



SWMC FALLS PREVENTION SAFETY NEEDS

(PATIENTS, VISITORS, AND STAFF)



THE PROBLEM

- Falls are the largest single category of reported incidents in hospitals
- Falls are the leading cause of nonfatal injuries and trauma-related hospitalizations in the U.S.
- 2% to 4% of all patients fall & 2% to 6% of these falls result in a serious injury

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- One out of every three people aged 65 and older fall each year
- Falls are a leading cause of traumatic brain injuries and morbidity
- Falls affect all patient populations and occur regularly among patients in acute care facilities like SWMC.



THE COSTS

- U.S. medical costs for fall-related injuries equal \$20.2 billion and are expected to rise to \$32.4 billion by 2020.
- The financial repercussions and adverse consequences (including fracture, head injury, depression, and fear of falling) associated with patient falls are among the most serious risk management issues that hospitals face.



THE GOALS

- Reduce the risk of patient harm resulting from falls
- To provide education on the importance of maintaining a “culture of safety”



THE SOLUTION

PREVENTION

Although it may not be possible to prevent every fall, most falls are preventable. Each fall prevented is one less potential injury, fracture, head trauma, or death, thereby preserving the mobility, quality of life, and independence of patients, visitors, and staff.

DEFINITION OF A FALL

A fall is defined as an unplanned movement of a patient to the ground or from one plane to another

- A near miss is defined as a trip, slip, stumble or controlled fall or slump in which the patient is assisted to the floor.



TYPES OF FALLS

- Witnessed fall
- Unwitnessed fall
- Assisted to the floor or near miss
(this should be reported)

TYPES OF RISK FACTORS

- Nonmodifiable intrinsic factors
- Medical conditions
- Modifiable or lifestyle risk factors
- Medications
- Psychological and cognitive risk factors
- Fear of falling
- Cardiovascular causes of falls
- Extrinsic risk factors

NONMODIFIABLE INTRINSIC RISK FACTORS

Gender

- Women fall more often and are almost three times more likely than men to require hospitalization for a fall-related injury.

Race

- White people have the highest risk of falling.
- White men have the highest rate of fall-related deaths, followed by white women.

Age

- Falls are the most common cause of injuries and hospital admissions due to trauma for people aged 65 and older.
- More than 60% of people who die from falls are aged 75 and older.
- The chance that a fall will cause a severe injury that requires hospitalization increases significantly with age.
- A previous fall doubles or triples the likelihood of an older adult falling again.

MEDICAL CONDITIONS

Having more than one chronic disease of any kind

Vascular disorders

(Stroke, high blood pressure, low blood pressure)

○ Neuromuscular disorders

● (Parkinson's disease, Multiple Sclerosis)

○ Musculoskeletal disorders

● (arthritis, hip fractures, osteoporosis, amputation, foot disorders)

○ Neurological disorders

● (seizures, dementia)

○ Sensory loss

● (poor vision, slow reflexes, diminished hearing)

MODIFIABLE OR LIFESTYLE RISK FACTORS

Inadequate nutrition

Low muscle mass and weakness

- Excessive alcohol intake
 - Affects balance, nutrition, and movement control
- Inactivity
 - Deterioration in muscle strength, bone mass, and joint flexibility
- Smoking
 - Poor cellular oxygenation and low bone mass

MEDICATIONS

- People who take more than four medications (any type and combination) are statistically more likely to fall than those who take fewer drugs. These could include diuretics, narcotic analgesics, beta blockers, anti-hypertensives, and laxatives.
- Psychotropic medications including sedatives, antidepressants, and neuroleptics slow reaction times and reduce awareness of the environment which increases the risk of falling.



PSYCHOLOGICAL AND COGNITIVE RISK FACTORS

○ Dementia

- Wandering
- Agitation
- Perceptual difficulties
- Lack of fear or caution/ poor judgment
- Balance impairments
- Gait impairments
- Postural instability



FEAR OF FALLING

- Individuals with some of the following factors have a higher fear of falling which causes them to avoid activity and leads to muscle deterioration, porous bones, and poor balance
 - Older age
 - Female
 - Previous fall
 - Decreased mobility
 - Chronic dizziness
 - Poor vision
 - Poor health
 - Frailty and the need for assistance

CARDIOVASCULAR CAUSES OF FALLS

- Cardiac abnormalities
 - Structural abnormalities, stenosis, MI, cardiomyopathy
- Pulmonary embolism
- Transient ischemic attacks (TIA's)
- Migraines



