

Frequent Flyers

Defining the Elements of the Fall Risk Screen

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As a result of the recent State survey, we would like to review the elements of the safety risk screen to improve scoring accuracy in identifying a fall risk. A safety assessment must be completed on admission (INA) and every 8-hours (patient flowsheets) to determine the patient's risk of falling. Give a full point value for each risk factor identified. For a score of 4 or more, or if patient's admission is related to a fall, implement fall prevention protocol. Attempts should be made to correct, modify or eliminate the underlying causes for fall risk.

Fall History to Ground or Floor (2 Points)

Award 2 points to a patient with a previous history of falling in hospital or at home within the past year or if their admission is directly related to a fall place patient on protocol. Be sure to:

- Determine/clarify the circumstance of prior falls & assess whether it is an active issue.
 - Acute illness (infection, weakness, delirium)
 - Home safety environment issues
 - Review medications & their potential contribution to fall
- Consider PT/OT consult
- Ambulate patient regularly
- Consider relocating patient for better visibility
- Reinforce activity limits/safety precautions with patient/family
- Include family in the plan of care, encourage them to stay with the patient

Confusion/Disorientation (4 Points)

Award 4 points to a patient who is unable to follow instructions, has poor safety awareness, attempts to get out of bed, is restless or impulsive, has a Positive CAM (delirium) and is forgetful. For patients identified with altered mental status (dementia, delirium, confusion, disorientation, anxiety), be sure to:

- Determine/clarify reason for above behavior & implement interventions (e.g., hypoxia, pain, or toileting needs)
- Assess mental status and provide reorientation/reassurance as appropriate
- Consider hourly rounding with RN/PCA to provide frequent monitoring
- Consider relocating patient for better visibility

- Include family in plan of care, encourage them to stay with the patient
- Minimize environmental stimuli
- Use sensory aides as appropriate (glasses, hearing aides)
- Provide diversional/calming activities as appropriate (music, stuffed animals, pocketbooks)
- Consider a Unit-based GRN consult, Geriatric Medicine Consult, Keeping in Touch Volunteers, Psych Consult
- Utilize bed/chair alarm & other safety devices
- Post reminders for the patient (i.e. " Stay in bed", "Use your call bell for help", post stop signs)

| ELEMENTS OF THE FALL RISK SCREEN* | |
|---|-----------|
| Fall History to ground or floor | 2 points |
| Confusion/disorientation | 4 points |
| Mobility impaired | 2 points |
| Elimination altered | 1 point |
| Other, i.e. nursing judgment, diagnosis related, admission r/t fall | 2 points |
| Fully oriented and aware of own ability | -2 points |

**N/A – patients who are comatose or incapable if independent movement are excluded from this protocol*

Mobility Impaired (2 Points)

Award 2 points to all patients with leg weakness, unsteady gait, or those who require supervision with all transfers.

Determine/clarify the reason for their impaired mobility (chronic versus acute change) and

- Keep assistive mobility devices within reach
 - Assist with ambulation (if toileting, stay with patient)
 - Increase mobility as tolerated; ambulate/assist patient every 2-4 hours
 - Consider PT/OT consults
 - Encourage patient to exercise (ie. in bed exercises, ROM, flexion)



Elimination altered (1 Point)

Award a single point to a patient with altered elimination (e.g., urgency, frequency, nocturia, incontinence, diarrhea). Remember that a foley catheter does not automatically indicate that the patient has altered elimination. Sometimes medications such as diuretics and bowel preps can alter elimination.



When a patient is identified with altered elimination, determine/clarify reason by assessing elimination patterns and individualize plan of care with regard to toileting frequency, special devices – commodes, urinals, raised toilet seat. In addition:

- Assess diuretics/laxative schedule and modify prn
- Assist patient to toilet every 2-4 hours & prn (stay with patient)

Other Elements (2 points)

There may be other elements such as nursing judgment, diagnosis-related assessments or admission r/t that may increase the likelihood of a patient fall. These may include:

- Sensory deficits (significant vision or hearing impairment)
- Becoming entangled in the tubing of foley catheters, IVs, and O₂
- Orthostatic hypotension
- Dizziness/vertigo
- Patients resistant to call/ask for help
- Medications (e.g., diuretics, antihypertensives, narcotics, sedatives, sleepers)
 - Educate patient and family of medications that could potentially put patient at risk to fall i.e.) psychotropics, narcotics, blood pressure medications, and diuretics/bowel preps
 - Monitor for polypharmacy (assess for side effects and consult with MD/pharmacy when appropriate)
 - Consider orthostatic vital signs, assist with ADLs
 - Assess for dehydration, need for fluid replacement, I&O's



Fully oriented and aware of own ability (minus 2 points)

Two points should be removed from the fall risk screen for patients who are fully oriented and aware of their surroundings.



The Fall Risk assessment is the first step in assuring that patients who need additional help to be safe while under our care are promptly and accurately identified.

A safety assessment must be completed on admission (INA) and every 8-hours (patient flowsheets) to determine the patient's risk of falling.

Give a full point value for each risk factor identified. For a score of 4 or more, or if patient's admission is related to a fall, implement fall prevention protocol.

Attempts should be made to correct, modify or eliminate the underlying causes for fall risk.

Contact Lynn Jansky or Christine Waszynski for additional details.