

PATIENT AT RISK FOR FALLS**OBJECTIVES:**

1. To identify on admission those patient(s) with safety/risk factors which increases their susceptibility to falls/injuries.
2. To prevent injury and/or minimize the risk for fall/injury.
3. To provide a safe risk free environment for the patient.
4. To educate the patient/significant other concerning fall prevention and management.

PROCESS STANDARDS:

1. Patients will be screened on admission; daily on the 7am shift; as the patient's condition change; as medications change which put the patient at risk for falling; upon transfer to another unit; and after a fall. (The fall assessment tool is located on Patient History and Discharge Record and the 24-Hour Nurses Notes).
2. If a patient is assessed to be at risk for falls/injury, precautions shall be implemented. These shall include as appropriate:
 - a. The "Fall Leaf" shall be placed on the patient room door and in the front of the medical record. Additionally, the "Falls" wrist bracelet/arm band will be placed on the patient.
 - b. The patient shall be oriented to the call system, call light, bed and unit on admission and reoriented frequently as indicated.
 - c. The patient shall be placed in the bed nearest the bathroom, if possible.
 - d. The bed shall be kept in low position with the wheels locked.
 - e. The frequently used items such as the call light and personal belongings should be placed within easy reach with the call lights answered promptly.
 - f. The room should be kept as free of clutter as possible, and the use of small objects limited.
 - g. The room should be properly lighted with walkways and bathrooms kept clear.
 - h. The IV pole should be placed on the side of the bed that the patient gets up from, and the overbed table placed on the opposite side.
 - i. The top siderails should be kept up for support and to assist with movement.
 - j. If ambulatory, advise the patient to sit on the edge of the bed for a few minutes before standing. Assess the need to stand by or utilize the gait belt to assist with toileting and ambulation.
 - k. If ambulatory, advise patient to wear shoes with nonskid soles.
 - l. The patient will be assessed for the need of an attendant/sitter if family is not available.
 - m. Assistive/Adaptive devices typically used by the patient (i.e. eye glasses) will be available.
 - n. Review of medication regimen to promote the reduction of fall risk
3. The patient/significant other shall be educated regarding activity restrictions, safety and falls precautions.

OUTCOME STANDARDS:**Upon discharge:**

1. The patient will have not suffered injury and/or the risk for injury/falls would have been lessened.
2. The patient's environment will have been free of hazards to safety/falls, as possible.

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Upon discharge continued:

3. The patient/significant other will have been educated regarding falls prevention and follow-up care.

HAVE I DOCUMENTED:

- * Assessment of safety/risk factors on admission
- * Precautions instituted when risk factors identified:
 - Orientation to room
 - Bed nearest bathroom if possible and in lowest position with wheels locked
 - Call light in easy reach
 - Room free of clutter and well lit
 - Top side rails up for support and assistance with movement
 - Review of medication regimen
- * Patient/significant other education regarding safety and falls precautions

At The Time of Discharge:

- * Patient/significant other communicate understanding regarding fall prevention and follow-up care

Reference:

1. Hospital Policy 5.42.0 Falls Policy:
http://www.sh.lsuhsu.edu/policies/policy_manuals_via_ms_word/hospital_policy/h_5.42.0.pdf
2. Nursing Policy G-15 Gait Belts:
http://www.sh.lsuhsu.edu/policies/policy_manuals_via_ms_word/Nursing/G-15.pdf
3. Meiner, S. and Luekenotte, A. Gerontologic Nursing-3rd ed. (2006). *Part Three: Wellness Issues. Safety-Falls.* [Mosby's Nursing Consult - Reference Books](#)