EXTRINSIC RISK FACTORS

- Furniture arrangement
 - Block pathways
- Floors
 - Slick
 - Change in floor level
 - Rugs
- Lighting
 - Too dark or too bright
- Clothing
 - Skirts, pants, or hospital gowns that touch the floor
- Footwear
 - Thick, rubbery soles catch easily on carpet
 - Socks without treads are slick



MODIFICATIONS BASED ON RISK FACTOR IDENTIFICATION

- Functional risk factor modifications
- Medication modifications
- Psychological and cognitive modifications
- Environmental modifications



FUNCTIONAL RISK FACTOR MODIFICATIONS

- Nutrition – Nutrition has a significant impact on the general health and well-being of patients. Older people have a greater need for nutrient-dense foods, since they often consume fewer calories than do younger adults. The food they eat must be full of beneficial elements, particularly calcium, vitamin D, and vitamin C for bone mass and protein for muscle strength.

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- Alcohol – Alcohol consumption can result in vasodilation, a factor in orthostatic hypotension, as well as dizziness, unsteady gait, impaired vision, impaired judgment, and sedation. In addition, alcohol often potentiates or otherwise interacts with the effects of medication in unpredictable ways.
- Nutrition for Orthostatic Hypotension – These individuals should have a liberal salt intake unless there are clinical contraindications, and they should drink plenty of fluids. They should also consume smaller and more frequent meals, with the biggest meal consumed in the evening. Individuals who suffer from orthostatic hypotension should drink 2 cups of coffee with breakfast and lunch as the caffeine has vasopressor effects.

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- Smoking – Smoking is an extremely difficult habit to break and often requires a doctor's assistance and medications to treat symptoms of nicotine withdrawal. Help and encourage any patient who is willing to make the effort to stop smoking. For those who are not, we must recognize that their habit has put them in a high risk category for falls.
- Exercise – Exercise is a major topic in fall-prevention research. Exercise, even brisk walking, actually increases the risk of falls and injuries. However, exercise has many benefits such as improving balance control, confidence, and bone mass. Because inpatient stays are generally brief, an exercise program is unrealistic. However, physical therapy and occupational therapy on a routine basis during an inpatient stay can assist patients at risk and help them develop, maintain, or improve their postural balance control. Appropriate activity should be encouraged by staff.

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- Sensory loss – Sensory loss is responsible for many preventable falls. Consider the following interventions for patients who are at risk for falling:
 - Eyeglasses available and clean
 - Encourage use of hearing aids while up and moving around, even in his or her own room.
 - Ear wax obstructing the ear canal can impair balance. Signs of impacted ear wax include:
 - Disturbance in balance, pain, tinnitus, nystagmus, nausea, and cough.

MEDICATION MODIFICATIONS

- At a minimum, a review of every patient's medications with an eye toward fall reduction is essential. The following should be considered:
 - Diuretics, narcotic analgesics, hypnotics, psychotropics, beta blockers, sedatives, anti-hypertensives, and laxatives.
 - Any patient taking any combination of four or more of the above listed medications

PSYCHOLOGICAL AND COGNITIVE MODIFICATIONS

- Fear of falling – Consider cognitive-behavioral interventions, along with education, exercise, and relaxation training. Improving the individual's confidence and self-efficacy may reduce the fear of falling and improve the ability to perform some of the functions of daily living.
- Cognitively impaired – Falling is an inevitable part of the disease process in degenerative dementia disorders such as Alzheimer's disease. However, some successes exist:
 - Physical Therapy
 - Flexible, soft soled shoes or socks allow patients to feel the floor and compensate for declining proprioception.
 - Changing a walking aid to something more appropriate.
 - Taking vitamin D and calcium to prevent fractures may be indicated for dementia sufferers with osteoporosis.



ENVIRONMENTAL MODIFICATIONS

The first step in reducing environmental causes of falls in a hospital is to educate every staff member about them. The first thing staff should know is that it is **their** responsibility to prevent falls.

Considerations that all staff should bear in mind:

1. The first person to see an object where it doesn't belong is responsible for picking it up or moving it ---
IMMEDIATELY.

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2. The first person who sees a wet or slick spot on the floor or ground is responsible for cleaning it up. If hazardous it should be reported and access blocked---IMMEDIATELY.
3. Anyone who sees a rough piece of flooring, such as wrinkled carpet, is responsible for fixing it or getting it fixed – IMMEDIATELY
4. Anyone who sees a light bulb that is out or a light fixture that isn't working is responsible for getting a new light bulb or finding someone who can fix the problem as soon as possible.
5. Cords or hoses trailing across pathways must be pulled up, or the pathway must be marked and blocked while the equipment is being used. Staff should be alert for trailing electrical cords in patients' rooms.
6. Anyone who notices that a patient's eyeglasses are dirty or that the patient is wearing pants or a hospital gown that are too long is responsible for helping the patient clean the eyeglasses and put on appropriate clothes.

