

FALL PREVENTION CLINICAL PRACTICE GUIDELINE
(For Adult and Pediatric Inpatients of Military Medical Treatment Facilities)

1. Purpose. This CPG addresses the clinical question regarding what evidence exists to support interventions that can be incorporated into guidelines for patients and visitors at risk for falls and/or who fall. All patients, family members and visitors have the right to a safe environment free from the risks associated with falls.

2. References. Appendix A

3. Definitions.

a. Fall. A sudden unplanned event, witnessed or unwitnessed, that results in the patient descending or coming to rest unintentionally on the ground/floor (or extension of the floor, e.g., trash can or other equipment) with or without injury. The descent begins from a standing, sitting or horizontal position to include slipping from a chair to the floor. All types of falls are included, whether they result from physiological reasons or environmental reasons. [1]

b. Developmental Pediatric Fall. Non injurious fall that is common to infant and toddlers as they are learning to walk, pivot and run. [1]

c. Accidental Fall. Fall that results from a person slipping, tripping, or having some other mishap. This type of fall is often caused by environmental factors such as water or urine on the floor. [2]

d. Anticipated Physiological Fall. Fall that occurs to patients identified at risk for falls. Factors including complicated patients such as those with multiple diagnoses, history of a previous fall, weak or impaired gait, IV/saline lock, and an ambulation aid may designate a patient at a higher risk for falling. [2]

e. Unanticipated Physiological Fall. Fall that cannot be predicted. Examples of this type of fall include seizures, drug reaction or side effect, fainting, or pathologic fracture. [2]

f. Near Miss Fall. An event or situation that could have resulted in an accidental, anticipated or unanticipated fall, but did not either by chance or through timely intervention. Or, where a patient is assisted to the floor/lower surface by another individual without injury to the patient.[1]

g. Patient-Centered Bedside Rounding. Deliberate, planned bedside interaction between a nursing staff member and a patient at prescribed intervals using a standardized checklist to individualize patient-centered interventions. [3]

h. Degree of Harm. Defined by Agency for Healthcare Research and Quality (AHRQ) Harm Scale (assigned by Patient Safety Manager) [4]

1) **No Harm** - Event reached patient, but no harm was evident

2) **Emotional Distress or Inconvenience**

a) Mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies).

b) Distress/inconvenience since discovery, and/or expected in the future as a direct result of event.

3) **Additional Treatment**

a) Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury.

b) Treatment since discovery, and/or expected treatment in future as a direct result of event

4) **Temporary Harm** - Bodily or psychological injury, but likely not permanent. Prognosis at the time of assessment.

5) **Permanent Harm** - Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis at the time of assessment.

6) **Severe Permanent Harm** - Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with the functional ability or quality of life. Prognosis at the time of assessment.

7) **Death** - Death at the time of the assessment.

4. Applicability. This CPG applies to all U.S. Army Medical Command healthcare professionals and paraprofessionals that provide adult and/or pediatric inpatient care.

5. Responsibilities.

a. Department Chiefs. Assist in the implementation of this policy.

b. Chief, Hospital Education. Initiate basic orientation regarding fall prevention policy education during New Employee Orientation and Department of Nursing Orientation.

c. Patient Safety Manager. Track all falls in the facility, identify trends, disseminate data, and participate in performance improvement strategies to improve care and prevent future occurrences.[5]

d. Service/Section Chiefs. Assist in the development, assessment, and implementation of policies and strategies to educate staff and prevent falls at the facility.

e. Clinical Nurse OICs and NCOICs. Inspect all patient care areas for safety issues or concerns, promptly report falls, monitor trends, initiate performance improvement strategies, and ensure staff education regarding falls prevention policy and procedures. Ensure orientation and education is based on population specific and disease specific considerations and includes the following [6-8]:

1) Importance of the prevention of falls.

2) Assessment for falls risk.

3) Method to eliminate or decrease falls to include patient and family education.

4) Recognition of the common causes and types of falls.

5) Available strategies for the prevention of falls.

6) Ensure documentation of employee training in each competency assessment folder (CAF).

f. Nursing Staff. Perform fall risk assessment (licensed nursing staff only) and implement fall prevention procedures. Comply with the most updated and current Falls Prevention CPG. [6]

g. Housekeeping. While mopping or waxing floors, place signs and cones to alert all persons of wet and slippery floors. Mop or wax one side of the floor at a time to allow for safe passage. Remove safety signs promptly after completing floor work. Keep all housekeeping carts safely out of doorways to reduce a trip hazard. [9]

h. All Hospital Staff. All hospital personnel will strive to create and maintain a safe patient care environment to reduce falls. Each staff member will ensure documentation in his/her CAF regarding patient safety activities. All inpatient falls will be reported electronically in the Patient Safety Reporting System. [5]

6. Fall Prevention Procedures.

a. Inpatients - Adult.

(1) Fall Risk Assessment

(a) Utilizing the Johns Hopkins Hospital (JHH) Fall Assessment Tool a licensed nursing staff member will assess all patients regarding their risk of falling (Appendix C.a.) [10]Level VI, A; [12] Level V, B

(b) Fall Risk Assessment Frequency

1. Within 4 hours of admission and every shift. [11] Level VI, A

2. When there is a change in the patient's status (i.e. surgery, an invasive procedure, actual fall, changes in mental status, significant change in therapeutic regimens or medications, etc.). [11] Level VI, A

3. Upon transfer to another unit. [11] Level VI, A

4. PRN (e.g. with change in caregiver). [3] Level VII, A

(2) Standard fall prevention interventions will be provided to all adult patients by clinical staff regardless of risk assessment score. These include:

(a) maintain a safe unit environment including: [12]Level V, B; [11] Level VI, A; [7];[8]

1. removing excess equipment/supplies from rooms and hallways.

