Fall Risk Assessment and Prevention POLICY NUMBER: CHS-QPS-001

Highlights from Policy CHS-QPS-001: Please read policy for DETAIL

POLICY:
A patient fall is defined as: a sudden, unintentional descent with or without injury to the patient that results in the patient coming to rest on the floor, on or against some other surface (e.g. a counter) on another person, or on an object or in which any staff member (whether a nursing service employee or not) / family member was with patient and attempted to minimize the impact of the fall by slowing the patient's descent.

If patient has a fall the following notifications are recommended, these notifications should be documented in the medical record. A. Nurse Manager / Nursing Supervisor
B. Attending Physician
C. House Physician / Resident (When attending is not available to provide an assessment)
D. Patient's Family by the end of the shift if the patient has no injury

6. The patient should be **assessed by a LIP following a fall** and the **assessment** should be **documented** in the medical record.
 If the patient is on anticoagulation, has any injury to the head or it cannot be determined if the patient hit his/her head, a head **CT scan is recommended**
 If the patient is on anticoagulation and has any injury to the head or it cannot be determined if the patient hit their head, **neuro checks are recommended to be completed Q1 hours x 4 then Q2 hours x 4.**

7. An interdisciplinary team reviews falls prevention protocols and analysis fall data with the intent to identify potential risk reduction strategies.