Fall Prevention Education for RNs

Competency Skills Fair 2020

Definition of a Fall

- A patient fall is an unplanned descent to the floor or extension of floor (bed, toilet etc.) with or without injury to the patient.
- Fall Prevention Program Policy BHM-314.05

Objectives

- Demonstrate Falls prevention protocol/strategies.
- Understand how to properly use the Morse Fall Scale.
- Define types of falls and proper injury level of falls.
- Understand proper documentation and the post fall process.

Fall Bundle

Bed Alarm On

Use stars on doors

Blue Falling Star	Red Falling Star
Indicates patient is *at risk for falling.*	Indicates patient has *fallen within the admission or within the last 3 months*

Bed Check Audit

Date:_____ Shift_____

Room#	Call Bell Works?		Comments	Room#	Call Bell Works?		Comments
	Yes	No			Yes	No	
3201				3226			
3202				3227			
3203				3228			
3204				3229			
3205				3230			
3206				3231			
3207				3232			
3208				3233			
3209				3234			
3210				3235			
3211				3236			
3212				3237			
3213				3238			
3214				3239			

Perform bed checks

Ensure proper fitting non-skid socks

Fall Bundle (continued)

Activate virtual sitter if available and patient meets criteria

Use minimal lift equipment as needed

Educate patient, family and sitters to call for assistance

Hourly rounding

Utilize white boards for education and fall precautions

Actively monitor patient during activities of daily living. Do not leave patient alone, especially during toileting.

Purposeful Rounding

- Proactively address: Pain, Position/comfort, Possessions, Potty

  Example: "May I assist you to the bathroom now?"

  "Do you have pain?"

- Environmental safety check: call bell, bedside table, possessions and phone within reach. Clear of clutter, spills and garbage on the floor

- Document all rounding in Cerner
- Update communication boards every shift or as often as needed
- If the patient is sleeping, between the hours of midnight and 6am, it is not necessary to wake them but check for breathing, comfort, possessions, safety, etc.
- Policy BHM-757.00

Morse Fall Scale (MFS)

- Utilize the MFS during handoff. Update scores on every shift report.
- Consider changes in patient status that may happen during the shift.
- Implement Fall Bundle when patient's MFS score is 45 or higher.

	MORSE FALL SCALE	
RISK FACTOR	SCALE	SCORE
History of falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches/Cane/ Walker	15
	None/Bed Rest/Wheelchair/ RN	0
IV/Heparin Lock	Yes	20
	No	0
Gait/Transferring	Impaired	20
	Weak	10
	Normal/Bed Rest/Immobile	0
Mental Status	Forgets limitations	15
	Oriented to own ability	0

Morse Fall Scale

(Clarification)

- *Ambulatory Aid*:

  1. If the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest and does not get out of bed at all, score this as 0.

  2. If the patient uses crutches, a cane, or a walker, this item scores 15.

  3. If the patient ambulates clutching onto the furniture for support, score this item 30.

	MORSE FALL SCALE	
RISK FACTOR	SCALE	SCORE
History of falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches/Cane/ Walker	15
	None/Bed Rest/Wheelchair/ RN	0
IV/ Heparin Lock	Yes	20
	No	0
Gait/Transferring	Impaired	20
	Weak	10
	Normal/Bed Rest/Immobile	0
Mental Status	Forgets limitations	15
	Oriented to own ability	0

Morse Fall Scale

(Clarification)

- *Gait/Transferring*

  1. A *normal gait* is characterized by the patient walking with head erect, arms swinging freely at their side, and striding without hesitation. This gait scores 0.

  2. With a *weak gait* (score as 10), the patient is stooped but is able to lift their head while walking without losing balance. Steps are short and the patient may shuffle.

  3. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.

	MORSE FALL SCALE	
RISK FACTOR	SCALE	SCORE
History of falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches/Cane/ Walker	15
	None/Bed Rest/Wheelchair/ RN	0
IV/ Heparin Lock	Yes	20
	No	0
Gait/Transferring	Impaired	20
	Weak	10
	Normal/Bed Rest/Immobile	0
Mental Status	Forgets limitations	15
	Oriented to own ability	0

Weak versus Impaired Gait

Weak Gait or Impaired Gate?

Weak Gait or Impaired Gate?

Weak versus Impaired Gait (Cont.)

