DEFENSE HEALTH AGENCY
WEED ARMY COMMUNITY HOSPITAL
BOX 105109
FORT IRWIN, CA 92310-5109

DHA-WACH 6025.34 11 February 2025

Quality Services
FALL RISK REDUCTION/PREVENTION PROGRAM

1. PURPOSE. To establish process and procedures to reduce or prevent patient and visitor falls and establish reporting procedures.

2. REFERENCES.

a. DHAAI 6025.34 dated September 13, 2024.

3. DEFINITION OF TERMS: Terms used in this policy are defined in Appendix A

4. RESPONSIBILITIES.

a. Senior Leadership.

(1) Ensure the organization is committed to patient safety and fall prevention measures throughout the organization.

b. Department/Clinic Officer-in-Charge (OIC) and Non-Commission Officer-in-Charge (NCOIC), and/or Clinical Nurse Officer-in-Charge (CNOIC) will:

(1) Ensure team members comply with policy and procedures.

(2) Cultivate a "Just Culture" environment to encourage reporting of patient safety events in the Patient Safety Reporting system.

(3) Review all Patient Safety Reports from their areas and take appropriate action to reduce risks of falls.

(4) Ensure staff orientation on proper falls prevention protocol specific to department.

5. PROCEDURES.

a. Visitor Falls:

(1) Visitors with readily identified mobility problems (ambulation aids, wheelchair, or observed weak/impaired gait) will be assisted by staff.

(2) Visitors who fall will be assessed for injury and stabilized as necessary. They will be referred for a formal evaluation in the ED.

(3) The Safety Officer must be contacted so a report of the injury can be made to track the injury and to identify safety problems within the facility.

b. Outpatient Falls:

(1) Outpatients with readily identified mobility problems (ambulation aids, wheelchair, or observed weak/impaired gait) will be assisted by staff between waiting areas and examination areas.

(2) Outpatients who fall will be assessed for injury and stabilized as necessary. They will be referred for a formal evaluation in the ED.

(3) Staff member will complete a Patient Safety Report (PSR) regarding the incident, to track the injury and identify safety problems within the facility.

c. Inpatient Falls:

(1) All patients will receive a pair of non-skid socks upon admission.

(2) Patients and families will be educated on the Fall Prevention Protocol.

(3) All inpatients will be assessed for their potential for falls:

(a) Upon admission

(b) With each shift assessment

(c) Upon every change in condition or status

(d) Upon discharge or transfer

(e) At the nurse's discretion

(4) Falls Assessment Screening Tools will be used to determine if a patient is at risk for falls.

(a) Adult patients will be screened for falls using the Morse Falls Scale (Appendix C).

(b) Pediatric Patients will be screened using The Humpty Dumpty Scale Falls Assessment Tool (Appendix D).

(5) Placement on falls precautions may be a provider or nursing order. If a patient is placed on falls precautions by the nurse, the attending physician does NOT need to be notified unless a change in the patient's condition has occurred.

(6) Falls Precautions nursing orders will be entered into the patient's electronic medical records in GENESIS. The nursing orders should be individualized based on the nursing assessment of the patient.

(7) Patient will be identified as on falls precautions by color banding the patient and marking the record and the patient room. A yellow patient wrist band, with the words "FALLS RISK" will be used to identify these patients. The falls risk band will be placed as closed as possible to the patient ID band. For both adult and pediatric patients, the 'Fall Risk tab' on the room placard will be pulled out (Appendix B) to maximize staff awareness.

(8) Same Day Surgery (SDS): SDS patients will automatically be placed on falls precautions when they are processed into the Post-Anesthesia Care Unit (PACU) on their day of surgery. No initial falls risk assessment is necessary. SDS patients will remain on falls precautions throughout their surgical transitions (SDS to OR to PACU). They will be assessed with the appropriate Falls Risk Assessment Tool (Morse or Humpty Dumpty) during the discharge process so that appropriate patient teaching and discharge planning can occur.

(9) Emergency Department (ED): The Emergency Department will complete a falls risk assessment upon check-in using the appropriate Falls Risk Assessment Tool (Morse or Humpty Dumpty) and take precautions appropriate with their level of risk. In addition to the initial risk assessment, staff will update the risk assessment based on changes in the patient's clinical condition.

