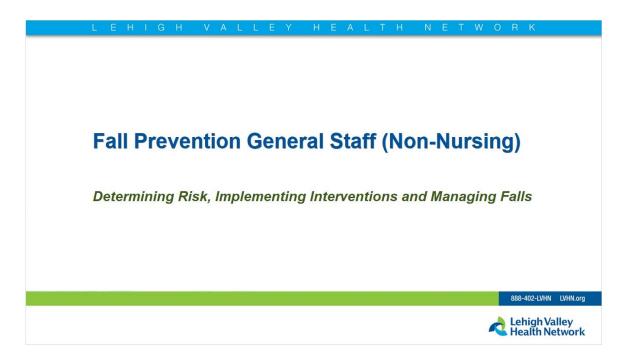
#### 1. Fall-Prevention-

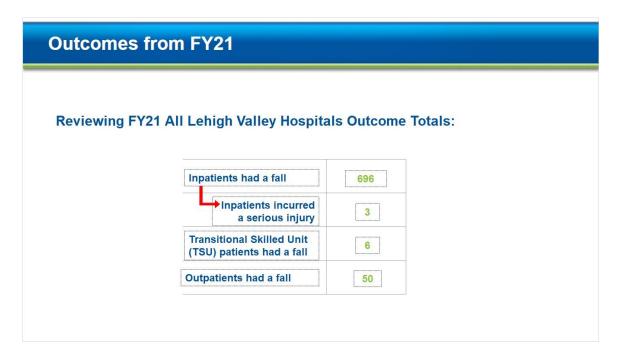
### 1.1 Fall Prevention



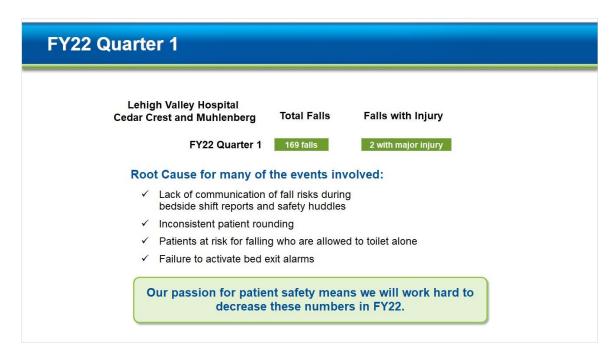
## 1.2 Course Information



## 1.3 Outcomes from FY21



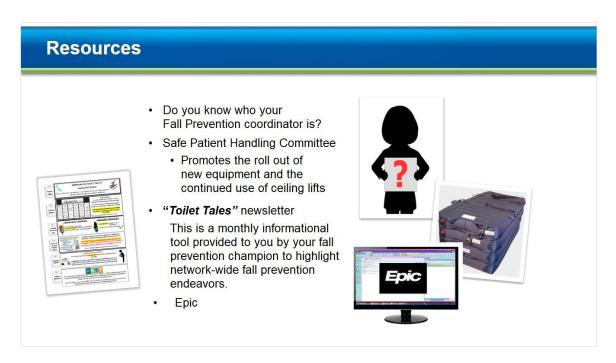
## 1.4 Compared to Last Year



### 1.5 Patient Safety and The Triple Aim



#### 1.6 Resources



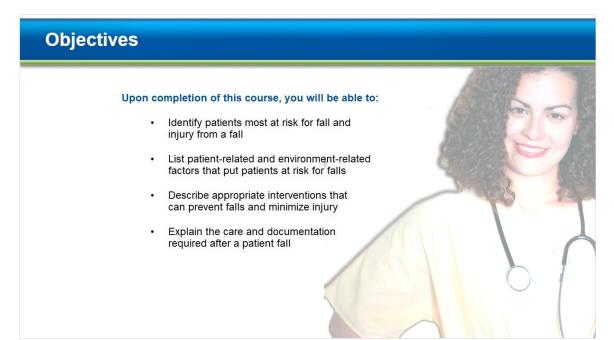
#### 1.7 Thank You

## **Thank You**

The Joint Commission and our Magnet certification identify fall prevention as a patient safety concern so we will support collaborative efforts in our network that lead to improved patient safety.



## 1.8 Objectives



## 1.9 Determining Risk



## 1.10 Patients at Risk



## **Toileting**

# Patients at Risk - Toileting

### Toileting













Patients who need assistance with toileting.

Click to advance

### **Mental Status**

## Patients at Risk - Mental Status

#### **Mental Status**











Patients who are confused, impulsive, or disoriented.

