When a Patient Falls

- Complete vital signs and Physical Assessment per clinical judgement
- Address immediate needs and assist patient to safe position

*Do not move the patient if suspicious of spinal injury or long bone deformity

Unwitnessed and/or known head injury

Ongoing Assessments

- Vital signs
- Glasgow Coma Scale of Neurological assessment EHR
- Neuromuscular Strength assessment of 4 limbs in EHR

q1hour x 4 then q4hour until 24 hours

Witnessed and no head injury

Ongoing assessment will be specific to injury if injury occurred

- Document assessments in EHR
- Complete an up-to-date Fall Risk Assessment and Fall Review PowerForm in EHR

- Notify MRP or delegate– Urgency based on patient condition/time of day
- Notify family/SDM as needed and/or if patient incapable
- Apply Yellow armband to patient and Yellow fall magnet to whiteboard
- Update Transfer Card
- Complete Least restraint documentation as needed
- Enter in Incident Management System