(10) Pre-operative surgical patients who are regular admissions will be assessed upon admission. Immediately prior to transition to OR, applicable unit staff will place all pre-surgical patients on falls precautions. No falls risk assessment is required. Surgical patients will remain on falls precautions until their return to the inpatient unit. Then they will be re-assessed of falls risk as part of their transfer assessment.

(11) Staff members will collaborate to reduce patient vulnerability to falls by reducing risk factors. After the falls risk assessment is completed, the falls risk factors will be reviewed by the nurse. After review, the nurse will initiate actions (coordinating with the attending physician as necessary to alleviate or reduce any

factors that can be changed). Example: Dizziness that is medication related may be reduced by a change in medication type or dosage; patients who use hearing aids or eyeglasses should have them easily available for use.

(12) Patients on falls precautions will be identified during nursing change of shift as well as during daily nursing huddles.

6. Age Specific Inpatient Falls Precautions.

a. Pediatric patients:

(1) Patient will be placed in a bassinet or crib, as age, size, and level of mobility indicate.

(2) Side rails on cribs will be maintained in the up and locked position unless a care provider or parent is at the bedside.

(3) Covers (soft or hard) will be placed on cribs when patient is developmentally able to climb.

(4) When side rails are not available (exam tables, during some patient transports, bathing/showering), the "Hands on" is defined as a staff member or family member maintaining physical contact with the patient during any times when bedrails are not up or are not available.

(5) Patient transport "in the parent's arms" will be allowed at the nurse's discretion. Safety of the patient is the primary consideration. The nurse will consider child size, condition, presence of ancillary equipment, and the parent's physical stability and orientation to the building. To ensure safety, no patient will be transported outside the building without a staff member escort.

(6) Patient transport via titter or wheelchair will include use of a safety strap, even if parent or staff member occupy the litter or wheelchair with the patient.

(7) Staff will ensure that equipment wheels on beds, cribs, bassinets, wheelchairs and/or litters are locked whenever the equipment is stationary and during all patient transfers between equipment.

(8) Band the patient with the falls risk bank (a yellow patient ID band). Mark the bedside areas, census board, and chart with the falls precaution indicator.

(9) Notify support service areas (lab, radiology) that a patient is on falls precautions if the patient goes to that area to receive care.

(10) Family education will include information regarding the patient's status as "on falls precautions," the importance of "hands on" rule, and the

specific components of the pediatric falls precautions. Family member instruction will be documented in the patient record. Family member instruction may include patient-oriented handouts appropriate to the topic.

(11) The nurse may identify additional measures to implement for patient safety. Note: Ensure that any additional measures do not constitute "restraint" as defined in the restraint policy. ff the additional measures are necessary to ensure patient safety, this policy will be superseded by MEDDAC Regulation No. 40-81 on restraints.

b. Adult Patients:

(1) Ensure that bed wheels are locked.

(2) Maintain the bed in the lowest position.

(3) Maintain two bed rails in the up position, unless an adult family member is at the bedside. **Note**: *Beds with four side rails in the up position is considered a restraint and not allowed without an order from the physician.*

(4) Ensure that personal care articles are within easy reach of the patient. These include (but not limited to) call light, TV remote, light cord, phone and water pitcher.

(5) Mark the patient, room, and electronic medical record with the falls precaution indicator and falls risk band.

(6) Perform hourly care rounds for every patient, offering them food/water, and assistance to the toilet.

(7) Instruct the patient to call for assistance as needed and ensure the call light is within reach.

(8) Patients will ambulate waring well-fitted footwear or non-skid socks.

(9) Patient will ambulate only with staff assistance. Extra personnel will be utilized based on the patient condition.

(10) Ambulation Assistance:

(a) Sit patient up in bed/dangle with rails up prior to standing. Assess for dizziness. Do not progress with ambulation until patient is no longer dizzy.

(b) Ambulate per physician orders while constantly monitoring for patient tolerance, e.g., patient weakness, dizziness, or instability.

