GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

Fall Prevention Protocol

PATIENT/FAMILY INFORMATION SHEET

Fall Information

Falls are a common occurrence in the elderly population. Approximately thirty three percent of people greater than age 65 and fifty percent of people over age 75 experience falls each year. Falls are the leading cause of accidental death in the elderly. The risk of falling may increase due to a change in one's environment or medical condition.

How do I know my family member is at risk to fall?

The Morse Fall Scale is an assessment tool that scores 6 items to determine if a patient is at risk for falling. The items include:

- History of falls
- Secondary diagnosis (more than one illness)
- Use of an ambulatory aide (walker, cane, furniture)
- Intravenous therapy
- Type of gait (ability to walk)
- Mental status

The range of scores on this tool is 0 to 100. Any patient receiving a score of 50 or greater is considered at risk for fall by the organization. The Registered Nurse (RN) starts the Fall Prevention Protocol.

What is a Fall Prevention Protocol?

The Fall Prevention Protocol is a series of steps that the RN and nursing assistants perform to maintain a safe environment for patients. An RN evaluates every adult patient using the Morse Fall Scale during their initial admission, daily physical assessment and when there is any change in the patient's status. The tool identifies a patient's risk to fall.

What are the steps of the Fall Prevention Protocol?

Every 2 hours nursing staff will perform the following steps:

- Toileting: assisting to the bathroom, performing commode or incontinence care
- Bed or chair alarm in place
- Call bell within reach of the patient
- Environmental rounds: removing clutter, appropriate lighting and bed in the lowest position
- Identified patients will have a "fall risk" decal placed outside their door underneath their room number and a "fall risk" sticker on the binding of their chart.

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When is the Fall Prevention Protocol stopped?

The Fall Prevention Protocol will be stopped once a patient scores below 50 points on the Morse Fall Scale with the RN's assessment.

Fall Risk Decal

Resources:

The Hartford Institute for Geriatric Nursing. http://www.hartfordign.org/index.html

Rubenstein, Powers & Maclean (2001) Quality indicators for the management and prevention of falls and mobility problems in vulnerable elders. Annals of Internal Medicine

For more Patient Education Fact Sheets, see the Greenwich Hospital web site at www.greenhosp.org and click on Patients & Visitors, then Patient Education

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