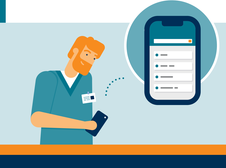
Fall Prevention Plan Implementation

Are Your Nurses Checking All the Boxes?

Accidental falls in a hospital or healthcare setting are extremely dangerous for patients and detrimental to the healthcare institution. Patient injury or death occurring as a result of an accidental fall in a hospital is classified as a "never event" (i.e., a preventable event that should never happen) by the National Quality Forum (NQF), the Centers for Medicaid & Medicare Services (CMS), and the UK National Health Service (NHS). In addition to potential injury and the negative impact to patients' health, accidental falls can also result in increased length of stay, healthcare cost and healthcare facility liability as well as decreased care provider moral.

A strong fall prevention plan prevents or minimizes patient falls and injury, while promoting the highest level of patient independence possible. Check out the Dynamic Health™ competency checklist below to see if your nurses are checking all the boxes when it comes to fall prevention plan implementation.



PRE-PROCEDURE STEPS

- [ ] 1. Review the facility/unit specific protocol for use of fall risk assessment tools and fall prevention, if available
- [ ] 2. Review the treating clinician's orders regarding fall risk and prevention strategies, if any exist
- [ ] 3. Review the patient's medical history/medical record
- [ ] 4. Follow standard pre-procedure steps

PROCEDURE STEPS

- [ ] 1. Explain the components of the fall prevention plan and its purpose
- [ ] 2. Answer any questions
- [ ] 3. Provide emotional support as needed
- [ ] 4. Assess the patient for risk for falls using a facility-approved fall risk assessment tool, if available.
- [ ] 5. Interview family members, as necessary, to gather information about the patient's medical history and personal habits, including use of medications and diet, that could contribute to fall risk
- [ ] 6. Follow facility protocols for choosing appropriate strategies that will reduce fall risk based on the individualized risk assessment
- [ ] 7. Place a label or sign on the door to the patient's room, on the headboard of the patient's bed, and/or in or on the cover of the patient's medical record, if indicated by facility protocol
- [ ] 8. Collaborate with other members of the multidisciplinary team to implement the individualized plan of care to reduce risk for falls
- [ ] 9. Keep the bed in the lowest position, lock the wheels
- [ ] 10. Keep the side rails up when no one is in attendance
- [ ] 11. Place the call light within the patient's reach
- [ ] 12. Promptly respond to call light when activated
- [ ] 13. Place personal belongings and assistive devices within the patient's reach
- [ ] 14. Verify that the patient is wearing non-skid footwear when ambulating
- [ ] 15. Provide ambulatory and balance aids, as appropriate
- [ ] 16. Verify that the wheels are locked when transferring to or from a wheelchair
- [ ] 17. Anticipate toileting needs and offer assistance, especially during nighttime hours
- [ ] 18. Assess the patient for one-on-one monitoring and arrange for monitoring as appropriate
- [ ] 19. Avoid the routine use of physical restraints
- [ ] 20. Implement the use of a bed or chair alarm to alert staff if the patient is attempting to get up without assistance, as appropriate and if available
- [ ] 21. Identify and modify environmental hazards (e.g., clutter, wet floors)
- [ ] 22. Monitor for adverse medication effects (e.g., postural hypotension, sedation, confusion, or dizziness) that increase fall risk
- [ ] 23. Collaborate with the treating clinician to explore alternatives to the prescribed medication regimen, as appropriate
- [ ] 24. Request referral to physical therapy for education and training in exercises for building strength and improving balance

POST-PROCEDURE STEPS

- [ ] 1. Follow standard post-procedure steps
- [ ] 2. Incorporate the results of the physical therapist's assessment into the nursing plan of care. The physical therapist typically conducts an independent assessment of gait, stability, strength, and balance
- [ ] 3. Collaborate with nursing administration to provide continuing education to colleagues and other staff members on the patient's individualized fall prevention plan
- [ ] 4. Provide ongoing evaluation of the effectiveness of the fall prevention plan
- [ ] 5. Document patient response to interventions at regular intervals per facility protocol
- [ ] 6. Document the details of a fall or near fall, including time the fall occurred, patient adherence to safety strategies, events that preceded the fall/near fall, and clinical staff interventions, if any
- [ ] 7. Update and modify all components of the plan as needed
- [ ] 8. If the patient experiences a fall despite preventive efforts, follow the facility/unit-specific protocol to assess the patient for injury, notify the treating clinician, and perform/assist with any ordered therapy
- [ ] 9. Complete a facility incident report to detail the fall

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