2. coiling and securing excess electrical and telephone wires.

3. cleaning spills in patient room or in hallway immediately.

4. placing signage to indicate wet floor danger.

5. restrict window openings.

(b) provide basic safety interventions including: [12] Level V, B

1. Orient patients to their room and bathroom. Show them how to use the call bell and ensure the call bell is within easy reach. [12] Level V, B; [11] Level VI, A

2. Educate the patient and his/her family and visitors regarding fall risk and prevention activities. [13] Level IV, B; [14] Level I, A; [11] Level VI, A

3. Encourage patients/families to call for assistance when needed. [12] Level V, B; [11] Level VI, A

4. Place beds in the lowest position with the wheels locked. [12] Level V, B; [11] Level VI, A

5. Lock all wheels on wheelchairs and cardiac/geriatric chairs when in a stationary position. [12] Level V, B; [11] Level VI, A

6. Place side rails in an upright position as needed. Evidence indicates use of all 4-bed rails has been linked to patient injury. (Placing all bed rails in the up position may be considered a restraint depending on your hospital restraint policy.) [12] Level V, B; [11] Level VI, A

7. Ensure patients wear snug fitting, non-slip footwear while ambulating. [12] Level V, B; [11] Level VI, A

8. Ensure hallways and floors remain dry and clear of any obstacles, especially items that slide or roll. [11] Level VI, A

9. Clearly identify any hazardous areas or obstacles upon which the patient might trip (i.e., trashcans, laundry containers, computer terminal stands and cords, patient's personal items, etc). [11] Level VI, A

10. Ensure bedside tables with personal items and any ambulatory devices (walkers, canes, etc) are within easy reach of the patient at all times. [12] Level V, B; [11] Level VI, A

11. If a patient becomes disoriented, attempt reorientation.

12. Ensure patient's eyeglasses are clean and within reach.

13. Ensure proper lighting is available, especially at night. [12] Level V, B; [11] Level VI, A

14. When transporting a patient in a wheelchair or on a litter, ensure the safety strap is in place and/or side rails are up.

(3) In addition to the standard fall prevention interventions, patients determined to be at moderate risk for falling, with a score of 6-13 on the JHH Fall Assessment Tool, will have moderate risk fall prevention interventions initiated which include:

(a) Identify patients at risk for falling with visual cues. [15] Level V, A; [16] Level V, B; [12] Level V, B; [11] Level VI, A

1. Post an at-risk indicator (Falling Star sign, Appendix D) in a visible area within the patient's room and on the census board to alert staff that fall prevention precautions are in effect. [15] Level V, A; [16] Level V, B; [12] Level V, B; [11] Level VI, A

2. Place the yellow Falls Risk ID Band on the patient's wrist and yellow non-skid socks on the patient. [17] Level VI, B; [15] Level V, A; [11] Level VI, A

(b) During nursing shift reports, identify and discuss all patients deemed at risk for falling.

(c) Educate the patient and his/her family and visitors regarding falls risk and prevention activities. [11] Level VI, A

(d) Conduct patient-centered bedside rounds at least every 2 hours. Check patient for the 4 Ps: pain, positioning, pottying, possessions and environmental hazards. Ensure the bedside commode or urinal is readily accessible and empty. [18] Level III, B; [11] Level VI, A

(e) Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate. [12] Level V, B; [11] Level VI, A

(f) Reorient confused patients as necessary.

(g) Establish an elimination schedule, when appropriate incorporate use of bedside commode. [19] Level I, A; [12] Level V, B; [11] Level VI, A

(h) Consider consult to Physical/Occupational Therapy if patient has a history of a fall and/or mobility impairment. [10] Level V, B; [11] Level VI, A

(i) Consider using a bed exit or personal alarm for all patients scoring 1 or greater on cognition in the JHH Fall Assessment Tool. [11] Level VI, A

1. Ensure that the alarm works and is audible at the time it is initiated and each time a new nurse assumes care.

2. Respond rapidly to the alarm when it is activated.

(j) Communicate to Licensed Independent Provider (LIP) factors influencing the patient's risk so that orders written by the LIP support activities that will reduce fall risk or fall occurrence.

(4) In addition to the standard and moderate risk fall prevention interventions, patients determined to be at high risk for falling, with a score of greater than 13 on the JHH Fall Assessment Tool, will have high risk fall prevention interventions initiated which include:

(a) Remain with the patient while toileting. [12] Level V, B

(b) Conduct patient-centered bedside rounds every hour. [12] Level V, B; [18] Level III, B

(c) Move the patient to a room with best visual access to the nursing station to facilitate frequent and closer observation. [12] Level V, B; [11] Level VI, A

(d) Transport off unit with assistance of staff or trained caregivers. Notify receiving area of high fall risk. [12] Level V, B

(e) Encourage family to stay with the patient or consider using a sitter. [12] Level V, B; [11] Level VI, A

(f) Provide diversion therapy such as TV, lacing cards, or volunteer reader. [15] Level V, A

b. Inpatients - Pediatric.

