Fall Prevention Program
MORSE TOOL
“It’s all about patient safety”
Falls

- Not all patient falls are predictable or preventable in acute care hospitals.

- Some falls are simply the result of individual physiological response to illness or treatment in care settings in which patient ambulation is essential to recovery.
NDNQI

- NDNQI = National Database for Nursing Quality Indicators

- NDNQI is the only national nursing quality measurement program

- Provides hospitals with the ability to compare themselves to like size
**NDNQI Definition of Falls**

**Major:**
- A fall that resulted in surgery, casting, traction, or required consultation for neurological or internal injury

**Moderate:**
- A fall that resulted in suturing, application of skin closure device or splinting

**Minor:**
- A fall that resulted in the application of first aid treatment and application to the patient

**Assisted:**
- A fall in which any staff member was with the patient and attempted to minimize the impact of the fall by easing the patient’s descent to the floor or in some manner attempting to break the patient’s fall
Fall risk factors

Evidence related to risk factors are mainly derived from retrospective audits and expert opinions

Environmental
- Obstacles and clutter
- Poor lighting
- Mobile beds and furniture

Elimination Needs
- Inability to toilet independently
- Medications- diuretic, laxatives
Patient Identification Armbands

Goal:

Improve communication between caregivers

Five different colored patient identification armbands
Armband Colors

**YELLOW** = HIGH FALL RISK

**RED** = ALLERGIES

**GREEN** = LATEX SENSITIVITY/ALLERGY

**PURPLE** = DO NOT RESUCITATE

**PINK** = LIMB ALERT- NO BLOOD PRESSURE OR NEEDLESTICK
Armbands-American Hospital Association

- **National Consensus to Adopt Three Colors for Common Condition Alerts**
  - **Yellow** = High Fall Risk
  - **Red** = Allergy
  - **Purple** = Do Not Resuscitate

- **In addition, MSHA recognizes:**
  - **Pink** = Limb Alert
    - (No needle stick/blood pressure)
  - **Green** = Latex allergy
DRN=Purple Armband

- The **Nurse** will Only place **PURPLE DNR** armband on patient **after** the Physician Order has been verified

AND

- The patient has been **IDENTIFIED** by **TWO** approved patient identifiers

**Purple DNR** armband is only to be placed on a patient with a **FULL DNR CODE Status**
SMS and Navicare

How do you communicate the patient is fall risk to other team members

- Nurse places a yellow armband on patient to indicate the patient is a Fall risk

- SMS
  - Indicate Low or High Fall Risk (do not enter color)

- Navicare
  - Indicate Low or High Fall Risk (do not enter color)
MSHA uses the MORSE Fall Scale (MFS)

A method of assessing/evaluating the patient's likelihood of falling

- Quick and easy to use tool
  - < 3 minutes to evaluate a patient and implement interventions

- It has a six variable risk factor scale

- Consistent fall assessment/evaluation with accurate targeting of interventions

- Evidence based fall prevention tool
MORSE Fall Scale
What is the MORSE Fall Scale (MFS)

Janice M. Morse, the creator of the Morse Fall Scale, speaks to nurses providing patient care at the bedside with the following words.

“The burden of preventing falls has been placed firmly on your shoulders. Your wisdom and judgment, your observational skills, and your past experiences provide an excellent background for you to develop a repertoire of innovative and creative ways to prevent patients from falling.”
If you are unable to do evaluation

- **Unable to evaluate fall risk status due to:**
  - Drug Induced Coma
  - Comatose
  - Other (quadriplegic)
  - Must implement interventions
    - Even if you’re unable to identify a risk level
    - Use your nursing judgment

- **If you are unable to conduct evaluation, the next step is:**
  - Sign and date form
  - No other documentation required at this time

- **When or if the patient’s condition changes, the next step is:**
  - Utilize the PRN recheck column and conduct fall evaluation
PRN/RE-Check Column

- **When to use**
  - anytime your clinical judgment warrants
    - Patient’s condition changes or status changes
  - If unable to assess fall risk initially
  - After a patient falls
  - If multiple reassessments, will need additional forms to document
History of Falling

- **Score of 25 if patient has fallen during:**
  - Present hospital admission
  - Immediate history of physiological falls, i.e. seizure, impaired gait
    - last 3 months

- **If patient has no history of falls**
  - Score 0
  - Note: If patient falls for the first time, score immediately as 25
  - Utilize the PRN recheck column to document after initial fall assessment has been completed.

- **Use clinical judgment**
  - Differences between actual fall and not so graceful! (example- lost footing and slipped on wet grass, no history of falls)
**Secondary Diagnosis**

- If patient has more than 1 diagnosis
  - Score 15 points
    - likely to have multiple medications, which increases risk of drug interactions
- If only 1 medical diagnosis
  - Score 0
- Medications should be taken consideration
  - Patients presenting with more than 1 compliant will likely be receiving multiple medications= polypharmacy
    - Medication contribute to fall risk as they relate to other variables
      - Gait and Mental Status
  - **Explanation:** if there is a serious problem with medications they will contribute the fall risk score
    - Gait and Mental Status
  - **Goal:** A review of medications
    - Reduce side effects, reduce fall risk score
Ambulatory Aid

