

Fall 12-15-2017

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Fanny Ku
ku.fanny@hotmail.com

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Ku, Fanny, "Assessment of Falls Protocol Use on Medical-Telemetry Units" (2017). *Master's Projects and Capstones*. 684.
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Assessment of Falls Protocol Use on Medical-Telemetry Units
Fanny Ku
University of San Francisco

Abstract

Purpose: The purpose of this quality improvement project is to identify a root cause analysis for an increase in falls at a large, metropolitan hospital and implement interventions designed to reduce the incidence of falls on the medical-telemetry unit.

Background: Falls, regardless of severity, may inflict irreparable consequences on patients, families, and hospitals. Approximately 20-30% of falls result in physical or emotional harm, including minor bruises, emotional trauma, and fractures (“Falls,” 2004). When falls occur, hospitals are generally responsible for all costs incurred from the sentinel event, and do not receive re-imbursement from insurances for services provided. In the large, metropolitan hospital, falls increased from 31 in 2016 to 36 in 2017, prompting an analysis of current fall protocols and root causes for the increase.

Key words: falls, falls prevention

Statement of the Problem

In 2005, American Nursing Association defined “falls” as “...an unplanned descent to the floor with or without injury...”, and includes all falls regardless of the cause (Currie, 2008).

Some individuals are more susceptible to falling unintentionally, especially those with an acute or chronic illness that increases the risk for falls—in fact, hospital falls tend to occur more often in units like neurosurgery, medicine, and neurology (Bouldin et al., 2013). Other factors that contribute to the risk for falls are age, mental status, and ambulation devices (Bouldin et al., 2013).

Not only do falls generate a significant amount of cost for involved hospitals, they also result in repercussions and consequences felt by the patient, the patient’s family, and the healthcare team. For instance, 20-30% of falls result in moderate to severe physical injuries such as cuts, bruises, and fractures—hip fractures, primarily, can lead to a 10-15% reduction in an individual’s life expectancy (“Falls,” 2004). In addition, individuals on the older spectrum of life who fall are more susceptible to getting anxiety related to a fear of falling and loss of independence; the loss of independence results in a dramatic decrease in self-esteem and mobility, leading to “...decreased activity and [the eventual] inability to perform activities of daily living” (“Falls,” 2004).

The Masters of Science in Nursing (MSN) Clinical Nurse Leadership (CNL) students focused on the history of falls for medical-telemetry units at a large, metropolitan hospital from fiscal years 2016 and 2017. Specific to the hospital, falls are classified into five different levels: level 1 falls result in no harm to the patients; level 2 falls result in minute harm to the patients; level 3 falls result in harm that requires minor superficial operations such as sutures; level 4 falls result in a fracture of some sort; level 5 falls, unfortunately, result in death for the patient. Based

on the pre-determined hospital data presented to the students, the incidence of falls, regardless of severity, increased from 31 falls in 2016 to 36 falls presently; data pulled for 2017 showed there were currently 27 level 1 falls, 8 level 2 falls, and 1 level 3 fall. This indicated to the MSN/CNL students that a quality improvement project specific to falls was required.

Upon superficial assessment, it was revealed that the hospital currently employs several interventions to prevent or reduce the occurrence of falls in its medical-telemetry units. For example, the Morse Fall Assessment Risk Tool is an assessment tool practiced by the nurses to evaluate a patient's mobility status and possible risk for falls; patients are typically evaluated during the admission process and once a shift thereafter, although patients are also eligible for assessment once they are transferred or after any harm that may have affected their balance or mobility capability. In addition, the hospital's policy requires vigilance in ensuring fall-risk patients have access to yellow fall socks, activated bed alarms, fall arm band, and clearly posted fall signs outside the door.

To understand the adversity of this issue, the MSN/CNL students related it to the chaos and complexity theory. In 2007, Dean Rickles and his colleagues defined chaos and complexity as "...the generation of complicated, aperiodic, seemingly random behavior from the iteration of a simple rule..." and "...the generation of rich, collective dynamical behavior from simple interactions..." respectively (Rickles et al., 2007). To simplify it, the health care environment is inherently unpredictable and prone to changes – particularly in today's health care field, where innovative technology aimed to improve the quality of care is invented daily.