(1) Fall Risk Assessment

(a) Tool. Utilizing the Humpty Dumpty Fall Scale (HDFS) fall risk assessment tool a licensed nursing staff member will assess all pediatric patients regarding their risk of falling [13] Level IV, B; [20] Level VII, A

(b) Developmental Considerations. Normal developmental falls in infants, toddlers, and preschoolers are related to learning to stand, walk, run and pivot. The licensed nurse will consider the infant/child's development, family involvement and environment in regards to fall risk. [21] Level V, A; [20] Level VII, A

(c) Fall Risk Assessment Frequency

1. Within 4 hours of admission and every shift. [11] Level VI, A

2. When there is a change in the patient's status (i.e. surgery, an invasive procedure, actual fall, changes in mental status, significant change in therapeutic regimens or medications, etc.). [11] Level VI, A

3. Upon transfer to another unit. [11] Level VI, A

4. PRN (e.g. change in caregiver). [3] Level VII, A

(2) Standard fall prevention interventions will be provided to all pediatric patients by clinical staff regardless of risk assessment score. [21] Level V, A. These include:

(a) Keep hand contact with infants, young children, developmentally delayed or cognitively impaired children on treatment tables or scales to prevent a fall. [20] Level VII, A

(b) Children under four years will occupy cribs, bassinets, warmers or incubators. If all sides of these devices are not in the upright locked position, keep hand contact at all times. Do

not augment height of support surface unless other fall prevention interventions are implemented. [21] Level V, A; [22] Level IV, B

(c) A child under four may occupy a youth/standard bed if a parent is in attendance at all times. [21] Level V, A; [22] Level IV, B

(d) Use an enclosed crib (e.g. bubbletop) if the child is at risk for climbing over the rails. [21] Level V, A; [22] Level IV, B

(e) Use non-skid footwear for ambulating patients, use appropriate size clothing to prevent risk of tripping. [21] Level V, A; [20] Level VII, A

(f) Keep the environment clear of unused equipment, keep furniture in place and clear of hazards. [9]

(g) Ensure adequate lighting, leave nightlight on. [12] Level V, B

(h) Educate patient and/or parents regarding fall risk and prevention activities. [20] Level VII, A; [22] Level IV, B

(i) Consistently enforce safety rules and activity limitations. [20] Level VII, A

(j) Maintain direct surveillance of children in bathtub/shower. [20] Level VII, A; [22] Level IV, B

(k) For children less than 4, keep crib sides in the upright and locked position, unless constant hand contact is maintained. [20] Level VII, A

(l) Lock bed and crib wheels. [20] Level VII, A

(m) Always keep bed in lowest position. [20] Level VII, A; [22] Level IV, B

(n) Keep call light/bell within patient reach. [20] Level VII, A

(o) Maintain hand contact while caring for a child in a crib with side rails down. [21] Level V, A

(p) Transport infants and children appropriately. Position with proper support when transported by crib. Fasten safety belt when transporting on a gurney, stroller or wheelchair. The patient's nurse will determine appropriate mode of transportation. [21] Level V, A

(q) Fasten safety belts on high chairs, strollers and swings. [20] Level VII, A

(3) In addition to the standard fall prevention interventions, pediatric patients determined to be at high risk for falling, with a score of 12 or greater on the HDFS, will have high risk fall prevention interventions initiated by the licensed nurse which include:

(a) Identify patients at risk for falling with visual cues. [15] Level V, A; [16] Level V, B; [12] Level V, B

1. Post an at-risk indicator (Falling Star sign, Appendix D) in a visible area within the patient's room and on the census board to alert staff that fall prevention precautions are in effect. [15] Level V, A; [16] Level V, B; [12] Level V, B

2. Place the yellow Falls Risk ID Band on the patient's wrist and yellow non-skid socks on the patient. [15] Level V, A; [17] Level VI, B

(b) During nursing shift reports, identify and discuss all patients deemed at risk for falling. [16] Level VII, A

(c) Conduct patient-centered bedside rounds every hour. [12] Level V, B; [18] Level III, B

(d) Accompany patient with ambulation.

(e) Move the patient to a room with direct line of sight to the nursing station to facilitate frequent and closer observation. Keep room door open at all times unless patient is directly attended. [12] Level V, B

(f) Encourage parent to stay with the patient or consider using a sitter. [12] Level V, B

(g) Provide diversion therapy such as an age-appropriate toy, TV, or volunteer reader. [15] Level VII, A

(h) As appropriate, establish an elimination schedule and remain with the patient while toileting. [12] Level V, B; [19] Level I, A

7. Care of the inpatient who falls. If a patient falls, nursing staff will:

a. Immediately assess the patient for injury and stabilize as necessary. [3, 5]

b. Notify the patient's LIP. [3, 5]

c. Initiate orders as written. [3, 5]

d. Initiate the Fall Prevention Protocol if not already in place. [21] Level V, A

- e. Document the fall, circumstances, description of any injury, fall-related interventions, and outcomes in a clinical note. (Do not document in the medical record that a patient safety report was initiated). [21] Level V, A
- f. Conduct a debrief with the nursing team. [23] Level VI, B
- g. Discuss the fall and review safety precautions with the patient and family. [15] Level VII, A
- h. Inform the staff of the increased fall risk for the patient and communicate the incident at the nursing shift report. [21] Level V, A; [20] Level VII, A
- i. Submit a patient safety report using the on-line Patient Safety Reporting (PSR) System. [5, 21] Level V, A
- j. Annotate information on the 24-hour Nurses Report. [5, 21] Level V, A
- k. Assess staffing requirements and contact the supervisor if additional staff is required. [3] Level VII, A

Appendix A
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Appendix B

1. Strength of Evidence Rating System for the Hierarchy of Evidence

Level I: Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs.

Level II: Evidence obtained from at least one well-designed RCT.

Level III: Evidence obtained from well-designed controlled trials without randomization.

Level IV: Evidence from well-designed case-control and cohort studies.

