



UNDERSTANDING
FALL RISK, PREVENTION,
& PROTECTION



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PROGRAM OVERVIEW



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ABSTRACT

In 2000, direct medical costs totaled \$0.2 billion for fatal falls and \$19 billion for non-fatal fall related injuries. By the year 2020, the cost of fall related injuries may reach \$32.4 billion. In the hospital setting the annual incidence rate is approximately 1.4 falls per bed per year, in long term care facilities that rate is 1.6 falls per bed per year. Understanding fall risk, prevention, and protection aims to improve clinical, cost, and satisfaction outcomes when managing the health care needs of the at-risk fall patient.

COURSE DESCRIPTION

This resource based program serves to provide the participant with the understanding and tools necessary to implement, or improve upon, a fall risk, prevention, and protection program.

TARGETED AUDIENCE

Anyone in the healthcare setting including licensed health care professionals and other parties involved in the care of fall risk patients. This includes, but is not limited to, registered nurses, clinical educators, physical therapists, lift team members, transport team members, volunteers, front desk personnel, administrative staff, etc.

OBJECTIVES

At the conclusion of the program the participant will be able to:

- Identify patients at-risk for falls.
- Utilize fall assessment to determine level of risk for individual patients.
- Compare/contrast intrinsic and extrinsic fall risk factors.
- Describe the need for fall risk, prevention, and protection in terms of clinical, cost, and satisfaction outcomes.
- Explain the connection between The Joint Commission National Patient Safety Goals and fall risk, prevention, and protection protocol.
- Understand the keys to a successful fall risk, prevention, and protection program.
- Obtain resources to develop, and/or improve upon, a fall risk, prevention, and protection program.

METHODOLOGY

This program is comprised of audio/visual guided discussion, debate, and resources.



REFERENCES

Morse, J.M. (1997). Preventing patient falls. Thousand Oaks: Sage Broda. 1999 Safety operating instructions.

National Center for Injury Prevention and Control. CDC fall prevention activities. Available at: www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm. Accessed January 19, 2007.

National Center for Injury Prevention and Control. Injury fact book 2001-2002. Available at: www.cdc.gov/ncipc/fact_book/15_Falls_Among_Older_Adults.htm. Accessed January 26, 2007.

Newton R. HEROS reducing falls and serious injuries training program manual. June 2004. Available at: http://develop.temple.edu/older_adult/HEROS%20toolkit%20by%20Newton.doc. Accessed January 29, 2007.

Root causes tips strategies for addressing the top three root causes of falls. *Joint Commission Journal on Quality and Safety* [serial online]. June 2003; 3(6):5. Accessed January 19, 2007.

Szumlas S, Groszek J, Kitt S, Payson C, Stack K. Take a second glance: a novel approach to inpatient fall prevention. *Joint Commission Journal on Quality and Safety* [serial online]. June 2004; 30(6):298. Accessed January 19, 2007.

The Joint Commission. 2007 Hospital/critical access hospital national patient safety goals. Available at: www.jointcommission.org. Accessed June 17, 2007.

VHA NCPS Toolkit. VA national center for patient safety. May 2004. Available at: <http://www.va.gov/ncps/SafetyTopics/fallstoolkit/index.html>. Accessed January 23, 2007.



STATISTICS & FACTS



FACT SHEET

RISK FACTORS FOR INJURIOUS FALLS:

- Previous history of falls
- Cognitive impairment
- Impaired balance, gait, or strength
- Impaired mobility
- Neurological problems such as stroke and Parkinson's disease
- Musculoskeletal problems such as arthritis, joint replacement, deformity, and foot problems
- Chronic diseases such as osteoporosis, cardiovascular disease, lung disease, and diabetes
- Nutritional problems
- Medications (particularly more than four prescription medications)

COST OF FALLS:

- In 2000, direct medical costs totaled \$0.2 billion for fatal falls and \$19 billion for non-fatal fall related injuries
- Of the non-fatal injury costs 63% (\$12 billion) were for hospitalizations, 21% (\$4 billion) were for emergency department visits, and 16% (\$3 billion) were for treatment in outpatient settings
- Fractures accounted for just 35% of non-fatal injuries, but 61% of the costs
- According to a study done by the National Center for Patient Safety, the average cost of a fall with injury is \$33,785
- By 2020, the cost of fall related injuries may reach \$32.4 billion

STATISTICS ASSOCIATED WITH FALLS AMONG OLDER ADULTS WHO ARE HOSPITALIZED OR WHO RESIDE IN A NURSING HOME:

- Hospital setting: annual incidence rate is approximately 1.4 falls per bed per year
- The Departments of Neuroscience, Rehabilitation, and Psychiatry have the highest fall rates ranging from 8.9-17.1 falls per 1,000 patient days
- Long term care facility: annual incidence rate is approximately 1.6 falls per bed per year
- Nursing home residents often experience multiple falls averaging 2.6 falls per person per year
- Approximately 10% to 20% of all falls in the nursing home cause serious injuries and approximately 2% to 6% result in fractures
- Approximately 35% of fall related injuries occur among the non-ambulatory residents



CAUSE OF FALLS:

- Accidental/environmental: 31%
- Gait/balance: 17%
- Dizziness/vertigo: 13%
- Drop attack: 10%
- Confusion/cognitive impairment: ... 4%
- Postural hypotension: 3%
- Visual impairment: 3%
- Unspecified or unknown: 18%

KEYS TO A SUCCESSFUL FALL PREVENTION PROGRAM:

- Patient safety is an organizational priority
- Simplified and standardized approach
- Simple key messages:
 - **All** patients are at risks for falls
 - **All** employees have a role in fall prevention
- Easy-to-understand data that drives change at the unit level
- Designated resources for managers
- Rigorous surveillance of control plan
- Staff educations and training
- Proper support equipment and resources

HOW SIZEWISE CAN HELP YOU:

- Educational programs on Fall Risk and Prevention, also available for CEU credit
- Clinical support for protocol development within your facility
- Incomparable customer service with our 24/7 personal assistance and unsurpassed delivery guarantees
- Equipment sales and rentals that ensure both patient and care giver safety. Highlighted equipment:
 - Tapered fall pads for ease of entry into bed with non-tripping hazard
 - Bed and chair alarms available upon request

For more information, contact SIZEWise at 1.800.814.9389



References:

National Center for Injury Prevention and Control. CDC Fall Prevention Activities. Available at: www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm. Accessed January 19, 2007.