(c) Discontinue ambulation process at any point patient is intolerant.

(11) Patient and family education will include information regarding the patient's status as "on falls precautions" and the specific components of the falls precautions. Patient/family member instruction will be documented in the patient record.

(12) The nurse may identify additional measures to implement for patient safety. **Note**: *Ensure that any additional measures do not constitute "restraint" as defined in the restraint policy*.

7. Procedure for When an Inpatient Fall Occurs.

a. Assess patient for injuries and provide immediate care and/or stabilization.

b. Notify attending provider of fall. Implement any orders given by the provider and reassess patient.

c. Document event, notification of provider, and actions taken in patient record. (Appendix E)

d. Initiate a PSR regarding the event.

8. The proponent for this publication is the Chief of Quality and Safety, Weed Army Community Hospital, MCXK-QS.

F. CAMERON JACKSON
COL, MS
DIRECTOR

APPENDIX A

DEFINITIONS

a. Fall. A sudden unplanned event witnessed or un-witnessed, that results in a person descending or coming to rest unintentionally on the ground/floor or extension of the floor (for example, trash can or other equipment) with or without injury. The descent begins from a standing, sitting, or horizontal position to include slipping, tripping or other mishap. All types of falls are included, whether they result from physiological or environmental reasons.

b. Developmental pediatric fall. Non-injurious falls that are common to infants and toddlers as they learn to walk, pivot and run.

c. Fall risk factors. Patient characteristics and clinical or medical diagnoses objectively measured to predict a fall potential.

d. Fall risk assessment. An activity using clinical judgment and a fall risk assessment tool that lists risk factors with associated scores.

e. Injury. A disruption of structure or function of some part of the body as a result of an unplanned event (such as fractures, sprains, cuts, bruises, aggravation of preexisting complaint).

f. Near miss fall. An event or situation that could have resulted in an accidental anticipated, or unanticipated fall, but did not, either by chance or timely intervention; or, where a patient is assisted to the floor or lower surface by another individual without injury to the patient.

APPENDIX B

APPENDIX C
Morse Fall Scale

(Adapted with permission, SAGE Publications)

The Morse Fall Scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling. A large majority of nurses (82.9%) rate the scale as "quick and easy to use," and 54% estimated that it took less than 3 minutes to rate a patient. It consists of six variables that are quick and easy to score, and it has been shown to have predictive validity and interrater reliability. The MFS is used widely in acute care settings, both in the hospital and long term care inpatient settings.

Item	***Scale***	***Scoring***
1. History of falling; immediate or within 3 months	No 0 Yes 25	_____
2. Secondary diagnosis	No 0 Yes 15	_____
3. Ambulatory aid Bed rest/nurse assist Crutches/cane/walker Furniture	0 15 30	_____
4. IV/Heparin Lock	No 0 Yes 20	_____
5. Gait/Transferring Normal/bedrest/immobile Weak Impaired	0 10 20	_____
6. Mental status Oriented to own ability Forgets limitations	0 15	_____

The items in the scale are scored as follows:

History of falling: This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

Secondary diagnosis: This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.

Ambulatory aids: This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.

Intravenous therapy: This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.

Gait: A *normal gait* is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a *weak gait* (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.

Mental status: When using this Scale, mental status is measured by checking the patient's own selfassessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the ambulatory order on the Kardex®, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.

Scoring and Risk Level: The score is then tallied and recorded on the patient's chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

Important Note: The Morse Fall Scale should be calibrated for each particular healthcare setting or unit so that fall prevention strategies are targeted to those most at risk. In other words, risk cut off scores may be different depending on if you are using it in an acute care hospital, nursing home or rehabilitation facility. In addition, scales may be set differently between particular units within a given facility.

