Fall Prevention & Modified Morse Scale

Falls

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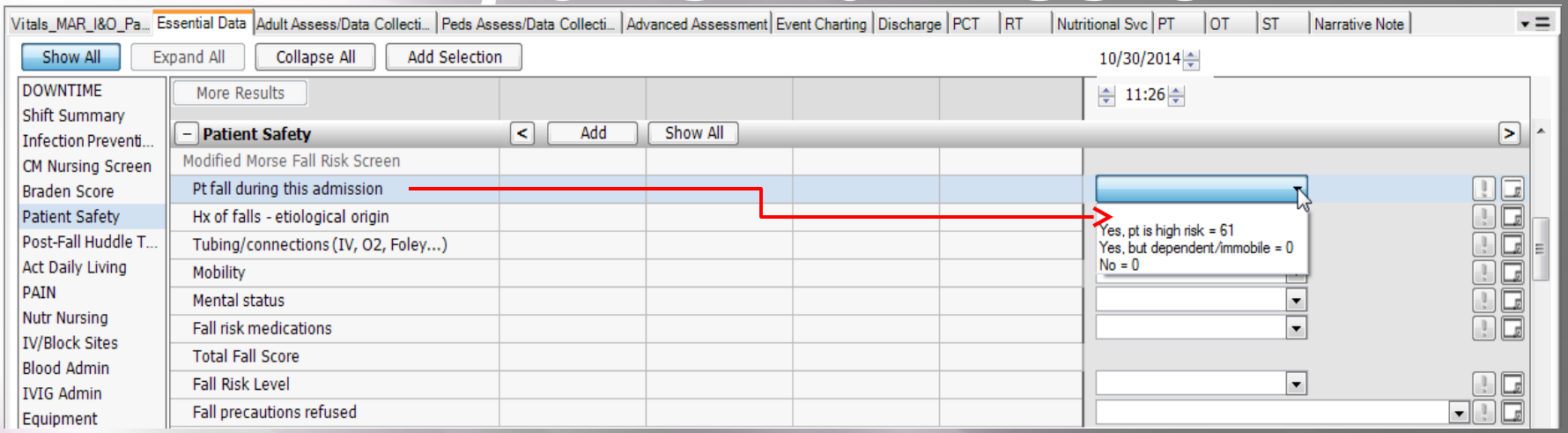
Any unplanned descent from one level to another

- Immediately notify charge nurse/nurse manager

Fall Prevention is of Critical Importance

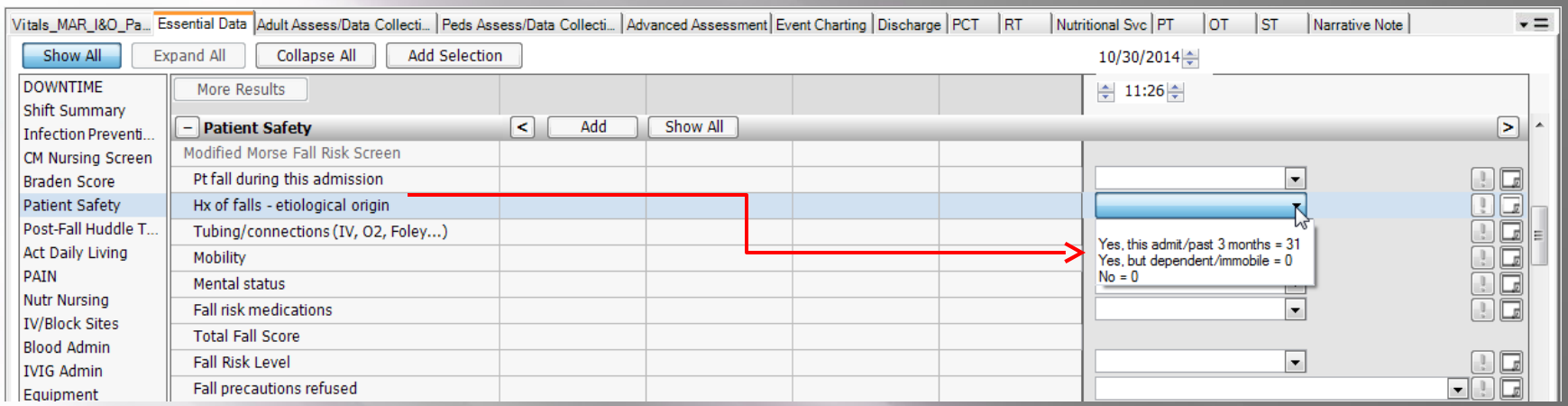
- Falls are strongly correlated with increased morbidity and mortality (rates as high as 50% depending on co-morbidity and level of injury at time of fall)
- The Modified Morse Scale was developed by representatives from SRH clinical team members to assist in reduction of falls
- The scale is to be completed no less than once per 12 hour period