Literature Review

Many task-specific interventions and technological innovations have been made to try and combat this problem. The Timed Up and Go Test at Kaiser Permanente during admissions is

one such example, and it is an intervention that can be performed quickly and easily by a well-trained health care professional. In this test, the patient is instructed to wear regular footwear and utilize their normal walking gait (Lee et al., 2013); the patient is then timed while going from a sitting position to rising and walking three meters before sitting back down (Lee et al., 2013). The health care professional also observes the patient's gait, stride length, and postural stability during the entire process (Lee et al., 2013). Although the normal range for the timed test is 10 seconds, the test is only considered abnormal if the time exceeds 20 seconds—if abnormal, the patient will undergo a more comprehensive risk assessment to identify any predisposing factors (Lee et al., 2013).

In addition, the explosion of technology-based applications and devices targeted at fall risk populations have significantly reduced the incidence of falls at many institutions that choose to utilize them. For example, wearable body-sensors or smart socks allow health care professionals to monitor the mobility of their prospective patients continuously; in the event of a possible fall, the sensors would immediately notify the health care professionals

Other interventions directed at preventing the occurrence of falls include enrolling at-risk patients in exercise or physical therapy programs, managing foot problems, treating orthostatic hypotension, minimizing administration of psycho-active medications, and patient education (Lee et al., 2013).

Cost Analysis

The MSN/CNL students calculated the cost of evaluating practices of 60 nurses by employing only eight MSN/CNL students. Due to the estimate that nurses generally take two hours for the complete assessment of four patients, it was concluded that a total of 120 hours will

be allocated for evaluation of the nurses' initial assessment of patients. However, it should be noted that the MSN/CNL students will not be charging for the evaluation.

In addition, the following hours have been estimated for allocation: five hours for meeting discussions and staff coordination, ten hours for the creation of an educational flow design for how MSN/CNL students plan to evaluate the falls protocol assessment, and five hours to report observed data. Nurses will be assessed three times each, and each evaluation will last about 30 minutes. As such, an estimated total of 90 hours will be allocated for the training of the 60 nurses. In total, it will take approximately 230 hours to evaluate all 60 nurses.

If the cost of labor per hour for each Registered Nurse is \$38, then the estimated total cost for the 230 hours to train 60 nurses will be \$8,740. The CDC estimates the average cost of one hospital fall injury \$30,000, which means that the savings generated by training 60 nurses is estimated at \$3.40 per \$1.00 spent; these values were determined by dividing 30,000 by 8,740. It is also expected that savings should continue to increase with added extra expense to the hospital, as the 60 nurses will continue to have background from the training. However, it is important to note that there is no guarantee that all 60 nurses will still be working at the same hospital from year to year, so additional expenses may be necessary if new employees are hired.

Clinical Microsystem Assessment

Purpose and Methodology

After approval by the Institutional Review Board (IRB), the MSN/CNL student team will conduct a cumulative total of 12 on-site assessments at the large, metropolitan hospital. The team will be split up into smaller teams of two—for a total of four teams—to avoid disturbing the hospital environment during assessments; consequently, each team will conduct three 12-hour shift assessments on-site, six during the morning and six during the night. The purpose of these

evaluations is to collect data on how nurses communicate with each other during shift report. In addition, the MSN/CNL student team will collect data on the overall compliance and competency of nurses on following the fall protocol in the medical-surgical telemetry units.

To facilitate this process, the MSN/CNL nurse will be assigned to shadow one floor nurse during shift change as well as during initial patient encounters. During these shift assessments, the MSN/CNL nurse will collect data on nurse communication effectiveness among one another with regards to a patient's ambulation and toileting requirements. The student nurse will make strict observations for any mention of a patient's present fall risk status, ambulation requirements, and elimination needs; observations will also be made on whether the oncoming nurse had any questions regarding these matters for the nurse from the previous shift.

When shift nurses make initial contact with assigned patients, the MSN/CNL nurse will pay attention to how the shift nurse engaged the patient in fall protocol precautions. Subsequently, the MSN/CNL nurse will observe the shift nurse conduct a Morse Fall Scale assessment on assigned patients and note the nurse's charting for this assessment—data collection for this will not be disclosed to the shift nurse to prevent changes in assessment behavior. In addition, and as an extension for data collection, the shift nurses will be given a questionnaire which evaluated their general confidence with regards to completing a proper falls assessment as well as their understanding of universal fall precautions and hospital-specific fall protocol interventions.

To assist the MSN/CNL nurse in collecting protocol compliance and competency data, the student will gain access to the list of patients identified for fall risk in each participating unit. The list will be used primarily as a guide for the MSN/CNL nurse to evaluate for the following

measures: three side rails up, posted fall risk sign outside door, activated bed alarms if necessary, and call light placement for ease of access.

