Fall

DEFINITION/PATHOPHYSIOLOGY

A patient fall is an unplanned descent to the floor with or without injury to the patient. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Include assisted falls, such as when a staff member attempts to minimize the impact of the fall.

SIGNS & SYMPTOMS

- Bruising
- Bone fractures
- Bleeding
- Loss of balance
- Pain
- Difficulty walking
- Altered consciousness

ASSESSMENT:

History

Assess for circumstances associated to increase the level of fall risk: upon admission to unfamiliar surroundings; following any alteration in the patient's physical condition or cognitive status; whenever a fall happens; systematically during a hospital stay; or at defined times in long-term care settings.

Assess the patient's environment for factors known to increase fall risk such as unfamiliar setting, inadequate lighting, wet surfaces, waxed floors, clutter, and objects on the floor.

Physical-Mental

- Mental status changes
- Age-related physical changes
- Sensory deficits
- Balance and gait
- Use of mobility assistive devices
- Disease-related symptoms
- Medications
- Unsafe clothing

Nursing Interventions

- For patients at risk for falls, provide signs or secure a wristband identification to remind healthcare providers to implement fall precaution behaviors.
- Transfer the patient to a room near the nurses' station.
- Move items used by the patient within easy reach, such as call light, urinal, water, and telephone.
- Respond to call light as soon as possible.
- See to it that the beds are at the lowest possible position. If needed, set the patient's sleeping surface as adjacent to the floor as possible.
- Use side rails on beds, as needed. For beds with split side rails, leave at least one of the rails at the foot of the bed down.
- Avoid the use of restraints to reduce falls.
- Guarantee appropriate room lighting, especially during the night.
- Encourage the patient to don shoes or slippers with nonskid soles when walking.
- Familiarize the patient to the layout of the room. Limit rearranging the furniture in the room.
- Provide heavy furniture that will not tip over when used as support when patient is ambulating. Make the primary path clear and as straight as possible. Avoid clutter on the floor surface.
- Bed and chair alarms must be secured when patient gets up without support or assistance.
- Provide the patient with chair that has firm seat and arms on both sides. Consider locking wheelchair wheels as appropriate.
- Inform patient the advantage of wearing eyeglasses and hearing aids and to have these checked regularly.
- Consider physical and occupational therapy sessions to assist with gait techniques and provide the patient with assistive devices for transfer and ambulation. Initiate home safety evaluation as needed.
- If patient has a new onset of confusion (delirium), provide reality orientation when interacting. Have family bring in familiar items, clocks, and watches from home to maintain orientation.

Patient Teaching

- Teach patient how to safely ambulate, including using safety measures such as handrails in bathroom.
- Appropriate use of mobility/ambulation devices.

Cultural Considerations

Assess the patient's religious beliefs or practices that affect health and disease management.

Assess the patient's beliefs about the treatment plan.

Coordinating Care with Nursing Assistant

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