The UC San Diego Fall Prevention Program is designated to identify and intervene in patients who are at risk for falls in order to prevent injury and provide a safe environment.

Fall Reduction Inpatient
The Joint Commission (TJC) and Center for Medicare and Medicaid Services (CMS) mandate a fall prevention program and the need to complete a fall risk assessment on all patients.

Background Information
- The average age of patients who have fallen at UC San Diego Health is 56yrs, not the frail elderly; on average less than 30% of our patients who fall are over 65yrs of age
- The top 3 contributing factors related to falls identified at UC San Diego Health are:
  - Staff education/competency/training
  - A patient’s mental status
  - Patient mobility issues
- Patients are at risk for major, life threatening injuries due to falls
- Financial consequences – Additional costs related to falls can range from $5000 for patients with no injury to $54,000 for patients with a major injury (Based on a safety survey conducted at UC San Diego Health by Posey)

Fall Risk Assessment/Interventions
The Hester Davis Scale Fall Risk Assessment is used for all inpatients (except infants) a minimum of every shift, following a change in the level of care and as needed on changes in the patient’s condition.
- Universal Fall Precautions are to be implemented regardless of fall risk:
  - Call light/belongings within reach
  - Bed in low/locked position
  - Non-slip footwear
  - Side rails up X2
  - Clutter free room
  - Fall/level of risk education
- For patients assessed as being a high fall risk, an individualized plan of care is to be implemented based on modifiable risk factors identified (ex. mobility, medications and mental status)
- When rounding, consider saying and writing on the patient white board the approximate time you will return to check on them; this has shown to reduce patient anxiety, call light usage and falls because patients will wait for nurse rounding
- Review Fall Risk during handoffs

Falls and Fall Prevention Guideline is are located on the Nursing Resource Hub.
- IMEDIATE RESPONSE:
  - Basic life support and reassurance
    - Check if patient is responsive; check ABC’s and call for help
  - Check for injuries and notify provider (utilize SBAR)
    - If signs of head trauma, do NOT move the patient and initiate c-spine precautions
    - Assess for symptoms of pain/deformity (head to toe), for new onset back pain or pain/deformity of extremities; do NOT move the patient; immobilize as appropriate
    - Check for other signs of injury: bruising, laceration, swelling, or abrasion, initiate first aide; assist back to bed/chair via appropriate means
    - If no apparent injury, assist patient to bed/chair via appropriate means; if the patient can get off the floor independently, then allow them to
  - Baseline Observations
    - Monitor level of consciousness/mental status
    - Assess vital signs
    - Monitor for nausea/vomiting
  - Additional Considerations
    - Observe for hip deformity (shorter leg or abnormal rotation)
    - Monitor vital signs for indication of occult bleeding (i.e., decrease in BP or increase in HR)
    - Increase in systolic blood pressure (or widening pulse pressure) may indicate rise in ICP
Patients on anticoagulation therapy are at increased risk of bleeding

**SECONDARY RESPONSE:**
- Notify family of fall; current condition and safety interventions provided
- Document fall event in medical record noting both pre and post-fall safety interventions and head to toe assessment; update the plan of care
- *Huddle* with team, charge RN and patient/family and complete post fall huddle form
- Complete iReport

**Educational Points**
- The identified color for fall risk is YELLOW
- Multiple visual cues increase staff awareness of fall risk (i.e. yellow ID charm, yellow signage, and yellow footwear)
- Always review fall risk and risk for injury during handoff
- Include patient and family in fall prevention education
- Educate ancillary staff and providers regarding yellow cues for fall risk

**Fall Reduction Ambulatory/Clinic Specific**
- Patients at risk for falls include those who:
  - Have fallen in the last 6 months
  - Require assistance with walking or have an unsteady gait
  - Use a cane, walker, crutches, or wheelchair
  - Have difficulty getting out of a chair
  - Are confused, comatose or sedated
  - Are dizzy or lightheaded
  - Have low blood pressure
  - Are determined by fall staff to be a fall risk for any reason
- If a patient is a fall risk, at least one intervention must be marked in Epic.

**Fall Risk Interventions**
- Assist with mobility
- Room near the nurse’s station when possible
- Orient the patient to the exam room
- Leave the exam room door open; use the curtain for privacy
- Orient to the bathroom and call light as needed
- Do not leave confused or immobile patients in the bathroom alone
- Lock wheelchairs and stretchers before transferring patients
- Ask patient if they need help
- Make other staff aware of patients’ fall risk by placing a yellow card outside the door or turning on the yellow light of the exam room if you’re clinic is equipped the above door exam room lights
- Provide “Preventing Falls at Home” Brochure (English and Spanish)

**Post Fall Interventions**
- Follow the post fall guidelines
- Provider should assess patient after any fall
- Don’t move patient until it has been determined that there is no obvious injury or change in neurological status
- Transfer the patient to the ED if needed
- Complete an iReport

**Document the following with a patient fall**
- Cause
- Patient activity at time of the fall
- Symptoms associated with the fall (i.e. dizziness, pain)
- Vital signs and pain score
- Assessment by a provider and any actions taken

Source: Brad Vandersall