(RISK FOR FALL) NURSING CARE PLAN

Medical Diagnosis: Risk for Fall		
Subjective Data: • Weakness • Dizziness	**Nursing Intervention (ADPIE)**	**Rationale**
	Apply risk for Fall Band (yellow band)	This alerts staff this patient is at risk for fall
	Instruct patient to use the call light for assistance before getting up (may put up signs on walls/board as reminders for them)	Patient safety is number one priority. Want to make sure they have assistance to do anything to avoid a fall
	Place patient close to nurses station	This provides increased observation and better ability for the nurse to respond quickly to the patient if needed
Objective Data: • Hypotension • Confusion • Sensory deficit • Unsteady gait	Activate bed alarms/chair alarms- respond promptly when they go off	Helps prevent a fall from happening
	Make sure bed is in the lowest position possible and a fall mat placed/non skid socks on	Some patients still may end up out of bed quicker then you can respond. These further measures may not prevent the fall, but reduce the risk of injury Non-skid socks-allow patient to not slip walking on the floor
	Lock bed/chair wheels in place	Furnturing moving while patient is trying to sit down or sit up may cause them to lose balance and fall
	Place personal items within reach for the patient	Trying to reach for items on the table or somewhere else in the room can cause a patient to lose balance and fall
	PT/OT consults	Frequent exercises and gait training may help improve muscle strength and balance decreasing fall risk. Also, using canes, walkers, and wheelchairs may be necessary.

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