# Falls Risk Nursing Protocol Overview

**Falls Risk Assessment per Last Word** | **Corresponding Falls Protocol Orders** | **Tips**
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**Automatic High Risk:**  
Fall History  
- Patient has history of 1+ fall in last 6 months  
- Patient had a recent fall event that lead to this hospital admission.  
- Patient has experienced a fall during this hospitalization.  
**Related Diagnoses**  
- Syncope/near Syncope > 50 y/o  
- Acute seizures  
- Acute/chronic cognitive changes (including delirium and ETOH)  
- Symptomatic hypotension  
- Vertigo  
**Automatic High Falls Risk:**  
- **High falls risk equipment:** low bed and falls alarm  
- Nurse alert: Place high falls risk signage  
  - Yellow falls sticker on patient’s identification bracelet  
  - Check “Falls” box on “Alert Tag” on front of patient chart  
  - Red falls risk indicator on patient’s whiteboard  
- Nurse alert: Remain within arms’ reach of the patient when out of bed/chair  
- Level of assistance per Q shift nursing assessment; must = assist/one or greater  
- Rounding for results  
**Tips:**  
- If any one item of the patient’s fall history or related diagnoses is checked, the patient is categorized as an automatic high falls risk. *You do not need to score the patient using the tool.*  
- Implement automatic High Fall Risk Protocol throughout hospitalization  
- **ALL** interventions must be selected for Auto High Risk patients  
  - **Exceptions:** mechanically ventilated patients & 3West patients do not require low bed/equipment

**High Falls Risk:**  
*Total Score from assessment = > 13*  
**High Falls Risk:** *(equipment is the only optional intervention and is based on nursing judgment)*  
- High falls risk equipment: low bed and falls alarm  
- Nurse alert: Place high falls risk signage  
  - Yellow falls sticker on patient’s identification bracelet  
  - Check “Falls” box on “Alert Tag” on front of patient chart  
  - Red falls risk indicator on patient’s whiteboard  
- Nurse alert: Remain within arms’ reach of the patient when out of bed/chair  
- Level of assistance per Q shift nursing assessment; must = assist/one or greater  
- Rounding for results  
**Tips:**  
- Falls risk equipment is the **ONLY** optional intervention for a High Falls Risk patient and this decision should be made based on nursing judgment

**Moderate Falls Risk:**  
*Total score from assessment = 6-13*  
**Moderate or Low Falls Risk Orders:**  
- Nurse alert: Place moderate or low falls risk signage  
  - Yellow/green falls risk indicator on patient whiteboard  
- Level of assistance per every shift nursing assessment  
- Nurse alert: Rounding for results  
**Tips:**  
- If you feel that a moderate or low risk patient could benefit from additional interventions, please order them to help prevent falls and patient harm

**Low Falls Risk:**  
*Total score from assessment = 0-5*  
**Auto Low Falls Risk Orders:**  
- Nurse alert: Place low falls risk signage  
  - Green falls risk indicator on patient whiteboard  
- Level of assistance = total assist  
- Nurse alert: Rounding for results  
**Tips:**  
- If the patient is categorized as an automatic low falls risk, you do not need to score the patient using the tool

**Auto Low Risk:** Complete paralysis, or completely immobilized.  
**Auto Low Falls Risk Orders:**  
- Nurse alert: Place low falls risk signage  
  - Green falls risk indicator on patient whiteboard  
- Level of assistance = total assist  
- Nurse alert: Rounding for results

**Reminders:**  
- **ALL** patients need a Falls Protocol entered — the difference will be in the level and interventions selected  
- Please enter your employee number in the “Ordered By” field and select “Per Protocol” — these are all Nursing orders