Fall Prevention Guidelines and Strategies for Laboratory staff

Learning Objectives

- Review fall prevention screening standards and practices as outlined in the St. Luke's Fall Prevention Program policy PE026.
- Identify who is at risk for falls during laboratory procedures.
- Describe safety equipment and signage to promote patient safety.
- Explain methods to ensure a safe environment and reduce fall risks.
- Document fall or near-miss events.

Learning Objective

Review fall prevention screening standards and practices as found in C360. Both the St. Luke's Fall Prevention Program policy PE026 with related policy appendices / safety guides and PE016 Ambulatory Clinic Guidebook appendix xw have Fall Risk materials outlined in them.

OVERVIEW

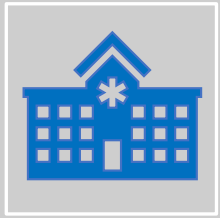
- Fall screening helps identify patients at risk of falling to guide prevention efforts in healthcare and home settings.
- Falls in healthcare can cause injuries from minor to severe, but about one-third are preventable through risk assessment and environment management.
- SLHS prioritizes fall risk identification as part of a National Patient Safety Goal.

Fall Prevention Policy

PE026 SLHS – Fall Prevention Program

PE026 SLHS Appendices xg and xi – Ambulatory Clinical Fall Prevention Program.

Tips &Tricks for Assisting a Patient with Mobility issues (non-clinician)



Everyone working for the Laboratory is responsible for ensuring a safe environment for SLHS patients.

Updates have been made to the Fall Prevention Procedure in C360. All staff are accountable to this information.

Review PE026 - Fall Prevention Program Policy.

Review PE026xg and PE026xi - Ambulatory Clinical Fall Prevention Program Appendices.

Fall Prevention strategies PE026

- There are numerous appendices for PE026. You are also responsible for this information as well. Please review carefully.

Fall Screening

Phlebotomy can raise fall risk, so take care with:

- patients 65+,
- those under 65 with fall risks,
- pediatric patients.

Awareness of the patient's risk for falling is the first step toward preventing falls

Intrinsic – factors caused by specific situational or environmental related issues part of or inside the patient's body

Extrinsic – factors caused by situations in the environmental surroundings outside the patient

Risk factors for Falls

Intrinsic Factors	Extrinsic Factors
History of previous fall Behavioral • Patient does not seek assistance for toileting • Patient does not know, forgot, or chose not to use call light Altered cognition • Dementia, sedation, delirium • Patient awareness and acknowledgment of own risk for falls Altered mobility • Lower extremity weakness • Abnormal gait • Shuffling and stumbling • Requires assistance with mobility and/or assistive device Sensory deficit • Needs corrective lenses • Wears hearing aids • Hard of hearing and does not wear hearing aids Medications • Benzodiazepines • Antipsychotics • Antidepressants • Opiates • Barbiturates • Antihistamines • Anticonvulsants • Sedatives • Antihypertensives • Diuretics Toileting problems • Takes diuretics • Has urgency or frequency Disease conditions causing: • Dizziness • Peripheral neuropathy • Pain (especially in lower extremities) • Hypotension	

IV, intravenous

[a]Miake-Lye, I.M. and others. (2013). Inpatient fall prevention programs as a patient safety strategy: A systematic review. *Annals of Internal Medicine, 158*(5 Pt 2), 390-396.

(From Perry, A.G. and others. [Eds.]. [2021]. *Clinical nursing skills & techniques* [10th ed.]. St. Louis: Elsevier.)
Figure 1

What a Phlebotomist would recognize as a patient's risk for falling

Age 65 years old or older
Possible dizziness
Altered mobility
- Decreased energy or fatigue
- Loss of muscle strength
- Decreased reflexes
- Decreased vision
- Gait disturbances

(needs a walker or cane)

Altered cognition
- Impaired memory and cognition
- Confusion

Risk factors for Falls

Intrinsic Factors	Extrinsic Factors
[redacted]	Communication issues • Frequency of rounding • Inconsistent or incomplete communications of patient risk for falls between caregivers Fall prevention education for patient and family is not used or is inconsistently used Physical hazards • Liquids on floor • Electrical cords near walking path • Uses IV pole to walk • Wears compression stocking with cords Increased use of restraints[a] Decreased efforts by hospital staff to mobilize patients[a] Inappropriate or no footwear

IV, intravenous

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Figure 1

What a Phlebotomist would recognize as a patient's risk for falling

Environmental factors:

