### 1. Understands how patients are assessed for falls by RN.
   - a. DUHS Fall Assessment Tool identifies patients at high risk for falls based on:
     - History of falls
     - Alterations in gait and/or mental/behavior
     - Additional factors such as sensory alterations, medications, co-morbid conditions, equipment, bowel/bladder alterations, or abnormal lab values
   - b. Communicates inconsistencies in falls risk with RN; notifies nurse if patient is:
     - NOT identified as HIGH falls risk but should be, i.e. patient fell in your department or PT/OT determine high falls risk per therapy assessment
     - No longer HIGH falls risk, but is still wearing yellow wristband and socks

### 2. Identifies patients at HIGH risk for falls.
   - a. Yellow armband
   - b. Yellow socks
   - c. Signage on door

### 3. Understands components of safety rounds and assists patients with 4 “P”s.
   - a. Potty: Stays within arm’s reach of patient at all times when in bathroom
   - b. Position:
     - Keeps bed/stretcher in low position and locked
     - Places call bell in patient’s reach
     - Ensures patient necessities are within reach (i.e., call light, phone, glasses)
     - Alters environment to maximize mobility (i.e., removes obstacles, IV pole on side of bed where bathroom is located)
   - c. Pain: Facilitates pain management with RN
   - d. Partner: Supports RN education of family to notify RN when leaving room and patient alone and to call for health care personnel to assist patient out of bed/chair to bathroom

### 4. Supports plan of care for patient identified as HIGH risk for falls.
   - a. Yellow armband
   - b. Yellow socks
   - c. Signage on door
   - d. Sets and maintains bed and chair alarms on all patients at HIGH risk for falls
   - e. Documentation
   - f. Identifies patient who has fallen since admission by “Red Leaf”

### 5. Verbalizes action to take when fall occurs.
   - a. Communicates with RN
   - b. Participates in post-fall huddle
   - c. Completes documentation in SRS file
   - d. Documents facts related to a fall in patient chart without reference to SRS

### 6. Verbalizes process for post-fall huddle.
   - a. Calls “CODE fall” for patient that falls
   - b. Participates in discussion regarding falls incident
     - What happened?
     - What should/could have been in place to prevent this fall?
     - What can be done to prevent another fall with this patient?