

Fall Interventions – Quick Reference

Other Fall Risk Considerations:

Age: More than 1/3 of adults 65 years and older fall each year

Mobility: Assessment of gait and balance

Vision: Assess for vision problems

Medications: CNS, cardiovascular, polypharmacy

Underlying conditions: Postural hypotension, cognitive changes,

fear of falling, neurological and cardiovascular problems

Environment: Tripping and slipping are common reasons for falling

Standard Interventions for all Patients

- > Bed in low position, brakes locked, siderails up x 2
- Nonskid socks
- Call light within reach
- Personal items within reach
- Unobstructed, clear path to bathroom
- Adequate lighting
- Floor clean and dry
- Consider PT eval for any patient with a change in mobility status

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atient 65 years or younger with fall		Patient with fall in the past 3 months		Patient with fall risk on anticoagulation		Patients of any age with cognitive dysfunction		
	risk				therapy or documented bleeding risk,		and/or unable to follow directions, receiving	
				osteo	porosis and/or > than 65 years of	medic	ations that alter cognition or create a sense	
					age		of urgency (diuretics, laxatives)	
>	Utilize nurse call technology	>	Utilize nurse call technology	>	Utilize nurse call technology	>	Utilize nurse call technology	
>	Yellow Fall signage-room	>	Yellow Fall signage-room	>	Yellow Fall signage-room	>	Yellow Fall signage-room entrance	
	entrance		entrance		entrance	>	Call, don't fall signage (foot of bed, inside	
>	Call, don't fall signage (foot	>	Call, don't fall signage (foot of	>	Call, don't fall signage (foot of		BR door)	
	of bed, inside BR door)		bed, inside BR door)		bed, inside BR door)	>	Bed in the lowest position	
>	Bed in the lowest position	>	Bed in the lowest position	>	Bed in the lowest position	>	Yellow socks	
>	Yellow socks	>	Yellow socks	>	Yellow socks	>	Bed/chair/ alarm	
>	Complete falls agreement	>	Complete falls agreement (if	>	Complete falls agreement (if A/O)	>	Hourly rounding (include toileting)	
	(if A/O)		A/O)	>	Bed/chair alarm	>	Assistive devices (gait belt, walkers, canes,	
>	Bed/chair alarm	>	Bed/chair alarm	>	Hourly rounding (include		etc) readily available	
>	Hourly rounding (include	>	Hourly rounding (include		toileting)	>	Do not leave unattended in the bathroom	
	toileting)		toileting)	>	Assistive devices (gait belt,	>	Communication of fall risk and	
>	Assistive devices (gait belt,	>	Assistive devices (gait belt,		walkers, canes, etc) readily		interventions at every handoff	
	walkers, canes etc) readily		walkers, canes, etc) readily		available	>	Consider virtual safety assistant use	
	available		available	>	Do not leave unattended in the	>	Consider use of floor mats	
>	Do not leave unattended in	>	Do not leave unattended in		bathroom	>	Move patient closer to nurses' station	
	the bathroom		the bathroom	>	Communication of fall risk and	>	Diversion activities	
>	Communication of fall risk	>	Communication of fall risk and		interventions at every handoff	-		
	and interventions at every		interventions at every handoff	>	Consider virtual safety assistant			
	handoff	>	Consider virtual safety		use			
	Hallacii		assistant	>	Consider use of floor mats			

UPDATE PLAN OF CARE FOR FALL RISK AND INTERVENTIONS

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