Patient Fall and Injury Prevention Protocol

Patient Safety is our #1

Palms West HOSPITAL

The Children's Hospital at Palms West

Objectives

- Identify patients at risk for fall with injury
- Focus on approaches to reduce physical injury associated with patient falls that occur on inpatient units
- Identify measures used at PWH to prevent falls and injuries associated with falls

Policy Review

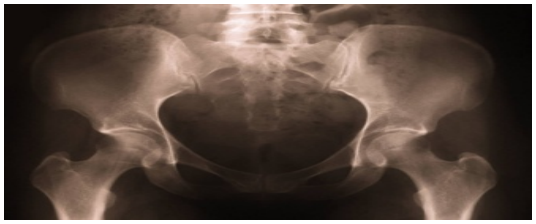
- All inpatient's will be assessed upon admission to determine their risk for falls
- Patients will be reassessed every shift, with any change in level of care, with any change in condition and immediately post fall
- A "post fall" assessment must be completed after each fall in the hospital – Post Fall Debriefing Tool
- An assisted fall bill treated as a fall

Assess Risk for Serious or Major Injury

- You should:
  - Perform an assessment of all patients' fall *and* injury risks
  - Identify the patients most at risk of moderate to serious injury of a fall
    - ABCS

Risk for Injurious Falls:

- **A** – Age>85
- **B** - Bones - weak bones from osteoporosis, bone cancer, previous fractures
- **C** – Anticoagulants – could have bleeding after a fall
- **S** – Surgery on chest, abdomen, legs



Fall Prevention Interventions

Regarding interventions for fall preventions, patient care is dictated upon the global care given to ALL patients, specific care given to patients identified as high risk of falling, and individualized care given to the patient based on the specific risk elements associated with them.

- Global – standard of care for all patients
- Generic-standard of care for high risk fall patient
- Specific-addresses the fall element the patient has

Interventions for Highest Risk Patients

- **Post Fall Injury Risk triangle on White Board** to communicate to all caregivers.
- Educate patient and/or family about Injury Risk using **"Critical Conversation" handout**
- Offer assistance to bathroom/commode or use bedpan hourly while awake.
- **Remain with the patient when assisted to the bathroom.**
- Place patient on **low bed**
- Use **floor mats** at side of bed to cushion patient. Floor mats are located in the Clean Utility Room
- Consider **use of low bed for obese patients** with poor mobility; **specialty bed (big boy)** can be obtained through the **Charge Nurse or Nursing Supervisor.**

Communicate and Educate

- **Communicate to all staff information regarding patients who are at risk for sustaining a fall-related injury during bedside report.**
- **Educate the patient and family about risk of injury from a fall on admission and throughout the hospital stay, and about what they can do to help prevent a fall.**

Critical Conversation

A Critical Conversation for Preventing Falls with Injury:

Our goal is to keep you safe from harm…

"You have been identified as having certain traits which may increase your risk of falling. Most often this is a history of falling, a change in your balance or the steadiness when walking. The hospital is very different from what you are used to at home. This changes your ability to get up and around by yourself. Tell me if you feel dizzy, weak, or lightheaded. **Always ask for assistance to get out of bed."**

Scenario #1

75 year old female admitted 4/19/13. Patient was post left total knee arthroplasty. Patient was disoriented; not placed on bed alarm. There is no post fall assessment. Patient was found on the floor on her back next to her bed. Patient was unable to provide how she fell, but denied hurting her head. Patient c/o left leg pain.

Question:

What is the risk of injury to this patient?

Scenario #1

Answer:

Dislocation of the implant, re-fracture of the leg; dehiscence of the incision.

Question:

What could have been done to prevent this potential injury?

Answer:

Use of bed alarm and use of floor mats that could prevent serious injury by cushioning the patient's fall.

Scenario #2

79 year old female admitted 5/22/13 with back pain. Ambulated to the bathroom with her own rolling walker. The CNA was present, but outside the door for privacy. When patient turned around, she lost her balance and fell into the tub hitting her head against the wall. No apparent injury. Physician notified. The patient assessed as not a high risk for falls. She was on Coumadin and Heparin.

Question:

What do you think was a potential risk for this patient?

Scenario #2

Answer:

This patient was at risk for a subdural hemorrhage as she was on Coumadin and Heparin

Question:

What should have been done to prevent this patient's fall?

Scenario #2

Answer:

The CNA should have assisted her to safely get out of the bathroom.

Food for Thought…

Was there even room for the patient to maneuver in our bathroom with her rolling walker from home?

Scenario #3

92 year old male admitted 5/18/13 with tachycardia/bradycardia syndrome was found on the floor lying between the room and the anteroom. The patient was confused and had been saying he wanted to leave. He was assessed as forgetful and was a high risk for falls. The nurse was in the next room and heard the patient fall. When she came in he was lying on his left side with his head off the floor.

Question:

What were some of the fall risk factors for this patient?

Scenario #3

Answer:

The patient's age – patients >85 years of age have a higher risk for injury from a fall.

Patient was forgetful, confused and said he wanted to leave.

Question:

What fall and injury prevention interventions should have been implemented?

Scenario #3

Answer:

Bed Alarm
Room close to station
Camera Room
Floor Mats
Low Bed

Scenario #4

48 year old female admitted 6/13/13 for left total knee. She was found on the floor at the side of the bed. All 4 rails were up. She was looking for her husband who had been there earlier. She had received Restoril 15mg at 2200, Benadryl 25mg at 2200 and Dilaudid 1mg po at 2300. She had been assessed as high risk for falls.

Question:

What could have contributed to this patient's fall?

Scenario #4

Answer:

Analgesics and sedatives given close together may have had a synergistic effect on the patient, causing confusion and disorientation.

Question:

This patient was high risk for injury…why?

Answer:

The patient was status post left knee replacement and could have re-injured the operative knee or suffered another injury as the patient's gait and balance are affected

Scenario #5

73 year old female was admitted 4/11/13 patient admitted with altered mental status, syncope. Patient was being assisted back to bed from bedside commode by staff. As patient sat on the side of the bed she started to slide off the edge of the bed and was assisted to floor by 3 staff members. She complained of pain in her left foot and an X-ray revealed a mildly displaced fracture through the lateral malleolus.

Question:

What interventions could have prevented this event form occurring?

Scenario #5

Answer:

Consider the use of a low bed with obese patients to allow ease in getting up and returning to bed.

Consult with Physical Therapy for tips in transfer to avoid staff injury

Use Stand N Sit Lift to protect patient and staff when transferring patient that requires multiple staff members to move.