Fall Risk: Has Patient Fallen During this Admission?



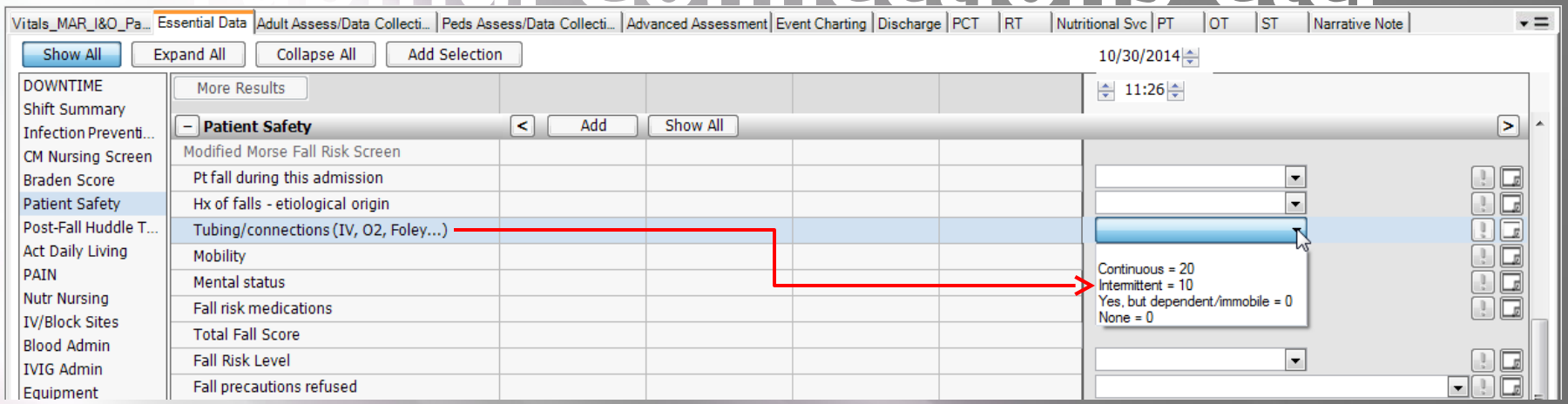
- Any patient who falls during their admission, regardless of fall-risk score at the time of the fall, is to automatically be made a high fall risk