National Center for Injury Prevention and Control. Injury Fact Book 2001-2002. Available at: www.cdc.gov/ncipc/fact_book/15_Falls_Among_Older_Adults.htm. Accessed January 26, 2007.

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DEVELOPMENT OF POLICY & PROTOCOL



PATIENT FALLS REDUCTION PROTOCOL

I. **Statement of Protocol**

Patient safety is an ongoing responsibility of all staff. In order to reduce the risk of patient injuries as a result of a fall, the staff will assess and re-assess the patient's level of risk for fall and in conjunction with the treatment team institute appropriate interventions through the following procedures.

II. **Purpose**

A process exists to prevent patient falls by:

1. Establishing a consistent mechanism to identify patients who are at risk for a fall upon admission utilizing the "Falls Risk Assessment".
2. Identifying patients, not initially deemed a fall risk, through daily re-assessment.
3. Providing on-going assessment to those patients identified as a fall risk utilizing the "Daily Fall Risk Assessment".
4. Establishing comprehensive standards of care for the initiation of appropriate safety measures and interventions.

III. **Definition**

Fall: A patient fall is a witnessed or un-witnessed unplanned descent to the floor (or extension of the floor, e.g. trash can or other equipment) with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). This would include assisted falls such as when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

IV. **Procedure**

1. The registered nurse will screen every patient for fall risk potential upon admission by utilizing the "Daily Fall Risk Assessment" located in Care Manager.
2. Each patient will be reassessed on a daily basis.
3. Reassessment must also be completed if there is a significant change in the patient's mental status or physical condition.

(See Fall Prevention & Management Interventions)

V. **Instructions for Completion of the Daily Falls Risk Assessment**

1. The RN will evaluate the patient by scoring each of the of "At Risk" criteria the patient presents with. The total score of the assessment, along with the RN's clinical judgment, will dictate the patient's level of risk for a fall. If the RN, based upon clinical judgment, chooses to deviate from the risk level determined by the fall risk assessment he/she must document in the patient chart the reason which substantiates his/her decision.

2. The patient will be classified into 1 of 3 Fall Risk categories. **(See Daily Fall Risk Assessment)**

Score on Falls Risk Assessment	Risk for Falls
0-4	Low (L)
8-8	Moderate (M)
9 or more	High (H)



3. The RN will then identify and adhere to the “Fall Prevention Measures” based upon:
 - a. Identified Level of Risk
 - b. Individualized patient needs and limitations
 - c. Patient history of falls and use of safety devices
 - d. Clinical Daily Assessment
4. The Falls Prevention Measures for patients at either low, moderate or high risk must be implemented and appropriate equipment must also be utilized.
5. Documentation
 - a. Documentation will occur in Care Manager on the Falls Risk Screen, and then, if applicable on the Daily Falls Risk Assessment.
 - b. All Moderate and High-risk falls patients will have their fall status documented on the Interdisciplinary Plan of Care (IPOC) under the “Protection” section.
6. Communication
 - a. Each patient's assessed risk for falls will be communicated every shift through end-of-shift report.
 - b. The RN is responsible for ensuring the LPN's, and NA's are updated as to patient's level of risk. If either the LPN or NA is unsure as to the patient's level of risk it is then their responsibility to inquire to the RN in charge.
7. Reassessment
 - a. All patients, regardless of fall risk, will be reassessed by an RN daily while the patient is awake
 - b. Any change in the patient's level of risk will be incorporated into the Interdisciplinary Plan of Care.

VI. Fall Prevention Measures for all patients regardless of risk

1. Orient patient to environment.
2. Position call bell, urinal if applicable, and bedside stand within reach.
3. Keep walkways obstruction/spill-free.
4. Keep all cords from equipment away from traffic areas.
5. Place bed in lowest position with brakes locked (Specialty low beds are to be kept at a height of 25” or less from the floor to the top of the mattress.)
6. Determine the safest use of side rails. **Note that the use of four side rails is considered a mechanical restraint.**
7. Patient to wear non-skid footwear whenever out of bed.
8. Make sure that nightlights are turned on in patients' rooms during evening rounds.
9. Place patient's items of need within easy reach.
10. Assist patient with toileting as appropriate.
11. Evaluate effectiveness of medications that predispose patients to falls (sedatives/hypnotics, antihypertensives, diuretics, benzodiazepines, etc.) and consult with MD and pharmacist as needed.
12. Collaborate with MD regarding the need to obtain PT/OT consults for patients with gait or balance problems and/or functional decline.
13. Reassess patient's ambulation status daily.
14. Monitor for Orthostatic Hypotension if patient complains of dizziness or vertigo and teach patient to rise slowly when getting in and out of bed.
15. Use of elevated toilet seat as needed.
16. Encourage use of assistive devices (i.e. walker / wheeled walker and cane) as appropriate.
17. Utilize educational materials to teach fall prevention techniques to patients and families, when appropriate.



VII. Fall Prevention Measures for Moderate and High Risk Patients

1. These additional Fall Prevention Measures will be initiated for all patients identified as either moderate or high risk for falls immediately upon admission to the nursing unit.
 - a. Utilize a marker/sign in or outside the patient's room to identify the patient at risk for falls.
 - b. Relocate patient's room closer to nurse's station, if possible.
 - c. Check patient at least every hour and maintain close supervision.
 - d. Ensure that at all times, unless bedside care is being provided, that patient beds are in the lowest position and the 2 upper side rails are in the upright position.
 - e. Offer bathroom visits every 2 hours.
 - f. Reinforce activity limits and safety precautions with patients and family.
 - g. Nursing Staff will notify family member or responsible party to obtain footwear and ambulation equipment from home (i.e. walker, cane) when applicable.
 - h. Assess the need for a physical therapy consultation
 - i. Assess patient gait every waking shift or as needed and document in the "Care manager" under the "fall problem".
 - j. Ensure that the patient is using the proper assistive device to ambulate
 - k. Collaborate with Interdisciplinary Team regarding a fall prevention plan.
 - l. Ensure that patient safety devices identified on the Fall Risk Assessment are in use and functioning properly.

