CHI St. Joseph Health

Fall Prevention Volunteer Program

Safety Monitor

Objectives

1. Identify prevalence and severity of falls in the US.
2. Application of The Joint Commission National Patient Safety Goal 9.
3. CHI St. Joseph Health Safe Care Fall Prevention Program, policy no. 40.
4. Role of the Safety Monitor Volunteer

Prevalence and Severity

- Falls are the leading cause of death due to injury for people 65 years or older (National Center for Injury Prevention and Control 2002)
- 75% of nursing home residents are expected to fall each year (Rubenstein 1994)

Prevalence and Severity

- By 2040 estimate of 500,000 hip fractures per year (Cooper 1992, Brainsky 1997)
- 17-32% of hip fractures lead to death (Kannis et al 2003)
- 50% of all adults who fracture a hip cannot return home and never regain their former level of function

Prevalence and Severity

- Falls are the most common adverse event reported in hospitals
- Most common is the 65 year old, female, alert, oriented, and ambulatory patient
- In 1991, costs associated with hip fractures were estimated at $4.7 billion
- By 2030 it is estimated to reach a cost of $240 billion

How Falls Affect Patients

- Even with minor or no injury, quality of life is affected
- Fear of falling
- Self-imposed activity restrictions
- Social isolation
- Depression

National Patient Safety Goal

The Joint Commission requires each hospital to “Implement a fall reduction program including the evaluation of effectiveness of the program”.

SAFE Care Fall Prevention Program

Stay

Alert for

Fall

Event

Safe Care Fall Prevention Program

Multidisciplinary Patient Care Manual Policy No. 40
CHI SJH will minimize opportunities for falls by:

- Creating a safe and hazard free environment for patients, visitors and staff;
- Identify patients at risk for falls on assessment and reassessment;
- Place at risk patient on Safe Care program;
- Using interventions to prevent falls;
- Educating patients, family and staff about falls; and
- Monitoring falls data for performance improvement.

Safe Care – Patient Assessment & Reassessment

- Initial assessment is done by RN using the Morse Fall Scale and placed into a low risk, medium risk or high risk category
- All patients, regardless of fall risk, will receive the Fall Prevention Guidelines.
- Patients are reassessed by RN at each shift and after a fall.

Morse Fall Scale

The **Morse Fall Scale** (MFS) is a rapid and simple method of assessing a patient's likelihood of **falling. Rates the following:**

1. History of falling
2. Secondary diagnosis
3. Ambulatory aid (bed rest, nurse assist, crutches, cane, walker, furniture)
4. IV or IV Access
5. Gait (normal, bed rest, wheelchair, weak, impaired)
6. Mental status (oriented, overestimated ability, forgets limitations.

Morse Fall Scale

Risk	Patient Score
High	45 or higher
Moderate	24-44
Low	0-24

Safe Care Program Standards

- All patients receive information about fall prevention.
- Patients who score 25 and above are placed in Safe Care Program.

Patient Interventions
All Patients & Low Risk

- Orient patient to surroundings, i.e. bathroom and routines
- Instruct on white board and nurse's name
- Instruct patient to call for help before getting up
- Inform patient/family of fall prevention interventions
- Hourly rounding for position, toileting, pain
- Anticipate side effects from medication

Patient Interventions
All Patients & Low Risk

- Wheels on bed and wheelchairs locked, document number of side rails up
- Call light, urinal, telephone and personal belongings within reach
- Patient room free of obstacles
- Additional lighting for vision
- Provide patient with non-skid slippers/socks

Patient Intervention
Patients scoring 25 or greater

- Place Safe Care Fall Prevention Plan on white board
- Place “fall alert” armband on patient

•We use a yellow triangle that clips to armband

•Give patient yellow non-skid socks (patients who score 45 and above on Morse Fall Scale have red non-skid socks)

Patient Intervention
If patient scores 25 - 44

- Post fall sign on door
- Review safety program, risk factors and interventions with family
- Commode at bedside, urinal/bedpan within easy reach
- Initiate Safe Care
- Place patient at nurses station as needed for observation
- Move patient to room near nurse's station