- ill-fitting shoes
- physical restraints
- inappropriate clothes
- clutter in the walking path
- spills
- dim lighting
- height of the bed
- wheelchair use

Interventions

- ✓ "Leave it like you find it" –
  - ➢ Return the tray table to original location if you have moved it
  - ➢ Re-establish Privacy
- ✓ Return assistive devices (e.g., walking aids, bedside commodes) on the exit side of the bed if moved for blood draw access
- ✓ Replace the patient's bedside table, water, and personal care items (e.g., eyeglasses, dentures, telephone) within easy reach.
- ✓ Ensure that the ambulatory patient's pathway to the bathroom, waiting area or exit is clear.
- ✓ Ensure that the floor surfaces are clean and dry.
  Clean up all spills promptly.

Recognition of Risk of a Fall

Observation of the patient

- Loss of color, turning pale
- Clammy skin or sweaty palms
- Heavy or slowed breathing
- Nonresponsive but eyes open

Who should stay in the room

- At least one person should stay with patient until they are stable
- Driving – Observe for 30 minutes
- Observe for 15 otherwise

Tips & Tricks for Assisting a Patient with Mobility concerns

If a patient is exhibiting <u>ANY</u> signs below -- seek clinical assistance, use a wheelchair and/or use a mechanical lift.

Observe Signs & Falls Risk Factors

Muscular Weakness

Uneven gait or poor balance when walking

Decreased speed of mobility

Dizziness or drowsiness

Dependence or need assistance (cane, arm support)

Cognitive decline or impairment

Check the Scene for Trip Hazards

- Uneven ground
- Changes in flooring (carpet to tile, tile to carpet), floor mats
- Wet or slick surfaces
- Cords, Chairs, Garbage bins
- Stairs

Tips & Tricks for Assisting a Patient with Mobility concerns

Use a Wheelchair

Feel free to suggest a wheelchair when necessary.

- If you are worried about a patient's fall risk, don't wait for the patient to decide on using the wheelchair.

Always lock the brakes before getting in or out of the chair.

Utilize the patient transfer chair whenever possible.

- Keep the armrests down so the patient can hold onto them for support.

Move the leg rests aside when possible for transferring.

Whenever feasible, keep the patient in the wheelchair during the exam to minimize extra transfers.

Tips & Tricks for Assisting a Patient with Mobility concerns

Coach the Patient

- Use the armrests to help lower yourself into or rise from the seat.
- Since it's a long walk, let's use a wheelchair.
- If you can't safely support mobility, ask if they'd prefer to have their blood taken while seated in the wheelchair.
- Inform me if you feel weak, dizzy, or at risk of falling.
- Have a plan to safely lower the patient if they fall.

Tips & Tricks for Assisting a Patient with Mobility concerns

Manual Support
(NOT recommended)

Minimize	Avoid	Stand
Minimize "hands-on" help when possible, prioritizing clinical support and patient safety.	Avoid pulling or pushing the patient to move them.	If manual support is needed, stand **beside** the patient—not in front—and support under the armpits rather than using their arms or hands.

Tips & Tricks for Assisting a Patient with Mobility concerns

Sit

- Prevent patients from standing too long in the outpatient waiting area.
- Encourage patients to sit while waiting, if feasible.

Bathroom for urine collection

Suggest	Suggest a nearby restroom
Offer	Offer help walking to or from the restroomSuggest using a wheelchair
Seek	Seek clinical support if assistance is needed in the restroom
Explain	Briefly explain how to use the restroom alarm

Lowering a Falling Patient to the Ground Safely

Brace

Take a wide stance. Keep your back straight and tighten your core.

Hug

Bring the patient close to your body.

Slide

Slowly slide the patient down your leg.

Lower

Lower the patient to the ground while keeping your back straight.

Support

Support the patient's head.

Call lights and Alarms – toilet or bed

- Call lights are used to notify nursing
  - Use this button to call when you need any assistance with the patient.
  - If patient requests assistance to leave bed during phlebotomy, activate call light so that nursing can assist.
- Bed and toileting alarms
  - Nursing responds to bed and/or toileting alarms

Hospitalized patients determined to be at risk for falls are often identified with:

- yellow wrist bands,
- yellow non-skid socks, and
- a visual cue on the patient's door.

Pediatric Interventions

Patient instruction, education, & engagement

Remind parent / caregiver to supervise the child at all times

- Discuss of elements of risk inherent to the clinic environment:
  - standing on chairs or exam tables,
  - sitting on rolling stools, and/or
  - playing with equipment intended for staff
- Encourage moving the child to the exam table only when provider indicates a necessity
- Remind parent / caregiver to help their child on and off the exam table
- Remind parent / caregiver to keep a hand on the child while on the exam table and not to turn or walk away

If a Patient loses Consciousness, there is a potential for fall risk -

What steps must be taken immediately once a patient loses consciousness and there is a risk that he/she may fall to the floor?

