

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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MEDCOM Regulation
No. 40-59

10 March 2014

Medical Services
**STANDARDIZATION OF INPATIENT FALLS RISK ASSESSMENT
AND DOCUMENTATION FALLS PREVENTION PROGRAM**

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CP-A.

1. History. This issue publishes a major revision of this regulation.

2. Purpose

a. Function. This regulation directs standardized implementation of endorsed evidence-based falls risk assessment tools: the Johns Hopkins Hospital Fall Risk Assessment[®] (adult) and the Miami Children's Hospital's Humpty Dumpty Scale[®] (pediatric). In addition, this regulation requires incorporation of falls assessment documentation into the inpatient (Essentris) electronic medical record (EMR).

Note: The Army Medical Command has licensing agreements allowing the use of the Johns Hopkins Hospital Fall Risk Assessment[®] and Miami Children's Hospital's Humpty Dumpty Scale[®].

b. Scope. This regulation addresses standards for military treatment facilities (MTFs) that provide inpatient services.

c. Objectives. The objectives of the regulation are to—

(1) Standardize falls risk assessment tools throughout all MTFs that provide inpatient services;

(2) Standardize nursing documentation in the inpatient EMR of falls risk assessments addressed in this regulation; and

(3) Prescribe interventions based on the patient's identified risk.

*This regulation supersedes MEDCOM Regulation 40-59, 21 June 2011.

3. Applicability. This regulation applies to all administrative, professional, and clinical staff (military and civilian) assigned, attached, or under the U.S. Army Medical Command (MEDCOM).

4. References. Required and related publications and prescribed and referenced forms are listed in appendix A.

5. Explanations of terms. Abbreviations used in this regulation are explained in the glossary.

6. Responsibilities

a. The MEDCOM Patient Safety Center will—

(1) In collaboration with the Department of Defense Partnership for Patients (PfP) Campaign, Falls Prevention Implementation Initiative, provide guidance and support to all regional and local patient safety programs.

(2) Act as a conduit and maintain contact with the falls assessment tools' authors and applicable copyright/trademark holders on matters pertaining to author revisions/updates to assessment tools or local facility requests for any modification to assessment tools.

(3) Coordinate with the Office of the Surgeon General, Office of the Chief Information Officer, regional chief management information officers, and Army MTFs to ensure the Johns Hopkins Hospital Fall Risk Assessment[®] (adult) (app B) and the Miami Children's Hospital's Humpty Dumpty Scale[®] (pediatric) (app C) are maintained within the EMR, according to copyright/trademark permissions/licensing agreements.

(4) In accordance with the PfP campaign, assist facilities in gathering, analyzing, and trending falls data.

(5) Maintain training modules on use of tools and paper versions of the tools on the Quality Management Office (QMO) Patient Safety Web site; available at <https://www.qmo.amedd.army.mil/ptsafety/pts.htm>.

b. The regional patient safety manager will—

(1) Ensure appropriate “champion” staff members coordinate the overall falls reduction inpatient program within their assigned MTF.

(2) Ensure outcome/process measure metrics are gathered and reported as prescribed (monthly).

(3) Report status of compliance with copyright/trademark permissions/licensing agreement and validating that no changes have been made locally on the tool used in the EMR as directed by this policy.

c. MTF senior leadership will—

(1) Promote a culture that emphasizes communication and cooperation for reducing falls.

(2) Promote a heightened vigilance for patients at risk for falls and situations that may increase a patient's risk for falls.

(3) Promote communication to patients and families that fall prevention is an important part of their care.

(4) Ensure implementation of falls risk assessment tools and documentation.

(5) Ensure MTF staff is trained on proper lifting techniques so they are not injured while assisting patients post-fall.

d. Department, service, and clinic chiefs and management/supervisory staff will—

(1) Educate respective personnel on their role in identification of fall risks and management of patient falls, assessment, and documentation.

(2) Inspect respective patient care areas for safety issues or concerns.

(3) Review all patient safety reports from their areas and take appropriate action to reduce risks for falls.

(4) Encourage all staff to report inpatient falls, near misses, and unsafe conditions for potential falls, electronically in the Patient Safety Reporting System.

e. MTF patient safety managers will review all falls within the facility via the Patient Safety Reporting System and—

(1) Will aggregate, analyze, identify trends, and disseminate data and evaluate the effectiveness of the program by periodic evaluation of the falls data.

