

# Preventing Patient Falls Assessing Risk-rcd10212

## Text Version

### Page 1

No audio file.

### Page 2

To help keep our patients from falling we take precautions and put preventive measures in place – for *all* of our patients.

But some patients are more likely to fall than others. For those who are at highest risk, we take *special* precautions and *additional* preventive and protective measures.

If we don't know which of our patients are most at risk, then we can't target our fall prevention efforts effectively. If we *can* determine which patients are prone to falls, then we can give special attention to them – and often prevent the fall.

But, how do we know which patients are at risk? Who are they? Is it the older patients? How about medication? What role does that play? How about those who are using walkers or canes?

According to studies in acute care hospitals, about 2-10% of patients will fall during their hospital stay. In this facility, we have a Falls Prevention protocol so we can more easily target those patients at greater risk for falling.

### Page 3

The protocol starts with a falls risk assessment for all patients when they are admitted. The Assessment procedure used in this facility is the Morse Fall Scale Assessment. In randomized studies, the Morse Fall Scale has been shown to identify up to 78% of those patients who would fall. Why is this number, 78%, an important number?

### Page 4

In this lesson you'll see a model for administering the Morse Fall Scale. In later lessons you'll get a deeper level of detail and you'll have an opportunity to practice and to check your understanding. A large number of patient falls are reported as resulting from accidents or from other causes not related to the patient's condition. An example would be a fall in which a patient slips or trips on a bit of water on the floor. Or, a fall that occurs when a patient catches a foot on a piece of furniture.

Falls like these may seem unpredictable, and if they are unpredictable, the reasoning goes, they may be unavoidable. When facilities use the Morse Falls Scale however, they find that a great many of these falls can be predicted. A

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

much smaller percentage of falls is actually unforeseeable, so many more might be able to be prevented.

### Page 5

Users of the Morse Falls Scale consider three types of falls. About 8% of all falls are classified as accidents. The rest are classified as physiological falls, that is, they are falls that are related to the condition of the patient. About 14% of falls are related to patient conditions that are not easily foreseeable. For example, a patient who has never before manifested symptoms has a stroke while in the hospital. Because the event was the first of its kind for the patient, it wouldn't show up on an assessment. Physiological falls of this kind are called unanticipated physiological falls.

The remaining falls are those that are predicted by the Morse Falls Scale. They are called anticipated physiological falls. So the benefit of the Morse Falls Scale is clear, the main benefit is reliable prediction. This scale predicts a larger percentage of falls than can be predicted by other common methods.

### Page 6

The scale predicts the anticipated physiological falls. As a result, caregivers can better target preventive and protective actions. Fewer patients are likely to fall, and those who do fall will be less likely to be injured.

In this lesson, you'll see a demonstration by a nurse as she administers the Morse Falls Scale. In later lessons, you'll get a deeper level of detail. And, you'll have an opportunity to practice and to check your understanding.

### Page 7

This is a med/surg unit at Anytown Hospital. The unit has adopted a new protocol for preventing patient falls. The protocol starts with a formal risk assessment, administered by the admitting nurse as part of her initial patient assessment.

### Page 8

In this unit, nurses complete a follow up risk assessment at the beginning of each shift. When a patient is identified as "High Risk" on the risk assessment, the care team creates an individualized fall plan to try to prevent the patient from falling or to protect the patient if they do fall. In fact that's the purpose of Risk Assessment: to identify those patients for whom an individualized fall prevention plan will be required.

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

We'll observe Charlotte, a staff nurse, as she conducts a falls risk assessment for her patient, Mr. Goodman. First we'll just watch. Then we'll take a closer look at each step of the assessment.

Charlotte's patient, Mr. Goodman, was admitted on the previous shift. At the time of admission the admitting nurse evaluated him as being in the high risk category for falls. That's why the orange sticker appears on the cover of his chart. This facility uses orange stickers to identify its "high risk" patients.

### Page 9

Charlotte has reviewed Mr. Goodman's chart. An opportunity presents itself. She gets a chance to observe Mr. Goodman's ambulation.

*(The patient, Mr. Goodman, is returning to his bed from the toilet, assisted by a nurse aide. Charlotte observes him. He is bent forward, holding his rib cage as he walks, supported by the nurse aide.)*

Charlotte takes a moment to talk with Mr. Goodman.