Fall Risk: History of Falls



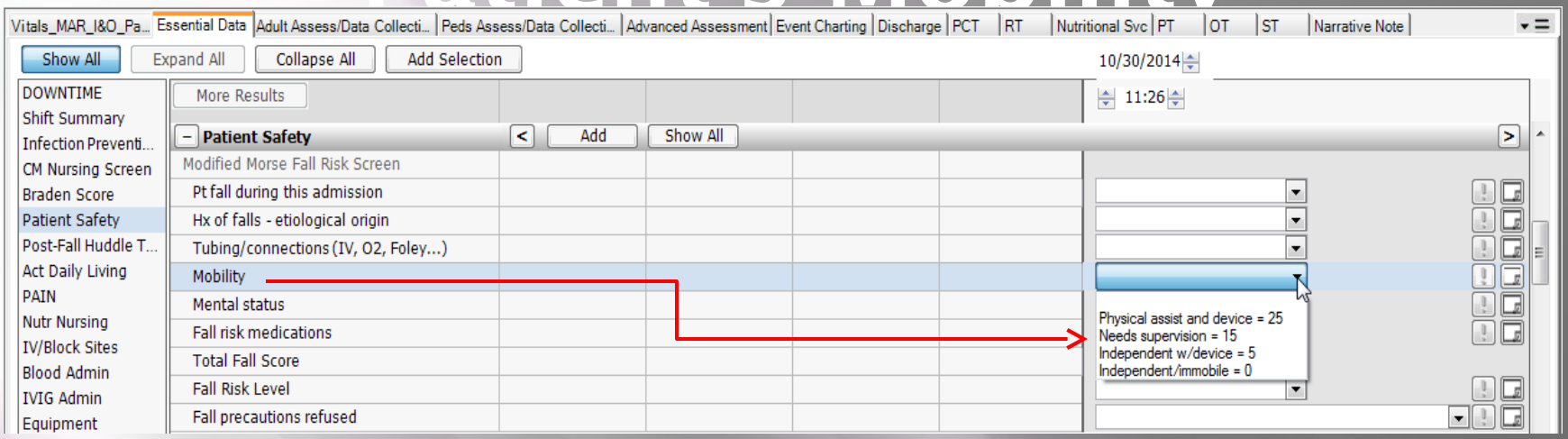
- A past history of falls prior to admission (ex: at home) is a good predictor of future falls
- The key issue for nursing related to this question is to determine whether or not the patient fell because of a physiological reason (ex: issues with balance, vision, orthostatic hypotension etc..) vs. a true accident (ex: patient states they were at Wal Mart and fell on a slippery floor
- Ask probing questions – these will help to determine if the nature and cause of fall was of an etiological nature

Fall Risk: Patients with Tubing, Connections etc.



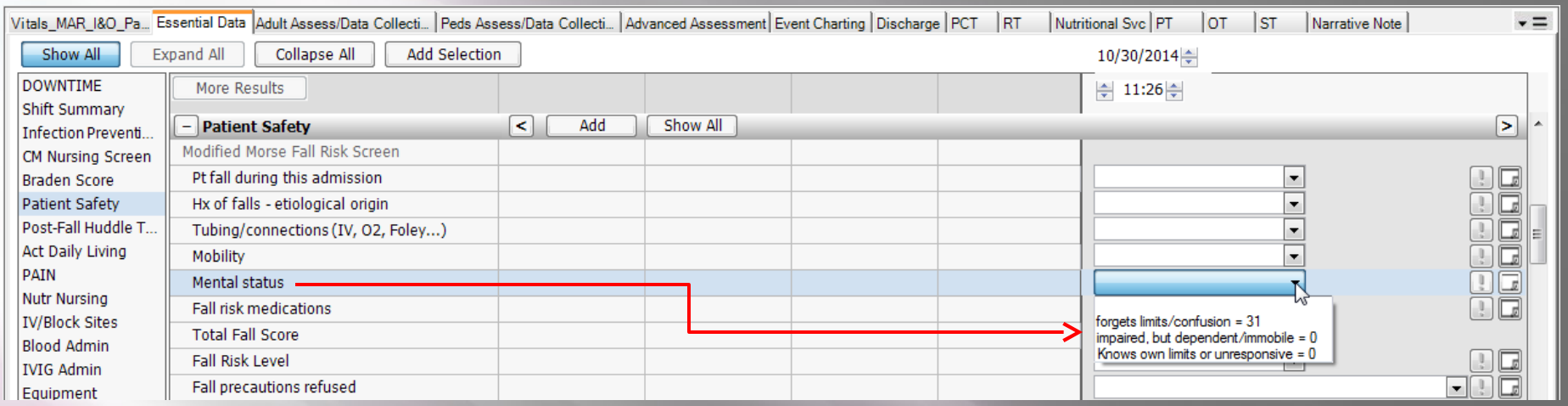
- Patients receiving interventions such as O2 therapy via nasal cannula, an indwelling foley catheter, or IV therapy are at greater risk for falls
- This level of risk increases when these interventions are being delivered continuously.

