STANDARD OPERATING PROCEDURE

# Resident Fall Response SOP

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| **Document no.** | SOP-SNR-004 |
| **Revision** | 1.0 |
| **Owner** | Director of Nursing |
| **Effective date** | September 15, 2026 |
| **Review cycle** | Every 12 months |

## 1. Purpose

To respond safely and consistently when a resident falls, assess for injury before moving them, notify the right people promptly, and reduce the chance of a repeat fall.

## 2. Scope

Applies to the immediate response after a witnessed or found fall involving a resident. Routine fall risk prevention measures are covered by a separate SOP.

### Definitions

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| **Witnessed fall** | A fall observed directly by a staff member as it happens. |
| **Found fall** | A fall discovered after the fact, where the resident is found on the floor or shows signs of having fallen. |
| **Post-fall huddle** | A short team discussion held after a fall to identify contributing factors and adjust the care plan to reduce repeat risk. |

## 3. Responsibilities

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| **Certified Nursing Assistant (CNA)** | Stays with the resident, calls for help and assists the nurse with the response. |
| **Licensed Nurse (LPN/RN)** | Assesses the resident for injury, decides on safe handling and notifies the physician and family. |
| **Director of Nursing** | Reviews the incident report, leads the post-fall huddle and tracks fall trends. |
| **Family Member / Responsible Party** | Is notified of the fall and any resulting care changes. |

### RACI matrix

| Activity | Certified Nursing Assistant (CNA) | Licensed Nurse (LPN/RN) | Director of Nursing | Family Member / Responsible Party |
|---|---|---|---|---|
| Stay with the resident and call for help | R/A | I | - | - |
| Assess the resident and decide on safe handling | C | R/A | I | - |
| Notify the physician and family | I | R/A | I | I |

| Activity | Certified Nursing Assistant (CNA) | Licensed Nurse (LPN/RN) | Director of Nursing | Family Member / Responsible Party |
|---|---|---|---|---|
| Lead the post-fall huddle and update the care plan | C | R | R/A | I |

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

## 4. Materials and PPE

### Materials, tools and systems

- Fall incident report form
- Vital signs equipment
- Post-fall assessment checklist
- Care plan for updating fall risk interventions
- Physician and family notification log

### Personal protective equipment

- Disposable gloves

## 5. Procedure

| Step | Task | Owner | Done |
|---|---|---|---|
| 5.1 | **Stay with the resident and call for help**<br>Do not leave the resident alone; call out or use the call system to get another staff member to bring help and equipment. | Certified Nursing Assistant (CNA) | ☐ |
| 5.2 | **Do not move the resident immediately**<br>Do not attempt to move or lift the resident until a licensed nurse has assessed them, unless there is an immediate danger such as fire that requires moving them.<br>**Warning:** Never move a resident before a nurse assesses for possible injury, especially head or spine injury, unless there is an immediate danger. | Certified Nursing Assistant (CNA) | ☐ |
| 5.3 | **Assess the resident for injury**<br>Check the resident's level of consciousness, look for visible injury, bleeding or deformity, and ask about pain before deciding how to proceed.<br>**Checkpoint:** A licensed nurse assesses for injury before the resident is moved or repositioned. | Licensed Nurse (LPN/RN) | ☐ |
| 5.4 | **Call emergency services if warranted**<br>Call emergency services immediately if the resident shows signs of a serious injury, cannot be safely assessed, or per your facility's clinical judgment protocol.<br>**Warning:** When in doubt about a possible head, spine or hip injury, call emergency services rather than attempting to move the resident yourself. | Licensed Nurse (LPN/RN) | ☐ |
| 5.5 | **Assist the resident up safely if appropriate**<br>If no signs of serious injury are found and it is safe to do so, use a proper lift technique or mechanical lift and the appropriate number of staff to assist the resident up. | Licensed Nurse (LPN/RN) | ☐ |
| 5.6 | **Take vital signs**<br>Take and document vital signs immediately after the fall and again at the intervals required by facility policy over the following hours. | Licensed Nurse (LPN/RN) | ☐ |

| Step | Task | Owner | Done |
|---|---|---|---|
| 5.7 | **Notify the physician**<br>Notify the resident's physician of the fall, the assessment findings and any injury identified, following facility policy for timing.<br>**Checkpoint:** The physician is notified of every fall, with the assessment findings, before the end of the shift. | Licensed Nurse (LPN/RN) | ☐ |
| 5.8 | **Notify the family or responsible party**<br>Notify the resident's family or responsible party of the fall and the resident's current condition promptly. | Licensed Nurse (LPN/RN) | ☐ |
| 5.9 | **Increase monitoring after the fall**<br>Increase observation frequency for the resident following the fall, watching for delayed symptoms such as increasing pain, confusion or swelling. | Certified Nursing Assistant (CNA) | ☐ |
| 5.10 | **Complete the incident report**<br>Document the circumstances of the fall, the response taken, assessment findings and notifications made on the fall incident report form. | Licensed Nurse (LPN/RN) | ☐ |
| 5.11 | **Hold the post-fall huddle**<br>Gather the involved staff shortly after the fall to review what happened, identify contributing factors such as footwear, lighting or timing, and agree on any immediate changes. | Director of Nursing | ☐ |
| 5.12 | **Update the care plan**<br>Update the resident's care plan and fall risk interventions based on the huddle findings, and communicate the changes to the full care team. | Director of Nursing | ☐ |

## 6. Quality checks

- Every fall has a licensed nurse assessment documented before the resident is moved.
- Physician and family notification is documented for every fall.
- A post-fall huddle is held and documented for every fall.
- Vital signs are taken and documented at the required intervals following a fall.

## 7. Records

- Fall incident report
- Post-fall vital signs log
- Physician and family notification log
- Post-fall huddle notes and care plan updates

## 8. KPIs

- Falls per resident days
- Percentage of falls with a documented nurse assessment before moving the resident
- Time from fall to physician notification
- Repeat fall rate for the same resident within 30 days

## 9. Common mistakes

- Helping a resident up right away without a nurse assessing for injury first.
- Delaying physician notification until the next scheduled check-in.
- Skipping the post-fall huddle when the fall seems minor.
- Not increasing observation frequency after a fall with no obvious injury.

## 10. Revision history

| Revision | Date | Description | Reviewed by |
|---|---|---|---|
| 1.0 | September 15, 2026 | Initial release | Alexa Uskova |

## Approval

| Prepared by | Approved by | Date |
|---|---|---|
| | | |

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