Charlotte	Hello, Mr. Goodman. My name is Charlotte. I'll be your nurse today. How are you feeling this morning?
Mr. Goodman	Well . . . I'm kind of banged up, and tired. I had a really short night last night. We got here about nine o'clock, and I didn't think I got to sleep until . . . well almost morning, I guess.
Charlotte	I'm sorry about that; let's see if we can't get you some extra rest time after breakfast.
Mr. Goodman	I sure hope so. I could use it.
Charlotte	I'll bet you can. How have you been getting to the bathroom?
Mr. Goodman	The doctor downstairs, Doctor Rivers, he said I should ring for the nurse and wait to get help before I got in and out of bed. I've been doing that so far.
Charlotte	Well, you've been handling it the right way. You just need let us know if you do want to get up, we'll come in and help so that you don't get hurt. And let us know if there's anything else we can do for you.
Mr. Goodman	Well, let's talk about your schedule around here just a little bit. then. This morning they woke me up at 5 o'clock to take my blood . . .

While Charlotte and Mr. Goodman discuss the hospital's lab schedule, we'll review what Charlotte did to get a Fall Risk rating on Mr. Goodman.

If Mr. Goodman scores high risk on the assessment scale, the care team will set up an individualized prevention plan for him. If he scores under the cut off score, the team will continue to monitor his risk of falling. As long as the score stays low, however, they will rely on the standard prevention practices that have

## **Preventing Patient Falls Assessing Risk-rcd10212**

### **Text Version**

been put in place for the whole unit. So, the purpose of the assessment is to decide whether to set up the individualized plan.

Mr. Goodman was assessed for fall risk when he was admitted to the unit. Charlotte is conducting a follow-up assessment. On this unit, for follow-up assessments nurses use exactly the same procedures that they use at admission.

The Morse Fall Scale evaluates risk by checking six indicators. Now we'll watch Charlotte administer the assessment again – and look at what she's really doing.

#### **Page 10**

The whole assessment takes about one to three minutes. It's short, but it has been validated scientifically to produce a reliable estimate of a patient's likelihood of falling.

First, Charlotte checks the chart. She looks for any history of falls, and checks for diagnosis and ambulation orders. She sees that Mr. Goodman reports that he blacked out last week and fell in his kitchen. And she sees that he has congestive heart failure. So there is a secondary diagnosis.

#### **Page 11**

His activity orders show "Up with Assistance."

#### **Page 12**

She doesn't see anything in the patient orders about IV therapy.

#### **Page 13**

Then she observes the patient. In this case, she can make a direct observation. Charlotte sees Mr. Goodman walking with the nurse aide.

She notes that he takes short steps, and places his hand on the aide for support, characteristics of a weak gait. Since this is a follow up evaluation, Charlotte can look at the previous Fall Risk assessment, which was completed by the admitting nurse.

#### **Page 14**

The check of mental status is focused on one item only.

**Preventing Patient Falls Assessing Risk-rcd10212  
Text Version**

**Page 15**

Is Mr. Goodman oriented to his own physical abilities or does he overestimate or forget his limitations? To score Item 6 Charlotte asks him about his abilities.

**Page 16**

*Partial replay to review assessment procedure.*

Charlotte	Hello, Mr. Goodman. My name is Charlotte. I'll be your nurse today. How are you feeling this morning?
-----------	---

By listening to Mr. Goodman's response, Charlotte can see that Mr. Goodman is well aware of his limitations. Notice that Charlotte's check of Mental Status is different from the standard practice. It is an additional, very specific evaluation, beyond the normal check of orientation to person, place and time.

For now, you just need to be aware that Charlotte is looking only at Mr. Goodman's awareness of his limitations. Mr. Goodman knows how he should handle ambulation. So Charlotte assigns a zero to the last item.

Charlotte adds up the score for the assessment. This facility uses a cut-off score of 45 to identify high-risk patients. Mr. Goodman's score is 50, which is above the unit's cut off score.

Charlotte records the scores in the chart. And that's all there is to it. You can administer the Morse Fall Scale as quickly, easily and accurately as Charlotte can. To make sure you can handle all the variations that you might run into, complete the following four sections of this learning program.

In the first Review and Practice segment you'll practice decision making – how to assign a patient to the high, or low, or sometimes medium risk categories.

**Page 17**

The purpose of a Risk Assessment is to determine whether a patient is at high risk for falling. In this lesson you can learn two things: how to compute a total risk score and how to classify the numerical score as a rating of high risk or low risk.

**Page 18**

Healthcare facilities go to great lengths to protect patients from injuries. Facilities are designed for patient safety; procedures are devised to reduce fall risk; the facility staff is trained to monitor patients and to assist them.

