Overview

Preventing falls is a three step process: 1) identifying risk factors; 2) developing a tailored or personalized plan to decrease risk; and 3) consistently carrying out the plan. The paper Fall TIPS tool is designed to support nurses in partnering with patients and their family members in the 3-step fall prevention process.

How To Use:

1. Write the patient’s first name and last updated date. Erase all information when patient is discharged.
2. Left column lists all fall risk factors from the Morse Falls Scale (MFS). Go through assessment with the patient and check off any risks that apply to patient. These risk factors should match your MFS documentation completed in the EHR and be updated at all times.
3. Right column lists all evidence-based interventions and matches them by color to the appropriate risks. Selecting the interventions that match the color associated with each risk factor will result in a plan that is most likely to prevent a fall for a patient with that particular risk profile. However, you should also use your clinical judgment to tailor the interventions to your patient. Based on individual patient differences, you may choose more interventions or you may choose not to select a recommended intervention.
4. Corresponding MFS item refers to multiple co-morbidities. Patient with multiple co-morbidities are often on many medications that can increase the risk for falls. Some of these medications may increase the need for frequent toileting.
5. If patient has a heplock and does not have equipment attached, check off the risk factor “IV and/or Equipment” without circling the corresponding intervention “IV Assistance When Walking”. As always, use your clinical judgment.
6. Both the “Medication Side Effects” and the “IV and/or Equipment” risk factors have the “Toileting Schedule” as a recommended intervention. Toileting schedule should be ordered for every 1 or 2 hours based on your clinical judgment.

For any questions, please contact Patricia Dykes RN PhD via pdykes@partners.org

### Fall Risks (Check all that apply)

- **History of Falls**
- **Medication Side Effects**
- **Walking Aid**
- **IV Pole or Equipment**
- **Unsteady Walk**
- **May Forget or Choose Not to Call**

### Fall Interventions (Circle selection based on color)

#### Communicate Recent Fall and/or Risk of Harm
- **Crutches**
- **Cane**
- **Walker**

#### IV Assistance When Walking
- **Bed Pan**
- Assist to Commode
- Assist to Bathroom

#### Toileting Schedule: Every _______ hours

#### Bed Alarm On

#### Assistance Out of Bed
- **Bed Rest**
- 1 person
- 2 people

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Fall T.I.P.S.* Training Slides

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*Tailoring Interventions for Patient Safety
Overview

• Review the types of patient falls
• Review the components of an evidence-based fall prevention program
  – Universal fall precautions (all patients)
  – 3-Step Fall Prevention Process
    1. Fall risk assessment
    2. Personalized fall prevention planning
    3. Strategies to ensure consistent implementation of the fall prevention plan
• Review Fall TIPS as a tool to implement the 3-step fall prevention process
• Complete two case studies
• Discuss the role of the PCA in fall prevention
Is My Patient At Risk For Falling?

TYPES OF PATIENT FALLS
Types of Falls: Not Preventable

Unanticipated physiological falls:

- Occur in those who have no risks for falling
- Caused by physiologic changes
  - Such as seizure
- 8% of falls

Most difficult to prevent. Some may not be preventable.

Types of Falls: Preventable

Accidental falls:

• Occur in those who have no risks for falling
• Usually caused by environmental hazard/error in judgment
• 14% of falls

Prevented through universal fall precautions

Types of Falls: Preventable

Anticipated physiological falls:

• Occur in those who have risk for falling
• The fall risk assessment (Morse Fall Scale) completed by the nurse every shift predicts this type of fall
• 78% of falls

**Prevented through fall risk assessment, personalized care planning, and carrying out the planned interventions consistently**

Is My Patient At Risk For Falling?