Sample Risk Level

Risk Level	MFS Score	Action
No Risk	0 - 24	Good Basic Nursing Care
Low Risk	25 - 50	Implement Standard Fall Prevention Interventions
High Risk	≥ 51	Implement High Risk Fall Prevention Interventions

APPENDIX D
The Humpty Dumpty Scale

Parameter	Criteria	Score
Age		
	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years old and above	1
Gender		
	Male	2
	Female	1
Diagnosis		
	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments		
	Not Aware of Limitations	3
	Forget Limitations	2
	Oriented to own Ability	1
Environmental Factors		
	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant Toddler in Crib or Furniture/Lighting (Tripled Room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia		
	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage		

	Multiple Usage of: Sedatives(excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives /Diuretics Narcotics	3
	One of the Meds listed above	2
	Other Medications/None	1
	Total	

Fall Risk

Low Humpty Dumpty Score = 7-11

High Risk Humpty Dumpty Score = 12 or above

APPENDIX E
Fall Event Data Collection Form

Joint Commission Center for Transforming Healthcare

tst

* Indicates required field

Fall Event Data Collection Form

Was the fall determined to be intentional? *
(If Yes, please answer only pt ID, Room #, Date, Time and Additional comments / fall description)

Patient ID (Last 4 – 6 digits of MR#)	Room Number	Date of Fall	Time	Time of Last Rounding	Staff : Patient Ratio
					1 :

Was the patient identified as a fall risk? *(If no fall risk assessment was performed on the patient, select NA)* * Yes No NA

If Yes, were any fall risk identifiers used for the patient? * Yes No

If Yes, which fall risk identifiers were used for the patient? (check all that apply) *
Signs, Arm Bands, Gowns, Chart Indicators, Whiteboard
Socks, Fall Mats, Low Bed, Blankets, Other

Was the patient discharged prior to fall? * Yes

Number of staff required to assist this patient

Did the fall occur during shift change? Yes

Has the patient fallen previously during this hospital stay? * Yes N

Did the fall result in injury to the patient? * Yes N

If Yes, please indicate the injury level classification (developed by NCC NOI) *
- Resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion **(Minor Injury)**
- Resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain **(Moderate Injury)**
- Resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall **(Major Injury)**
- Patient died as result of injuries sustained from fall (not from physiologic events causing the fall) **(Death)**

Was a sitter (staff) being utilized at the time of the fall? Yes

FALL LOCATION

Where did the fall occur? *
Patient Room, Bathroom/Shower room, Hallway *(Go to related location below)*

PATIENT ROOM

What was involved in the Patient Room fall? *
Patient bed, Commode, Other _____
Patient chair / wheelchair, Patient ambulation
(Go to related sub-section below. If related sub-section doesn't exist, skip to "Assistance")

PATIENT ROOM - Bed

How did the fall occur? *
Patient slid out of bed, Patient was getting into or out of bed, Other _____

If the patient slid out of bed

Was the patient reaching for something? * Yes

If Yes, were the patient's belongings within reach? * *(Skip to "Education" section)* Yes

If the patient was getting into or out of bed

Were the bed wheels locked at the time of the fall? * Yes

Was an alarm (personal, bed) being utilized at the time of the fall? * Yes No NA

If Yes, was the alarm activated? * Yes No

Was the patient bed set at lowest height? * *(Skip to "Assistance" section)* Yes No

PATIENT ROOM - Chair / Wheelchair

How did the fall occur? *
Patient slid out of the chair/wheelchair, Other _____
Patient was getting into or out of a chair/wheelchair

If the patient slid out of the chair/wheelchair

Was the patient reaching for something? *	○Yes ○No
If Yes, were the patient's belongings within reach? * *(Skip to "Education" section)*	○Yes ○No

If the patient was getting into or out of chair/wheelchair

Were the chair/wheelchair wheels locked at the time of the fall? *	○Yes ○No
Was a chair alarm being utilized at the time of the fall? *	○Yes ○No ○NA
If Yes, was the alarm activated? * *(Skip to "Assistance" section)*	○Yes ○No

PATIENT ROOM - Commode

How did the fall occur? *

○Patient fell off commode ○Patient was getting on or off the commode ○Other _____

Was the patient left alone while using the commode? * *(If the pt fell off commode, skip to "Education" section Otherwise skip to "Assistance" section)*	○Yes ○No

BATHROOM / SHOWER ROOM

How did the fall occur? *

○Patient fell off toilet/shower chair ○Patient was ambulating/standing ○Other _____

