****

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 1. Review Fall Prevention Policy located on Intranet

**I attest that I have completed and understand the above, prior to performing task:****Learner’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

 **When you are ready, notify the validator to assess your return demonstration.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Competency** | **Met** | **Unmet** | **Comments** |
| Identity those patients at risk for falls:* Drug, Alcohol abuse on admission
* Fall history within the past 3 months
* Impulsive behavior
* Lethargic/sedated/confused
* Responsive patients at risk for falls that do not follow fall precautions
* Use of assistive devices for ambulation: cane/walker/crutch
* Urinary/bowel Incontinence, urgency, frequency
* Decreased muscle coordination
* Tethered device, e.g., intravenous pole, Foley catheter
* Unsteady gait
 |  |  |  |
| Make sure patient’s fall risk is identified on Mycare board and overhead light  |  |  |  |
| Implement fall bundle (yellow bracelet/yellow socks/fall risk on door frame if applicable) |  |  |  |
| If patient refuses bed/chair alarm notify nurse/nurse leader immediately and document |  |  |  |
| Check the patient for possible dangers and clutter when rounding and correct immediately. |  |  |  |
| Ensure the call light is within the patient's reach; provide adequate lighting, place the patient's personal belongings and assistive devices within reach. |  |  |  |
| Make sure bed is in its lowest position and bed wheels are locked |  |  |  |
| Make sure surfaces are clean and dry, and when needed clean up spills. |  |  |  |
| Have a gait belt readily available on workstation. |  |  |  |
| Use a chair alarm before sitting high risk patients in chair. |  |  |  |
| Demonstrates proper utilization of bed/chair alarm. Set bed alarm on appropriate setting and when rounding hourly check alarm to ensure it is set. |  |  |  |
| Notifies nurse before ambulating patient. |  |  |  |
| Encourages patient to call before getting up out of bed. |  |  |  |
| Address 4Ps during rounding (pain/potty/position/possessions) |  |  |  |
| States process when bed/chair alarm broken or not available |  |  |  |

I acknowledge that I am knowledgeable to perform the tasks or manage the equipment documented above based upon the criteria statement as a result of training and experience.

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**Employee Signature Date**

**Competency Met: \*Reevaluation Completed (If needed)**

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**Evaluators Signature Date Evaluators Signature Date**

\*Reevaluation should be completed within 30 days of initial assessment

Fall Prevention Post Test

1. Which patient is consider a fall risk?
2. 19 yr. old male with diagnosis of UTI
3. 34 yr. old female with diagnosis of Asthma
4. 70 yr. old male with diagnosis of dizziness
5. 80 yr. old female with diagnosis of pneumonia
6. Who should respond to a bed alarm?
7. Nursing Assistant assigned to patient
8. Registered Nurse assigned to patient
9. Nursing Assistant and RN assigned to patient
10. Everyone
11. When a patient is high risk for falls should you get the patient up out of bed alone?
12. Yes
13. No
14. What is a part of the fall bundle?
15. Yellow Bracelet
16. Bed/chair alarm
17. Yellow nonskid socks
18. Fall Risk identified on the board
19. All of the above
20. When should you check the bed alarm to make sure it is set properly?
21. When you are completing vital signs
22. When the patient presses the call light
23. When you are hourly rounding
24. Whenever you go into the room
25. All of the above