However, since the MSN/CNL team did not gain access to the hospital pending approval by the IRB, the data was given to the team instead.

Patient Population

The MSN/CNL students focused on all patients in the medical-telemetry units; the general patient population in these units include patients who have cardiac and neurologic deficits as well as alcohol dependence. In an interview with the unit manager, it was discovered that most falls occur because patients underestimate their mobility disability, either due to a lack of knowledge regarding the side effects of current medications or diagnoses. In addition, many of the patients have toileting necessities that prompt them to get out of bed unassisted.

In this microsystem, the Morse Fall Assessment Tool is used by the nursing staff to identify patients who may be at risk for falls. The Morse Fall Assessment Tool consists of six items or evaluations to classify at-risk patients; these items are history of falling, greater than two diagnoses, ambulatory aid necessity, IV therapy or Heparin lock, gait, and mental status (AHRQ, 2013). The number scale ranges from 0, for no disability, to 25, for current or a history of the disability (AHRQ, 2013); the scoring range is as follows: 0 for no fall risk, low fall risk for scores less than 25, moderate fall risk for scores between 25 and 45, and high fall risk for scores above 45 (AHRQ, 2013).

As mentioned previously, patients who are considered fall risks undergo policies specific to the hospital. To reiterate, standard policy interventions include access to yellow socks, fall arm bands, activated bed alarms, and posted fall signs. Posted fall signs, yellow socks and arm bands indicate to all health care staff on the unit that the patient is at risk for falls, resulting in

more safety awareness for the patients. Bed alarms, when activated, notify the health care team when the patient has gotten out of bed, with or without assistance, and prompts a rapid response by the staff.

Professionals

There are 61 beds available in the medical-telemetry units. During any shift, there is generally one charge nurse, one unit receptionist, four to five nursing aids, and 12 to 15 Registered Nurses at any time. Nurses on the floor are assigned three to four patients per shift, and nursing aides typically receive eight to ten patients per shift. Nurses are held accountable for overseeing care provided by nursing aides and ensuring that patients receive care quality held to a high standard; nursing aids work with the nurses and helps the patients perform activities of daily living where necessary. The charge nurse supervises and assists all nursing staff as necessary for crucial decision making, contacting physicians, and etcetera.

Processes

The current policy of the hospital requires that each patient is assessed for falls at least once during every shift, transfers, admissions, and discharge. Once patients have been identified as a fall risk, healthcare professionals, such as nursing aides and nurses, must ensure that the patients have yellow non-skid socks on, access to call lights, and bed alarms activated. The staff members must also frequently re-orient the patient as needed, post a fall sign outside the patient's door, and keep the bed at the lowest height possible once all care has been finished. Standard hourly rounding is also required at this facility.

Patterns

When the shift starts, the medical-telemetry nurses participate in a "huddle," which is where the charge nurse discusses all relevant information to staff prior to shift start. The charge

nurse will inform all staff members of the following: the daily goal and significant patient statuses. Post-huddle, the nurses disperse and receive report from the nurses of the previous shift for their assigned patients. These reports generally occur at the nursing station or by the patient's bedside for about 25 to 30 minutes. Information exchanged during the report include: attending physician, diagnoses, laboratory results, diagnostic results, ambulation status, toileting needs, medications needed or given, dressing changes required, and etcetera.

It is important to note that the MSN/CNL students were unable to observe these patterns at the hospital since the IRB did not get approved.

Results

Due to the IRB's pending approval, the data utilized in this paper will be hypothetical results from the University of San Francisco in absence of real data. The data given to the MSN/CNL students were data for the observation of only five nursing shifts, not 12 (Appendix C). Two of the shifts were conducted at night, while the other three were conducted during the day. 44 patients were identified as a fall risk in the morning shift, and 34 patients were identified as a fall risk in the evening shift – totaling 78 fall risk patients.

The data showed that the percentage of nurses who communicated the patient's gait and balance status and the number of diagnoses were 42% and 45%, respectively. In addition, there was only a 7% compliance with activating the bed alarms for at-risk patients, and a 36% compliance for placing call lights within reach of patients and putting three side rails up. Other data from this report were 78% orientation and cognition, 72% continence status, 60% prescribed medication, and 63% fall risk sign posted outside door.

