

Falls Risk Nursing Protocol Overview

FALLS RISK ASSESSMENT PER LASTWORD	CORRESPONDING FALLS PROTOCOL ORDERS	TIPS
<p>AUTOMATIC HIGH RISK: Fall History</p> <ul style="list-style-type: none"> ▪ Patient has history of 1+ fall in last 6 months ▪ Patient had a recent fall event that lead to this hospital admission. ▪ Patient has experienced a fall during this hospitalization. <p>Related Diagnoses</p> <ul style="list-style-type: none"> ▪ Syncope/near Syncope > 50 y/o ▪ Acute seizures ▪ Acute/chronic cognitive changes (including delirium and ETOH) ▪ Symptomatic hypotension ▪ Vertigo 	<p>AUTO HIGH FALLS RISK:</p> <ul style="list-style-type: none"> ▪ High falls risk equipment: low bed and falls alarm ▪ Nurse alert: Place high falls risk signage <ul style="list-style-type: none"> ○ Yellow falls sticker on patient’s identification bracelet ○ Check “Falls” box on “Alert Tag” on front of patient chart ○ Red falls risk indicator on patient’s whiteboard ▪ Nurse alert: Remain within arms’ reach of the patient when out of bed/chair ▪ Level of assistance per Q shift nursing assessment; must = assist/one or greater ▪ Rounding for results 	<ul style="list-style-type: none"> ▪ If any one item of the patient’s fall history or related diagnoses is checked, the patient is categorized as an automatic high falls risk. <u>You do not need to score the patient using the tool</u> ▪ Implement automatic High Fall Risk Protocol throughout hospitalization ▪ ALL interventions must be selected for Auto High Risk patients <ul style="list-style-type: none"> ○ EXCEPTIONS: mechanically ventilated patients & 3West patients do not require low bed/equipment
<p>HIGH FALLS RISK: Total Score from assessment = > 13</p>	<p>HIGH FALLS RISK: <i>(equipment is the only optional intervention and is based on nursing judgment)</i></p> <ul style="list-style-type: none"> ▪ High falls risk equipment: low bed and falls alarm ▪ Nurse alert: Place high falls risk signage <ul style="list-style-type: none"> ○ Yellow falls sticker on patient’s identification bracelet ○ Check “Falls” box on “Alert Tag” on front of patient chart ○ Red falls risk indicator on patient’s whiteboard ▪ Nurse alert: Remain within arms’ reach of the patient when out of bed/chair ▪ Level of assistance per Q shift nursing assessment; must = assist/one or greater ▪ Rounding for results 	<ul style="list-style-type: none"> ▪ Falls risk equipment is the ONLY optional intervention for a High Falls Risk patient and this decision should be made based on nursing judgment
<p>MODERATE FALLS RISK: Total score from assessment = 6-13</p> <p>LOW FALLS RISK: Total score from assessment = 0-5</p>	<p>MODERATE OR LOW FALLS RISK ORDERS:</p> <ul style="list-style-type: none"> ▪ Nurse alert: Place moderate or low falls risk signage <ul style="list-style-type: none"> ○ Yellow/green falls risk indicator on patient whiteboard ▪ Level of assistance per every shift nursing assessment ▪ Nurse alert: Rounding for results 	<ul style="list-style-type: none"> ▪ If you feel that a moderate or low risk patient could benefit from additional interventions, please order them to help prevent falls and patient harm
<p>AUTOMATIC LOW RISK: Complete paralysis, or completely immobilized.</p>	<p>AUTO LOW FALLS RISK ORDERS:</p> <ul style="list-style-type: none"> ▪ Nurse alert: Place low falls risk signage <ul style="list-style-type: none"> ○ Green falls risk indicator on patient whiteboard ▪ Level of assistance = total assist ▪ Nurse alert: Rounding for results 	<ul style="list-style-type: none"> ▪ If the patient is categorized as an automatic low falls risk, <u>you do not need to score the patient using the tool</u>

REMINDERS:

- **ALL** PATIENTS NEED A FALLS PROTOCOL ENTERED – THE DIFFERENCE WILL BE IN THE LEVEL AND INTERVENTIONS SELECTED
- PLEASE ENTER YOUR EMPLOYEE NUMBER IN THE “ORDERED BY” FIELD AND SELECT “PER PROTOCOL” – THESE ARE ALL NURSING ORDERS