**Patient Fall Reduction Strategies**

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| Contributing Factors | Reduction Strategies |
| Lack of standardized fall prevention program | * Reference the Center Fall Prevention Policy and Procedure, and tools * Implement center wide education initiative for all employees * Display employee fall prevention poster * Identify a physician champion to cultivate a culture of safety within the Center and gain the support of the medical staff members |
| Absent or inconsistent fall scale rating by healthcare team | * Reference the Center Fall Prevention Policy and Procedure, and tools * Use the policy approved fall assessment tool for the initial assessment and reassessment * Train staff on the fall risk assessment tool and policy on use |
| Absent or inconsistent patient and family pre-operative fall prevention education | * Reference the Center Fall Prevention Policy and Procedure, and tools * Display patient fall prevention poster * Ensure all patients and family members receive fall prevention education in pre-operative area * Provide patient falls brochure to patient/family |
| Patient and family awareness and acknowledgment of the patient risk for falls | * Patient expectation is a critical factor in preventing falls * Inform of the patient of what to expect in recovery * Let the patient know they may feel fine but the sedation/anesthesia places them at a high risk for falls * Set the expectation that a nurse or designee with be responsible for assisting them with dressing and walking * Document their acknowledgement in the chart |
| Patient on one or more medications increases the risk of falls (e.g., antidiabetic agents, cardiovascular agents, antipsychotic agents, anticonvulsants, anticholinergics, and analgesics | * Patient education on medication side effects and the increased risk of falls * Provide patient falls brochure to patient/family |
| Patient did not know about, forgot about or did not to use call light | * Let the patient know they may feel fine but the sedation/anesthesia places them at a high risk for falls * Educate patient and family on the use and indications for using the call light for assistance * Place call light at patient side and reinforce use when using the restroom or getting into and out of bed |
| Patient did not know about, forgot about or did not seek help and fell while toileting | * Let the patient know they may feel fine but the sedation/anesthesia places them at a high risk for falls * Educate patient on the using the call light for assistance when toileting * Place call light at patient side and reinforce use when using the restroom or getting into and out of bed |
| Patient did not know to, forgot to or did not seek help and fell while dressing | * Let the patient know they may feel fine but the sedation/anesthesia places them at a high risk for falls * Educate patient and family on need for nursing assistance when dressing * Educate patient that family can be present while the nurse or designee is assisting with dressing * Place call light at patient side and reinforce use when ready to get out of bed to get dressed |

**Remember:**

* It is important that *all staff* receive the same education and training regarding patient fall prevention
* Pre-operative fall risk education to the patient and family is critical in falls prevention
* Treat *all* patients as a fall risk post-sedation
* The nurse or center designee should assist *every*patient with dressing and ambulation *- do not rely on the family*