

**PARKLAND HEALTH & HOSPITAL SYSTEM
LEADERSHIP & ORGANIZATIONAL DEVELOPMENT**

**COMPETENCY VALIDATION
FALL PROTOCOL**

Name: _____ ID#: _____

Unit: _____ Date: _____

FALL PROTOCOL	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Assess patient utilizing Morse Fall Score (see below) on admission and every 8 to 12 hours, and document in flowsheet.			
2. On admission provide all patients educational materials “Tips to Keep You From Falling.”			
3. If patient has a risk score of 51 or greater, place patient on Fall Protocol. If patient is not placed on Fall Protocol document rationale in Nurses Notes.			
4. Using nursing judgment determine if patient should be placed on Fall Protocol based on patient history, condition, and medications.			
5. Initiate Nursing diagnosis, place “Fall Precautions” armband, sign on wall at head of bed, sign on outside of door, and sticker on the front of the chart.			
6. Patients on fall protocol will have rounds every hour to confirm: <ul style="list-style-type: none"> a. Bed is in low position b. Call light/Bell are in reach c. Personal effects are in reach d. Toileting offered if awake and allowed by treatment plan/condition e. Fluids offered if awake and allowed by treatment plan/condition f. Side rails are elevated as appropriate 			
7. Rounds will be documented by initialing the appropriate section of the “Daily Patient Care Record/Flow Sheet.”			
8. If a patient is on the Fall Protocol when transferred to another unit, the sending nurse will notify the receiving nurse of the Fall Protocol and rationale for use as part of “hand off communication.”			
9. Fall protocol shall be discontinued when the patient’s risk for fall score is less than 51 for more than 24 hours using nursing nursing judgment.			

The completion of this form validates the above nurse's competency for this skill.

#1 Pass / Fail Competency Validator Signature: _____

#2 Pass / Fail Competency Validator Signature: _____