

*Patient Education Sheet***Fall Prevention on 6/7 West****The danger of falling is very real for hospitalized psychiatric patients****There are several factors that increase the risk for falls:**

1. Having a long-standing, poorly controlled, or newly diagnosed psychiatric illness and being in unfamiliar surroundings.
2. Being on multiple medications or having recent changes in dosage levels. Being on certain medications such as mood altering, antipsychotic, or anti-anxiety drugs, sleep aids, or pain relievers.
3. Having a previous history of falls, an unsteady gait, leg or back pain, muscle weakness, or an injury. Having a fever or urgent need to toilet and getting up too quickly. Multiple medical conditions and pain are also associated with a risk for falls.
4. Developing new confusion from illness, such as alcohol or drug detox, delirium, or dementia.

5. Having sensory impairments such as numbness in the feet, or vision and/or hearing problems
6. Receiving post electroconvulsive therapy (ECT)

**How will the staff know that I have a risk of falling?**

1. If you, your family, or a member of your treatment team feels you are at risk, we will initiate a special plan of care to address safety issues and reduce the danger of an accidental fall and injury.
2. It is important to tell your nurse if you feel you are at risk or if you were/are experiencing:
  - a. Recent falls
  - b. Periods of dizziness, blurred vision, hearing loss
  - c. Weakness or balance loss
  - d. Numbness or tingling in your feet
3. Also tell your nurse if you use a walker, crutches or a cane and are using them correctly.

**What are our common practices for fall risk?**

1. Upon admission, all patients are considered a fall risk for the first 24 hours, regardless of age or ability.
2. A yellow identification band will be placed on your wrist and a yellow card will be posted outside your door. This alerts the staff you are on fall-risk precautions. Based on your assessment additional measures may include use of

a tap bell; a bed alarm and non-skid footwear. In addition you may be moved to a bedroom closer to the nurses' station for increased supervision. Your belongings will be kept within easy reach and you will receive assistance getting in and out of bed, walking and going to the bathroom.

3. You may also be checked on more frequently, and in some cases assigned a safety companion.
4. After the first 24 hours, patients are reassessed. If they do not meet fall-risk criteria, they will be taken off the fall precautions list. If safety remains a concern, a falls prevention plan will remain in place and be tailored to your specific needs.

### **Other Safety measures to prevent falling:**

1. Sit up slowly and dangle your legs at the side of the bed before getting up. This will prevent your blood pressure from dropping quickly, causing dizziness.
2. Keep your room free of clutter and any clothes or other belongings off the floor. Keep a clear pathway in your room.
3. Do not lean back in chairs, causing the front chair legs to lift off the floor. This will cause the chair to tip back and slide, causing a fall and possible injury.
4. **Always tell staff if you believe there has been a change in your mood, behavior, or condition. Early communication and interventions can be crucial in preventing falls or injury.**



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*For more information, or to learn about the specialized services and programs available at Western Connecticut Health Network, please visit [www.WCHN.org](http://www.WCHN.org)*