- **Score 0**
  - Walks without walking aid (even if assisted by caregiver)
  - Uses a wheel chair
  - On bed rest/does not get out of bed at all

- **Score 15**
  - Crutches
  - Cane
  - Walker

- **Score 30**
  - Ambulates clutching on to furniture for support
Intravenous Therapy/Saline Lock

- IV or IV Access

- Score 20
  - IV apparatus
  - Saline lock

- Score 0
  - If no IV or IV access
Gait

3 types of gait regardless of physical disability or underlying cause

• **Score 0**
  – Normal Gait
  – Walking with head erect
  – arms swinging freely at side
  – stride without hesitation

• **Score 10**
  – Weak Gait
  – Stooped, but able to lift head while walking without losing balance
  – Support from furniture required, this is with a feather weight touch almost for reassurance rather than grabbing to remain upright.
  – Steps are short and person may shuffle
Gait cont’d

- **Score 20**
  - Impaired Gait
  - Difficulty rising from chair
  - Attempts to get up by pushing on the arms of the chair or bouncing (several attempts to arise)
  - Head is down, watches the ground
  - Balance is poor, grabs onto furniture, a support person, or a walking aid for support (can not walk without assistance)
  - Steps are short and patient shuffles

- If in a wheelchair, score according to the gait used when transferring from the wheelchair to the bed
Mental Status

- Mental status is measured by checking the patient’s own self assessment with their ability to ambulate
  - “Do you need assistance to go to the bathroom?”

- **Score 0:**
  - If the patient’s reply, judging from their own ability is consistent with the activity order
  - Patient is rated as normal

- **Score 15:**
  - If the patient’s response is not consistent with the activity order or if their response is unrealistic
  - Patient is considered to overestimate their own abilities and forget their own limitations.
Document Risk Level

- Total Score
  - Sum of the risk factors

- Indicate low risk or high risk
  - Check mark
  - Initials
  - Numerical score

- Low Fall Risk Score
  - 0-44

- High Fall Risk Score
  - 45 or above
Intervention/Implementation

- All low risk patients will have Standard Interventions Bundle implemented
  
- If implemented with modifications, document what modifications were made
  - i.e. if patient is bilateral amputee, may not need to implement “non-slip footwear when ambulating” intervention

- High Risk Interventions Bundle- Implemented for all patients that are high risk- no modifications

- Individualized Additional High Risk Interventions- based on clinical judgment for patients that score higher than 45
LPN/RN Signature

Scope of Practice
• Licensed Practical Nurse (LPN) may gather data; however, the RN is responsible for the assessment of patient care needs based on data obtained.

TN Nurse Practice Act
• Licensed Practical Nurse
  • Contributes to the assessment by collecting, reporting, and recording objective and subjective data in an accurate and timely manner.
• Registered Nurse
  • Conduct and Document Assessments of health status of individuals and groups by
  • Collecting objective and subjective data
  • Accurately sorting selecting, recording and reporting data
  • Validating refining and modifying the data by utilizing the available resources including interactions with client, family, significant others and health team members.
• RN must have oversight of data collected by LPN and countersign
SBAR Post Fall Evaluation Form

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Humpty Dumpty

The Humpty Dumpty Falls Assessment Tool is a tool that can help predict the possibility of a pediatric fall.

The tool is a cumulative calculation.
- There are 7 parameters: each parameter receives at least a minimum score of 1.
  - If for some reason the items in any parameter are not applicable the child would receive the minimal score of 1.
  - If a child falls into multiple categories in a parameter, the highest score of the possible choices would be given.
  - Each parameter is added in a cumulative fashion.
    - The highest possible score a child can receive is 23.
    - The lowest score a child can receive is 7.
    - Any child with a score of 12 or above is considered ‘high risk’.
Low Risk Protocol

- Assess elimination needs, assist as needed
- Call light is within reach, educate patient/family on its functionality
- Environment clear of unused equipment, furniture’s in place, clear of hazards
- Orientation to room
- Bed in low position, brakes on
- Side rails X2 or 4 up, assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety precautions.
Low Risk Protocol (7-11)

- Use of non-skid footwear for ambulating patients
- Use of appropriate size clothing to prevent risk of tripping
- Assess for adequate lighting, leave nightlights on
- Patient and family education available to parents and patients
- Document fall prevention teaching and include in the plan of care
Pediatric Fall Assessment Tool

- High Risk Protocol- score 12 or more

- Humpty Dumpty Sticker placed on child

- Humpty Dumpty Signage placed in appropriate place (per facility)
Pediatric-High Risk (score 12 or more)

- Evaluate medication administration times
- Remove all unused equipment out of room
- Protective barriers to close off spaces, gaps in the bed
- Keep door open at all times unless specified isolation precaution are in use
- Keep bed in the lowest position, unless patient is directly attended
- Educate Patient/Family regarding falls prevention
- Document in the nursing narrative teaching and plan of care
Pediatric-High Risk (score 12 or more)

- Check patient minimum every hour
- Accompany patient with ambulation
- Move patient closer to nurses’ station
- Assess need for 1:1 supervision

*Miami’s Children Hospital, Humpty Dumpty Pediatric Falls Assessment and Prevention Program.*
If you have any questions related to fall prevention, please call the Patient Education Coordinator at 431-1887.