#### **Assistive Device**

## Patients at Risk – Assistive Devices

#### **Assistive Devices**











Patients who use an assistive device (walker, cane, or wheelchair).



## History

# Patients at Risk – History of Falls

#### **History of Falls**







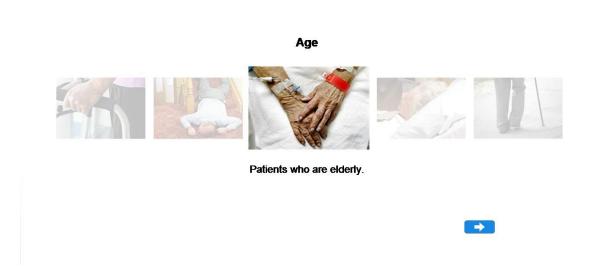




Patients with a history of falls.



# Patients at Risk - Age



## Post-Op

# Patients at Risk - Post-Operative



## **Balance**

## Patients at Risk - Balance

#### **Balance**











Patients who have balance and/or gait disturbance.



### Vision

## Patients at Risk - Vision

#### Vision











Patients who have vision problems.



### Weakness

## Patients at Risk - Weakness

#### Weakness











Patients who are weak or have been in bed a long time.



### Medications

## **Patients at Risk - Medications**

#### **Medications**











Patients who take medication for pain, blood pressure, anxiety, or sleep.



## Patients at Risk - Gender

#### Gender











Research shows that on average, male patients have a higher incidence of falls.



### 1.11 Altered Mental Status

## **Altered Mental Status**

Here are some safety tips that you should keep in mind when caring for a patient with an altered mental status:

- 1. Perform hourly rounding
- 2. Help orient the patient:
  - Provide visual cues, like a clock or family pictures by the bedside
  - Keep the white board in the patient room up to date
- Frequently observe the patient for example, use bed and chair checks and/or lap buddies as reminders. Notify the nurse if the patient is attempting to get out of bed without asking for assistance.



