

Fall Prevention & Modified Morse Scale

Falls

Falls

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?

The screenshot displays a medical software interface with a navigation bar at the top containing tabs like 'Vitals', 'Essential Data', 'Adult Assess/Data Collect...', 'Peds Assess/Data Collect...', 'Advanced Assessment', 'Event Charting', 'Discharge', 'PCT', 'RT', 'Nutritional Svc', 'PT', 'OT', 'ST', and 'Narrative Note'. Below the navigation bar are buttons for 'Show All', 'Expand All', 'Collapse All', and 'Add Selection'. The main content area is divided into a left sidebar with a list of assessment categories (DOWNTIME, Shift Summary, Infection Preventi..., CM Nursing Screen, Braden Score, Patient Safety, Post-Fall Huddle T..., Act Daily Living, PAIN, Nutr Nursing, IV/Block Sites, Blood Admin, IVIG Admin, Equipment) and a central table. The 'Patient Safety' category is selected, and the table shows a 'Modified Morse Fall Risk Screen' with rows for 'Pt fall during this admission', 'Hx of falls - etiological origin', 'Tubing/connections (IV, O2, Foley...)', 'Mobility', 'Mental status', 'Fall risk medications', 'Total Fall Score', 'Fall Risk Level', and 'Fall precautions refused'. The 'Pt fall during this admission' row is highlighted in blue. A red arrow points from this row to a dropdown menu on the right, which displays the calculated fall risk score: 'Yes, pt is high risk = 61', 'Yes, but dependent/immobile = 0', and 'No = 0'. The date '10/30/2014' and time '11:26' are shown in the top right corner.

Category	Item	Value
Patient Safety	Modified Morse Fall Risk Screen	
	Pt fall during this admission	Yes, pt is high risk = 61 Yes, but dependent/immobile = 0 No = 0
	Hx of falls - etiological origin	
	Tubing/connections (IV, O2, Foley...)	
	Mobility	
	Mental status	
	Fall risk medications	
	Total Fall Score	
	Fall Risk Level	
Fall precautions refused		

- 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

The screenshot shows a medical software interface with a sidebar on the left containing various assessment categories. The main area displays a table of assessment results. The 'Patient Safety' section is expanded, showing several rows. The row 'Hx of falls - etiological origin' is highlighted in blue. A red arrow points from this row to a dropdown menu on the right. The dropdown menu shows the following options: 'Yes, this admit/past 3 months = 31', 'Yes, but dependent/immobile = 0', and 'No = 0'.

Category	Assessment	Result
Patient Safety	Modified Morse Fall Risk Screen	
	Pt fall during this admission	
	Hx of falls - etiological origin	
	Tubing/connections (IV, O2, Foley...)	
	Mobility	
	Mental status	
	Fall risk medications	
	Total Fall Score	
	Fall Risk Level	
	Fall precautions refused	

- 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.

The screenshot shows a medical software interface with a sidebar on the left containing various assessment categories. The main window displays a 'Patient Safety' assessment form. A red arrow points from the 'Tubing/connections (IV, O2, Foley...)' row to a dropdown menu on the right. The dropdown menu shows the following options:

- Continuous = 20
- Intermittent = 10
- Yes, but dependent/immobile = 0
- None = 0

- 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

The screenshot displays a medical software interface with a navigation pane on the left and a main data table. The navigation pane lists various assessment categories, with 'Patient Safety' selected. The main table contains several rows under the 'Patient Safety' section, including 'Modified Morse Fall Risk Screen', 'Pt fall during this admission', 'Hx of falls - etiological origin', 'Tubing/connections (IV, O2, Foley...)', 'Mobility', 'Mental status', 'Fall risk medications', 'Total Fall Score', 'Fall Risk Level', and 'Fall precautions refused'. The 'Mobility' row is highlighted in blue. A red arrow points from the 'Mobility' row to a dropdown menu on the right side of the table. The dropdown menu shows the following options: 'Physical assist and device = 25', 'Needs supervision = 15', 'Independent w/device = 5', and 'Independent/immobile = 0'.

Category	Item	Value	Value	Value	Value
Patient Safety	Modified Morse Fall Risk Screen				
	Pt fall during this admission				
	Hx of falls - etiological origin				
	Tubing/connections (IV, O2, Foley...)				
	Mobility				
	Mental status				
	Fall risk medications				
	Total Fall Score				
	Fall Risk Level				
	Fall precautions refused				

- 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

The screenshot displays a medical software interface with a sidebar on the left containing various assessment categories. The main window shows the 'Patient Safety' section, which includes a table with several rows. A red arrow originates from the 'Mental status' row in the table and points to a dropdown menu on the right. The dropdown menu is open, showing three options: 'forgets limits/confusion = 31', 'impaired, but dependent/immobile = 0', and 'Knows own limits or unresponsive = 0'.