Was the patient left alone while toileting or showering? * *(If the patient fell off toilet/shower chair, Skip to "Education" section Otherwise skip to "Assistance" section)*	○Yes ○No

HALLWAY

How did the fall occur? *

○Patient fell while sitting at the nurse's station ○Patient was ambulating/standing ○Other _____

(If pt fell while sitting at the nurse's station, Skip to "Education" section Otherwise continue)

ASSISTANCE

Was the patient being assisted at the time of the fall? *	○Yes ○No
If Yes, was the patient assisted by staff? *	○Yes ○No

If Yes, what staff (role) assisted the patient? *

☐Chaplain ☐CNA ☐Food Service ☐Housekeeping
☐Maintenance ☐Nurse Manager ☐Occupational Therapy/OTA ☐Patient Care Tech
☐Physical Therapy/PTA ☐Physician/Resident/PA ☐Sitter ☐Staff Nurse
☐Transport ☐Other _____

Was the patient required to use an assistive ambulation device? *	○Yes ○No
If Yes, was the patient using the assistive device at the time of the fall? *	○Yes ○No

If Yes, which assistive device was the patient using? *

○Standard Cane ○3-4 pronged cane ○Walker with wheels ○Walker without wheels
○Crutches ○Gait Belt ○Other _____

Was the patient wearing no skid footwear? *	○Yes ○No

EDUCATION

Were family members/friends present at the time of the fall? *	○Yes ○No
If Yes, Did family members/friends attempt to notify staff that the patient needed assistance? *	○Yes ○No ○NA
Did family members/friends receive education regarding falls and fall safety? *	○Yes ○No
Did the patient receive standardized education regarding falls and fall safety? *	○Yes ○No
If Yes, did the patient comprehend/understand the education? *	○Yes ○No ○Unknown

MEDICATIONS

Was the patient on any medication that could increase his/her risk for falls, including but not limited to the following: diuretic, analgesic, allergy medication (such as Benadryl), laxative, narcotic, anti-hypertensive, benzodiazepine, anti-seizure, or anti-psychotic? *	○Yes ○No
If Yes, please answer the following questions as they pertain to the above medication types	
Was the patient educated regarding the medication side effects specific to increased risk of falls? *	○Yes ○No
Was the patient's medication changed w/in past 24 hours (new medication, dosing, and/or scheduling changes)? *	○Yes ○No
Was the medication administered within 2 hours prior to bedtime? *	○Yes ○No
Was the medication administered within 2 hours prior to fall? *	○Yes ○No

CALL LIGHT

Did the patient use the call light prior to fall? *	○ Yes ○ No ○ NA
If Yes: Did the patient get up (or attempt to) prior to a staff member entering the room? *	○ Yes ○ No
Was the call light functioning properly? *	○ Yes ○ No
If No: Was the patient cognitively and physically able to use the call light? *	○ Yes ○ No
Did the patient refuse to use it? *	○ Yes ○ No

TOILETING

Was the patient trying to get to or from the bathroom? *	○ Yes ○ No
If Yes, Was a commode made available to the patient? *	○ Yes ○ No

If Yes, Where was the commode located at the time of the fall? *

○ Next to patient bed ○ In patient bathroom ○ Opposite side of the room ○ Other _____

If No, why wasn't the commode made available? *

☐ Patient refuses to use commode ☐ No commode available ☐ Patient not identified as a fall risk
☐ Commode removed from room ☐ Other _____

If Yes, was the patient on a toileting schedule? *	○ Yes ○ No

PRIMARY CAUSE OF FALL

What was the primary cause of the fall? *

○ Medical cause ○ Patient slipped ○ Patient tripped ○ Patient lost balance ○ Other _____

If Patient slipped, what was the cause of the slip? *

☐ Slick floor/tile ☐ Wet floor ☐ Slippery socks or footwear ☐ Other _____

If Patient tripped,What did the patient trip over? *

☐ SCD tube ☐ IV pole ☐ Foley tubing ☐ Other _____
☐ Phone cord ☐ Loose linens ☐ Oxygen tubing

ADDITIONAL COMMENTS / FALL DESCRIPTION