Fall Risk Assessment Procedure

Purpose: To prevent patient falls/falls with injury through appropriate assessment of fall risk and implementation of appropriate fall/injury prevention interventions.

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Definitions: Fall — An unplanned descent to the floor.
Performed By: Registered Nurse or Licensed Practical Nu

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Required Action Steps	Supplemental Guidance
NOTE: All medical record documentation shall be completed on the patient care flowsheet, nursing notes, and/or in the Electronic Computer Documentation System according to unit-specific documentation procedures.	
Fall Risk Assessment & Prevention Interventions	
Assess and determine a fall risk score for each new patient admitted or transferred to the unit using the Conley Fall Risk Assessment Scale.	The Conley Fall Risk Assessment Scale is found in the Electronic Computer Documentation System or on the nursing flowsheet. See Conley Scale Job Aid. Fall Prevention Patient Care Protocol/Intervention may also be implemented based on nursing judgment including risk associated with medication regimen.
Document the fall risk score and indicate the fall risk criteria in the medical record.	
3. Review "Fall Prevention Tips" with the patient, family, and/or significant other.	
4. Instruct all patients — regardless of fall risk — on universal fall prevention interventions.	Universal fall prevention interventions are found on the "Fall Prevention Interventions" job aid.
5. Implement Fall Prevention Patient Care Protocol or Fall Prevention Template for patients who have a Fall Risk Score of 2 or higher.	High-risk fall interventions are found on the "Fall Prevention Interventions" job aid.
6. Implement any additional patient-specific interventions deemed necessary to prevent a fall, based on the patient's fall risk score, condition, or mental status.	Patient-specific interventions for consideration are found on the Fall Prevention Interventions job aid.
7. Document all interventions considered and implemented in the medical record.	Educate the patient and family regarding the fall prevention program.
8. Reassess the patient twice daily or as the patient's condition changes. Monitor for changes in fall risk status and appropriateness of fall prevention interventions.	
Document reassessment findings in medical record.	
10. Practice clear communications and effective handoffs of fall risk status and precautions during shift reports and transfer between departments and/or procedural areas.	
Responding to a Patient Fall CAUTION: Respond immediately to any patient injury sustained in the fall by contacting the patient's physician and proceeding with diagnostic orders or treatments.	
11. Document the patient's post-fall vitals signs, injuries, education, and fall interventions implemented.	Refer to Post Fall Algorithm Job Aid for instructions and expectations about fall documentation.
12. Notify the nursing supervisor (or designee) and the patient's physician and family of the fall and document all notifications.	
13. Document the patient vital signs and neurological status within one hour after the fall.	 Reassessment should occur sooner than one hour if the patient experienced a change in vital signs, pain, or neurological status as a result of the fall. In the Electronic Computer Documentation System, document any changes in the patient's fall risk assessment criteria as a focus note.
14. Complete a Sentara Tracking and Reporting System (STARS) report.	
NOTE:The Sentara Tracking and Reporting System (STARS) report is not a part of the medical record and should not be referenced in medical record documentation.	
15. Check to ensure that all necessary fall documentation was entered into the medical record.	Required Medical Record Fall Documentation Immediate post fall assessment documentation Documentation of notifications made after fall 1-hour post-fall reassessment documentation
16. Send the STARS report along with a copy of the documentation, if appropriate, to risk management.	