Category	Item	Value	Value	Value	Value
Patient Safety	Modified Morse Fall Risk Screen				
	Pt fall during this admission				
	Hx of falls - etiological origin				
	Tubing/connections (IV, O2, Foley...)				
	Mobility				
	Mental status				
	Fall risk medications				
	Total Fall Score				
	Fall Risk Level				
	Fall precautions refused				

- 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

The screenshot shows a clinical software interface with a top navigation bar containing tabs like 'Vitals', 'MAR', 'I&O', 'Pa...', 'Essential Data', 'Adult Assess/Data Collecti...', 'Peds Assess/Data Collecti...', 'Advanced Assessment', 'Event Charting', 'Discharge', 'PCT', 'RT', 'Nutritional Svc', 'PT', 'OT', 'ST', and 'Narrative Note'. Below the navigation bar are buttons for 'Show All', 'Expand All', 'Collapse All', and 'Add Selection'. The main content area is divided into a left sidebar with a 'DOWNTIME' section and a main table. The sidebar lists various assessment tools, with 'Patient Safety' selected. The table has columns for different assessment areas, and the 'Fall risk medications' row is highlighted in blue. A red arrow points from this row to a dropdown menu on the right, which shows 'Yes, more than 1 scheduled/given = 10' and 'No = 0'.

Assessment Area	Value
Modified Morse Fall Risk Screen	
Pt fall during this admission	
Hx of falls - etiological origin	
Tubing/connections (IV, O2, Foley...)	
Mobility	
Mental status	
Fall risk medications	Yes, more than 1 scheduled/given = 10 No = 0
Total Fall Score	
Fall Risk Level	
Fall precautions refused	

- 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

The screenshot shows the 'Patient Safety' section of the software. The 'Patient Safety' tab is selected. A red arrow points from the 'Fall Risk Level' row to a dropdown menu. The dropdown menu shows three options: 'Low Risk: <25', 'Moderate Risk: 25-60', and 'High Risk: >60'.

- 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

The screenshot displays a medical software interface with a sidebar on the left containing various assessment tools. The main area shows the 'Patient Safety' section, which includes a table for tracking fall risk. A red arrow points from the 'Fall Risk Level' field in the table to a dropdown menu on the right. The dropdown menu lists various fall prevention measures, including 'pt refused', 'family refused-document name in comment', 'pt education', 'family education', 'High Risk door sign', 'bed alarm', 'chair alarm', 'Yellow non-slip slippers', and 'Fall risk snap on bracelet'.

More Results				
- Patient Safety	<	Add	Show All	>
Modified Morse Fall Risk Screen				
Pt fall during this admission				
Hx of falls - etiological origin				
Tubing/connections (IV, O2, Foley...)				
Mobility				
Mental status				
Fall risk medications				
Total Fall Score				
Fall Risk Level				
Fall precautions refused				
+ Post-Fall Huddle Tool	<	Add	Show All	>

- ☐ pt refused
- ☐ family refused-document name in comment
- ☐ pt education
- ☐ family education
- ☐ High Risk door sign
- ☐ bed alarm
- ☐ chair alarm
- ☐ Yellow non-slip slippers
- ☐ Fall risk snap on bracelet

- 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.

The screenshot displays the 'Post-Fall Huddle Tool' interface. At the top, there is a navigation bar with tabs for 'Flowsheet', 'Vitals_MAR_I&O_Pa...', 'Essential Data', 'Adult Assess/Data Collecti...', 'Peds Assess/Data Collecti...', 'Advanced Assessment', 'Event Charting', 'Discharge', 'PCT', 'RT', 'Nutritional Svc', 'PT', 'OT', 'ST', and 'Narrative Note'. Below the navigation bar are buttons for 'Show All', 'Expand All', 'Collapse All', and 'Add Selection'. The date '10/19/2015' and time '11:42' are shown in the top right corner.

The main interface is divided into three sections:

- Left Panel:** A list of assessment items including 'DOWNTIME', 'Shift Summary', 'Infection Preventi...', 'Advanced Directiv...', 'CM Nursing Screen', 'Braden Score', 'Patient Safety', 'Post-Fall Huddle T...', 'Act Daily Living', 'PAIN', 'Nutr Nursing', 'IV/Block Sites', 'Blood Admin', 'IVIG Admin', 'Equipment', 'Review and Co-Sign', 'INTAKE', and 'OUTPUT'.
- Central Table:** A table with columns for data entry. The first row is 'More Results'. The second row is 'Post-Fall Huddle Tool', which is highlighted with a red circle. Below this are rows for 'Team members present for huddle', 'Pt states reason for fall is', 'Fall assisted by employee', 'Injury level', 'Risk assessment completed prior to fall', 'Risk assessment score', 'Time since last risk assessment', 'Patient at fall risk', 'Fall Prevention protocol', 'Physical restraints in use', 'MD notified', 'MD response', and 'Name of family member notified'.
- Right Panel:** A panel with dropdown menus and checkboxes for each assessment item. The 'Post-Fall Huddle Tool' row has a dropdown menu set to 'Rectangular Snip'.

At the bottom, there are buttons for 'Add' and 'Show All'.

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

