

1) When should a falls assessment be done on your patient? List 3 instances:

2) Give examples of what a change in status would be for your patient:

3) List 3 places the Fall Risk Assessment is documented:

4) When is the Yellow Arrow Protocol Implemented?

5) List the interventions for patients on the Yellow arrow Protocol:

**Falls (con't.)**

**2010**

6) You are walking into your patients room and see her getting out of bed when slips on some water which had spilled on the floor. As a witnessed fall - what nursing interventions will you initiate on this patient?

**Witnessed fall:**

7) If your patient who has fallen was also complaining of neck pain what additional nursing interventions would you anticipate will be completed for this pt.?

8) How would the process change if your patient fell at an offsite location and was c/o neck pain?