FALL PREVENTION STRATEGIES
Evidence-based Fall Prevention Strategies

• Universal Fall Precautions
• 3-Step Fall Prevention Process
Universal Fall Precautions

- Cornerstone of any hospital fall prevention program
- Apply to all patients at all times
Examples of Universal Fall Precautions

• Clear pathways.
• Wipe up spills immediately.
• Provide access to call bell.
• Provide non-skid footwear.
3-Step Fall Prevention Process

1. Conduct fall risk assessment (FRA) with the patient at the bedside

2. Personalized to each area of risk identified through FRA

3. Consistent implementation of the preventative interventions (based on tailored plan)

Patient engagement is a key component of each step of the 3-step process.
Fall Risk Assessment

• Morse Fall Scale
• Completed every 8 hours by the nurse
• Used to identify each patient’s individual risk factors for falling
• Used to identify the interventions to decrease patient risk for falling
Risk Factors for Falls Identified by Morse Fall Scale

- History of falling
- Secondary diagnosis—Associated with incontinence, vision problems, multiple medicines, orthostatic hypotension
- Ambulatory aid
- IV therapy/heparin (saline) lock
- Gait
- Mental status

Recommended Interventions

History of falling (in past 3 months): *Most significant indicator for falling*

- Use safety precautions.
- Communicate risk status via plan of care, change of shift report, and signage.
- Document circumstances of previous fall.

**PCA:** Ask the patient about previous falls. Collaborate with the nurse on implementing a plan to prevent similar falls.

Patient who have fallen in the past are likely to fall again and under similar circumstances. Plan accordingly!
**Secondary diagnosis**

- Think about factors that may increase risk for falls that are related to symptoms of multiple medical problems and side effects from the medications to treat medical problems:
  - Illness/multiple medicines
  - Side effects such as dizziness, frequent urination, and unsteadiness
  - Vision problems

- Consider implementing a toileting schedule.

**PCA:** Ask the nurse if the patient requires frequent rounding/toileting due to symptoms of medical problems or medication side effects.
Recommended Interventions, cont.

Ambulatory aid

• Use ambulatory aid at bedside if needed.
• Review dangers of using furniture or hospital equipment as an ambulatory aid.
• Assess ability to use ambulatory aid.
• If no ambulatory aid but needs it, consider PT consult.

PCA: Make sure patients have their ambulatory aid when walking. Remind patient about the dangers of using furniture as an aid in the hospital.
Recommended Interventions, cont.

IV therapy/heparin (saline) lock
- Implement toileting/rounding schedule.
- Tell patient to call for help with toileting.
- Review side effects of IV medications.
- Assist patient with IV pole when walking.

**PCA:** Remind the patient that the IV will cause them to urinate more frequently and to call for help with toileting. Conduct frequent rounding.
Gait

• Assess gait when patient has ambulatory aid as baseline.
• Help patient get out of bed.
  – Determine if patient requires 1 or 2 person assist.
• Consider PT consult.

**Normal gait:** Walks with head erect, arms swinging freely at the side, striding without hesitation.

**Weak gait:** Stooped, but able to lift head without losing balance. If furniture required, uses as a guide (feather-weight touch). Short steps, may shuffle.

**Impaired gait:** Difficulty rising from chair (needs to use arms; several attempts to rise). Head down; watches ground while walking. Cannot walk without assist; grabs at furniture or whatever available. Short, shuffling gait.
Recommended Interventions, cont.

Mental status

• Use bed or chair alarm.
• Place patient in visible location.
• Encourage family presence.
• Do frequent rounding.

**PCA:** make sure bed/chair alarm are turned on when leaving the room. Do not leave patients in the bathroom unattended.

**Mental status test:** “Are you able to go to the bathroom alone, or do you need assistance?”
- **Normal:** Patient response is consistent with orders or kardex.
- **Overestimates/forgets limits:** Patient response is inconsistent with orders or unrealistic.
ABCS of Harm

Patient is at high risk for injury if they fall with:

- **Age**: 85 years old or older, frailty
- **Bones**: osteoporosis, risk or history of fracture, etc
- **Coagulation**: risk for bleeding, low platelet counts, or taking anticoagulation
- **Surgery** (recent): lower limb amputation, major abdominal or thoracic surgery

**Intervention**

- Communicate the patient is at an increased risk for injury if they fall. Emphasize the importance of following their personalized fall prevention plan.
Fall TIPS uses MFS data to plan interventions to prevent patient falls

- Review the areas of risk identified by the MFS for a specific patient.
- On the Fall TIPS tool, select those identified risks then circle interventions for each area of risk.
- The tool is color coded to indicate the evidence-based interventions for each area of risk.
Case Study 1