The most alarming data then, which is also what will be considered as part of the root cause analysis, is the fact only 42% of nurses communicated to one another regarding the

patient's gait and balance. In addition, only 7% of nurses activated the bed alarms for at-risk patients, and only 36% of nurses put three side rails up and kept the call light within reach of the patient. These results clearly indicate that nurses are not following the universal and standard hospital fall protocol.

Implementation

After discussing the results with the MSN/CNL student team, it was decided that the best intervention to implement on the medical-telemetry units is Just-In-Time training. This training module is based heavily on Kotter's Eight Step Change Model (Appendix A), and focuses on decreasing fall incidences for the units. Kotter's eight steps are as follows (Kotter, 1996):

1. Establishing a sense of urgency;
2. Creating a guiding coalition;
3. Developing a vision and strategy;
4. Communicating the change vision;
5. Empowering broad-based action;
6. Generating short-term wins;
7. Consolidating gains and producing more change;
8. Anchoring new approaches in the organization.

In the first step, an evaluation of the microsystem will be conducted by the MSN/CNL students to collect data on patient falls, including incidence reports, patient and staff surveys, item analyses, and observations for RN assessments; in addition, MSN/CNL students will bring an awareness to the idea that the Morse Fall Assessment Tool may be being carried out incorrectly, leading to an increase in patient falls. In the second step, a group will be created primarily for process improvement on patient falls, and will involve unit managers, nurses, and nursing

assistants. In the third step, the end goal will be defined by the MSN/CNL students, which would be educating staff members on how to conduct the Morse Fall assessment. In the fourth step, the vision and end goal will be communicated to the staff members as well as the managers. In the fifth step, barriers will be identified and removed, if possible, to ensure participation in the training. In the sixth step, short-term benchmarks will be established for the evaluation of staff on Morse Fall assessments. In the seventh step, short-term goal achievements over time, such as a reduction in the incidence of patient falls, is expected to encourage nurses to continue the assessments. Finally, in the eighth step, evaluation of the staff will continue and should become a part of the units' fall protocol.

There are three parts proposed for Just-In-Time training. In the first encounter, the MSN/CNL students will demonstrate proper Morse Fall Assessment techniques to the 60 nurses being trained. In the second encounter, the nurse will demonstrate and return teaching to the MSN/CNL student; incorrect techniques will be identified and addressed at this time. In the final encounter, the nurse will perform the Morse Fall Assessment correctly each time and competencies will be checked off by the MSN/CNL students.

Evaluation

The evaluation of the training has been determined to occur in three different phases. The first phase will occur simultaneously as the last part of Just-In-Time training (third encounter). During this phase, the nurses will be assessed to check for competency in performing the Morse Fall Assessment correctly. In the second and third phases, the nurses will be asked to complete a questionnaire to evaluate whether Just-In-Time training met their specific needs, how well they felt they were able to learn the material from the MSN/CNL students, and whether they enjoyed the opportunity to learn. However, it is important to emphasize that evaluation of the nurses will

be ongoing so that the MSN/CNL students can determine whether the nurses continue to conduct the Morse Fall Assessment correctly. A correlation with fewer falls on the unit is expected.

Discussion

In this discussion, the focus will be primarily on the challenge with getting approval from the IRB to move forward with the quality improvement project. The hospital with which the MSN/CNL students were contracted with would not accept the proposed project as quality improvement, and insisted to view it as a research project – this issue delayed many aspects of the project that the MSN/CNL students wanted to implement.

However, falls prevention remains an integral part of nursing and healthcare since so many patients are affected daily by a simple event capable to wreaking havoc. As mentioned previously, a total of 530 hours is required for the implementation of this quality improvement project (230 for the CNL and 300 for the MSN/CNL students). Even if the IRB had been approved, the amount of time needed to complete this project would have stretched all available resources thin, even with eight students on the team. This is largely due to scheduling difficulties with students; in addition, the hospital's falls committee only meets once a month, which means the MSN/CNL students would not have had a lot of flexibility in terms of scheduling.

Even so, had the IRB been approved, the MSN/CNL students could have paved the way for future students to continue the quality improvement project, as immediate results were not expected to occur in a short period of three months.

Nursing Relevance

This identified issue remains significant for all practicing nurses in today's health care system despite technological advances. Falls have a negative outcome for both patients and the health care team, regardless of whether it results in physical harm to the patient. By emphasizing

the importance of an individual fall risk assessment, nurses can improve the quality of care received by their patients and reduce any additional time spent residing in the hospital due to undesirable falls. Every patient's body is different and reacts differently to medications or illnesses, no matter how similar the diagnoses or case appears to be; therefore, it is imperative for nurses to assess each patient as a new individual and complete an assessment during each shift change or change in condition.