2. Based upon the patient's identified Level of Risk, evaluate the use of the following safety equipment. Refer to the guide indicating the appropriate level of risk that is indicated for its usage. **(See attached Falls Risk Assessment, Intervention Strategies & Equipment Safety Checklist.)**

<u>Safety Device</u>	<u>Risk Level</u>
a. *Walker/ Wheeled Walker	L,M,H
b. *Cane/ Quad Cane	L,M,H
c. Wedge/ Pommel Cushion	L,M,H
d. Elevated Commode Seat	L,M,H
e. Non-slip Grip Matting	L,M,H
f. Bed Alarm/Chair Alarm/Pull-String Alarm	M,H
g. Lap Buddy	M,H
h. Gait Belt	M,H
i. Specialty Low beds	H

*The use of a walker or cane can be implemented only if the patient was walking with that piece of equipment at the time of admission or has been recommended its use through a physical therapy consultation.



VIII. In the event of a patient fall, with or without injury:

1. The staff member discovering the fall will attend to the patient's immediate needs:
 - a. A nurse will assess the patient immediately.
 - b. The attending Physician and/or Resident will be promptly notified to determine the need for further evaluation.
 - c. The nurse follows the physician's treatment orders post-fall.
 - d. Move the patient closer to the nurse's station if a bed is available.
 - e. If the patient is demonstrating some degree of cognitive impairment, utilize a bed alarm and /or chair alarm. If those measures prove ineffective a non-emergent restraint may be considered.
 - f. Neurological checks and vital signs as ordered or appropriate for injury.
 - g. Patient to be OOB only with assistance for the first 24 hours then re-assess.
 - h. With the patient's consent or in the event that the patient has a legal guardian or POA the patient's family will be notified of any patient fall, including injuries in a timely manner.
 - i. The fall will be documented in Care Manager under "Problem".
 - j. The caregiver witnessing a fall or finding a patient after an un-witnessed fall will complete an incident report and send to the Nurse Manager or designee. The Nurse Manager will then route the incident report to the Risk Management Department.
 - k. The RN is to complete the "Fall Addendum Form" and attach it to the incident report.
 - l. Teaching about falls and safety will be reinforced to patient/family as needed.
 - m. Patient's fall risk will be reassessed utilizing the "Daily Falls Risk Assessment" immediately after the fall, identifying appropriate interventions and needed safety devices.

IX. Criteria for Specialty Low Bed:

- a. Patient's initial assessment utilizing the "Daily Falls Risk Assessment" denotes High (H) falls risk.
- b. Daily re-assessment of patient's condition places patient at high (H) risk for falls.
- c. A patient "fall" under the following circumstances:
 - i. Patient is experiencing confusion
 - ii. Patient fell while getting into or out of bed

X. Procedure for using Specialty Low Bed

- a. If the bed is being utilized for a patient assessed to be a high fall's risk the bed needs to be kept at its lowest position. The bed should only be elevated to provide nursing care, medical evaluation and/or treatment transfers.
- b. When the bed is in use, a bed pad needs to be placed along at least one side of the bed. In the event that only one pad is used it should be the side the patient normally uses to exit the bed. The side rails on either side of the bed must be placed in the upright horizontal position. The upright vertical position is only used as a support for patients getting out of bed who are **not** a high falls risk.

Note: Because the side rails are less than ½ of the bed's length they are not considered a mechanical restraint.

- c. If the bed is being used for a patient who is not a high falls risk the bed's height from the floor to the top of the mattress cannot exceed 25". The side rails can be used in either the upright horizontal or vertical position dependent upon patient preference.



XI. Procedure for Testing Bed/Chair Pad Alarms

1. Turn alarm on.
2. Test by placing hand on pad and removing.
3. Alarm sounds---May use.
4. Alarm does not sound-----Remove alarm and replace immediately.
5. Notify Nurse Manager.

XII. Procedure for Testing Pull String Alarm

1. Turn alarm on.
2. Pull string away from the alarm unit.
3. Alarm sounds---May use.
4. Alarm does not sound-----Remove alarm and replace immediately.
5. Notify Nurse Manager.

***Sources of Evidence:**

The Definition of a patient fall is consistent with the National Database or Nursing Quality Indicators (NDNQI)
The Daily Falls Risk Assessment was developed based upon the following standardized assessments:

- Morse Fall Scale – **(See Attached Scale)**
- Schmid Fall Scale
- Hendrick Fall Risk Assessment



Month	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Total corresponding #'s check all that apply										
Over 70 years of age	1									
Unfamiliar with surroundings	1									
Impaired judgment on safe ambulation/transfer.	3									
Fall within 2 last weeks	3									
Confused or disoriented	2									
Unsteady gait or limited range of motion	3									
Urinary frequency/urgency/incontinence	3									
Presence of orthostasis/syncope	2									
History of disrupted sleep pattern	1									
Impaired vision or hearing	1									
Walks with assist of others	3									
Limited activity tolerance	1									
Does not use footwear when getting OOB	2									
Prescribed any of the following medications below:	2									
TOTAL Risk Score										
Check if on any of the following medications:										
Psychotropic										
Diuretics										
Antihypertensive										
Anti-Parkinson										
Opioids										
Hypnotics										
Cardiovascular										
Anxiolytic										
Laxative										
EQUIPMENT NEEDS: (Check)										
*Walker/ Wheeled Walker	L,M,H									
*Cane/ Quad Cane	L,M,H									
Wedge / Pommel Cushion	L,M,H									
Elevated Commode Seat	L,M,H									
Non-slip Grip Matting	L,M,H									
Lap Buddy	M,H									
Bed /Chair /Pull-String Alarm	M,H									
GAIT BELT	M,H									
FALL RISK RATING (L,M,H)										
STAFF Initials										

Name: _____ Room # _____ Bed # _____

DAILY FALL RISK ASSESSMENT:

0-4 = Low Fall Risk (L)

more = High Fall Risk (H)

5-8 = Moderate Fall Risk (M)

9 or

*The use of a walker or cane can be implemented only if the patient was walking with that piece of equipment at the time of admission or has been Is

Name: _____ Room # _____ Bed # _____

Is part of the
"Catch A Falling Star Program"



If you have any questions about the program please contact your nurse.