(2) On an annual basis, collaborate with the local Essentris database administrator and review the tools to ensure (per copyright/trademark permissions/licensing agreements) that no changes to the tools are made locally as directed by this regulation.

(3) Collaborate with unit practice councils to participate in performance improvement strategies to improve care, provide education on falls prevention, and prevent future occurrences of falls.

f. Privileged providers will—

(1) Collaborate with nursing and ancillary personnel to identify patients who are at risk for falls.

(2) Write activity orders to support activities that will reduce fall risk or fall occurrence.

(3) Document in the progress notes when a patient is identified at risk for falls.

(4) Communicate information on patient's fall risk status during transitions of care to responsible caregiver.

(5) If appropriate, write an order for protective devices and ensure patient has visual acuity testing, gait assessment, a mini-mental status examination, a 12-lead electrocardiogram, and/or a neurological evaluation, as needed.

g. Housekeeping staff will—

(1) 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.

(2) Keep all housekeeping carts safely out of doorways to reduce a trip hazard.

h. Nursing staff will—

(1) Complete fall risk assessments of inpatients as delineated in paragraph 7 of this regulation and the Fall Prevention Clinical Practice Guidelines (app D).

(2) Implement fall prevention interventions (nursing initiated order (NIO) sets) in accordance with the patient's level of fall risk (app E). MEDCOM has endorsed the fall prevention clinical practice guideline interventions as a standardized process for implementing falls prevention interventions.

7. Inpatient procedures

a. A licensed nursing staff member must assess each inpatient's risk for falling using the appropriate evidence-based falls risk assessment tool: the Johns Hopkins Hospital Fall Risk Assessment Tool[®] for adults or the Miami Children's Hospital's Humpty Dumpty Scale[®] for pediatrics. Both the adult and pediatric fall

risk assessment and documentation tools are copyrighted/trademarked but may be used in accordance with permissions/licensing agreements.

b. At a minimum, fall risk assessments and documentation must be completed—

(1) During the initial nursing admission assessment to the inpatient unit and at subsequent re-assessments.

(2) Every shift.

(3) After transfer from one inpatient unit to another.

(4) When there is a change in the patient's condition.

(5) After a procedure/surgery.

c. Nursing staff must implement fall prevention interventions and NIOs in accordance with the patient's fall risk score. If nursing perceives that a particular patient's fall risk is greater than that which is reflected in the tool's actual score, then that nurse may implement a higher level of intervention as needed. However, nursing cannot implement a lower level of intervention than is indicated by their fall risk score (that is, they cannot implement only standard interventions for a patient whose fall risk is scored as moderate or high).

d. Patients at risk for falling and their families are an important source of information about the history of previous falls. Patients and families should receive and participate in educational programs on strategies and interventions to reduce the risk for falling.

e. Post fall.

(1) The patient's attending/covering physician, if available, or the medical officer of the day ("responding physician") must physically evaluate the patient within 1 hour of being notified of the fall event and document in the medical record a description of the fall, the harm (if any), the post-fall examination findings, and the actions taken/interventions ordered.

(2) The responding physician must notify the patient's family, caretaker, or patient's designee of the fall and document that notification appropriately in the patient's medical record. Notification should occur within a reasonable time period, with expedited notification in cases of significant harm.

(3) The responding physician must coordinate with nursing to complete an online Patient Safety Reporting Form. The report form (or a copy thereof) will not

be kept or become a part of the medical record. The report form will not be mentioned or addressed in the medical record.

- (4) Communicate information of the patient's fall to the next provider of care.

8. Metrics

a. Outcome measures—

- (1) Total patient fall harm rate to be tracked by month: total patient falls with harm/total number of patient falls X 100.

- (2) Total patient fall rate to be tracked by month: total number of patient falls per month/total number of patient bed days/month X 1000.

b. Process measures—

- (1) The Johns Hopkins Hospital Fall Risk Assessment[®] (adult) and the Miami Children's Hospital's Humpty Dumpty Scale[®] (pediatric) are utilized in accordance with the clinical practice guideline (app D) and permissions/licensing agreements.

- (2) All nursing actions (NIOs) are implemented according to the patient's level of falls risk.

- (3) Timely and appropriate documentation of falls risk assessment and preventive interventions.

- (4) Methodologies for ensuring compliance may include any of the following: individual patient tracers, medical record audits, rounding, and so forth.