In an **outpatient** setting, whether the patient is standing or sitting in the draw station chair –

You must always look out for the safety of the patient.

- The patient should never be left alone once they have lost consciousness.
- Activate the call button
  - ✓ In Clinic, this will bring nursing staff to come to the room. RN/LPN, Provider will take charge of the situation when they arrive on scene.
  - ✓ At a Laboratory draw station, this will bring co-workers to come assist. Emergency Room nursing or the Rapid Response Team may need to be activated.
  - ✓ If in an area without a call button, call 9-1-1 if medical intervention is needed.
- If the patient has stopped breathing while in syncope, activate the code blue call if an RN is not in room or call 9-1-1if call button is not available.

If a Patient loses Consciousness, there is a potential for fall risk –

Once an outpatient loses consciousness, who can release the patient and/or the phlebotomist from care?

- ✓ In Clinic, an office nurse or triage nurse must be the one to dismiss the patient if the patient losses consciousness.
  - ➢ The phlebotomist should stay by patient side to assist and give info to office/triage nurse until no longer needed by nurse.
  - ➢ The office/triage nurse will take over the situation once they arrive on scene.

- ✓ At a Laboratory draw station, if Emergency Room nursing, the Rapid Response Team or EMS have been engaged, they will take over the situation once they arrive at the scene.

A SpeakUP MUST be placed each time a patient loses consciousness.

If a Patient loses Consciousness, there is a potential for fall risk -

What steps must be taken immediately once an Inpatient loses consciousness?

In an **inpatient** setting, even if the patient is safely lying in bed or sitting in a chair – **You must always look out for the safety of the patient.**

- Activate the call button to get nursing staff to come to the room.
- The patient should never be left alone once they have lost consciousness.
- RN will take charge of the situation when they arrive on scene.

- If the patient has stopped breathing while in syncope, activate the code blue call if RN is not in room.

A SpeakUP MUST be placed each time a patient loses consciousness.

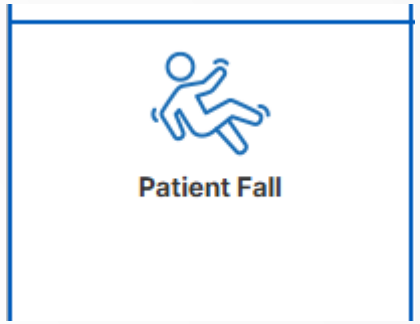
If a Patient has Fallen

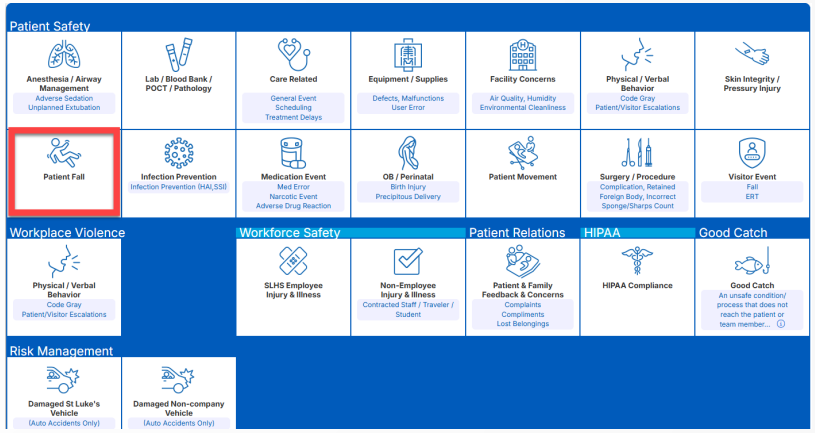
Ask if the patient is OK

- Activate the call button to request help
- Do not attempt to carry or lift the patient
- Report incident to supervisor

How to Document Falls in SpeakUP

- To log a fall in any laboratory setting, click on Patient Fall in the Icons
- The Fall Icon has been updated to include laboratory appropriate scope.
- If a visitor or patient who has not been checked in falls, use the visitor event Icon.
- If you witness a fall in a public area, communicate with responders on who will fill out the SpeakUP





Positive feedback

Use safety huddles to review and reinforce when a “good catch” or “near miss event” occurs and patient safety is maintained.