- John, an 82-year-old man with diabetes was admitted to BWH medical unit with chest pain and shortness of breath. On admission, patient was found to be alert and oriented. He had IV and was placed on cardiac monitor.
- During admission interview, patient reported that with his cane, he was independent with walking and transfers. However, the nurse noted that the doctor’s order was for walking with cane and assistance only.
- With further questioning, the patient reported that he had fallen at home several times over past year, most recently last month.
- As nurse assisted patient to bathroom, she noted that initially he used bedside table and other furniture as guide and needed to be reminded to use his cane.
- Once he was given cane, patient walked with short, steady steps to bathroom.
### Answers

**Patient Name:** John  
**Date:** 05/12/2016

#### Increased Risk of Harm If You Fall
- [ ]

#### Fall Risks (Check all that apply)
- **History of Falls**
- **Medication Side Effects**
- **Walking Aid**
- **IV Pole or Equipment**
- **Unsteady Walk**
- **May Forget or Choose Not to Call**

#### Fall Interventions (Circle selection based on color)

**Communicate Recent Fall and/or Risk of Harm**
- [ ]

**Walking Aids**
- Crutches
- Cane
- Walker

**IV Assistance When Walking**

**Toileting Schedule:** Every [ ] hours
- Bed Pan
- Assist to Commode
- Assist to Bathroom

**Bed Alarm On**

**Assistance Out of Bed**
- Bed Rest
- 1 person
- 2 people
Case Study 2

- Jane, an 86 year old woman with high blood pressure, diabetes and chronic lower back pain is admitted to a BWH medical unit with severe abdominal pain and nausea. The patient is alert, oriented and pleasant. She is on a long list of medications.

- She is short of breath when walking.

- During the interview, the patient states that occasionally she uses a cane. Upon further questioning, the patient revealed that she fell at home last month and the month prior.

- When walking to the bathroom, the nurse and nursing assistant noted that the patient’s was gait steady with the use of a cane. The patient is NPO and is started on intravenous fluids. She is too weak to carry the IV pole to the bathroom alone.
PAPER FALL TIPS

**Patient Name:**

**Fall Risks** (Check all that apply):

- History of Falls
- Medication Side Effects
- Walking Aid
- IV Pole or Equipment
- Unsteady Walk
- May Forget or Choose Not to Call

**Fall Interventions** (Circle selection based on color):

- Communicate Recent Fall and/or Risk of Harm
- Walking Aids:
  - Crutches
  - Cane
  - Walker
- IV Assistance When Walking
- Toileting Schedule: Every ________ hours
  - Bed Pan
  - Assist to Commode
  - Assist to Bathroom
- Bed Alarm On
- Assistance Out of Bed
  - Bed Rest
  - 1 person
  - 2 people
Answers

Patient Name: Jane

Date: 5/12/16

Increased Risk of Harm If You Fall

Fall Risks (Check all that apply)

- History of Falls
- Medication Side Effects
- Walking Aid
- IV Pole or Equipment
- Unsteady Walk
- May Forget or Choose Not to Call

Fall Interventions (Circle selection based on color)

Communicate Recent Fall and/or Risk of Harm

Walking Aids
- Crutches
- Cane
- Walker

Toileting Schedule: Every 2 hours
- Bed Pan
- Assist to Commode
- Assist to Bathroom

Bed Alarm On

Assistance Out of Bed
- Bed Rest
- 1 person
- 2 people

Bed Rest
1 person
2 people
Regular Audits

- Regular audits will be conducted on your unit to ensure the Fall TIPS protocol is adopted into the workflow.

- Audit questions assess:
  - Whether or not the Fall TIPS poster is correct and updated.
  - Whether or not patients and family are engaged in the 3-step fall prevention process.

- Audit questions:
  1. Is the patient’s Fall TIPS poster updated and hanging at the bedside?
  2. Can the patient/family verbalize the patient’s fall risk factors/personalized fall prevention plan?
The Role of Patient Care Assistant in Fall Prevention

- Utilize universal fall precautions for all patients
- Communicate with nurse about each patient’s risk factors and the plan to prevent a fall
- Assist/remind patients as needed regarding fall prevention interventions
- Communicate interventions via bedside shift report
- Reinforce use of the tool/plan with nurses
- Provide feedback to the nurse related to the fall prevention plan
- Ensure the tools are updated by RN