

PROTOCOL FOR: Falls: Perioperative Risk Identification, Prevention  
Management, and Treatment of Ambulatory Patients

- POLICY:
1. The perioperative nurse will identify patients' fall risk utilizing the John Dempsey Hospital Fall Risk Identification Tool included in the on-line documentation application as follows:
    - a. all outpatients and all admit day of surgery patients upon admission;
    - b. for unit transfers, receiving unit will be provided with information to identify the patient's fall risk
    - c. prior to patient discharge; and
    - d. after a fall
  2. An individual fall prevention treatment plan will be developed for each patient based on the patient's risk for falls. The plan will be implemented by the nurse utilizing appropriate safety measures.
    - a. patients who score 0 points will be allowed to ambulate unassisted unless nursing assessment deems it otherwise unsafe;
    - b. patients who score positively under the categories of Confusion / Disorientation or Mobility, impaired will not be allowed to ambulate at all, regardless of assistance; and
    - c. patients who score positively under the categories of History of falling; Elimination, altered; or Medications may be allowed to ambulate if the nursing assessment deems it is safe.
  3. Falls will be defined as follows:
    - a. A person unintentionally and abruptly goes from a standing, sitting or lying position to a lower level. Excluded from this definition are such position changes caused by overwhelming force (e.g., being pushed);
    - b. Patients who are assisted to the floor by staff members and who otherwise would have fallen without the assistance of staff members will also be identified as having fallen.
  4. The organization will monitor falls to identify trends and to enhance patient care and safety.

DESIRED  
PATIENT  
OUTCOMES:

Optimal safety of patients will be maintained throughout the perioperative phase.

CLINICAL  
ASSESSMENT AND

- CARE:
1. All ambulatory surgery and admit day of surgery patients will be assessed for fall risk using the John Dempsey Hospital Fall Risk Identification Tool, which is incorporated into the on-line documentation application.
  2. The admission assessment for risk of falls will include each of the following five categories
    - a. History of Falling: (total can equal up to 4 points)

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- within the past three months (2 points)
  - fall was reason for admission (2 points)
  - b. Confusion / Disorientation: (4 points for any positive assessment)
    - unable to follow instructions
    - poor safety awareness
    - unaware of own ability or lack thereof
    - attempts to get out of bed, stretcher or recliner despite instructions not to do so
    - restless or impulsive
  - c. Mobility, impaired: (2 points)
    - unable to stand without assistance
    - unable to maintain balance once standing
    - unable to move forward and walk unassisted
  - d. Elimination, altered: (2 points for any)
    - frequency
    - urgency
    - nocturia
    - diarrhea
    - incontinence
  - e. Medications: (2 points)
    - anticoagulants
    - hypnotics
    - anticonvulsants
    - antihypertensives
    - psychotropics
    - diuretics
    - neuroleptics
    - narcotics
    - sedatives
3. The nurse will implement an individualized fall prevention treatment plan determined by the fall risk identification score and any interventions will be documented in the medical record, including patient and family teaching.
  4. An entry into the medical record will be made whenever a patient is noncompliant, such as attempting to ambulate without permission.
  5. The individualized perioperative fall prevention treatment plan may incorporate, but is not limited to, the following:
    - orient patient to surroundings and staff;
    - physically safe environment, including adequate lighting to promote safe ambulation and unobstructed pathways;
    - as appropriate, placement of call bell within reach of and visible to patient, with associated teaching provided;
    - use of non-slip footwear;
    - assure sensory / ambulatory prostheses are used, as appropriate;
    - instruct patient regarding use of grab bars;
    - actively education and engage patient and family in fall prevention strategies.
  6. Document in the medical record about fall risk identification and prevention management.
  7. In the event of a fall, do as follows:
    - a. document pertinent facts in the medical record;
    - b. notify the attending surgeon and the service;

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- c. document a physical assessment at the time of fall, including blood pressure, heart rate, respiratory rate, pulse oximetry level, level of consciousness, and any observable injuries;
- d. if head trauma is suspected or injury is apparent, document the neurological assessment completed at the time of the fall, including:
  - Glasgow Coma Scale: eye opening, verbal response, motor response; and
  - pupillary light reflex: pupil size and reactivity to light
- e. document any preventive measures initiated;
- f. Notify immediate family / significant others;
- g. Notify nurse manager regarding all falls and initiate *PSN* report; notify administrative supervisor for any falls resulting in moderate to major injury.

APPROVAL: Nursing Standards Committee

EFFECTIVE

DATE: 8/08