STANDARD OPERATING PROCEDURE

# Patient Fall Prevention SOP

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| **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

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| **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

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| **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**<br>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**<br>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.<br>**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**<br>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**<br>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**<br>Turn on and test the bed or chair alarm for patients identified as high risk, and confirm it is functioning before leaving the room.<br>**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**<br>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**<br>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**<br>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.<br>**Warning:** Never leave a high-risk patient unattended while out of bed or mid-transfer. | Nursing Assistant (CNA) | ☐ |
| 5.9 | **Perform hourly rounding**<br>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**<br>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**<br>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**<br>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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