Name: _____ Room # _____ Bed # _____

Is part of the
"Catch A Falling Star Program"



If you have any questions about the program please contact your nurse.





RISK FACTORS

There are many risk factors for falls which can be grouped into two categories:

1. Intrinsic – Related to the person’s condition, this includes factors that address a person’s physiological condition.
2. Extrinsic – Related to the environment, this includes factors that address the physical environment.

Additionally, these risk factors can be either anticipated or unanticipated. The anticipated risk factors are the ones we can address before a patient falls.

	Related to the Person’s Condition (Intrinsic)	Related to the Environment (Extrinsic)
Anticipated	<ul style="list-style-type: none"> ▪ Recent history of falls (most significant risk factor) ▪ Incontinence, etc. ▪ Cognitive/psychological status ▪ Mobility/balance/s ▪ Age (over 65 years old) ▪ Osteoporosis (can lead to pathological hip fractures and increases likelihood of fracture if a fall occurs) ▪ Overall poor health status 	<ul style="list-style-type: none"> ▪ Environment (wet floor, floor glare, cluttered room, poor lighting, inadequate handrail support, monochromatic color schemes, loose cords or wires) ▪ Inappropriate, or lack of, footwear ▪ Low toilet seat ▪ Wheels on beds or chairs ▪ Restraints (including side rails in the up position) ▪ Prolonged length of stay ▪ Unsafe equipment (unsteady IN poles) ▪ Broken equipment ▪ Beds left in high positions
Unanticipated	<ul style="list-style-type: none"> ▪ Seizures ▪ Cardiac arrhythmias ▪ CVA or TIA ▪ Syncope ▪ ”Drop Attacks” 	<ul style="list-style-type: none"> ▪ Individual reactions to medications



Intervention Strategies									
Intervention	Level of Risk			Area of Risk					
	H	M	L	Frequent Falls	Altered Elimination	Muscle Weakness	Mobility Problems	Multiple Medications	Depression
Low beds	X	X	X	X	X	X	X		X
Non-slip grip footwear	X	X	X	X	X	X	X	X	X
Assign patient to bed that allows patient to exit toward stronger side	X	X	X	X	X	X	X	X	X
Lock movable transfer equipment prior to transfer	X	X	X	X	X	X	X	X	X
Individualize equipment to patient needs	X	X	X	X	X	X	X	X	X
High risk fall room setup	X	X		X	X	X	X	X	X
Non-skid floor mat	X	X		X	X	X	X	X	X
Medication review	X	X		X	X	X	X	X	X
Exercise program	X	X		X	X	X	X	X	X
Toileting worksheet	X	X			X				
Identifying factors (colored wristband, etc.)	X			X	X	X	X	X	X
Perimeter mattress	X			X	X	X	X		
Hip protectors	X			X		X	X		
Bed/Chair alarms	X			X		X	X		

Note: this list is not all-inclusive, nor is it required to be used. Facilities should use their best judgment in implementing recommendations.

Intervention Strategies can be based on level of risk and/or area of risk. It is helpful to provide the available strategies in the policy.



FALL PREVENTION & MANAGEMENT INTERVENTIONS

1. Orient patient to surroundings and assigned staff
2. Lighting adequate to provide safe ambulation
3. Non-slip footwear
4. Instruct to call for help before getting out of bed
5. Demonstrate nurses' call system
6. Call bell within reach, visible, and patient informed of the location and use
7. Light cord within reach, visible, and patient informed of the location and use
8. Consider use of sitters for cognitively impaired patients
9. Provide physically safe environment (i.e. eliminate spills, clutter, electrical cords, and unnecessary equipment)
10. Personal care items within arm length
11. Bed in lowest position with wheels locked
12. Ambulate as early and frequently as appropriate for the patient's condition
13. Educate and supply patient and family with fall prevention information
14. Identify patient in fall prevention program (i.e., colored wrist band, themed sign outside patient's room and above patient bed)
15. Every 3, 2, or 1 hour comfort and toileting rounds
16. Comfort rounds include positioning as indicated; offering fluids, snacks when appropriate and ensuring patient is warm and dry
17. PT consult is suggested to PCP
18. Consult with the falls team and pharmacy (review medications)
19. Bed alarm
20. Wheelchair alarm
21. Room placement closer to nurses' station
22. Bedside mat
23. Low bed
24. Evaluation by the interdisciplinary team
25. For risk of head injury consider consult for PT for consideration of a helmet (those at risk of head injury are patients on anticoagulants, patients with severe seizure disorder and patient mechanism of fall is by history to fall hitting head)
26. Elevated toilet seat
27. Assign bed that enables patient to exit towards stronger side whenever possible
28. Relaxation tapes/music
29. Exercise/activities program
30. Transfer towards stronger side
31. Actively engage patient and family in all aspects of the fall prevention program
32. Instruct patient in all activities prior to initiating
33. Individualize equipment specific to patient needs
34. Minimize distractions
35. Check tips of canes, walkers, and crutches for non-skid covers
36. Instruct patient in use of grab bar



MORSE FALL RISK ASSESSMENT

Risk Factor	Scale	Points	Patient's Score
History of Falls	Yes	25	
	No	0	
Secondary Diagnosis (Two or more medical diagnoses)	Yes	15	
	No	0	
Ambulatory Aid	Furniture	30	
	Crutches/Cane/Walker	15	
	None/Bedrest/Wheelchair/Nurse	0	
IV/Saline Lock	Yes	20	
	No	0	
Gait/Transferring	Impaired	20	
	Weak	10	
	Normal/Bedrest/Immobile	0	
Mental Status	Forgets Limitations	15	
	Oriented to own ability	0	

TOTAL: _____

High Risk = 45 and higher**Moderate Risk** = 25-44**Low Risk** = 0-24

Source: Morse, J.M. (1997). Preventing Patient Falls. Thousand Oaks: Sage Broda. 1999 Safety Operating Instructions.