Appendix A References

Section I Required Publications

This section contains no entries.

Section II Related Publications

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

Hospital Standards Manual
The Joint Commission (current edition)

Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines
2007, Indianapolis: Sigma Theta Tau International, Newhouse, R., Dearholt, S., Poe, S., Pugh, L., White, K.

Partnership for Patients Implementation Guide to Prevention of Falls
Department of Defense Military Health System Patient Safety Program, February 14, 2013.

Section III Prescribed Forms

This section contains no entries.

Section IV Referenced Forms

This section contains no entries.

Appendix B
Adult Fall Risk Assessment Tool
The Johns Hopkins Hospital Fall Risk Assessment®

<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> <ul style="list-style-type: none"> <input type="checkbox"/> Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions. <input type="checkbox"/> Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization. <input type="checkbox"/> Patient has experienced a fall during this hospitalization. Implementing high fall risk interventions throughout hospitalization. <input type="checkbox"/> Patient is deemed high fall-risk per protocol (e.g., seizure precautions). Implement high fall-risk interventions throughout hospitalization per protocol.
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COMPLETE THE FOLLOWING AND CALCULATE FALL RISK SCORE. IF NO BOX IS CHECKED, SCORE FOR CATEGORY IS 0.	POINTS
AGE (SINGLE-SELECT) †60 – 69 years (1 point) †70 – 79 years (2 points) †≥ 80 years (3 points)	
FALL HISTORY (SINGLE-SELECT) †One fall within 6 months before admission (5 points)	
ELIMINATION, BOWEL AND URINE (SINGLE-SELECT) †Incontinence (2 points) †Urgency or frequency (2 points) †Urgency/frequency and incontinence (4 points)	
MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (SINGLE-SELECT) †On 1 high fall risk drug (3 points) †On 2 or more high fall risk drugs (5 points) †Sedated procedure within past 24 hours (7 points)	
PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCD, ETC. (SINGLE-SELECT) †One present (1 point) †Two present (2 points) †3 or more present (3 points)	
MOBILITY (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER) †Requires assistance or supervision for mobility, transfer, or ambulation (2 points) †Unsteady gait (2 points) †Visual or auditory impairment affecting mobility (2 points)	
COGNITION (MULTI-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER) †Altered awareness of immediate physical environment (1 point) †Impulsive (2 points) †Lack of understanding of one's physical and cognitive limitations (4 points)	
*Moderate risk = 6-13 Total Points, High risk > 13 Total Points	

The Johns Hopkins Hospital © 2007

Appendix C
Pediatric Fall Risk Assessment Tool
Miami Children's Hospital's Humpty Dumpty Scale®

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, Narcotics	3
	One of the meds listed above	2
	Other Medications/None	1
	At risk for falls if score is 12 or above TOTAL	

Minimum Score = 7

Maximum Score = 23

Appendix D
Fall Prevention Clinical Practice Guideline
(For adult and pediatric inpatients of MTFs)

D-1. Purpose. This clinical practice guideline addresses the clinical question regarding what evidence exists to support interventions that can be incorporated into guidelines for patients at risk for falls and/or who fall.

D-2. References

a. The references listed in this paragraph apply to this clinical practice guideline.

b. References listed in this paragraph are cross-walked with the discussion in paragraph B-5, below. Paragraph B-5 relates the discussion there to the appropriate reference number from this paragraph; the numbers below are bracketed in paragraph B-5.

(1) MEDCOM, MEDCOM Workgroup for Standardization of Inpatient Falls Risk Assessment and Documentation. 2009: San Antonio, TX.

(2) Lyons, S. S., University of Iowa., & National Institute of Nursing Research (U.S.). (2004). *Fall prevention for older adults*. Iowa City, Iowa: University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core.

(3) EBPWG, Loan, L., McCarthy, M., et al., Evidence-Based Practice Work Group (EBPWG). 2010: Madigan Healthcare System.

(4) Agency for Healthcare Research and Quality. (January 2013).

(5) DA, The Patient Safety Program. MEDCOM Reg 40-41. 8 May 2013: San Antonio, TX.

(6) Sherman, R., & Pross, E. (2010). Growing future nurse leaders to build and sustain healthy work environments at the unit level. *OJIN: The Online Journal of Issues in Nursing*, 15(1). DOI: 10.3912/OJIN.Vol15No01Man01.

