, Critical Care, Rehabilitation.
G. Communicate patient's risk for falling during report or if patient leaves the unit.
H. For any pediatric patient under 1 year of age:
   1. Place child who is able to stand in a caged crib.
   2. Secure child when in chair or transport device.
   3. On warmers, maintain all 4 sides in up position.
   4. On isolettes, secure all port holes.
I. For pediatric patients under the age of 2:
   1. Place child who is able to stand in caged crib.
   2. Secure child when in chair or transport device.
J. Should a fall occur, document the following on the Medical Record:
   1. Date, time, location and what happened
   2. If witnessed or unwitnessed
   3. Safety measure in effect at time of fall
   4. Vital signs, any observable injuries and skin assessment
   5. Who was notified and if an evaluation was done
   6. New orders or additional precautions implemented.
   7. Complete incident report and notify Clinical Supervisor/Manager.

IV. DOCUMENTATION

A. Document Morse Fall Scale and indicate color and sticker placed on armband on the 24 hour patient record.
C. Document patient/family education on Patient Education Interdisciplinary Record or on 24 hour patient record.

V. PATIENT TEACHING

A. Conduct Patient/family education regarding Fall Precautions.
B. Provide patient with patient education sheets.
C. Upon discharge (if low or high risk) provide patient/family with a copy of ____ (whatever home education that the organization utilizes)

VII. RELATED POLICIES

Critical Patient Care Alarm

VIII. REFERENCES


