

## **Minimizing Postoperative Fall Risk: A PACU Fall Prevention Bundle**

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**Introduction:** Postoperative patients are inherently at higher risk for falls due to mobility limitations, effects of anesthesia, surgical pain, and the use of opioid and sedative medications. Falls in the Post Anesthesia Care Unit (PACU), as identified through Keepsafe data, frequently occurred during ambulation, toileting, and dressing, often when patients were assisted by an escort/family member. These incidents, occurring across multiple age groups, highlighted the need to strengthen fall prevention during recovery and discharge. A comprehensive “Fall Prevention Bundle” was developed to reduce preventable falls and improve staff adherence to safety practices.

**Identification of the Problem:** Increase in patient falls in 2025. Six falls in 2025 vs. one fall in 2024.

**QI Question/Purpose of the Study:** To minimize postoperative fall risk in the perioperative setting.

**Methods:** Pre- and post-intervention (July and Sept–Oct 2025), Keepsafe data and chart audits assessed Morse Fall Assessment accuracy and staff dressing assistance during discharge. In August 2025, the “Fall Prevention Bundle” was implemented, featuring preoperative staff education, preoperative patient teaching on postoperative fall risk, removal of surgical pants pre-op, availability of ambulatory devices, clinical assistance with dressing, and safety signage reminding patients to request help and remain seated while changing.

**Outcomes/Results:** Pre-intervention (Jan-July 2025), six patient falls were reported in the PACU. Post-intervention (Sept-Oct 2025), no fall occurred. Direct observations preintervention (N=18) revealed the majority of patients were provided dressing assistance by escort/family. Post-intervention (N=22), 86% of the cases a clinical personnel (RN/PPA) provided patients dressing assistance upon discharge.

**Discussion:** The “Fall Prevention Bundle” reduced PACU falls from six to zero, demonstrating the effectiveness of education, environmental cues, and team collaboration. Increased staff participation in assisting patients during discharge improved safety adherence. Continued education, monitoring, and teamwork are essential to sustain these results.

**Conclusion:** The “Fall Prevention Bundle” eliminated PACU falls, highlighting the impact of standardized, team-based strategies. Ongoing monitoring and education are key to sustaining safety.

**Implications for perianesthesia nurses and future research:** Perianesthesia nurses are essential in preventing postoperative falls through vigilant assessment, patient education,

and teamwork. Standardized fall prevention bundles enhance safety and consistency in care. Future research should explore long-term sustainability and replication of this model across diverse perioperative settings.