(7) MEDCOM, Supervisory Nurse YJ-0610-02. Position description. 1997, Madigan Healthcare System.

(8) MEDCOM, Supervisory Practical Nurse GS-0620-07. Position description. 2003, Madigan Healthcare System.

(9) DA, Safety. Hospital/Medical Facility Safety Management. 2007, Department of Army Pamphlet 385-80, Chapter 2, Mishap Accident Reporting: Washington D.C.

(10) Poe, S.S., Cvach, M.M., Gartrelu, D.G., et al. (2005). An evidence-based approach to fall risk assessment, prevention, and management: lessons learned. *J Nurs Care Qual*, 20(2): p. 107-16, quiz 117-8.

(11) VHA, Veterans Health Administration National Center for Patient Safety Falls Toolkit (VHA, NCPST). (2004). Veterans Health Administration.

(12) Poe, S.S., Cvach, M.M., Gartreul, D.G. et al., An evidence-based approach to risk assessment, prevention, and management: lessons learned. *J Nurs Care Qual*, 2005, 20(2): p. 107-16; Quiz 117-8.

(13) Wood, M., Hill-Rodriquez, D., Messmer, P., et al. (2006, July). Implementing a Humpty Dumpty Falls Scale for Pediatric Patients. In *17th International Nursing Research Congress Focusing on Evidence-Based Practice*. Montreal Quebec, Canada.

(14) Oliver, D., Hopper, A., & Seed, P. (2000). Do hospital fall prevention programs work? A systematic review. *J Am Geriatr Soc*, 48(12): p. 1679-89.

(15) Lancaster, A.D., Ayers, A., Belbot, B., et al. (2007). Preventing falls and eliminating injury at Ascension Health. *Jt Comm J Qual Patient Saf*, 33(7): p. 367-75.

(16) Boushon, B., Nielsen, G., Quigley, P., Rutherford, P., Taylor, J., Shannon, D., & Rita, S. How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012. Available at www.IHI.org.

(17) Bemis-Dougherty, A. & Delaune, M. (2008). Reducing falls in inpatient settings. *PT: Magazine of Physical Therapy*, 16.

(18) Meade, C., Bursell, A., & Ketelsen, L. (2006). Effects of nursing rounds on patients' call light use, satisfaction, and safety. *AJN*, 106(9): p. 58-70.

(19) Coussement, J., De Paepe, L., Schwendimann, R., et al. (2008). Interventions for preventing falls in acute- and chronic-care hospitals: a systematic review and meta-analysis. *J Am Geriatr Soc*, 56(1): p. 29-36.

(20) CHCA, Child Health Corporation of America Nursing Falls Study Task Force: Pediatric falls: State of the science. (2009). *Pediatr Nurs*, 35(4): p. 227-31.

(21) Cooper, C., & Nolt, J., (2007). Development of an evidence-based pediatric fall prevention program. *Journal of Nursing Care Quality*, 22(2): p. 107-112.

(22) Levene, S., & Bonfield, G. (1991). Accidents on hospital wards. *Archives of Disease in Childhood*, 66(9): p. 1047-9.

(23) Quigley, P.A., Hahm, B., Collazo, S., et al. (2009). Reducing serious injury from falls in two veterans' hospital medical-surgical units. *J Nurs Care Qual*, 24(1): p. 33-41.

D-3. Definitions

a. Fall. A sudden, unintended uncontrolled downward displacement of a patient's body to the ground or other object. This includes situations where a patient falls while being assisted by another person, but excludes falls resulting from a purposeful action or violent blow. (National Quality Forum Patient Safety Terms and Definitions. www.qualityforum.org/Topics/Safety_Definitions.aspx.)

b. Developmental pediatric fall. Non-injurious fall that is common to infant and toddlers as they are learning to walk, pivot and run. *Note:* As exception to policy, the newborn intensive care unit and newborn nursery patient population do not constitute a "fall risk," but instead are considered a "drop risk," managed through new parent education.

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.

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, intravenous/saline lock, and an ambulation aid may designate a patient at a higher risk for falling.

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.

f. 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.

g. Degree of harm. Defined by the Agency for Healthcare Research and Quality Harm Scale (assigned by patient safety manager).

(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.

h. Strength of evidence rating system for the hierarchy of evidence—

(1) 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.

(2) Level II. Evidence obtained from at least one well-designed RCT.