Level V: Evidence from systematic reviews of descriptive and qualitative studies.

Level VI: Evidence from a single descriptive or qualitative study.

Level VII: Evidence from the opinion of authorities or reports of expert committees.

From *Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice* (p. 10), by B.M. Melnyk & E. Finout-Overholt, 2005. Philadelphia: Lippincott Williams and Wilkins. Copyright 2005 by Lippincott Williams and Wilkins.

2. Quality of Evidence Rating

From Newhouse, R., Dearholt, S., Poe, S., et al., *Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines 2007*, Indianapolis: Sigma Theta Tau International.

Grade	Nomenclature	Definition For Research Evidence	For Non-Research Evidence
A	High	Consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence	Expertise is clearly evident
B	Good	Reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.	Expertise appears to be credible
C	Low/Major Flaw	Little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn	Expertise is not discernable or is dubious

Appendix C.a.
FALL RISK ASSESSMENT TOOLS

THE JOHNS HOPKINS HOSPITAL FALL ASSESSMENT TOOL

<p>Fall Risk Factor Category Scoring not completed for the following reason(s) (check any that apply). Enter risk category (i.e. Low/High) based on box selected.</p> <p><input type="checkbox"/> Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.</p> <p><input type="checkbox"/> Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization.</p> <p><input type="checkbox"/> Patient has experienced a fall during this hospitalization. Implement high fall risk interventions throughout hospitalization.</p> <p><input type="checkbox"/> Patient is deemed high fall-risk per protocol (e.g. seizure precautions). Implement high fall-risk interventions throughout hospitalization per protocol.</p>	
COMPLETE THE FOLLOWING AND CALCULATE FALL RISK SCORE. IF NO BOX IS CHECKED, SCORE FOR CATEGORY IS 0.	POINTS
<p>AGE (SINGLE-SELECT)</p> <p><input type="checkbox"/> 60 – 69 years (1 point)</p> <p><input type="checkbox"/> 70 – 79 years (2 points)</p> <p><input type="checkbox"/> ≥ 80 years (3 points)</p>	
<p>FALL HISTORY (SINGLE-SELECT)</p> <p><input type="checkbox"/> One fall within 6 months before admission (5 points)</p>	
<p>ELIMINATION, BOWEL AND URINE (SINGLE-SELECT)</p> <p><input type="checkbox"/> Incontinence (2 points)</p> <p><input type="checkbox"/> Urgency or frequency (2 points)</p> <p><input type="checkbox"/> Urgency/frequency and incontinence (4 points)</p>	
<p>MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (SINGLE-SELECT)</p> <p><input type="checkbox"/> On 1 high fall risk drug (3 point)</p> <p><input type="checkbox"/> On 2 or more high fall risk drugs (5 points)</p> <p><input type="checkbox"/> Sedated procedure within past 24 hours (7 points)</p>	
<p>PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDS, ETC) (SINGLE-SELECT)</p> <p><input type="checkbox"/> One present (1 point)</p> <p><input type="checkbox"/> Two present (2 points)</p> <p><input type="checkbox"/> 3 or more present (3 points)</p>	
<p>MOBILITY (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)</p> <p><input type="checkbox"/> Requires assistance or supervision for mobility, transfer, or ambulation (2 points)</p> <p><input type="checkbox"/> Unsteady gait (2 points)</p> <p><input type="checkbox"/> Visual or auditory impairment affecting mobility (2 points)</p>	
<p>COGNITION (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER)</p> <p><input type="checkbox"/> Altered awareness of immediate physical environment (1 point)</p> <p><input type="checkbox"/> Impulsive (2 points)</p> <p><input type="checkbox"/> Lack of understanding of one's physical and cognitive limitations (4 points)</p>	
<p>*Moderate risk = 6-13 Total Points, High risk > 13 Total Points Total Points The Johns Hopkins Hospital © 2007</p>	

Appendix C.b.
FALL RISK ASSESSMENT TOOLS

Falls Humpty Dumpty Inpatient Scale



Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

**Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient**

Parameter	Criteria	Score (circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to own ability	1
Environmental Factors	History of Falls or Infant Toddler Placed in Bed	4
	Patient uses assistive devices or Infant-Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage	Multiple usage of Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotic	3
	One of the meds listed above	2
	Other Medications/None	1
TOTAL		

Form 10450002

Date: _____
 Name: _____
 MR#: _____
 Acct#: _____
 D.O.B.: _____
 Age: _____

**At risk for falls
if score is 12 or Above**

Minimum Score 7
Maximum Score 23

↳ Patient Falls Safety Protocol on back

PLACE
YOUR LOGO
HERE

HUMPTY DUMPTY SCALE – INPATIENT™

Parameter	Criteria	Score
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to Own Ability	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant-Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage	Multiple usage of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotic	3
	One of the meds listed above	2
	Other Medications/None	1
TOTAL		

**AT RISK FOR FALLS
IF SCORE 12 OR ABOVE**

Minimum Score 7
Maximum Score 23

Appendix D
At Risk Visual Cue – Falling Star



Appendix E

Suggested Nursing Initiated Order Sets: Adult and Pediatric Inpatient

NIO: Adult Standard Fall Prevention Interventions

NIO: Orient to ward	X1	Orient pt to room/bathroom. Show how to use call bell and ensure call bell within easy reach.
NIO: Assess for falls risk	QShift	Johns Hopkins Hospital Fall Assessment (JHHFA) Tool
NIO: Bed in lowest position	QShift	Ensure wheels locked
NIO: Assess environment	QShift	every 2hrs for obstacles/hazards
NIO: Ensure call light is	QShift	within reach; promptly answer call light
NIO: Educate patient/family	QShift	regarding falls risk and prevention activities
NIO: Ensure patient wears	QShift	while ambulating non-slip socks
NIO: Patient rounding	Q2hrs	Check pt for pain, positioning, pottying, possessions and environmental hazards. Ensure BSC or urinal is readily accessible and empty.
NIO: Before leaving room	QShift	ask patient "Is there anything I can for you before I leave? I have time while I'm here in your room." Tell patient a member of the nursing staff will make bedside rounds within the next 2 hrs.

