A multi-disciplinary committee spanning the organization’s various clinics was created to establish a standardized process for assessing a patient’s risk of falling and steps to be taken immediately after a fall. This was important to establish the need for clinician decision-making related to specific diagnosis and encompass all disciplines of care.

This committee produced process improvements to the steps to establish fall risk, communicated risk amongst the team, and defined actions immediately after the fall to maximize patient care and safety.

Research\textsuperscript{1,3}, supports the use of fall prevention algorithms and assessments; however, the use of the STEADI was studied and intended for those 65 and older not all non-pediatric individuals. Similarly, the Humpty Dumpty Fall Scale identifies hospitalized children not outpatients at risk for fall; therefore, limitations existed in the ability to consider assessments as valid and reliable outcome measure, but merely a screen to maximize patient safety and generate need for additional multidisciplinary referrals and/or testing.

A reduction in overall falls was noted throughout the organization, specifically in the Outpatient SCI Clinic. While the fall reduction number was not statistically significant for the 6-month data collection following the project implementation, it is anticipated that over time this trend in reduction of falls will produce significant results. Overall, this design is both feasible and clinically appropriate to implement in advanced outpatient clinical practice settings to ensure both patient and staff safety.

\textbf{References}