Purpose
MGHS is committed to providing a safe environment for patients receiving services in all settings (inpatient and outpatient). A fall prevention program has been established to minimize the risk of falling. Identification of patients who are at high risk is essential for the success of the program. Inpatients will have a yellow wristband applied and a yellow sign hung outside of their room, and the chart will have a yellow dot. MGHS employees who see patients wearing a yellow wristband, ambulating unassisted or climbing out of bed/wheelchair should assist patient and call for help. Patients wearing a yellow wristband should not be left alone when they are transferred to another unit or transported to another department.

Definition of a fall
A fall is an unanticipated change in body position in a downward motion that may or may not result in physical injury. Falls may be witnessed or unwitnessed, assisted or unassisted. An unwitnessed fall reported to any staff member will be treated and reported in the same manner as a one that was witnessed.

Fall Prevention: Outpatient Visit (Test and Treatment Patients)
Patients entering MGH for tests and treatments will be screened for fall risk using the established criteria. The screening begins in the department where patients are registered. A fall risk screen is accomplished by completing the Fall Risk Screen For The Outpatient tool. Patients identified as being at risk will be banded with a yellow safety armband and transported to the treatment or test area by wheelchair. Patients will be instructed not to stand or ambulate without assistance. Fall Risk Screen For The Outpatient tool is transported with the patient to the testing and treatment areas on a clipboard and acts as a form of handoff communication. The staff member receiving the patient signs, times and dates the form acknowledging that they understand that the patient is high risk for falls.

<table>
<thead>
<tr>
<th>Age</th>
<th>76 years or older</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-75 years</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impaired Mobility</th>
<th>Unsteady gait</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of assistive device</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Dizziness</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Weakness</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>SOB</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fall History</th>
<th>Fell in the last week</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fell in the last 3 months</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total score</th>
</tr>
</thead>
</table>
High Fall Risk ≥15 points

Name of acceptable escort: ____________________________________

1st Contact Staff ________________________________ Time ____________ Date ______________
2nd Contact Testing/Treatment Staff ________________ Time ____________ Date ______________
3rd Contact Testing/Treatment Staff ________________ Time ____________ Date ______________
4th Contact Testing/Treatment Staff ________________ Time ____________ Date ______________
5th Contact Testing/Treatment Staff ________________ Time ____________ Date ______________

Due to what may be perceived as a risk for fall or injury, I have been offered mobility assistance by wheelchair, standby assistance, or other means, and refuse such aids at this time. I understand that I may request this type of support at a later time for any reason, should I feel that I am unable to safely walk unassisted.

Signature: ___________________________________ Date: ______________ Time: ______________

If a patient is determined to be at risk for a fall and refuses assistance they will be requested to sign the above statement of understanding on the bottom of the Fall Risk Screen For The Outpatient tool. At the time of the screen if a patient has an acceptable transporter, significant other, family member or volunteer that will remain with the patient throughout their stay, the name of the escort should be entered on the Fall Risk Screen For The Outpatient tool.

Any MGHS staff member who identifies a patient meeting any of the above criteria should assist the patient and transport either by assisting or by wheelchair to the destination department. The department will be notified of the risk by the assisting staff member. The level of patient assistance to complete the test, procedure or visit will be determined by the department. In outpatient departments that provide nursing care and or sedation, RN's will screen patients fall risk on admission and post procedure. Once the patient encounter is completed the patient will be assisted, or arrangements will be made for transportation, to the next destination. Patients may be scheduled for more than one procedure/visit; their identified risk for falls should be relayed to the next department, using the Fall Risk Screen For The Outpatient tool that will be placed on the clipboard as a part of the hand-off communication. The clipboard and the Fall Risk Screen For The Outpatient tool should be kept by the last department providing testing/treatment to the patient. The Fall Risk Screen For The Outpatient tool will be sent to Health Information Management(HIM) and the clipboard will be cleaned with disinfectant wipes prior to reuse.

Fall Management:

Outpatient Visit – Should a fall occur, either witnessed or unwitnessed occur, MGHS employees should take immediate supportive action including an offer of further evaluation in the nearest E.D. or with attending physician if desired by the patient. The patient should be checked for significant injury and alert the Hospital Supervisor or EMS if necessary if an injury occurs. A Patient Quality Review Report should be filed. The following information should be noted:

- Who: Patient Name, Witnesses
- When: Date and Time
- Where: Location of fall
- Why: Patient stated cause for fall
- Outcome: Patient injury and follow up
- Notification: Next of kin

If the fall was the result of an environmental factor, Building Services or Facilities Management, the Hospital Supervisor should be notified immediately.

Fall Risk Management Inpatient

All inpatients admitted to MGHS will be assessed for fall risk on admission to the hospital and every 8 hours thereafter. The initial assessment will be documented on the EMR. Subsequent assessments are documented on the Patient Care Record. Patients identified as high risk will have a yellow wristband applied, a yellow sign posted outside their door and a yellow dot applied to the patients chart. Refer to Nursing Procedure S-003.
Fall Management Inpatient

Inpatient – Staff should take immediate supportive action, noting significant injury, and notify a Nursing staff member immediately. Refer to Nursing Procedure S-003.

Patient Education

Any patient who is identified as at risk will receive teaching about the fall prevention program, including the wristband and precautions.

Discharge to another Facility

A patient, who has been identified as at risk for falls, who is discharged to another facility will have that information communicated on the Transfer Form, as well as verbally when report is called.

Staff Education

All employees will be educated in their role in identification of fall risks, fall prevention, response to a fall and reporting requirements during orientation and annually thereafter.

Outcome Measurements

Mandatory Reporting: Any witnessed or unwitnessed reported patient fall that occurs at MGHS will be reported to the Quality Management Department utilizing the Patient Quality Review Report. Monthly fall statistics will be distributed to Department Heads.

Performance Improvement: Patient fall data will be collected, aggregated, analyzed and reported as a component of the organization wide performance improvement program. Evaluation of patient falls, injuries, and outcomes will be utilized in an effort to identify opportunities to improve safety and fall prevention program. Hospital performance results will be reported at a minimum biannually to the Quality Council.

Fall Performance Action Team: Representatives from Nursing, Quality Management, Pharmacy, Clinical Engineering and Rehabilitation Services will meet at least twice annually to review fall data, including chart reviews done on a sample of major injuries as a means of identifying system issues that contributed to the fall. This team will also identify fall and injury prevention equipment, establish trial sites for equipment and review the results and establish criteria for the use of equipment. Departmental specific PI plans addressing fall prevention will be reviewed by the committee and recommendations made to departments with high fall indices.