Appendix E (continued)

NIO: Adult Moderate Risk Fall Prevention Interventions

NIO: Patient on Fall Prevention Protocol	QShift	
NIO: Place falling star on room door and on census board;	X1	place yellow ID wristband and yellow non-skid socks on patient
NIO: Educate Pt/Family on Fall Prevention Protocol;	X1	give "Fall Prevention Protocol Information to Patients" handout to Pt/Family
NIO: Move patient	X1	as close to nurses station as possible
NIO: Remind Pt to request	QShift	assistance whenever needed
NIO: Supervise and/or assist	QShift	bedside sitting, personal hygiene, and toileting as appropriate (remain within hearing distance)
NIO: Offer toileting	QShift	every 2hrs while awake; use bedside commode as appropriate
NIO: Transport throughout hospital	QShift	with assistance of staff or trained caregiver
NIO: Do not leave unsupervised	QShift	off unit
NIO: Reorient confused patient	QShift	as necessary
NIO: Evaluate need for PT/OT consult	X1	
NIO: Use seat belt	QShift	when in wheelchair
NIO: Place side rails up	QShift	as indicated; do not place more than 3 side rails up at a time.

Appendix E (continued)

NIO: Adult High Risk Fall Prevention Interventions

NIO: Patient on Fall Prevention Protocol	QShift	
NIO: Place falling star on room door and on census board;	X1	place yellow ID wristband and yellow non-skid socks on patient
NIO: Educate Pt/Family on	X1	Fall Prevention Protocol; give "Fall Prevention Protocol Information to Patients" handout
NIO: Move patient	X1	as close to nurses station as possible
NIO: Remind Pt to request	QShift	assistance whenever needed
NIO: Supervise and/or assist	QShift	bedside sitting, personal hygiene, and toileting
NIO: Patient-centered Rounding	QShift	every hour
NIO: Offer toileting	QShift	every 2hrs while awake
NIO: Remain with patient	QShift	while toileting (line of sight)
NIO: Transport throughout hospital	QShift	with assistance of staff or trained caregiver
NIO: Do not leave unsupervised	QShift	off unit
NIO: Reorient confused patient	QShift	as necessary
NIO: Evaluate need for PT/OT consult	X1	
NIO: Use seat belt	QShift	when in wheelchair
NIO: Place side rails up	QShift	as indicated; do not place more than 3 side rails up at a time.
NIO: Bed Alarm on	QShift	for score of ≥ 1 on JHHFA Cognition item
NIO: Consider 1:1 sitter	QShift	

Appendix E (continued)

NIO :Pediatric Standard Fall Prevention Interventions

NIO: Orient to ward	X1	Orient pt to room/bathroom. Show patient/parents how to use call bell and ensure call bell within easy reach.
NIO: Assess for falls risk	QShift	Humpty Dumpty Fall Scale
NIO: Bed in lowest position	QShift	Ensure bed/crib wheels locked
NIO: Crib rails/Side rails up	QShift	when not attended by parent or staff
NIO: Fasten straps	QShift	in wheel chair, stroller, swing, highchair
NIO: Assess environment	QShift	every 2hrs for obstacles/hazards
NIO: Ensure call light is within reach;	QShift	promptly answer call light
NIO: Educate patient/family	QShift	regarding falls risk and prevention activities
NIO: Ensure patient wears non-slip socks	QShift	while ambulating
NIO: Patient-centered rounding	Q2hrs	check pt for pain, positioning, pottying, possessions and environmental hazards. Ensure BSC or urinal is readily accessible and empty.
NIO: Before leaving room	QShift	ask patient "Is there anything I can do for you before I leave? I have time while I'm here in your room." Tell patient a member of the nursing staff will make bedside rounds within the next 2 hrs.

