Fall Prevention at SMH

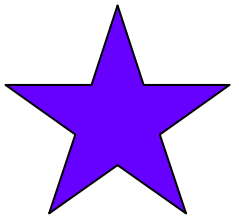
- ***All hospitalized patients are at Risk to fall.***
- The Fall risk assessment, located on the Nursing assessment flow sheet, helps to identify who is *most* at risk for falling.
- The fall risk assessment, is to be done on admission and Q shift and with any condition change.

- LOW risk: All patients are to have low risk interventions in place at all times, Bed low and locked, items in reach, tread socks,adequate lighting, assistance as needed.
- MODERATE risk: all of the above plus individualized choices from the following;

  - purple armband, purple Falling star signage, tread socks, Bed alarm, Chair alarm, Roll belt if confused or not using call bell, Geri-chair with locking table top.
- HIGH risk: Individualized interventions from the above plus;
  - move close to nurses station and talk to family about whether they can assist in keeping the patient safe.

Your case manager can provide family with info. on hiring a private sitter if family is interested. Please inform family of this option.

Fall scenario #1



Pt. “A” is acting somewhat confused/disoriented and is very forgetful. You have assisted her up to sit in the Geri chair and have locked the chair’s attached table in front of her. Additional fall prevention measures you should include are…

A. Chair alarm

B. Roll belt (rectangular panel goes across abdomen-opposite from when in bed)

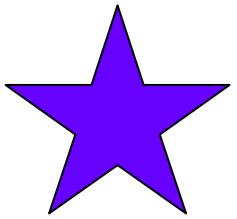
C. Frequently used items in reach

D. Tread socks

E. All of the above EXCEPT B

Confused patients are often restless and will need chair alarm even when table top of geri-chair is in place. Some patients’ have slid out of the chair under the table. Use a chair alarm.

Fall Scenario #2

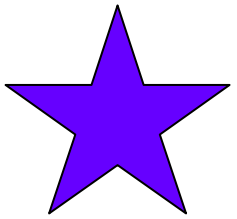


Pt. is an 83 y/o male with a history of Dementia admitted with “shingles”.

Family visits with him at his bedside often but doesn’t always tell you when they are leaving. What should you put in place to reduce his risk of falling?

A. prompted toileting
B. Tread socks
C. Bed alarm
D. None of the above

Fall Scenario #3



A 56 y/o female has been admitted with a muscle weakness disorder and has an elevated creatinine of 3.7. At 18:30 she was nauseated and was given 25mg of Phenergan IM. It is now 19:45 and she rings for assistance in getting to the bedside commode. You go in and assist her to the BSC. You are then vocera'ed to assist another one of your patients' to the bathroom. What do you do?

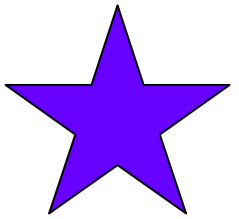
A. Give the patient you are with the hand held call bell and tell her to not get up alone but to call for assistance.

B. Ask the HUC to tell the PCA to be sure to check back on this patient since you are leaving to go assist the other patient.

C. Tell the HUC that it is unsafe to leave the patient you are with and you cannot assist the other patient.

D.Tell the patient you will be right next door and to just holler out when she is all done and ready to get back to bed.

Fall Scenario #4



You are caring for a 69 year old male that is alert yet has aphasia and his Right side is flaccid. He also has a history of falls. His wife is present most of the time.

Which fall prevention interventions should you institute?

A. Bed alarm

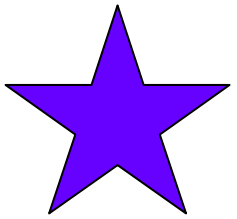
B. Tread socks

C. Chair alarm when up in chair

D. All of the above

E. Tread socks only

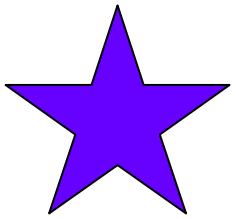
Fall Scenario #5



When caring for a 90 year old male who is Alert and Oriented yet is forgetful and has a recent history of falls which Fall prevention interventions would you put into place?

A. Just tread socks
B. Tread socks, purple arm band, purple star
C. Bed alarm
D. B & C
E. None of the above, he is Alert and Oriented
F. Four point restraints

Fall Scenario #6



It is 10:05 p.m. and your 79 y/o A&O patient has just requested a sleeping pill. Knowing that ALL sleeping pills can increase the risk for falling you may want to…

A. Check on him at 2:00 and 3:00 knowing that the pill will be wearing off and this is the time many wake up disoriented and unsteady and try to make it to the bathroom and end up falling.

B. Deny him a sleeping pill due to his age.

C. Ask him if instead of a sleeping pill would he agree to try some warm milk, a 3 min. neck rub, and listening to soft music instead.

D. Give him both the sleeping pill and the Morphine he has ordered so he will really sleep good even though he is not having any pain.

E. A and C

Roll belt/ Safety Belt

The roll belt should be thought of and used as a safety/ seat belt that is more of a preventive measure rather than waiting to use it after a patient falls (reactive)-similar to a seat belt in a car. Keep in mind it can only be used in the Bed- Not CHAIRS.