Patient Intervention
If patient scores 45>

- Red socks are used instead of yellow socks
- Bed Alarm is activated
- Pharmacist to evaluate medication regimen
- Night lights
- Low beds or putting mattress on floor
- Use of gait belt
- Provide ongoing reassessment of patients Determine patient's toileting habits and establish toileting schedule to meet those needs

Patient Intervention
High Fall Risk (45 or greater)

- Red Socks
- Individualized supervision (patient sitters)
- Chemical interventions

Fall Prevention Guidelines for Patients & Family

Why Falls Happen:

- Medications such as tranquilizers, sleeping tablets, pain relievers, blood pressure pills or diuretics may make patients dizzy and disoriented.
- Patient's illness or treatments such as enemas, laxatives, long periods without food, or tests ordered by the physician may leave the patient weak and unsteady

Why Falls Happen

- The hospital may seem foreign or unfamiliar to patients, especially when they wake up at night.
- Some falls, such as those associated with illness or therapy, cannot be avoided. However, by following the safety guidelines, the patient, their family, and friends can help reduce the patients risk of falling.

Safety Guidelines Given to Patients to Prevent Falls

- Ask the nurse for help if you feel dizzy or weak getting out of bed. Remember you are more likely to faint or feel dizzy after sitting or lying for a long time. If you must get up without waiting for help, sit in bed awhile before standing. Then rise carefully and slowly begin to walk.
- Wear rubber-soled or crepe soled slippers or shoes whenever you walk in the hospital. The hospital also has non-skid socks.

Safety Guidelines Given to Patients to Prevent Falls

- Remain lying or seated while waiting for assistance.
- Please be patient. Someone will answer your call as promptly as possible.
- Always follow your physician's orders and the nurses' instructions regarding whether you must stay in bed or required assistance to go to the bathroom.

Safety Guidelines Given to Patients to Prevent Falls

- When you need assistance, use your call light by your bed or in the bathroom and wait for a nurse/assistant to arrive.
- Walk slowly and carefully when out of bed. Do not lean or support yourself on rolling objects such as IV poles or your bedside table.

Safety Monitor Volunteers

Program Goals

1. Reduce patient falls and injuries
2. Increase staff compliance with fall prevention protocol
3. Create a safe environment for patients
4. Reinforce patient's role in fall prevention

Role of the Volunteers

Visit each patient in Safe Care Program on the assigned unit
Insure that all components of the fall prevention protocol are in place

- Fall risk yellow triangle on wrist band
- Fall sign on door
- Fall program on white board
- Bed alarms
- Call bell within reach
- Personal belongings within reach
- Room free from obstacles
- Yellow or red socks

Role of the Volunteers

- Reinforce fall prevention education with patient and family members
- Remind patient to call for staff assistance
- Round on patients before you leave – 3 P's (potty, pain, position)
- Provide unit director/clinical coordinator/charge nurse with feedback on staff compliance with fall prevention protocol

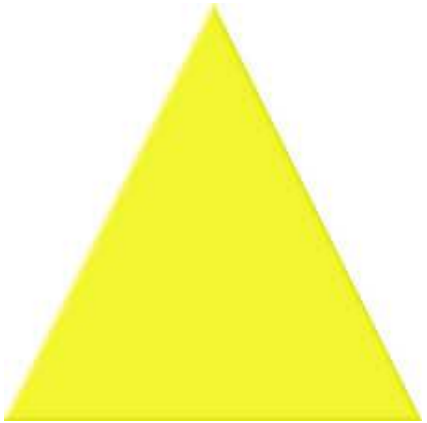
Safety Monitor Volunteer Procedure

- Sign in on the computer.
- Pick up clip board in cabinet under the printer.
- Check blue folder to see if there are any alerts or areas requiring immediate attention. Check to see if another volunteer has already rounded on an area that day.

Safety Monitor Volunteer Procedure

Pick up Morse Fall Scale report at information desk.
Visit all patients who have been designated as a fall risk by a score of 25 or greater on the fall report.