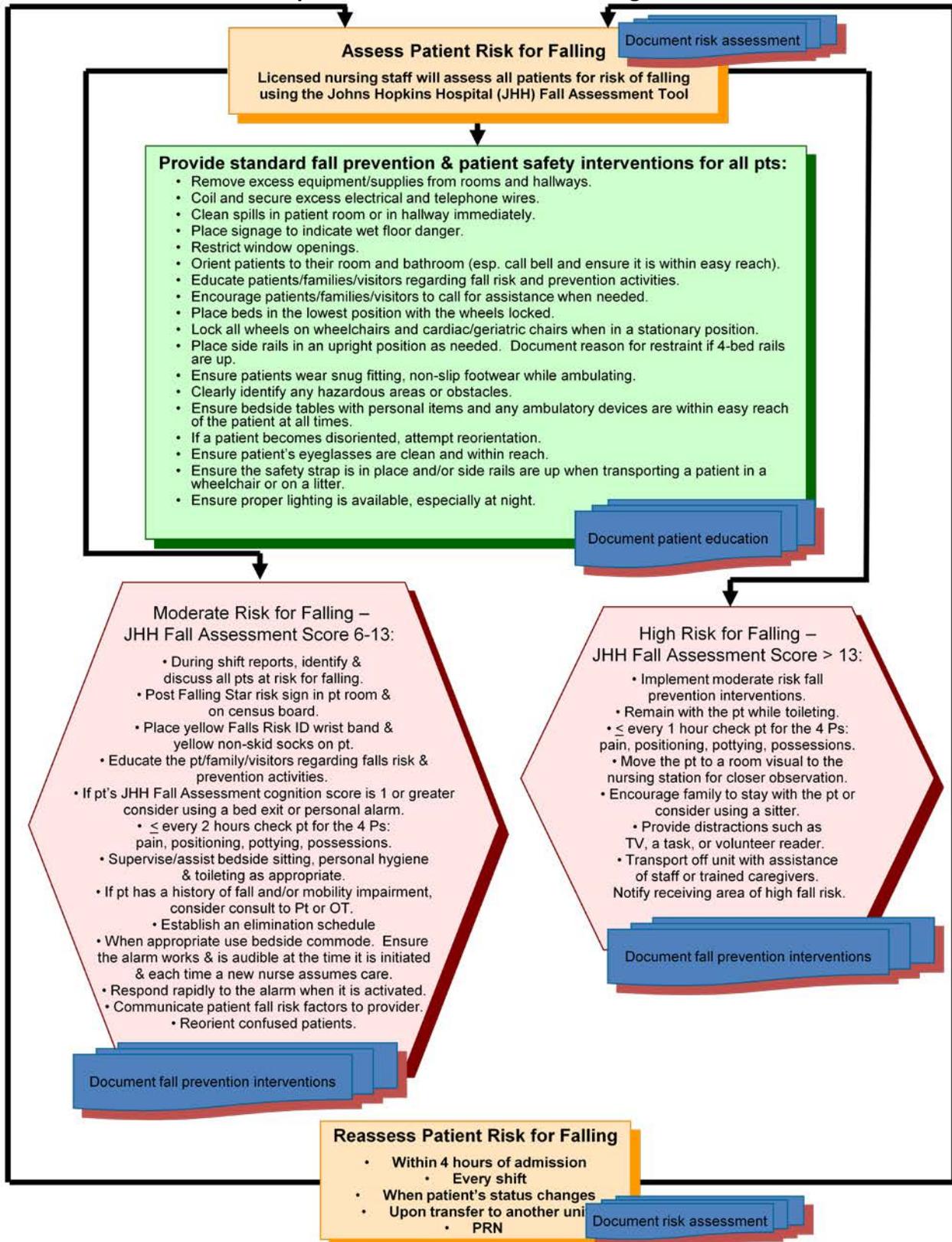
Appendix E (continued)

NIO: Pediatric High Risk Fall Prevention Interventions

NIO: Patient on Fall Prevention Protocol	QShift
NIO: Place falling star on room door and on census board;	X1 place yellow ID wrist band and yellow non-skid socks on patient
NIO: Educate Pt/Parents on Fall Prevention Protocol;	X1 give "Fall Prevention Protocol Information to Patients" handout to Pt/Family
NIO: Move patient as close to nurses station as possible	X1 Keep room door open at all times unless pt directly attended.
NIO: Patient-centered rounding	QShift every hour
NIO: Accompany patient with ambulation	QShift
NIO: Remind Pt/Parent to call for assistance	QShift as needed
NIO: Offer toileting every 2 hrs while awake	QShift remain with pt while toileting (line of sight)
NIO: Transport throughout hospital	QShift with assistance of staff or trained caregiver
NIO: 1:1 sitter	QShift

