THE STUDY VAULT

Clinical Chaos

Fall Prevention

SKILL SNAPSHOT

Purpose
- Reduces preventable falls and injury through individualized assessment, environment control, mobility support, and frequent reassessment.

When to use
- Every patient on admission and after transfer, status change, medication/procedure, fall, or change in mobility/cognition.

Supplies needed
- Validated fall-risk tool; nonskid footwear; gait belt/assistive device; alarms if indicated; low bed; signage/identifier per policy.

PREP + PATIENT SETUP

- Assess fall history, gait, weakness, cognition, toileting, vision/hearing, orthostasis, medications, lines, and environment.
- Identify patient-specific causes rather than relying only on a score.

VAULT TIP

- Prevent the reason the patient will stand up alone: pain, bathroom needs, confusion, or unreachable belongings.

STEP-BY-STEP

1. Hand hygiene; identify patient; complete validated fall and injury-risk assessment.
2. Explain the individualized plan and demonstrate call-light use; ask patient to teach it back.
3. Place bed low and locked; keep call light, water, phone, glasses, and personal items within reach.
4. Clear floor and pathway; provide lighting; secure cords/tubing; keep frequently used equipment accessible.
5. Apply correctly fitted nonskid footwear and ensure clothing does not drag.
6. Verify assistive device is appropriate, within reach, and in good condition.
7. Before mobility, assess pain, dizziness, strength, orthostatic symptoms, and need for staff/equipment.
8. Use gait belt and correct number of assistants when appropriate. Do not use a gait belt over contraindicated areas.
9. Offer scheduled toileting and purposeful rounding; respond promptly to calls.
10. Use bed/chair alarm only when indicated and as one part of the plan; confirm it is on and audible.
11. Review sedatives, antihypertensives, diuretics, hypoglycemics, and other risk medications with the team.
12. Reassess risk after medications, procedures, transfers, or any change. Communicate plan during handoff.
13. If a fall occurs, do not rush to lift. Assess ABCs, pain, neuro status, injury, anticoagulant use, and follow post-fall protocol.

SAFETY REMINDERS

- Do not restrain solely to prevent falls; restraints may increase injury.
- A fall-risk score never replaces clinical judgment.
- Stay within arm's reach during toileting when indicated.
- After an unwitnessed fall, consider head/spine injury and anticoagulation.

COMMON MISTAKES

- Using an alarm without rounding/toileting.
- Leaving walker out of reach.
- Telling patient to "call" without teach-back.
- Failing to update plan after status change.

DOCUMENTATION

- Risk score and individual risk factors.
- Prevention interventions and education.
- Mobility level, assistance, device.
- Reassessments and handoff communication.
- Fall event, assessment, notifications, post-fall actions.