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

### Page 19

These prevention efforts benefit **all** patients.

### Page 20

Not all patients are equally likely to fall. Some patients require special attention.

### Page 21

Many Risk Assessment tools have been developed to quantify patient risk. The best tools are those that best differentiate between patients who likely to fall and those patients who are **not** likely to fall. They are accurate, reliable and easy to use.

Dr. Janice Morse set out to develop an accurate, practical method for assessing fall risk. Over a 6-year period, the Morse Fall Scale was validated for accuracy and reliability. At the same time it was refined for simplicity and ease of use.

### Page 22

The research team started with a large number of possible indicators that had been suggested over the years. Using a randomized design, patient, assessment, observation and records, the team was able to identify indices that best discriminated between likely fallers and those who were less “at risk.” The researchers derived a system of weighting that further improved the accuracy of the scale. The scale in its final, weighted form produces accurate predictions of the risk of falling.

### Page 23

Here are the results of the testing and validation:

- The scale proved to be both reliable and accurate.
- It proved to be easy to administer throughout a facility, by all members of care teams.
- It proved to be quick to use.
- It enabled facilities to have consistency in assessment among all caregivers and from one time to another
- It enabled facilities to target their prevention and protection efforts more accurately.

In controlled studies, the scale identified nearly 80% of the patients who would fall. This 80% includes not only the patients who fell as a result of easily identifiable medical risk factors, but also those patients who fell in ways that would ordinarily have been classified as “accidents.”

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

For all these reasons, many facilities use the Morse Falls Scale. It helps caregivers to identify those patients who most need our help.

### Page 24

When you use the Morse Falls Scale, you assess a patient on variables, or indicators of risk. A typical assessment might look something like this.

### Page 25

You total the scores for each of the six variables. That's the patient's total risk score. You assign the patient to a high risk or low risk based on this single number.

### Page 26

Here the total risk score is 55, the total of 25, 15 and 15. Let's say, for example, that the cut-off score for high-risk cases is 45 points at this facility

In a facility that is using a high-risk cutoff score of 45, this patient will be identified as being at high risk for falling. This patient will get special attention.

Because patient populations differ from facility to facility – and from unit to unit within one facility – the cutoff score for high risk can vary, too. The training administrator for your facility will tell you the score that is used at your facility or in your department.

### Page 27

Charlotte has completed the first two variables for Mr. Goodman. Now it's your turn to practice.

### Page 28

No audio on this page.

### Page 29

Here's an example of the first part of the Morse Falls Scale administration. Watch the example. Then you'll have a chance to practice for yourself.

Charlotte looks for three things: any history of falling; a secondary diagnosis; and, orders related to ambulation. She looks at the admitting history and physical section of the chart.

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

### Page 30

She sees that Mr. Goodman fell at home last week. Item one rates 25 points.

### Page 31

For purposes of the Morse Falls Scale, a “yes” is indicated for History of Falls only if the fall was recent. When patients fall during a hospital stay, the fall is recorded and the patient should be re-evaluated for fall risk.

A “yes” should also be recorded in History of Falls if the patient has had a fall in the previous year, as is the case with Mr. Goodman.

### Page 32

Charlotte looks for a secondary diagnosis. She sees that Mr. Goodman was admitted as a result of an auto accident where he fractured two ribs. He was admitted because of injuries.

### Page 33

Also, he has congestive heart failure, a secondary diagnosis. The existence of a secondary diagnosis rates fifteen points.

### Page 34

The admitting physician has ordered nurse assistance for ambulation and toileting. The doctors note says, “Up with assistance.”

### Page 35

There’s no scoring required right now, but Charlotte will make sure that Mr. Goodman understands the orders when she talks with him, in order to score the Mental Status Indicator.

### Page 36

No audio on this page.

### Page 37

The next three items on the Morse Falls Scale are related to ambulation. To assess them, Charlotte uses the patient’s chart and sometimes observes the patient directly. She is looking for the use of ambulatory aids, for the existence of intravenous therapy or an apparatus for IV access. And, for patients who are not on bed rest, she will observe their gait.

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

When Charlotte sees Mr. Goodman, she notices that he is getting assistance from the nurse aide. His activity orders are “Up with Assistance.” There’s no indication of an ambulatory aid. Item 3 rates a zero.