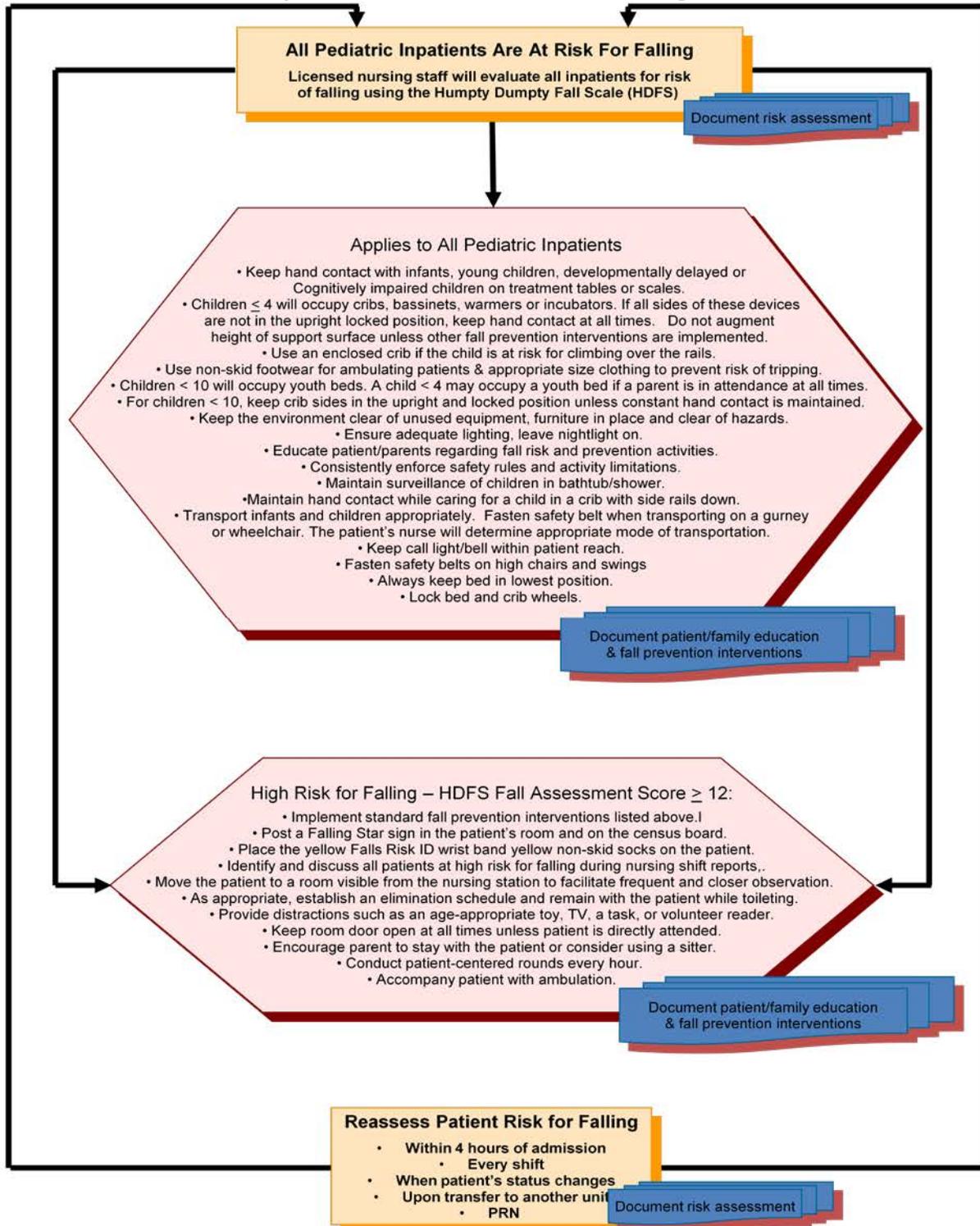
Appendix F

Inpatient Adult Fall Prevention Program



Appendix F

Inpatient Pediatric Fall Prevention Program



Appendix G.a.
Fall Tri-Fold Handout for Patient and Family

GREETINGS!



The _____ Staff would like to welcome you to _____ Hospital. We hope that your stay with us will be pleasant and as safe as possible. As part of our efforts to care for you, we have initiated a program to insure your safety. This program involves identifying risk factors that may make you prone to falling. These factors include:

1. Having an IV and the types of medications you are taking, especially water pills and medications that might make you drowsy.
2. Urgency, frequency or losing control of bowel or bladder.
3. Any difficulty walking.
4. Use of crutches, canes, walker or wheel chair.



5. Previous fall.
6. Complaints of being dizzy and/or confused.



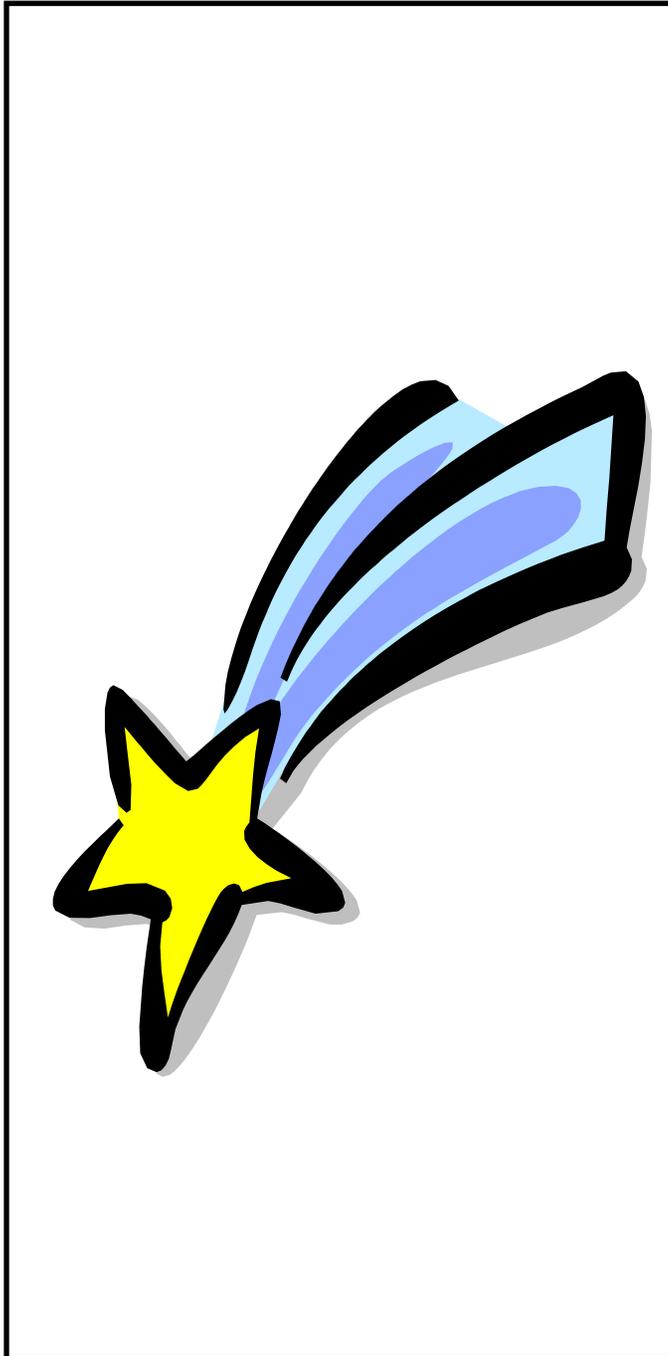
This program has proven effective and we request your cooperation. When you help us and we work together, we seem to be able to prevent falls. One way you help is to call for help should you need to get out of bed. We will be most willing and happy to assist you. In addition, we will do the following:

1. We will place a yellow ID band on your wrist and yellow non-skid socks on your feet and a falling star will be placed on your door, on the wall above your bed, and by your name on the board at the nurses' station to alert all health care providers that you may be at risk for falling.
2. Keep the call light and personal items within your reach while you are in bed.