In addition, nurses should advocate for patient safety relating to ambulation capabilities and continuously re-educate the patient regarding his or her fall risk status. Since it only takes one single fall event to traumatize a patient emotionally, physiologically, or physically, nurses should be vigilant in evaluating the patient's full understanding of what it really means to be a fall risk patient.

Clinical Nurse Leader Relevance

Clinical Nurse Leaders are duly qualified for this kind of quality improvement project. There are two main reasons for this. Firstly, CNLs have received formal training and possess the clinical expertise necessary to improvement projects such as this; this is demonstrated by the curriculum CNLs are required to go through. For example, CNLs must take the following courses: advanced pathophysiology, advanced clinical assessment, healthcare informatics, improvement science, healthcare systems leadership, and financial resources management. Secondly, the CNL profession is a profession that focuses primarily on process or quality improvement within the microsystem.

The required 300 CNL student hours, when added to the 230 hours necessary for implementation and evaluation, produce a total of 530 hours on the project. This means that, without a team of eight MSN/CNL students, the project will take a single individual

approximately 3.5 months to complete. In addition, nurse managers or floor nurses generally do not have extra time in their busy schedule to take on a quality improvement project on this scale.

Future Directions

A recommendation for the future includes involving the patients' families and interdisciplinary team, such as Certified Nursing Assistants (CNAs), Physical Therapists (PTs), and Occupational Therapists (OTs). By doing so, other causes for the increase in the incidence of falls may be identified.

In addition, and if applicable, the hospital should actively involve the Masters-prepared students in process improvement or intervention implementation – this is so that the students can evaluate the actual effectiveness of an intervention and whether it has a negative or positive impact on the fall census. To facilitate the process, the MSN/CNL students suggest that the IRB approval process be waived as it does not relate to the scope of practice for the students; furthermore, the IRB process utilized more time than anticipated and delayed processes imperative to the quality improvement project.

At this current point in time, it remains unclear whether this project will be succeeded by future students. However, since the plan for the project has been created, future students will only need to carry out its implementation and evaluation. It is important to note that future students may have to re-assess the microsystem, as changes might be made that will not reflect the microsystem outlined in the current plan.

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Appendix A**Kotter's 8 Steps**

Step 1	Create a climate for change
Step 2	Create a guiding coalition
Step 3	Develop a vision and strategy
Step 4	Communicate the vision
Step 5	Empower broad-based action
Step 6	Create short term wins
Step 7	Consolidate gains to produce more change
Step 8	Anchor new approaches in the organization

(Kotter, 1996)

Appendix B**COST ANALYSIS**

Intervention #1	Break down of training hours:	CNL Activity:	Hours Spent
“Just in time” training	1 st encounter: 30 min 2 nd encounter: 30 min 3 rd encounter: 30 min 1.5 hrs for training 1 RN or 90 hrs for training 60 RNs	Initial Assessment Coordination Educational Design Training 60 RNs Reporting Back	120 hours 5 hours 10 hours 90 hours 5 hours
Total hours to cover all 60 RNs			230 hours

Appendix C

ROOT CAUSE ANALYSIS

Table 1

Number of Fall Risk Patients on a Medical-Surgical/Telemetry Unit

Data	AM Shift	PM Shift	Total
Number of Shifts Observed	3	2	5
Number of Patients Identified as a Fall Risk	44	34	78
Average Fall Risk Patients per Shift	14.6	17	15.6

Table 2

Fall Risk Factor Assessment Composition

Fall Risk Factor	Percent Communication of Fall Risk Factor During Nursing Assessment
Patients level of orientation and cognition	78%
Continence status	72%
Number and types of prescribed medications	60%
Number of diagnoses	45%
Gait and balance	42%

Table 3

Care Planning Performance

Fall Risk Prevention Intervention	Percent Compliance with Fall Risk Protocol
Three side rails up	36%
Fall risk sign posted	63%
Bed alarm activated	7%
Call light placed appropriately within reach	36%

Appendix D

INTERVIEW QUESTIONS

Nursing Staff Questions:

1. What are some interventions most commonly used on this floor for fall prevention? In your opinion, is it effective? Why or why not?
2. What is the protocol used on this floor when a fall occurs?
3. Which patient population do you find to be most at risk for falls? Specifically, what age, gender and diagnosis are the most common.
4. Do you communicate with your patients the importance of using their call light when they need help out of bed? If so, how compliant are they, and what do you think would help them become more likely to comply?
5. Do you find that patient's family and friends understand that their loved one or friend is a fall risk and what that means specifically?
6. What are your feelings about falls? What is the climate on the unit about fall prevention?
7. What are the barriers that you have experienced while implementing the fall prevention protocol?
8. When you are giving a patient medication that might cause them to get up more (i.e diuretics), what interventions do you use to prevent them from falling? Do you feel these interventions are appropriate?
9. Under what circumstances would you implement the need for a patient to have a sitter if they are a fall risk?
10. Do you find that more patients fall during change of shift or during your breaks? Why or why not?

