

FALL PREVENTION + POST-FALL RESPONSE

RN CLINICAL QUICK GUIDE | ADULT ACUTE CARE

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CORE PRINCIPLE

Assess risk -> match interventions to the patient's specific risks -> execute consistently -> reassess after change or fall.

1 IDENTIFY THE FALL RISK PATTERN

History: Prior falls, near-falls, circumstances and time of day.

Mobility: Weakness, gait/balance change, transfer needs, assistive device.

Cognition: Delirium, impulsivity, poor safety awareness, new confusion.

Toileting: Urgency, frequency, incontinence, need for assistance.

Physiology: Orthostatic symptoms, dizziness, dehydration, acute illness.

Medications: Sedating, psychoactive, antihypertensive or other fall-risk-increasing drugs.

Environment: Footwear, clutter, tubing/lines, lighting, unfamiliar room setup.

2 MATCH PREVENTION TO THE RISK

- Keep bed low/locked; clear path; place call light, phone and personal items within reach.
- Use non-slip footwear and the correct assistive device; provide the level of assistance actually needed.
- Plan proactive toileting/rounding around the patient's usual pattern and current symptoms.
- Reorient as needed; use simple cues and teach-back with patient/family.
- Review medications and orthostatic symptoms when clinically indicated; escalate concerns for treatment adjustment.
- Use alarms, observers or other added safeguards only as part of an individualized plan and facility policy.
- Communicate the current plan at bedside, handoff and whenever risk factors change.

3 IF A FALL OCCURS: FIRST RESPONSE

- 1 Stay with the patient and call for assistance.
- 2 Do not rush to lift or move the patient. Assess first unless there is immediate danger.
- 3 Assess ABCs, level of consciousness, pain, bleeding, deformity, mobility, vital signs and obvious injury.
- 4 If head impact, neck/back injury or neurologic change is possible, use the facility's injury/head-trauma pathway and escalate promptly.
- 5 Notify the provider and appropriate clinical leader; obtain additional evaluation/orders as indicated.

ESCALATE URGENTLY FOR

New neurologic change or loss of consciousness; suspected head/neck/spine injury; uncontrolled bleeding; suspected fracture/hip injury; hemodynamic instability; severe or rapidly worsening pain.

4 COMPLETE THE POST-FALL CYCLE

Document: Objective assessment findings, circumstances, interventions, notifications and patient response.

Communicate: Update the care team and handoff; notify family/support person when required by policy.

Huddle: Reconstruct what happened: activity, location, assistance level, equipment, toileting, medications, symptoms and environment.

Revise: Update identified risk factors and the prevention plan so the next intervention addresses the likely contributors.

Follow through: Complete monitoring, reporting and additional assessments required by facility protocol/provider orders.

REASSESS WHEN THE PICTURE CHANGES

New weakness or confusion, medication change, transfer to a new setting, new mobility/toileting needs, or any fall/near-fall should trigger reassessment and plan revision per facility protocol.

EVIDENCE BASE

- AHRQ Fall TIPS: individualized fall-risk assessment + tailored prevention plan.
- CDC STEADI Inpatient Care (updated Aug 4, 2025): modifiable risks include mobility, medications and orthostatic symptoms.

Educational resource for licensed clinical staff. Use clinical judgment and follow current facility policy, provider orders, and emergency procedures.