3. Walking devices will be placed near your bed at night or before receiving sleep medications.
4. If you are on water pills, you will be offered an opportunity to go to the bathroom before going to bed at night, before receiving sleep medication, and throughout the day and night during rounds.
5. At night, we will make rounds to check on you at least every 1-2 hours.
6. Use a seat belt while you are sitting in a chair, wheelchair, bedside commode, or on a stretcher.
7. Prevent hazards such as a wet, slippery floor.

Working together to keep you safe!





**MADIGAN
HEALTHCARE
SYSTEM**

**FALL PREVENTION
PROTOCOL
INFORMATION TO
PATIENTS**



**Madigan Healthcare System
Quality Service Division
December 2004**

Appendix G.b.

Fall Tri-Fold Handout for Patient and Parents**5. Own awareness in keeping with ability to follow activity orders.****GREETINGS!**

The _____ Staff would like to welcome you to _____ Hospital. We hope that your child's stay with us will be pleasant and as safe as possible. As part of our efforts to care for your child, we have initiated a program to insure his/her safety. Falling may be normal in infants, toddlers and preschoolers as they learn to stand, walk, run and pivot. Other risk factors may make your child prone to "non-developmental related" falling. These factors include:

1. The age and gender of the child.
2. The health problems of the child.
3. Use of crutches, walker, or wheelchair.
4. History of falls or type of bed the child is placed in.



This program has proven effective and we request your cooperation. When you help us and we work together, we seem to be able to prevent falls. Some ways you can help include:

1. Keep side rails in appropriate position as instructed by nursing staff. When in a bed, rails must be up and in low position.
2. Your child will be placed in a crib for safety if under 4 years of age. Crib side rails must be in the high position at all times when you are not at the bedside or within arms reach.

3. For safety reasons, please do not carry your child around the hospital; children should walk if able or use the available strollers, wagons or wheelchairs.

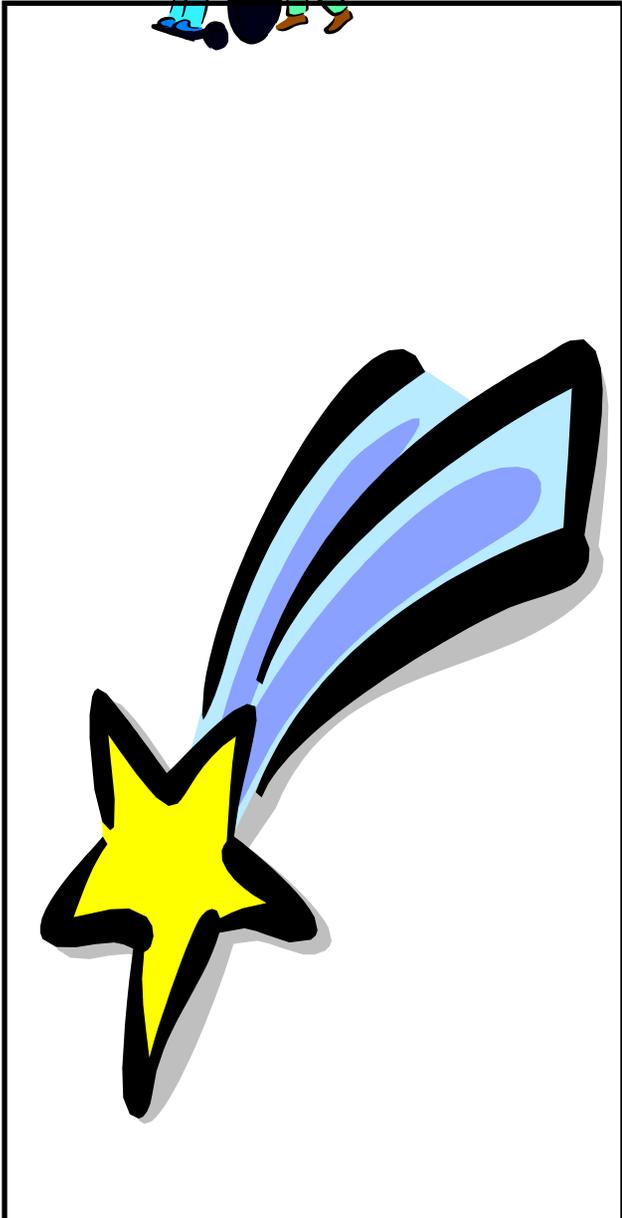
4. If your child is in a stroller, highchair, or wheelchair, seat belts must be used.

In addition, we will do the following:

1. We will place a yellow ID band on your child's wrist and yellow non-skid socks on their feet and a falling star will be placed on the door, on the wall above the bed, and by your child's name on the board at the nurses' station to alert all health care providers that your child may be at risk for falling.
2. Keep the call bell within reach while your child is in bed.
3. At night, we will make rounds to check on your child at least once an hour.
4. Secure your child with a seat belt while sitting in a highchair, wheelchair, or on a litter.

23 March 2011

5. Prevent hazards such as a wet, slippery floor.



CPG Fall Prevention

**Acknowledgement here
Date Approved**

Your Hospital Here

**FALL PREVENTION PROTOCOL
INFORMATION TO
PATIENTS AND PARENTS**