Fall Risk: Evaluating a Patient's Mobility



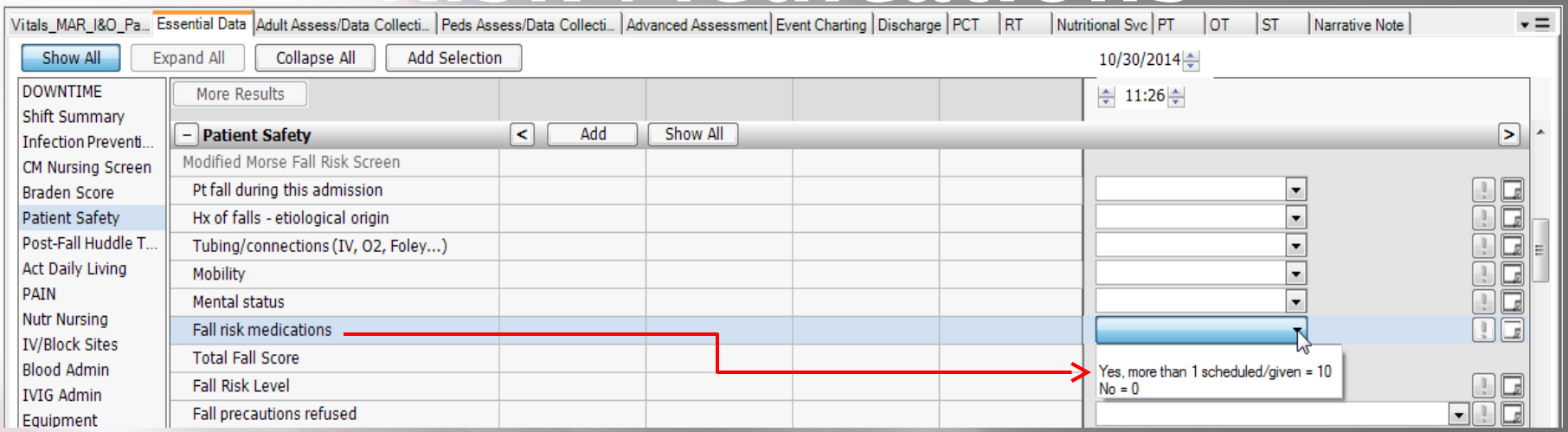
- Patient's who need assistance with ambulation are naturally at greater risk to fall than those who need no form of assistance
- Conduct a thorough history to determine patient's ambulation needs; verify when possible by direct observation of ambulation
- It is important to determine what level of assistance a patient needs and what devices they need to assist in safe ambulation. Remember PT is a good resource to assist in this determination

Fall Risk: Evaluating a Patient's Mental Status



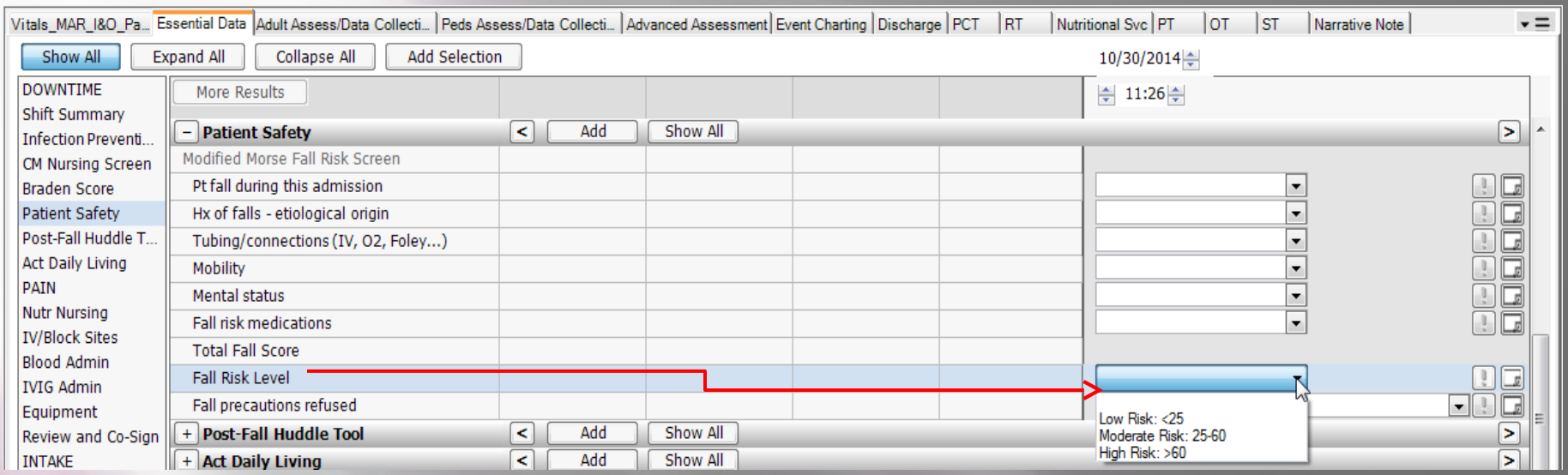
- Mental status is a natural predictor of fall risk
- Please remember that while not an indicator currently listed on the Modified Morse Scale, patients on CIWA protocol have a greater risk for falling given their mental status is often compromised