EQUIPMENT SAFETY CHECKLIST

Wheelchairs

Brakes	Secures chair when applied	_____
Arm Rest	Detaches easily for transfer	_____
Leg Rest	Adjusts easily	_____
Foot Pedals	Fold easily so that the patient may stand	_____
Wheels	Are not bent or warped	_____
Anti-tip devices	Installed, placed in proper position	_____

Electric Wheelchairs/Scooters

Speed	Set at the lowest setting	_____
Horn	Works properly	_____
Electrical	Wires are not exposed	_____

Beds

Side Rails	Raise and lower easily	_____
	Secure when up	_____
	Used for mobility purposes only	_____
Wheels	Roll/turn easily, do not stick	_____
Brakes	Secures the bed firmly when applied	_____
Mechanics	Height adjusts easily (if applicable)	_____
Transfer Bars	Sturdy, attached properly	_____
Over-bed Table	Wheels firmly locked	_____
	Positioned on wall-side of bed	_____

IV Poles/Stands

Pole	Raises/lowers easily	_____
Wheels	Rolls easily and turns freely, do not stick	_____
Stand	Stable, does not tip easily (should be a fine point base)	_____

Footstools

Legs	Rubber skid protectors on all feet	_____
	Steady – does not rock	_____
Top	Non-skid surface	_____



Call Bells/Lights

Operational	Outside door light	_____
	Sounds at nursing station	_____
	Room number appears on the monitor	_____
	Intercom	_____
	Room panel signals	_____
Accessible	Accessible in bathroom	_____
	Within reach while patient is in bed	_____

Walkers/Canes

Secure	Rubber tips in good condition	_____
	Unit is stable	_____

Commode

Wheels	Roll/turn easily, do not stick	_____
	Weighted, not "top heavy" when a patient sits on them	_____
Brakes	Secure commode when applied	_____

Mobility Chair

Chair	Located on level surface to minimize risk of tipping	_____
Wheels	Roll/turn easily, do not stick	_____
Brakes	Applied when chair is stationary	_____
	Secure chair firmly when applied	_____
Footplate	Removed when chair is placed in a non-tilt or non-reclined position	_____
Positioning	Chair is positioned in proper amount of tilt to prevent sliding or falling forward	_____
Tray	Secure	_____



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References:

Morse, J. 1997. Preventing patient falls. Thousand Oaks, CA: Sage Broda. 1999 Safety Operating Instructions



Suggested Membership for Fall Risk Teams

- 1. Senior leader**
- 2. Technical leader**
- 3. Clinical leader**
- 4. Day-to-day leader**
- 5. Recreation**
- 6. PM & RS**
- 7. Social Work**
- 8. EMS**
- 9. Dietary**
- 10. Pharmacy**
- 11. Nurse manager(s)**
- 12. Staff nurses, nursing assistants, and alternates from varied units**
- 13. Physical Therapy**



RESOURCES



FALL PREVENTION AND RESOURCE SAMPLE

- SCOPE:
 - Hospital Wide
- PURPOSE:
 - To establish a framework for assessing risk factors for patient falls, reducing the risk for falling, and protecting patients from injury if a fall should occur.
- PROCEDURES:
 - Initial Assessment/Screening
 - Upon entry into the hospital system, a nurse will complete the Morse Fall Scale Risk Screening Tool criteria (Exhibit A) within 4 hours of admission and document this assessment and score in the computer.
 - Intervention will be planned, implemented and documented on the interdisciplinary plan of care within 2 hours of risk screening.
 - Pharmacy and/or Physical Therapy screen is prompted with risk factors identified.
 - Follow up Assessment/Screening:
 - Each patient will be reassessed for fall risk every shift (two times/day), upon transfer to another unit, with a change in patient condition, with a patient fall and as condition warrants.
 - This will be documented on the computer using the Morse Fall Scale Risk Screening Tool and the interdisciplinary plan of care will be updated/modified as needed but at a minimum of every 24 hours.
 - To change fall risk status from high risk to low risk, 2 consecutive scores of less than 25 are required.
- Fall Prevention Interventions:
 - All patients admitted to the hospital are identified as at risk for falls and will have the following measures initiated:
 - Orientation to room and call light use.
 - Bed placed in lowest position except when performing nursing care, wheels locked, 2 side rails up.
 - Room free of clutter.
 - Ensure patient has personal items within easy reach (telephone, call light, bedside table, water, eyeglasses, urinal, etc.).
 - Assess environment, use adequate lighting based on patient's individual needs.
 - Place assistive devices within reach. (walkers, cane, crutches, etc.).
 - Optimize use of eyeglasses and hearing aids (assure they are clean and work).
 - Monitor effects of medication.
 - Encourage regular toileting.
 - Provide psychological and emotional support.
 - Educate patient and family in safety including enlisting family participation to support interventions and to alert staff to any changes in the patient.
 - Document fall precaution teaching/education.
 - All patients identified at high risk for falling (patients with a Morse fall score ≥ 45) will have the following measures initiated in addition to the above measures:
 - Identify patient's door with "Help Prevent Falls" magnet.
 - Place "Help Prevent Falls" sign in patient's room.
 - Identify patient with yellow armband placed on the wrist.
 - Non-skid slippers.
 - Offer assistance to bathroom/commode or use of bedpan and hydration every 2 hours while awake and periodically at night.
 - Visual hourly checks of patient by staff member.