Patient Questions:

1. Do you feel that the nursing staff is communicative with you about the fall risks?
2. Do you understand why you are considered a fall risk?
3. Does your family and friends understand why you are considered a fall risk?
4. How safe do you feel, in terms of risk of falling, with these prevention measures in place?
5. Do you feel that the nurses taking care of you respond to your call light within a reasonable time (1-5 minutes)? Or do you find it taking more than 5 minutes?
6. When you have to use the restroom, knowing you are a fall risk, what is your initial action?
7. Did the nurse provide you with instructions for getting up to use the restroom?
8. Did the nurse communicate the safest way to ambulate?
9. When you feel dizzy from standing, did the nurse speak to you about how you should react?
10. Did the nurse address to you the importance of keeping on your non-slip socks?

Appendix E

GUIDELINES FOR ON-SITE OBSERVATIONS

Students will be observing change-of-shift report on-site between nurses and nursing assistants for the following:

1. Discussion of existing fall risk or potential for fall risk during report
2. Discussion of current patient ambulation status
3. Mentions of patients' Morse Fall Scale (MFS) score

In addition to these three items, observations will be made continuously while on-site for the following:

1. Change in status of patients (altered level of consciousness, over medication, under medication, acute pain, sedation, nutrition imbalances, cardiac status, and etcetera)
2. Time it takes for health care providers to respond to call lights or beeping IV lines
3. How long patients take once situated in the bathroom or bedside commode and the exact location of the health care provider while patient is using the bathroom

Appendix F

DATA COLLECTION SHEETS

Patient Demographics	
Name	
Age/Sex	
Diagnosis	
Comorbidities	
Psych Diagnosis	
History of falls	
Bone Disease	
Coagulopathy	
Recent Surgery	
Current drug and/or alcohol use	
Hx of drug and/or alcohol use	
Homeless or Housed	
Was CIWA used? (circle one) If yes, indicate treatments/interventions used during the fall.	YES/NO
Detailed review of medications	

Appendix G

REVIEW OF INCIDENCE REPORTS

Review of Incidence Reports			
Date and time of fall: (eg. dd/mm/yy, 0000)			
Shift (Circle one)	AM shift, PM shift, or NOC shift		
Was the patient identified as a fall risk? (Circle one)	YES/NO		
Was Morse Fall Scale Used? (Circle one) If yes, how did the patient score? (as recorded on charting)	YES/NO		
	Item	Select Areas of Risk (check one per item)	Score
	1. History of falling	<input type="checkbox"/> No <input type="checkbox"/> Yes	0 25
	2. Secondary Diagnosis:	<input type="checkbox"/> No <input type="checkbox"/> Yes	0 15
	3. Ambulatory Aid	<input type="checkbox"/> None/bed rest/nurse assist <input type="checkbox"/> Crutches/cane/walker <input type="checkbox"/> Furniture	0 15 30
	3. IV Therapy/ HepLock/Saline Lock	<input type="checkbox"/> No <input type="checkbox"/> Yes	0 20
	4. Gait:	<input type="checkbox"/> Normal/bed rest/wheelchair <input type="checkbox"/> Weak <input type="checkbox"/> Impaired	0 10 20
	5. Mental Status:	<input type="checkbox"/> Oriented to one ability <input type="checkbox"/> Overestimates/forgets limitations	0 15
Patient is (select one) <input type="checkbox"/> No risk for falls (0) <input type="checkbox"/> Low risk for falls (<25) <input type="checkbox"/> Moderate risk for falls (25-45) <input type="checkbox"/> High Risk for Falls (>45)		Total:	
Nursing care plan to address fall risk:			
Did the patient have sitter (circle one)	YES/NO		
Who was with the patient when the fall occurred?			
The reason for the fall:			
Injuries sustained as a result of the fall:			
Post-fall interventions (eg. extended LOS, x ray, etc.):			