STANDARD OPERATING PROCEDURE

Patient Fall Prevention SOP

Document no.	SOP-HLC-009
Revision	1.0
Owner	Nurse Manager
Effective date	September 15, 2026
Review cycle	Every 12 months

1. Purpose

To identify patients at risk of falling early, apply consistent interventions, and reduce the number and severity of falls on the unit.

2. Scope

Applies to fall risk assessment and prevention for adult inpatients. Pediatric fall prevention and response to a fall that has already occurred are covered by separate SOPs.

Definitions

Fall risk assessment	A standardized tool used to score a patient's likelihood of falling based on factors such as mobility, medications and mental status.
Hourly rounding	A scheduled check-in with the patient roughly every hour to address needs such as pain, positioning, toileting and personal items within reach.
Bed alarm	A device that alerts staff when a patient attempts to get out of bed unassisted.

3. Responsibilities

Registered Nurse (RN)	Completes the fall risk assessment, sets up interventions and reassesses risk after any status change.
Nursing Assistant (CNA)	Performs hourly rounding, assists with mobility and toileting, and reports changes in patient condition.
Charge Nurse	Confirms high-risk patients have interventions in place and reviews fall incidents on the unit.
Physical Therapist	Assesses mobility for high-risk patients and recommends assistive devices or activity levels.

RACI matrix

Activity	Registered Nurse (RN)	Nursing Assistant (CNA)	Charge Nurse	Physical Therapist
Complete the fall risk assessment	R/A	I	I	C
Set up fall prevention interventions	R/A	R	I	C
Perform hourly rounding	R	R/A	I	-

Activity	Registered Nurse (RN)	Nursing Assistant (CNA)	Charge Nurse	Physical Therapist
Assess mobility for high-risk patients	C	I	I	R/A

R = Responsible, A = Accountable, C = Consulted, I = Informed

4. Materials and PPE

Materials, tools and systems

- Fall risk assessment tool in the EHR
- Bed and chair alarms
- Yellow fall-risk wristbands and door or bed signage
- Non-slip socks or footwear
- Hourly rounding log or checklist
- Assistive mobility devices (gait belt, walker, cane)

5. Procedure

Step	Task	Owner	Done
5.1	**Complete the fall risk assessment on admission** Complete the standardized fall risk assessment tool in the EHR within the required timeframe of admission, scoring mobility, medications, mental status and fall history.	Registered Nurse (RN)	☐
5.2	**Reassess after any status change** Repeat the fall risk assessment after a change in condition, a new sedating medication, a procedure, or a transfer, in addition to the routine reassessment schedule. **Checkpoint:** Fall risk is reassessed after any significant change in condition, not only on the routine schedule.	Registered Nurse (RN)	☐
5.3	**Apply the fall-risk identifier** For patients scoring as high risk, apply the yellow wristband and post door or bed signage so all staff recognize the risk at a glance.	Registered Nurse (RN)	☐
5.4	**Set up the patient environment** Keep the bed in the lowest position with brakes locked, the call light and personal items within reach, and the path to the bathroom clear of clutter and cords.	Nursing Assistant (CNA)	☐
5.5	**Activate bed or chair alarms for high-risk patients** Turn on and test the bed or chair alarm for patients identified as high risk, and confirm it is functioning before leaving the room. **Checkpoint:** Bed and chair alarms for high-risk patients are tested and confirmed active at the start of each shift.	Registered Nurse (RN)	☐
5.6	**Provide non-slip footwear** Provide non-slip socks or the patient's own non-slip footwear before any out-of-bed activity.	Nursing Assistant (CNA)	☐
5.7	**Request a mobility assessment for high-risk patients** Refer high-risk or newly deconditioned patients to physical therapy for a mobility assessment and recommended assistive device or activity level.	Registered Nurse (RN)	☐

Step	Task	Owner	Done
5.8	**Assist with transfers and ambulation** Use a gait belt and the recommended number of staff for transfers and ambulation according to the mobility assessment, never leaving a high-risk patient unattended during a transfer. **Warning:** Never leave a high-risk patient unattended while out of bed or mid-transfer.	Nursing Assistant (CNA)	☐
5.9	**Perform hourly rounding** Round on every patient approximately every hour, addressing pain, positioning, toileting needs and placement of personal items within reach.	Nursing Assistant (CNA)	☐
5.10	**Respond promptly to call lights and alarms** Answer call lights and bed or chair alarms as quickly as possible, especially for patients flagged as high fall risk.	Nursing Assistant (CNA)	☐
5.11	**Communicate fall risk at handover** Include fall risk status, active interventions and any recent near-misses in the shift handover report for every patient.	Registered Nurse (RN)	☐
5.12	**Review fall trends with the unit** Review fall and near-miss data at unit meetings, identify recurring contributing factors, and adjust interventions or staffing where needed.	Charge Nurse	☐

6. Quality checks

- 100 percent of admissions have a fall risk assessment completed within the required timeframe.
- All identified high-risk patients have an active bed or chair alarm and visible signage.
- Hourly rounding is documented for every patient every shift.
- Fall risk status is included in every shift handover report.

7. Records

- Fall risk assessment scores in the EHR
- Hourly rounding log
- Fall and near-miss incident reports
- Physical therapy mobility assessment notes

8. KPIs

- Falls per patient days
- Percentage of high-risk patients with active interventions in place
- Hourly rounding compliance rate
- Falls with injury as a share of total falls

9. Common mistakes

- Leaving a bed alarm turned off after repositioning the patient.
- Skipping fall risk reassessment after a new sedating medication is given.
- Leaving a high-risk patient unattended on the toilet or during a transfer.
- Not mentioning fall risk status during shift handover.

10. Revision history

Revision	Date	Description	Reviewed by

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1.0	September 15, 2026	Initial release	Ilia Pirozhenko

Approval

Prepared by	Approved by	Date

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