- Reorientation every 2 hours if indicated.
- Assess the need for
 - Physical and occupational therapy consultation and arrange as needed.
 - 1:1 monitoring and arrange as needed.
 - Bed alarms and arrange as needed.
 - Low bed and arrange as needed.
 - Place a patient in a room close to a nurse's station and arrange as needed.
- Plan of Care Strategies:
 - General strategies for patients at risk for falls may include but are not limited to:
 - Offering hydration and toileting every 2 hours while awake.
 - Use of 2-3 side rails.
 - Call light within patient reach, have patient return demonstrate the use of the call light.
 - Reinforcement to patient to call for assistance.
 - Personal items within reach.
 - Weekly multidisciplinary care conference with participation of care team.
 - Referral to appropriate discipline for specific assessment, i.e., PT.
 - Assign patient to a bed that enables patient to exit his/her stronger side when possible and indicated.
 - Strategies for reduction of anticipated physiologic falls may include but are not limited to:
 - Provide reality orientation for safety.
 - Involve patient in diversional activities/ activities of choice.
 - Close monitoring of the effects of medications, including psychotropic medications.
 - Decreased noise level/stimuli.
 - Frequent re-assessment.
 - Provide psychological and emotional support.
 - Environmental strategies for fall risk reduction may include but are not limited to:
 - Call lights within reach.
 - Bed in low position.
 - Floors non-glare and non-slippery.
 - Sufficient lighting.
 - Room free of clutter.
 - Toileting facilities close to patient.
 - Post fall management
 - Assess for any injury (e.g., abrasion, contusion, laceration, fracture, head injury).
 - Obtain vital signs.
 - Assess for change in range of motion.
 - Monitor patients as condition warrants/per policy.
 - Document in the medical record.
 - Report the fall to the charge nurse and at shift reports and complete an Occurrence Report in the Risk Management System.
 - Modify the interdisciplinary plan of care as patient conditions warrants.
 - Patient/family education
 - Both patient and family should be informed and understand fall risk factors and agree on strategies to prevent the patient from falling. Patients and families should be educated about fall risk factors in the facility environment and continue their active involvement in all levels of safety education throughout the continuum of care.
 - Instruct patient and family on all activities prior to initiating assistive devices.
 - Teach patient to use grab bars.
 - Instruct patient in medications/time/dose, side effects, and interactions with food/medications.
 - Consider the patient's culture in determining interventions as some cultures consider asking for assistance unacceptable.



- Definitions/Classifications
 - Accidental Fall: Fall that occurs unintentionally (example: slip, trip). Patients at risk for these falls cannot be identified prior to a fall and generally do not score at risk for falling on a predictive instrument. These falls may be prevented through providing a safe environment.
 - Unanticipated Fall: Fall that occurs when the physical cause of the fall is not reflected in the patient's assessed risk factors for falls.
 - Anticipated Fall: Fall that occurs in patients whose risk factor score indicated the patient is at risk of falling.
 - Factors which may increase risk for falls:
 - Fear of falling
 - Transient ischemic attack
 - Parkinson's disease
 - History of fracture
 - Musculoskeletal deformities or myopathy
 - Bowel/bladder incontinence/frequent toileting
 - Auditory impairment
 - Dehydration
 - Previous fall
 - Use of restraints
 - Difficulty understanding/retaining instructions
 - Cardiac arrhythmia
 - Stroke
 - Delirium/agitation
 - Depression
 - Mobility/gait impairment
 - Visual impairment
 - Dizziness
 - Hypoglycemia
 - Multiple medications
 - Receiving laxatives and/or diuretics
 - Language barrier
- References
 - Hendrich, A, Kippenbrock, T, et al, (1995). Hospital Falls: Development of a Predictive Model of Clinical Practice. *Applied Nursing Research*, 8. 129-139.
 - Morse, J. Enhancing the Safety of Hospitalization by Reducing Patient Falls. *American Journal of Infection Control*, Vol. 30 (6), October, 2002, pg. 376-380.
 - Rawsky, E. (1998). Review of the Literature on Falls Among the Elderly. *Image*, 30 (1), 47-2.
 - Stefler, C, Corrigan, B, Sander-Buscami, K, Burns, M. Integration of Evidence into Practice and the Change Processes: Fall Prevention Program as a Model. *Outcomes Management in Nursing Practice*, July/Sep., 1999, pg 102-111.
 - VA National Center for Patient Safety (NCPS). (2000). NCPS Concept Dictionary.

Attachments:

Exhibit A – Morse Fall Scale Risk Screening Tool with instructions for using the tool.



Exhibit A

MORSE FALL SCALE RISK SCREENING

Observer: _____ Date: _____

Unit: _____ Time: _____

Score

1. History of falling within 12 months:

___ No = 0

___ Yes = 25

Score: _____

2. Secondary Diagnosis:

___ No 0

___ Yes 15

Score: _____

3. Ambulatory Aid

None / bed rest / nurse assist ___ 0

Crutches / cane / walker ___ 15

Furniture ___ 30

Score: _____

4. IN / IN Access

___ No 0

___ Yes 20

Score: _____

5. Gait

Normal / bed rest / wheelchair ___ 0

Weak ___ 10

Impaired ___ 20

Score: _____

6. Mental Status

Oriented to own ability ___ 0

Overestimates / forgets limitations ___ 15

Score: _____

Total Score: _____

No Risk score 0-24

β Low Risk score 25-44

β High Risk score 45 and above

Action Initiated

β Fall prevention measures

β Individualized plan



Signature: _____

Exhibit A

HOW TO USE THE MORSE FALL SCALE RISK SCREENING TOOL

History of Falling:

If the patient has fallen during the present admission or there was an immediate history of physiological falls, such as syncope or impaired gait, score 25. If the patient has not fallen, score 0.

Secondary Diagnosis:

If the patient has more than one medical diagnosis identified, score 15; if not, score 0.

Ambulatory Aid:

If the patient is clutching on the furniture for support, score 30. If the patient uses crutches, cane or walker, score 15.

If the patient walks without walking aid, score 0.

Intravenous Therapy:

If the patient has intravenous therapy, score 20; is not score 0.

Gait:

If the patient had an impaired gait; has difficulty rising from a chair, uses the arms of the chair to push off, head is down, eyes focus on the floor, uses moderate to heavy assistance for balance through use of furniture, persons or walking aids and steps are short or shuffled, score 20.

If the patient has a weak gait; patient is stooped; unable to lift head without losing balance or support is required with limited assistance and steps are short and shuffles, score 10.