Fall Risk: Presence of High Risk Medications



- Medications such as narcotics, sedatives, anti-psychotics, anti-epileptics, or recent anesthesia/recent epidural increase the chance of a patient falling
- Pharmacy is a good resource to assist with determining whether certain medications pose a higher level of fall risk for patients

Fall Risk Level

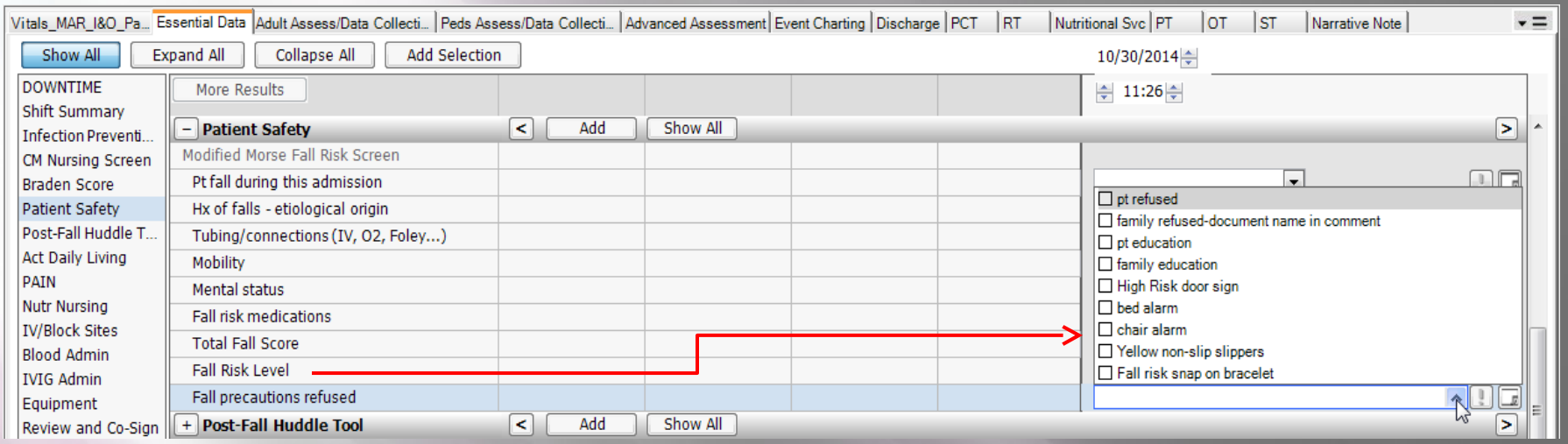


- Important: A fall risk level **must be chosen** for each patient based on the result of the patients fall risk score

- While the fall risk ***score*** automatically populates based on the information documented as part of the scale, the fall risk ***level*** does not automatically populate. Therefore, the level must be manually chosen

- The fall risk level is important b/c information from that field populates the High Risk icon on HEV

Patient Refusal of Fall Precautions



- Documentation must be present for any fall prevention measures a patient refuses
- The nurse manager or director must be consulted for any high-risk fall patients/families refusing fall precautions. This applies particularly to refusal of the bed alarm or chair alarm