- √ Introduce yourself to the patient and family members present
- √ Explain your purpose
- √ Check for yellow triangle on patient's armband



Safety Monitor Volunteer Procedure

✓Check to see if fall prevention is documented on the white board … “call nurse when you need to get up”
✓Is the patient wearing the yellow (or red) non-skid socks
✓Fall sign on door
✓Bed wheels are in the locked position
✓Room is free of obstacles
If the patient is in bed:
√ Bed alarm is “on” (required for 45>)

Safety Monitor Volunteer Procedure

If patient is sitting in a chair:

√ Evidence of safety device (chair alarm; wrap around – may be used on some patients).

Safety Monitor Volunteer Procedure

All patients will be:

- √ Asked to demonstrate how to use their call bell
- √ Reminded to use their call bell to call for assistance and to not get up alone.
- √ Check the room for fall hazards

Safety Monitor Volunteer Procedures

Rounding – The 3 P's (potty, position, pain):

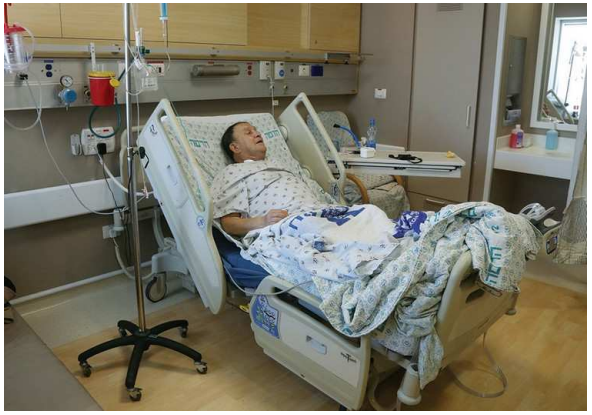
- Do they need to go to the bathroom?
- Are they comfortable?
- Are they in any pain?

Follow up immediately with the patient's nurse to deal with these rounding questions.

Safety Monitor Volunteer Procedure

In an attempt to improve patient safety, the volunteer will:

- √ Set bed alarm, if not active
- √ Move personal items within reach if appropriate
- √ Reposition call bell within patient's reach and clip it to the sheet
- √ Help the patient request staff assistance for all other needs
- √ Place yellow band clip and door sign, if not in place
- √ Indicate any measures taken to improve safety on the checklist



Safety Monitor Volunteer Procedure

- Before leaving … ask they patient if there is anything you can assist them with?
- Follow-up as appropriate.

Safety Monitor Volunteer Procedure

- Volunteer must wash hands prior to entering and leaving each room
- Volunteer will not enter isolation rooms
- If the patient has a sitter, please indicate this on checklist. Bed alarm should be on unless care is being given.
- Write the name of the nurse on the checklist. Obtained from patient's white board in room.

Safety Monitor Volunteer Procedure

- If during rounds the staff give explanations why protocol isn't being followed, please write that on the checklist (example: pt refuses to have bed alarm on)
- Volunteer can obtain extra yellow fall armband clips and Fall Precaution door signs from unit staff to correct those problems immediately (indicate if problem was corrected on your checklist tool).
- Alert staff if there are any issues you are unable to correct before you leave the unit.
- If you feel that immediate attention is required, please follow up in person with patient's nurse.
- Leave a copy of your finding for the clinical coordinator on each unit you round on.

Date: _____

Time: _____

Person Rounding: _____

Unit: Telemetry

Who was this form reviewed with? (circle on) Nurse / Director / Clinical Coordinator / Charge Nurse / Other _____

Tool/Questions	Room # _____	Room # _____
Room Visit		
Name of RN		
Morse Fall Score		
Pt received Fall Prevention Guidelines?	Yes No	Yes No
Pt understands fall precautions	Yes No	Yes No
Fall Prevention plan on whiteboard?	Yes No	Yes No
Armband?	Yes No	Yes No
Non-skid socks?	Yes No	Yes No
Fall sign on door?	Yes No	Yes No
Wheels on bed locked?	Yes No	Yes No
Call light within reach?	Yes No	Yes No
Room free of obstacles?	Yes No	Yes No
Rounding:		
Potty		
Position		
Pain		
Equipment issues?		
Notes:		