(3) Level III. Evidence obtained from well-designed controlled trials without randomization.

(4) Level IV. Evidence from well-designed case-control and cohort studies.

(5) Level V. Evidence from systematic reviews of descriptive and qualitative studies.

(6) Level VI. Evidence from a single descriptive or qualitative study.

(7) Level VII. Evidence from the opinion of authorities or reports of expert committees.

i. Quality of evidence rating—

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

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

D-5. Fall prevention procedures

a. Inpatients – adults—

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

(2) Fall risk assessment frequency and required documentation—

(a) Within 24 hours of admission and every shift [(11)] Level VI, A.

(b) When there is a change in the patient’s status (for example, surgery, an invasive procedure, actual fall, changes in mental status, significant change in therapeutic regimens or medications, and so forth) [(11)] Level VI, A.

(c) Upon transfer to another unit [(11)] Level VI, A.

(d) Pro re nata (PRN) (for example, with change in caregiver) [(3)] Level VII, A.

(3) 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/light/system and ensure the call bell/light/system 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 four 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-skid 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 (for example, trashcans, laundry containers, computer terminal stands and cords, patient's personal items, and so forth) [(11)] Level VI, A.

10. Ensure bedside tables with personal items and any ambulatory devices (walkers, canes, and so forth) 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.

(4) 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 Johns Hopkins Hospital 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, 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 ensure non-skid socks are 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 1-2 hours as determined by the patient's fall risk. Check patient for the 4 Ps: pain, positioning, pottying, and 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 Johns Hopkins Hospital 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 privileged providers any factors influencing the patient's risk so that orders written by them support activities that will reduce fall risk or fall occurrence.

(5) 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 Johns Hopkins Hospital 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 closer 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 Miami Children’s Hospital’s Humpty Dumpty Scale[®] 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.

(2) Fall risk assessment frequency and required documentation—

(a) Within 24 hours of admission and every shift [(11)] Level VI, A.

(b) When there is a change in the patient’s status (for example, surgery, an invasive procedure, actual fall, changes in mental status, significant change in therapeutic regimens or medications, and so forth) [(11)] Level VI, A.

(c) Upon transfer to another unit [(11)] Level VI, A.

(d) PRN (for example, change in caregiver) [(3)] Level VII, A.

(3) 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 (for example, 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 four years of age, 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.

(4) In addition to the standard fall prevention interventions, pediatric patients determined to be at risk for falling, with a score of 12 or greater on the Miami Children's Hospital's Humpty Dumpty Scale[®], will have at 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, 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 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 closer 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.

D-6. Care of the inpatient fall. Nursing will—

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

b. Notify the patient's attending/covering physician, if available, or the medical officer of the day immediately after the patient is assessed/stabilized [(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 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 System [5, 21] Level V, A.

j. Annotate information on the 24-hour Nurses Report, if applicable [(5), (21)]
Level V, A.

k. Assess staffing requirements and contact the supervisor if additional staff is
required [(3)] Level VII, A.

**Appendix E
Nursing Initiated Orders**

NIOs: Adult Standard Fall Prevention Interventions

NIO: Orient to ward Show	X1	orient patient to room/bathroom. how to use call bell /light/system and ensure call bell is within easy reach
NIO: Educate patient/family	X1	give "Fall Prevention Protocol Information to Patient" handout to patient/family
NIO: Assess for falls risk	QShift	Johns Hopkins Hospital Fall Assessment Tool
NIO: Bed in lowest position	QShift	ensure wheels locked
NIO: Assess environment	QShift	every 1-2 hrs for obstacles/hazards
NIO: Ensure call light system	QShift	within reach; promptly answer call light
NIO: Educate patient/family	QShift	regarding falls risk and prevention Activities
NIO: Ensure patient wears	QShift	non-skid socks while ambulating
NIO: Patient rounding	Q1-2hrs	check patient for pain, positioning, pottying, possessions and environmental hazards. Ensure BSC or urinal is readily accessible and empty.
NIO: Before leaving room	Q1-2hrs	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 1-2 hrs.
NIO: Place side rails up	QShift	as indicated; do not place more than 3 side rails up at a time