Weak
Head is looking forward as he walks.
He does not require walking aid for balance.

Impaired
The patient's head is down, and he or she watches the ground. The patient's balance is poor and needs a walking aid for support.

Morse Fall Scale

(Clarification)

- *Mental Status*

  1. When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the ambulatory order, the patient is rated as "normal" and scored 0.

  2. If the patient's response is not consistent with the nursing orders or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.

	MORSE FALL SCALE	
RISK FACTOR	SCALE	SCORE
History of falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches/Cane/ Walker	15
	None/Bed Rest/Wheelchair/ RN	0
IV/ Heparin Lock	Yes	20
	No	0
Gait/Transferring	Impaired	20
	Weak	10
	Normal/Bed Rest/Immobile	0
Mental Status	Forgets limitations	15
	Oriented to own ability	0

Classifications of Types of Falls

Anticipated Physiological Falls: Factors associated with known fall risks as indicated on the Morse Fall Scale that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur due to the patient's existing physiological status, history of falls, and decreased mobility upon assessment.

Unanticipated Physiological Falls: Factors associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale: unexpected orthostasis, extreme hypoglycemia, stroke, heart attack, seizure, etc.

Assisted Fall: A fall in which any staff member (whether a nursing service employee or not) was with the patient *and* attempted to minimize the impact of the fall by slowing the patient's descent. Assisting the patient back into a bed or chair after a fall does not make the fall an assisted fall.

Classifications of Types of Falls(Cont.)

Alleged Fall: The patient verbalized that they fell; staff did not visualize the patient on the floor.

Suspected Intentional Fall: An intentional fall occurs when a patient falls on purpose or falsely claims to have fallen. The reasons may include seeking attention or obtaining pain medication.

Accidental Fall: Fall that occurs due to due extrinsic environmental risk factors or hazards: spills on the floor (such as water or urine), tripping on clutter, tubing / cords on the floor, or errors in judgment, such as not paying attention or leaning against a curtain or unlocked furniture.

Unwitnessed Fall: Occurs when a patient is found on the floor and no one saw the actual fall.

Classification of Injury Level of a Fall

F1- None—resulted in no signs or symptoms of injury as determined by post-fall evaluation (which may include x-ray or CT scan)

F2- Minor—resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, **pain-related to the fall**, bruise or abrasion

F3- Moderate—resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain

F4- Major—resulted in surgery, casting, traction, required consultation for neurological injury (e.g., basilar skull fracture, small subdural hematoma) or internal injury (e.g., rib fracture, small liver laceration), or patients with any type of fracture regardless of treatment, or patients who have coagulopathy who receive blood products as a result of a fall

F5- Death—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

LIVE Post Fall Huddle

- Why do this? Proactive approach to discuss what happened and how to prevent further falls
- Who is involved? Direct care RN, CP, resource/supervisor, DOE, nurse manager, director and or AVP and CNO (if there is an injury)

TOTAL FALLS THIS MONTH:

INPATIENT FALLS:

FALLS WITH INJURY:

OUTPATIENT FALLS:

BHM Post Fall Huddle Template

Date of Fall: _____

Time of Fall: _____

Type of Fall (Check One): □ Accidental □ Anticipated Physiological

□ Unanticipated Physiological □ Assisted □ Suspected Intentional

□ Alleged

Injury Level (Check One): □ F1 □ F2 □ F3 □ F4 □ F5

Department: _____ Room Number: _____

Patient Age: _____

Admitting Diagnosis: _____

Pre Fall Morse Score: _____ Post Fall Morse Score: _____

Last Time Patient Rounded On: _____

Safety Measures in Place at Time of Fall (Falling Star on door, Virtual Sitter, Bed alarm, etc.):

_____

Action Plan (intervention/prevention measures):

_____

Details of Fall:

_____

_____

_____

Morse Fall Scale Scoring

Hx falls w/in 3mo: No=0 Yes=25

Secondary Dx: No=0 Yes=15

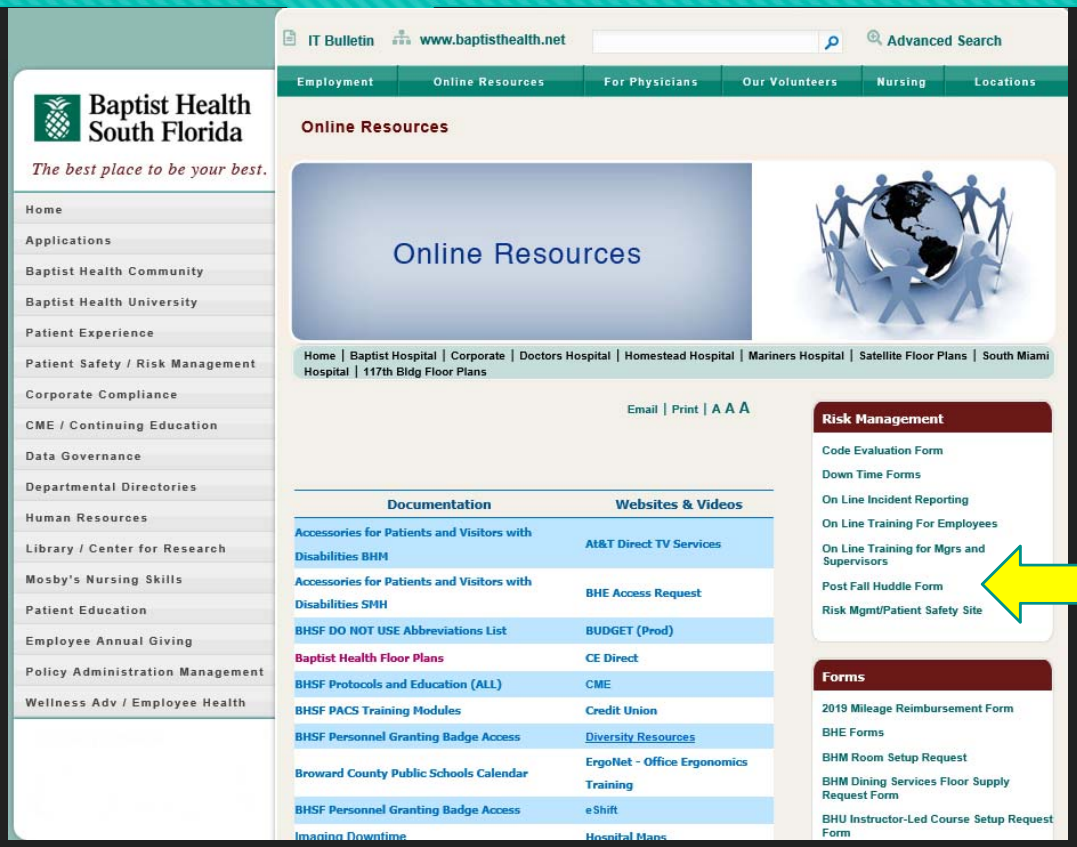
Ambulatory Aid:
Bed Rest/Nurse Asst=0
Crutches/cane/walker=15
Furniture=30

IV/Hep Lock: No=0 Yes=20

Gait/Transferring:
Weak=10 Impaired=20

Mental Status:
Oriented=0 Forgets Limitations=15

Intranet Post Fall Huddle



- Intranet Post Fall Huddle
  - Helps gather important data about details of any fall
  - Should be as complete as possible
  - Used by multiple departments
  - It is a Baptist Health system-wide document

Post Fall Protocol

- After every single fall you should :
  - Complete an incident report.
  - Complete a live post fall huddle.
  - Adjust the Morse Fall Scale score and document in Cerner.
  - Complete the intranet post fall huddle, in applicable areas.
  - Implement new safety measures - check the environment.
  - Assess what medications the patient is taking.
  - Educate the patient, family & sitters when applicable.


Baptist Hospital

RN

CP

Doctor
Médico

Today's goal
Meta de hoy

Day
Día

Hospital phone
Teléfono del hospital
786-596-1960

Room number
Número de habitación

Care Notes

Please speak up if you have questions or concerns or call 49201.
Por favor díganos si tiene preguntas or inquietudes o llame al 49201.

What is wrong in these pictures?

#1

#2

Scenario Answers

- #1
  - Cord of WOW is on the floor
  - Patient's socks are coming off
  - IV pump cable is wrapped around patient
  - WOW is in the hallway
  - The patient is ambulating alone
  - Spilled juice on the floor

- #2
  - Call bell far from patient
  - Patient's socks are coming off
  - Phone at bedside table, not within reach
  - Plastic garbage on floor
  - Patient belongings at the bottom of the bed
  - Should have 3 bed rails up