If the patient walks with a normal gait, score 0.

Mental Status:

Identifying the patient's self assessment of his/her ability to walk. If the patient over-estimates physical ability, score 15.

If the patient's assessment is consistent with his/her ability, score 0.

Morse Falls Risk Assessment completed on admission with initial assessment



PATIENT ADMITTED TO HOSPITAL



Pharmacy and/or Physical Therapy screen prompted with risk factors

Morse Falls Risk Assessment completed on admission with initial assessment

UNIVERSAL FALL PRECAUTIONS (ALL PATIENTS)

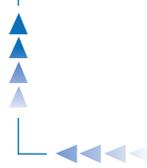
- Orientation to room and call light use.
- Bed in low position, wheels locked, 2 side rails up.
- Room free of clutter.
- Personal items within reach (telephone, call light, bedside table, water, eyeglasses, urinal).
- Adequate lighting based on patient's individual needs.
- Assistive devices within reach (walker, cane, crutches, etc).
- Optimize use of eyeglasses and hearing aids (assure they are clean and work).
- Monitor effects of medications.
- Provide psychological and emotional support.
- Patient and family education on fall precautions.
- Document fall precaution teaching/education.

COMPLETE MORSE FALLS RISK ASSESSMENT

- Two times/day
- Upon transfer to another unit
- PRN with change in patient condition
- With patient fall

HIGH RISK FALL PRECAUTIONS (PATIENTS WITH A MORSE FALL SCORE \geq 45)

- UNIVERSAL PRECAUTIONS PLUS THE FOLLOWING:
- Identify patient's door with "Help Prevent Falls" magnet.
 - Place "Help Prevent Falls" sign in patient's room.
 - Identify patient with yellow armband placed on wrist.
 - Nonskid slippers.
 - Offer assistance to bathroom/commode or use of bedpan and hydration every 2 hours while awake and periodically at night.
 - Visual hourly checks of patient by staff member. Reorientation every 2 hours if indicated.
 - Assess the need for
 - Physical and occupational therapy consultation and arrange as needed.
 - 1:1 monitoring and arrange as needed.
 - Bed alarm and arrange as needed.
 - Low bed and arrange as needed.
 - Placement of patient in room close to nurses station and arrange as needed.





2007 Hospital/Critical Access Hospital National Patient Safety Goals

Goal 1

Improve the accuracy of patient identification.

1A

Use at least two patient identifiers when providing care, treatment or services.

Goal 2

Improve the effectiveness of communication among caregivers.

2A

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and “read-back” the complete order or test result.

2B

Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

2C

Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

2E

Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

Goal 3

Improve the safety of using medications.

3B

Standardize and limit the number of drug concentrations used by the organization.

3C

Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

3D

Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

Goal 7

Reduce the risk of health care-associated infections.

7A

Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

7B

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

8A

There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.



8B

A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.

Goal 9

Reduce the risk of patient harm resulting from falls.

9B

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Goal 13

Encourage patients' active involvement in their own care as a patient safety strategy.

13A

Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

Goal 15

The organization identifies safety risks inherent in its patient population.

15A

The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals -- NOT APPLICABLE TO CRITICAL ACCESS HOSPITALS]

Goal 9

Reduce the risk of patient harm resulting from falls.

Goal 9b

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Note: Goals listed in orange directly relate to the need for effective fall management.



Restraint and Seclusion -- The Joint Commission

Q. There seems to be some confusion regarding where the Acute Medical and Surgical (Nonpsychiatric) Care restraint standards, and the Behavioral Health Care Restraint and Seclusion Standards apply in a hospital. What determines which set of standards would apply?

A. The decision to use restraints for medical/surgical reasons or for behavioral health care reasons is not based on the treatment setting but on the situation the restraint is being used to address. The Behavioral Health Care Restraint and Seclusion Standards apply to all behavioral health settings in which restraint and seclusion is used for behavioral reasons, such as free-standing psychiatric hospitals, psychiatric units in general hospitals, and residential treatment centers that are owned by the hospital. Further, these standards also apply to restraint or seclusion that is applied for behavioral health reasons, regardless of where these patients are in the organization, ED, medical/surgical units, etc.

In the latter cases only select Behavioral Health Care Restraint and Seclusion Standards would apply if behavioral restraint was applied anywhere in a hospital, other than a psychiatric unit. The select standards are PC.12.60, PC.12.70, PC.12.90, PC.12.100, PC.12.110, PC.12.130, PC.12.140.

The acute medical and surgical care restraint standards would apply to medical care, post-surgical care, and in situations in which behavior changes are caused by medical conditions or symptoms, for example, for confusion or agitation. In such cases protective interventions may be necessary.

Q. If the Behavioral Health Care Restraint and Seclusion Standards, (or select standards if the patient is not on a psychiatric unit in a hospital), apply only when restraint or seclusion is for behavioral health reasons. How is behavioral health reason defined?

A. The simplest way to determine what is a behavioral health reason is first to determine what it is not. When restraints must be applied to directly support medical healing - this is not a behavioral health reason. While the patient may be exhibiting behavior that could be classified as irrational or uncooperative, such as attempting to seriously interfere with a physical treatment or device, such as an IV line, other indwelling lines, respirator, or a dressing, and less restrictive approaches don't work to prevent this interference, then restraint could be applied.

However, regardless of where the patient is receiving this type of treatment in the hospital, (even if on a psychiatric or geriatric psychiatric unit), the Acute Medical and Surgical (Nonpsychiatric) Care restraint standards, PC.11.10 through PC.11.100 apply. Any other clinical justification to protect the patient from injury to self or others because of an emotional or behavioral disorder where the behavior may be violent or aggressive would then be behavioral health care reasons for restraint.