NO ENVIRONMENTAL RISK FACTOR SHOULD BE ALLOWED TO REMAIN IN PLACE ANY LONGER THAN THE TIME IT TAKES SOMEONE TO NOTICE IT .



SWMC's FALL PREVENTION EDUCATION AND INTERVENTIONS



FALL PREVENTION EDUCATION

- Fall Prevention Education - On admission, all patients/families will receive education on Safety Needs and Fall Prevention, which includes:
 - Use of call light and instruction to call for assistance if needed.
 - Top side-rail use (required two up at all times)
 - Use of non slip footwear

FALL PREVENTION INTERVENTIONS

- To facilitate early identification of safety needs and potential risk factors for a fall, the initial assessment/data collection of the patient begins upon admission to the hospital. All risk factors are assigned a point value. During the assessment/data collection, the patient's risk factor points are totaled, thereby placing the patient into a corresponding safety needs level. The levels include:
 - Low Risk
 - Level I
 - Level II

LOW RISK INTERVENTIONS

*****Low risks interventions are the standard of care for all patients******

Interventions include:

- *Call light in reach
- *Bed in low position/breaks locked
- *Side rail position (up x 2)
- *Non slip footwear when up; monitor gait and assist if necessary
- * Other nursing interventions (describe)

LEVEL 1 INTERVENTIONS

- Include all interventions in Low Risk
 - Identify patient's safety needs level on Kardex
 - Fall risk indicator – a bracelet with yellow clip - attached to the patient's wrist.
 - Extra light left on (evening and night)
 - Elimination needs monitored every two hours
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- NOTE: On the Psych Unit a yellow dot will be placed on the patient's ID bracelet.

LEVEL II INTERVENTIONS

- Include all interventions in Low Risk and Level I
- Use Safe Call System or close observation of the patient. Will use Safe Call or bed alarm System for confused Level II patients.
- Commode at bedside if appropriate
- Bedpan/urinal within easy reach
- Reorient patient to environment, time, place and person as indicated
- Family or significant other present if possible
- Move to a room closest to the nurse's station

FALL PREVENTION DOCUMENTATION

- Intervention/Daily Safety Needs Assessment – This assessment is used to document the patient's **safety needs and fall risk factors** and the interventions used to prevent a fall. It is initiated on admission and will then be completed every 24 hours by the 7-3 shift nurse. The fall risk assessment will also be completed with all transfers and after any fall.

PATIENT FALL DOCUMENTATION & INTERVENTION

If a patient falls, the following documentation must be included on the Interventions/Pre & Post Fall Documentation:

- Patient's comments regarding the fall
- Associated signs/symptoms before, during and after the fall.
- Vital signs
- Any loss of consciousness, physical injuries or motion limitations
- Skin condition, trauma, abrasion, circulation
- Orientation to person, place and time, pupils (if appropriate)
- Notification of Physician and family
- Notification of House Coordinator
- Reeducation of patient/family

Note: A patient fall will indicate a change in the patient's Safety Needs Level and this will be documented in the Daily Safety Needs Assessment and the Pre & Post Fall Interventions.

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- Any time a patient falls, the Safe-Call bed alarm (and chair alarm, if appropriate) will be utilized
- An event report will be completed for all falls and near misses
- All hospital staff are educated to correct/report extrinsic risk factors, i.e. poor lighting, equipment in need of repair, clutter, etc...
- Monthly environment rounds are made by the Safety Officer.

EMPLOYEE OR VISITOR FALLS

- An employee who has fallen will complete an employee accident form and see the Employee Health Nurse. If fall occurs after hours, report this to the House Coordinator. If fall results in severe injury the employee will report to the Emergency Room.
- In the event of a visitor fall, staff will be helpful, courteous and offer Emergency Room treatment without accepting or assigning blame or responsibility for the fall. An event report will be completed and House Coordinator will be notified.



Color Coded Wristband Clips

Color coded wrist band clips started in January 2009 :

- To have a standard process that identifies & communicates patient specific risk factors or special needs
- To communicate patient safety risk to all health care providers
- To reduce the risk of potential for confusion associated with the use of color-coded wristbands.

Meaning of each color coded band clip

- RED Allergy
- YELLOW Fall Risk
- PURPLE DNR
- PINK Restricted Extremity
- GREEN Latex Allergy



CONCLUSION

SWMC is dedicated to maintaining a safe environment for all employees, patients, and visitors and hopes that the philosophy of a “culture of safety” will remain a priority and become a “lifestyle modification” at work and at home.