## 1.12 Environmental Hazards



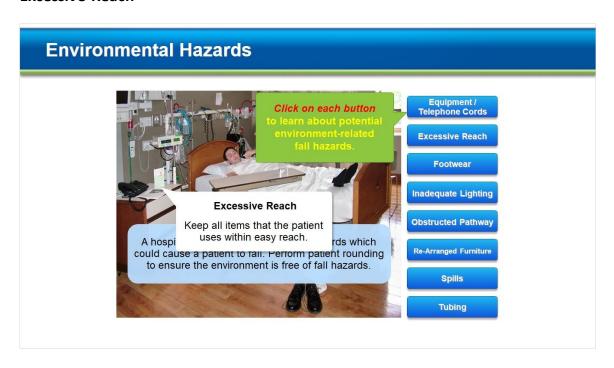
### 1.13 Environmental Hazards



#### Intro



#### **Excessive Reach**



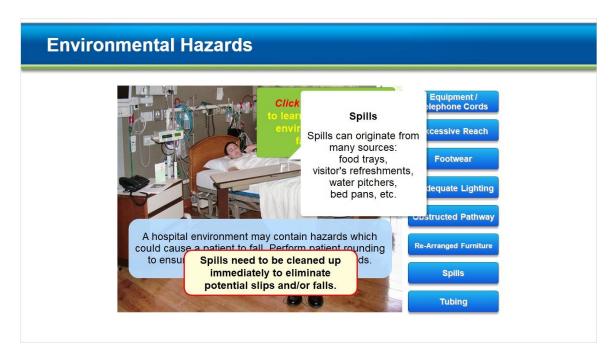
#### **Footwear**



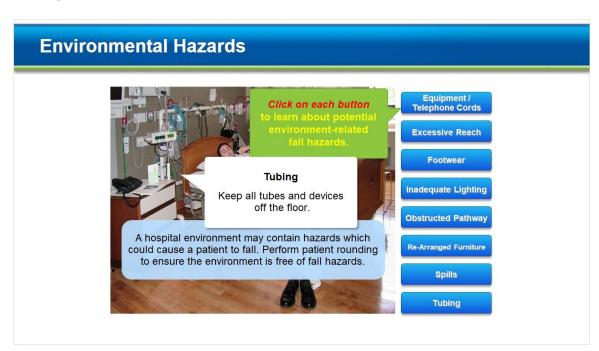
#### **Obstructed Path**



### **Spills**



## **Tubing**



## **Telephone Cords**



## **Inadequate Lighting**



#### **Rearranged Furn**



#### 1.14 Fall Prevention Interventions

### **Fall Prevention Interventions**

#### Follow these fall prevention musts:

- Perform patient rounding; assessing patients for the "three P's" pain, personal needs, and positioning.
- 2. Make sure call bell is within reach.
- Keep all personal items nearby. Reaching for items has been identified as a cause of falls at LVHN during root cause analysis.
- 4. Prior to leaving room, make sure bed alarm is functioning properly. Test alarm on initiation, daily, and as needed.
- Check for Orthostasis. Orthostasis is a sudden drop in blood pressure upon standing, or any change in position. Educate the patient to rise slowly and sit on the end of the bed for a few minutes. There are many medications that may cause a patient to experience orthostasis.
- Assist patients who are at risk for falls in the bathroom or on the commode. Do not leave patients unattended.
- 7. Use hand over communications in regards to patient independence in the bathroom.
- 8. Use yellow socks, identification bands, and fall risk magnet to identify patients at risk for a fall.

## 1.15 Always Remember to:

## **Always Remember to:**



#### To prevent patient falls:

- Identify at risk patients
- · Remind patients to call for assistance to get out of bed
- · Follow Physical Therapy recommendations
- · Use assistive and adaptive devices
- Make sure patients know how to use the call bell
- Answer call bells promptly and perform hourly rounding
- · Apply non-skid socks or the patient's own shoes
- · Assist patients with ambulation and transfers
- · Properly reset bed alarms as needed

## 1.16 HoverJack Air Lift System

## Portable Lift Equipment

#### Post Fall Intervention

- · Current available portable lifts (Mo-Lifts) are unable to lift above 560 lbs.
- The Mo-Lifts and/or the ceiling lifts cannot lift a patient with a suspected spinal injury safely from the floor.

### 1.17 HoverJack Air Lift System



<sup>1</sup> Note: Not all locations have the HoverJack Air Lift Sytem. Check with your supervisor if you have any questions.

Supply

### 1.18 Fall Hazards in the Patient Environment

### Fall Hazards in the Patient Environment

Falls can occur as a result of hazards in the patient's environment. You can help prevent patient falls by:

- Performing hourly rounding
- Checking locks on beds and wheelchairs
- Cleaning up spills promptly
- Eliminating clutter from patient walkways and hallways
- Checking for any loose equipment cords and securing them to the bedframe
- Placing the call bell and patient items within reach
- Following a timed toileting schedule
- Asking for assistance



### 1.19 Review Safety Tips

## **Review Safety Tips**

#### Review safety tips with the patient and family:

- · Use the call bell before getting out of bed or off the toilet
- · Rise slowly and sit on the edge of the bed for a few minutes
- · Wear your own shoes from home or non-skid socks
- · Engage and partner with the family to keep the patient safe
- · Educate the patient and their family on fall prevention



## 1.20 Fall Risk for Outpatients

## **Fall Risk for Outpatients**

Patients are screened for fall risk in the outpatient areas as well.

Patients in the outpatient areas are also at risk for falls.



#### Ask adult patients in outpatient areas:

- 1. Do you use anything to help you walk?
- 2. Do you feel unsteady on your feet?
- 3. Have you fallen in the past year?

One positively answered question indicates potential risk for falls.

### 1.21 Outpatient Interventions

## **Outpatient Interventions**

If a patient is identified as at risk, the staff in the outpatient department provides for the patient's safety.

As appropriate, interventions will be implemented for outpatients identified at risk for falls and may include:

- · Assist patient with ambulation to test/treatment area
- · Monitor patient frequently during test/treatment
- · Assist/accompany patient to examination area
- Consider use of assistive devices as needed (ie. wheelchair, walker, other transfer device
- · Remain with patient during study/treatment
- · Assure environment is hazard free



## 1.22 You Make the Difference

### You Make the Difference

# Patient falls can be prevented. You are responsible for protecting the safety of your patients.

- Be conscious of patient-related and environmentrelated factors that put patients at risk
- Implement fall prevention interventions to keep patients safe at all times
- Pay close attention to the patient who has fallen by following post-fall interventions
- · Communicate fall risks to all caregivers
  - Interventions in place to prevent a fall may change during a shift
  - · Hand over communication is important



## 1.23 Summary

# Summary

#### You should now be able to:

- ✓ Identify patients who are most at risk for fall and injury from a fall
- ✓ List patient-related and environment-related factors that put patients at risk for falls
- ✓ Describe interventions that can prevent falls and minimize injury