



The Importance of Fall Risk Assessment

First of a Series on Fall Risk Assessment...

As a nurse, it may sometimes be difficult to identify which patients are at risk for falls. This usually is due to the fact that the patient may not disclose this information and many of them may not appear to be at risk. Fall risk assessments are a crucial tool in identifying which patients could be at risk and therefore a candidate for a fall prevention intervention, such as Bed Check. Identification is the first step in fall prevention. This enables nurses to recognize those patients who are at high risk for falls and then initiate appropriate interventions. The Joint Commission mandates patients to be assessed and periodically reassessed for fall risks. The National Patient Safety Goal 09.02.01 requires organizations to implement and evaluate fall reduction programs.

Fall risk assessments not only identify patients at risk, but also aid in recognizing the type of intervention that should be utilized. They also assist in increasing staff knowledge in fall risk prevention and intervention. Fall risk assessments help the staff identify risk factors such as past falls or symptoms of dizziness, incontinence, confusion, etc. After identifying the patients that are a risk for falls, the appropriate interventions can be initiated to reduce falls at your hospital or facility.

Assessment Basics:

- Baseline fall risk assessments should be conducted on admission or within two hours
- An initial evaluation should be completed on all patients
- Elderly patients or other patients with risk factors should be given a more in-depth assessment
- Ongoing fall risk assessments help nurses identify changes in the patient's condition that might place that patient at risk for a fall

References: www.jointcommission.org