Q. Is a bed enclosure or side rail a restraint or is it seclusion?

A. The specific nature of a device does not in itself determine either, which set of restraint standards, or even if any of these standards would apply. It is the device's intended use, (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether the devices used triggers the application of restraint standards. Technically, a bed enclosure or side rails are neither purely a restraint nor a form of seclusion, based on the definitions that accompany the Joint Commission standards. However, a bed enclosure (e.g., net bed) and likewise a side rail could potentially restrict a patient's freedom to leave the bed and as such, would be restraint. If for example a bed rail is used to facilitate mobility in and out of bed, it is not a restraint. If the patient/client can release or remove the device, it would not be a restraint. You would still need to make a determination between applying the Behavioral Health Care Restraint and Seclusion Standards or the Acute Medical and Surgical (Nonpsychiatric) Care restraint standards based on the intended use, involuntary application and identified patient/resident/client need, (clinical justification).

Q. For Behavioral Health Care Restraint and Seclusion, when must an LIP, (licensed independent practitioner) perform a face-to-face assessment of the patient?

A. When a patient/resident/client is placed in restraint or seclusion it is done in a crisis situation and usually in the absence of an LIP to protect a patient/resident/client from injury to self or to others. The organization determines who is competent to make this decision in the absence of an LIP. However, if the hospital uses accreditation for deemed status purposes a physician or other LIP must evaluate the patient within one hour of the initiation of the restraint or seclusion, as required by CMS's Interim rule for Patient Rights (effective August 1, 1999).



Time Frames for Reevaluation/Reordering of Restraint or Seclusion for an Adult

Adult placed in restraint/seclusion.	Order obtained from LIP within 1 hour of initiation of restraints/seclusion.
Adult evaluated in person by LIP.	<ol style="list-style-type: none"> 1. If hospital uses accreditation for Medicare deemed status purposes, LIP in-person evaluation to be completed within 1 hour of initiation of restraint/seclusion. 2. If not for deemed status, LIP in-person evaluation to be completed within 4 hours of initiation of restraint/seclusion. 3. If adult is released prior to expiration of original order, LIP in-person evaluation conducted within 24 hours of initiation of restraints.
LIP reorders restraint. Evaluation by qualified staff.	Adult placed in restraint/seclusion.
In-person evaluation by LIP.	Occurs every 8 hours until adult is released from restraint/seclusion.

Time Frames for Reevaluation/Reordering of Restraint or Seclusion for an Children and Youth

Child or youth placed in restraint/seclusion.	Order obtained from LIP within 1 hour of initiation of restraints/seclusion.
Child or youth evaluated in person by LIP.	<ol style="list-style-type: none"> 1. Within the first 2 hours for youth 9-17 or for children under 9, LIP conducts an in-person evaluation of the youth or child. 2. If youth or child is released prior to expiration of original order (2 hour or 1 hour), LIP in-person evaluation conducted within 24 hours of initiation of restraints.
LIP reorders restraint. Evaluation by qualified staff.	Every 2 hours for youth (9-17) until youth is released. Every 1 hour for children (under 9) until child is released.
In-person evaluation by LIP.	Every 4 hours for children and youth (17 or younger) until child or youth is released.



Q. PC.12.130 seems to require that every 15 minutes a patient/resident/client in behavioral restraint or seclusion is assessed and assisted with:

- 1. Signs of injury associated with the application of restraint or seclusion;**
- 2. Nutrition/hydration;**
- 3. Circulation and range of motion in the extremities;**
- 4. Vital signs;**
- 5. Hygiene and elimination;**
- 6. Physical and psychological status and comfort; and,**
- 7. Readiness for discontinuation of restraint or seclusion.**

Does this mean that we need to address each of the items noted in the intent of the standard every 15 minutes? Are we then expected to also waken a patient to perform these tasks?

A. No, it is not expected that all of the bulleted items in the intent statement of PC.12.130, be assessed every 15 minutes. The intent is that some physical assessment of the patient/resident/client be performed immediately after the patient/resident/client is placed in restraints, and as appropriate to the patient/resident/client's condition, needs, and the type of seclusion or restraint employed some or all of these activities occur. After all, immediately after a patient/resident/client is placed in restraint or seclusion or even after the first fifteen minutes approaching the patient or attempting some of these activities could be dangerous and may increase the patient/resident/client's agitation. Use clinical judgment and knowledge of the patient/resident/client and their individual needs to set a schedule of when and what items need to be evaluated. Also, waking a patient/resident/client in restraint or seclusion can be dangerous for both the staff member and patient/resident/client. Finally, there are visual checks that can be done when and if the patient/resident/client is too agitated to approach.

Q. What is the meaning of continuously monitoring in PC.12.140?

A. Monitoring a patient/resident/client in restraint or seclusion is done to ensure that the patient/resident/client is physically safe in restraints or in the seclusion room. Continuous means uninterrupted observation of that patient/resident/client. For a patient/resident/client in restraint this observation must be done in-person as long as the individual is in restraint. For the patient/resident/client in seclusion, the in-person observation can progress to audio and visual monitoring after the first hour in seclusion.

In-person means that the observer must have direct eye contact with the patient/resident/client. However, this can occur through a window or through a doorway, since staff presence in the room in which the patient/resident/client is restrained or secluded could be dangerous or add to the agitation of a patient/resident/client.

Q. Is the circumstraint board used during circumcisions considered a restraint?

A. Restraint used for the protection of surgical and treatment sites in pediatric and adult patients are not considered restraint.

Q. How does the Joint Commission define the term "episode", as used in the phrase, "all restraint and seclusion episodes..." in standard PC.12/180?

A. The Joint Commission does not specifically define the term "episode" in the restraint and seclusion standards. An organization would be free to define this data element to meet their needs when collecting data on restraint and seclusion.

For example, an organization may wish to collect data each time an order for behavioral restraint orders are written. In this case the definition for episode might be; each time a behavioral restraint is ordered whether for the same patient/resident/client or for different patients/residents/clients.

An organization with a large behavioral population or multiple behavioral health care settings or psychiatric units might wish to collect data at a more general level. The definition in this organization might be, each time an LIP conducts a face-to-face reassessment and writes an order for restraint or seclusion.

In both cases the organization defined this data element to fit within the scope of their data collection needs. This is not prohibited by the restraint and seclusion standards. As long as an organization collects, aggregates, and uses data to improve a process they are free to define data elements that work for their measurement strategies.



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