Fall Risk: Moderate Risk Patients

- Implement a Fall Plan of Care
- Provide and document patient/family education
- Ensure non-skid socks applied

Fall Risk: High Risk Patients

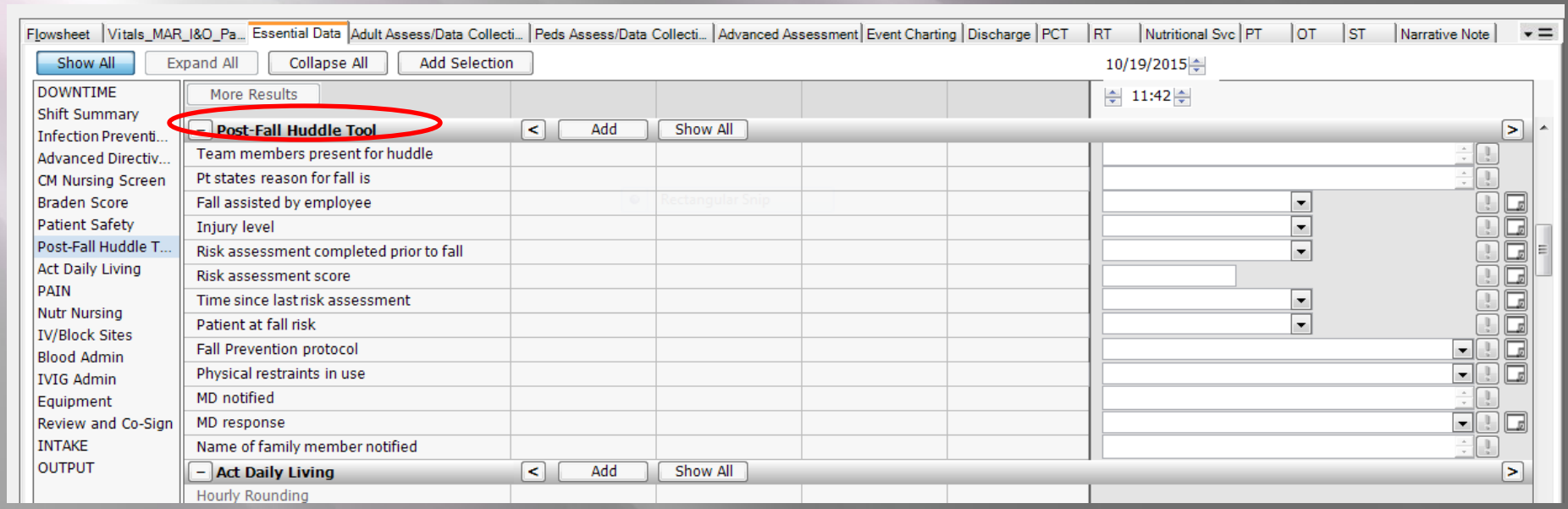
- Implement a Fall Plan of Care
- Provide and document patient/family education
- Ensure non-skid socks applied
- Apply yellow snap to wrist band
- Attach high-fall risk magnet to door
- Turn bed alarm on “high” sound and at “patient exiting” position
- Ensure PT has been consulted for evaluation

Fall Risk: High Risk Patients (additional requirements)

- Do not allow patient or family members to decline the use of the bed or chair alarm. If refusal persists after education the manager or director must be consulted to speak with patient or family
- Always assist with mobility and use Safe Patient Handling Equipment or mobility assistance equipment as indicated
- For toileting needs, always maintain a presence in the room. Never leave the room and never ask patients to use the call light when they are

Post Fall Huddle

- In the event of a patient fall, the Post Fall Huddle is to be completed using the Post Fall Huddle form (N-2360) and in HED.



Summary

- All adult inpatients are assessed upon admission and as indicated for their fall risk potential.
- **All team members play a role in fall prevention.**
  - **Always ensure call light is within reach**
  - **Personal items are in reach**
  - **Trip hazards are removed**
- If an inpatient is determined to be a fall risk, the following precautions are taken:
  - High risk magnet on door
  - Yellow slippers
  - Yellow snap on bracelets
  - Educate patient and family
  - Chair or bed alarm set for all high risk patients