



Protect Your Patients on Oxygen

Don't Let Them Fall Through the Cracks
of Your Fall-Risk Scale

Despite widespread use of fall-prevention measures, accidental falls continue to challenge those entrusted to care for and protect patients.

The CDC reports that [in older adults over 65, one out of five falls causes serious injury](#). Each year, more than 800,000 people are hospitalized for an injury following a fall, most frequently, for traumatic brain injury (TBI) or broken hip.

The hospital is not a safer place for patients when it comes to preventing falls.

The Agency for Healthcare Research and Quality reports that [falls occur in hospitals at a rate of 3–5 per 1000 bed-days](#).

The monetary cost of falls is high, as well.

The CDC reports that [medical care related to non-fatal fall injuries cost 50 billion US dollars, and care related to fatal falls costs 754 million, per year](#).

Most likely, your healthcare facility addresses this serious issue with an appropriate fall-safety protocol and your staff is educated on universal and role-specific responsibilities to decrease patient falls.

Perhaps your facility uses a popular validated fall assessment tool, such as the [Hendrich II Fall Risk Model](#) or the [Morse Fall Scale](#). But are you really doing everything you can to prevent falls?

In 2015, the [Joint Commission analyzed fall-related data from its Sentinel Event database](#) and reported that "successful strategies" included using standardized assessment tools to identify fall and injury risk factors, and interventions designed to mitigate risk.

The Commission also stated that along with the standardized assessment tool, it is important to consider "an individual patient's risks that may not have been captured through the tool" and that "in spite of wide-spread use of fall-risk screening tools and interventions, significant, sustained reduction has proven elusive."

**To illustrate the pitfalls of relying on a fall risk tool alone,
we present a fictional scenario.**

Suppose that your facility admitted Mr. Smith, a 45-year old male with a history of sarcoidosis and type 1 diabetes, and an admission diagnosis of hyperglycemia. Due to sarcoidosis, Mr. Smith uses oxygen at home and continues to use it in the hospital, while ambulating and as needed. He has been at your hospital for a few days now, and his hyperglycemia has been addressed and resolved. He is doing well and ready for discharge.

While the doctor prepares Mr. Smith's discharge order, the nurse is completing his morning assessment, including the [Morse Fall Scale](#). The nurse assigns scores within six categories and totals the score to determine the level of risk and need for interventions.



Mr. Smith has not had a fall within three months and scores a zero here. There is a secondary diagnosis of sarcoidosis, so 15 points are added. The patient is independent and ambulatory and scores another zero. His IV was discontinued the night before, because of the pending discharge; another zero is added. Mr. Smith has a normal gait and is oriented to his own ability, so he scores two more zeros.

His total score is 15, and according to the scale, he is determined to be at "No Risk" of falls.

What is NOT calculated into this and many other fall scales is the presence of the nasal-cannula tubing attached to oxygen.

Mr. Smith uses the long tubing attached to the wall oxygen while in the hospital bed, and shorter tubing attached to the oxygen cylinder when walking in the halls. However, this is not factored into his fall assessment.

Since the assessment tool finds him to be at "No Risk", interventions and teaching-needs specific to oxygen-users are not triggered for the busy nurse.

Preparing to go home, our fictional patient wears his nasal cannula to perform ADLs in the bathroom.



As he starts to walk to the bathroom, the long tubing gets caught on the bed rail, and yanks at his face, causing him to lose his balance and fall.

Thankfully, the patient is uninjured because we all like happy endings to our fictional scenarios.

But the reality is that even when a patient is not injured in a fall, the effect on quality of life can be dire.

Many patients who experience a fall become afraid of future falls.

This may lead a patient to limit his activity, resulting in deconditioning and musculoskeletal weakness. Weakness increases a patient's risk of falls, and a vicious cycle is born.

In fact, a [systematic review](#) found that the risk of developing a fear of falling in community-dwelling older adults was 6.41 times greater in those who had a history of at least one fall compared with those without a fall history.

It is also known that [mobility in hospitalized patients improves outcomes](#) in critically ill patients. Patients who are mobilized early in their recovery have decreased incidence of delirium, fewer ventilator days, shorter length of stay and higher functional status after discharge.

A study of patients recovering from bowel resection showed an inverse relationship between frequency of ambulation to median length of hospital stay and complications, including ileus, urinary retention and urinary tract infection, deep wound infection, pneumonia, deep vein thrombosis and pulmonary embolism, and even falls.

The benefits of ambulation are undeniable, but medical devices such as SCDs, foleys, and IVs tether the patient and should be considered as factors that can increase fall risk. Likewise, nasal cannulas tie patients to the oxygen source and can become tripping hazards, causing fear of falling, discouraging ambulation.



Patients on oxygen, whether in the hospital or in the community, should be encouraged to mobilize frequently AND protected from falls.

Your facility's fall-prevention program is designed to protect your patient from falls, of course. The falls-risk tool is just the beginning.

From the falls-risk assessment tool, recommended interventions are triggered, and orders are put into place that ensure that the patient's unique vulnerabilities are addressed. Standing orders may call for the use of color-coded bracelets and signage, targeted patient and family teaching, physical and occupational therapy consults, hourly rounding, bed and chair alarms, and closer monitoring.

However, there is another tool to add to your fall-prevention program, for patients on oxygen.

The **O2 Safety Strap** was invented by a man named Samuel Hall, who, like our fictional patient, uses a nasal cannula for supplemental oxygen, as needed. His invention was inspired after his cannula tubing was caught on a door handle while he was bringing in groceries, causing a fall. Unfortunately, he injured his patellar tendon in the fall



Future falls could be prevented, and patient mobility and independence promoted, with the use of a simple, elegant, affordable device.

Isn't that a happy scenario?



o2safetystrap.com

SAFETY, IT'S IN OUR
PRODUCT'S NAME



o2safetystrap.com

For more information, and to order the O2 Safety Strap, visit o2safetystrap.com