NIOs: Adult Moderate Risk Fall Prevention Interventions

NIO: Patient on	QShift	Fall Prevention Protocol
NIO: Place falling star sign on	X1	room door/census board/head board
NIO: Place yellow ID wristband	X1	on patient
NIO: Ensure patient wears	X1	non-skid socks when ambulating
NIO: Educate patient/family	X1	give "Fall Prevention Protocol Information to Patient" handout to patient/family
NIO: Remind patient 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	Q1-2hrs	every 1hr while awake; use bedside commode as appropriate
NIO: Reorient confused patient	QShift	as necessary
NIO: Evaluate need for	X1	PT/OT Consult
NIO: Consider Bed alarm on	QShift	for score of ≥ 1 on Johns Hopkins Hospital Fall Assessment Tool cognition item

NIOs: Adult High Risk Fall Prevention Interventions

NIO: Patient on	QShift	Fall Prevention Protocol
NIO: Place falling star sign on	X1	room door/census board/head board
NIO: Place yellow ID wristband	X1	on patient
NIO: Ensure patient wears	X1	non-skid socks while ambulating
NIO: Educate patient/family	X1	give "Fall Prevention Protocol Information to Patients" handout to patient/family

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NIO: Move patient	X1	as close to nurses station as possible
NIO: Remind patient to request	QShift	assistance whenever needed
NIO: Supervise and/or assist	QShift	bedside sitting, personal hygiene, and toileting
NIO: Patient-centered rounding	Q1hr	every 1 hr
NIO: Offer toileting	Q1hr	every 1 hr while awake
NIO: Remain with patient	X1	while toileting (line-of-sight)
NIO: Transport throughout	QShift	hospital with assistance of staff, trained caregiver
NIO: Do not leave patient	QShift	unsupervised off unit
NIO: Reorient confused patient	QShift	as necessary
NIO: Evaluate need for	X1	PT/OT Consult
NIO: Use seatbelt	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 Johns Hopkins Hospital Fall Assessment Tool cognition item
NIO: Consider 1:1 sitter	QShift	

NIOs: Pediatric Standard Fall Prevention Interventions

NIO: Orient to ward	X1	orient patient to room/bathroom show patient/parent/significant other how to use call bell/light/system and ensure call bell/light/system is within easy reach
NIO: Educate patient/parents	X1	give "Fall Prevention Protocol Prevention Protocol Information for Patients/Parents" handout to patient/parent/significant other

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 when highchair	QShift	in wheel chair, stroller, swing,
NIO: Assess environment	Q1-2hrs	every 1-2 hrs 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	non-skid socks while ambulating
NIO: Patient-centered rounding	Q1-2hrs	check patient for pain, positioning, pottying, possessions and environmental hazards. Ensure BSC or urinal is readily accessible and empty
NIO: Before leaving room	Q1-2hrs	ask patient/significant other "Is there anything I can do for you before I leave? I have time while I'm here in your room." Tell patient/significant other a member of the nursing staff will make bedside rounds within the next 1-2 hrs.

NIOs: Pediatric At Risk Fall Prevention Interventions

NIO: Patient on	QShift	Fall Prevention Protocol
NIO: Place falling star sign on	X1	room door/census board/head board/crib
NIO: Place yellow ID wrist band	X1	on patient
NIO: Ensure patient wears	X1	non-skid socks while ambulating

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NIO: Educate patient/parents	X1	give "Fall Prevention Protocol Prevention Protocol Information for Patients/Parents" handout to patient/parent/significant other
NIO: Move patient	X1	as close to nurses station as possible. Keep room door open at all times unless patient directly attended.
NIO: Patient-centered rounding	Q1hr	check patient for pain, positioning, pottying, possessions and environmental hazards. Ensure BSC or urinal is readily accessible and empty.
NIO: Accompany patient	QShift	with ambulation
NIO: Remind patient/parent	QShift	to call for assistance as needed
NIO: Offer toileting	Q1hr	every 1 hr while awake.
NIO: Remain with patient	X1	while toileting (line of sight)
NIO: Transport throughout	QShift	hospital with assistance of staff, trained caregiver, and/or family/significant other
NIO: 1:1 sitter	QShift	

Glossary

Section I Abbreviations

EBPWG

evidence-based practice working group

EMR

electronic medical record

MEDCOM

United States Army Medical Command

MTF

military treatment facility

NIO

nursing initiated order

PfP

Partnership for Patients

PRN

pro re nata

QMO

Quality Management Office

RCT

randomized controlled trial

Section II Terms

This section contains no entries.

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