### Page 38

The score would also be a zero for a patient who used a wheelchair or one who is on bed rest.” If Mr. Goodman had been using an ambulatory aid - such as a walker or crutches or a cane - the rating would have been 15.

### Page 39

Some patients use furniture or fixtures to assist their ambulation. In effect, their environment is their ambulatory aid. These patients are at higher risk for falling, so they are rated at 30 points on the Ambulatory Aid variable.

#### *Pause*

Here’s what the use of furniture looks like. Notice that the patient Ms. Johnson, makes her way about the room by moving from one support point to the next.

#### *Pause*

And she’s not just touching the furniture and fixtures in passing, she clutches each support forcefully. As she comes to a point where there is considerable space between support points, she may lunge or dive to the next. Here Ms. Johnson dives to the door frame as she attempts to leave the room.

Patients who exhibit these behaviors will be scored at 30 points on Ambulatory Aid.

### Page 40

Charlotte made another quick observation about Mr. Goodman. When she checked his chart, there was no indication of IV therapy. When she sees him, he doesn’t have an IV or an apparatus for IV access, just as the chart showed. So, Item 4 on the Morse Falls Scale receives a zero rating.

### Page 41

IVs can make ambulation hazardous. They can create a tripping hazard. If there had been any indication of an IV or IV access, Charlotte would have recorded a score of 20 points.

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

### Page 42

Charlotte assessed a third item on the scale just by observing Mr. Goodman. As she watched him walk, she mentally compared his gait to a Normal gait. A patient with a normal gait walks with his/her head erect and arms swinging freely at the side. There's not much hesitation in the stride.

Charlotte assessed Mr. Goodman's gait as 'Weak.' He is stooped but can lift his head while walking without losing his balance. His steps are short – almost shuffling. And she observed that the nursing assistant is providing little actual physical support or assistance. When Mr. Goodman gets support from the aide, he is using a featherweight touch, almost for reassurance. So she gave item 5 a score of "10."

Charlotte has another patient who has more difficulty walking. She has an "Impaired" gait. To keep her balance, Mrs. Sanchez grasps the aide and furniture for support. She walks with her head down, and she shuffles.

Often times, patients with an "Impaired" gait will have difficulty getting up from a chair. They will push on the arms or bounce, making several attempts to rise.

The patient you see here, an MS patient, would also be evaluated as having an "Impaired" gait. For this patient too, a patient who has had an amputation, gait would be evaluated as "Impaired." The gait of this Parkinson's patient would also be evaluated as "Impaired."

If you see any of these indicators of Impaired Gait in a patient, item 5 would receive 20 points.

### Page 43

For purposes of Risk Assessment, a patient's mental status is an either-or proposition. Either the patient is well oriented to their ambulatory capability, in which case you assign a score of zero.

Or, on the other hand, the patient overestimates his or her capabilities. Or they are forgetful of their limitations, in which case you assign a score of 15.

Charlotte has just asked Mr. Goodman whether or not he needs assistance. Here's what he says:

Mr. Goodman	The doctor downstairs, Doctor Rivers, he said I should ring for the nurse and wait to get help before I got in and out of bed. I've been doing that so far.
-------------	---

## Preventing Patient Falls Assessing Risk-rcd10212 Text Version

Charlotte knows that Mr. Goodman has orders for “Up with Assistance.” Based on how he responds to Charlotte, he seems oriented to his capabilities. So his evaluation is zero points on the Falls Scale.

Ms. Johnson’s situation is a little different. Like Mr. Goodman, she has orders for Nurse Assistance. Here’s how she responds to Charlotte’s question:

Charlotte	Do you need any assistance in getting to the bathroom?
Ms. Johnson	No. I take care of <i>that</i> myself.

Ms. Johnson seems not to be making a realistic response. Based on *her* response, the evaluation should be fifteen points on the Falls Scale.

And that’s all there is to evaluating the final item on the Falls Scale. Either patients are well oriented to their limitations, or they are *not* well oriented or forgetful of their limitations.

### Page 44

Here is your opportunity for a self check. Mrs. Sanchez, whom you see here, has “up-in-chair” and “nurse assist” on her activity orders.

Charlotte	Good morning Mrs. Sanchez. How are you doing?
Mrs. Sanchez	Oh, fine.
Charlotte	Do you need any help getting over to your chair?
Mrs. Sanchez	Oh, no thanks. I can do it my self. I don’t need any help.

Now click on the appropriate Mental Status score for Mrs. Sanchez.

When you’re ready, click on the button marked “Check My Answer.”