FALL PREVENTION WITH MORSE

Part II

Must complete Morse Fall Scale – It's all about patient safety first!

STOP!

- If you haven't yet completed the Power Point Education Morse Fall Scale – It's all about patient safety!, please do that education before going any further
- If you have, please continue!

Objectives

- Learn how to utilize the Morse Fall Scale to prevent patient falls and injury
- Learn how to optimize the use of the care plan in the EMR in planning the care for the patient and documenting the care provided and the interventions in place to prevent fall/injury
- Recall some tips from the original McKesson education

Care Plans within McKesson

NOW

- Not a working tool to plan the care for the patient
- Entered on admission and closed at discharge
- Not routinely being evaluated and updated

MCKESSON

- Can be electronically viewed by any discipline throughout the hospital
- It is a working tab on Clinical Care Station that you can update and implement easily
- Increases interdisciplinary cohesion and provides best outcomes for patients
- Will be reviewed every shift to keep current and to document care provided

Documentation

- Old process: documentation was done in the assessment tabs
- New process: through the patient plan of care
- **Recall if it's not documented, it's not done**

The Nursing Process (from the American Nurses Association)

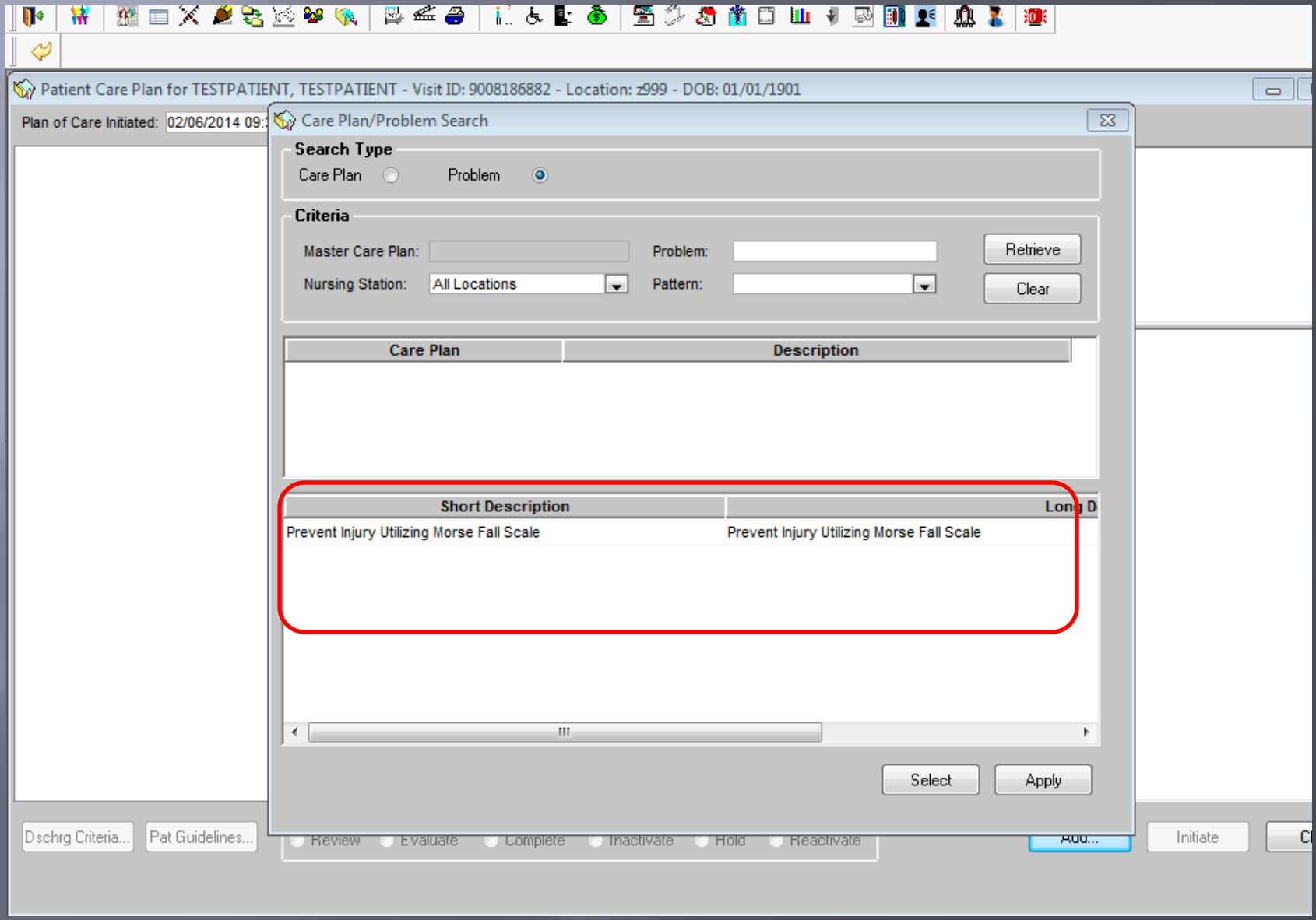
(the essential core of practice for the RN to deliver holistic, patient-focused care)

- Steps in Nursing Care Delivery:
  - **Assessment: RN collects and analyzes data** about a patient, including physiological, psychological, sociocultural, spiritual, economic and life-style factors
  - **Diagnosis: RN's clinical judgment** about the patient's **response to actual or potential health conditions or needs** – the *basis for the patient's care plan*
  - **Outcomes/Planning**: measurable and attainable short and long range **goals** for the patient
  - **Implementation**: **interventions** to provide continuity of safe and effective care during hospitalization and after discharge. **Care is documented** in the patient's record.
  - **Evaluation**: Status and effectiveness of **care is continually evaluated and** the plan of care is **modified** as needed

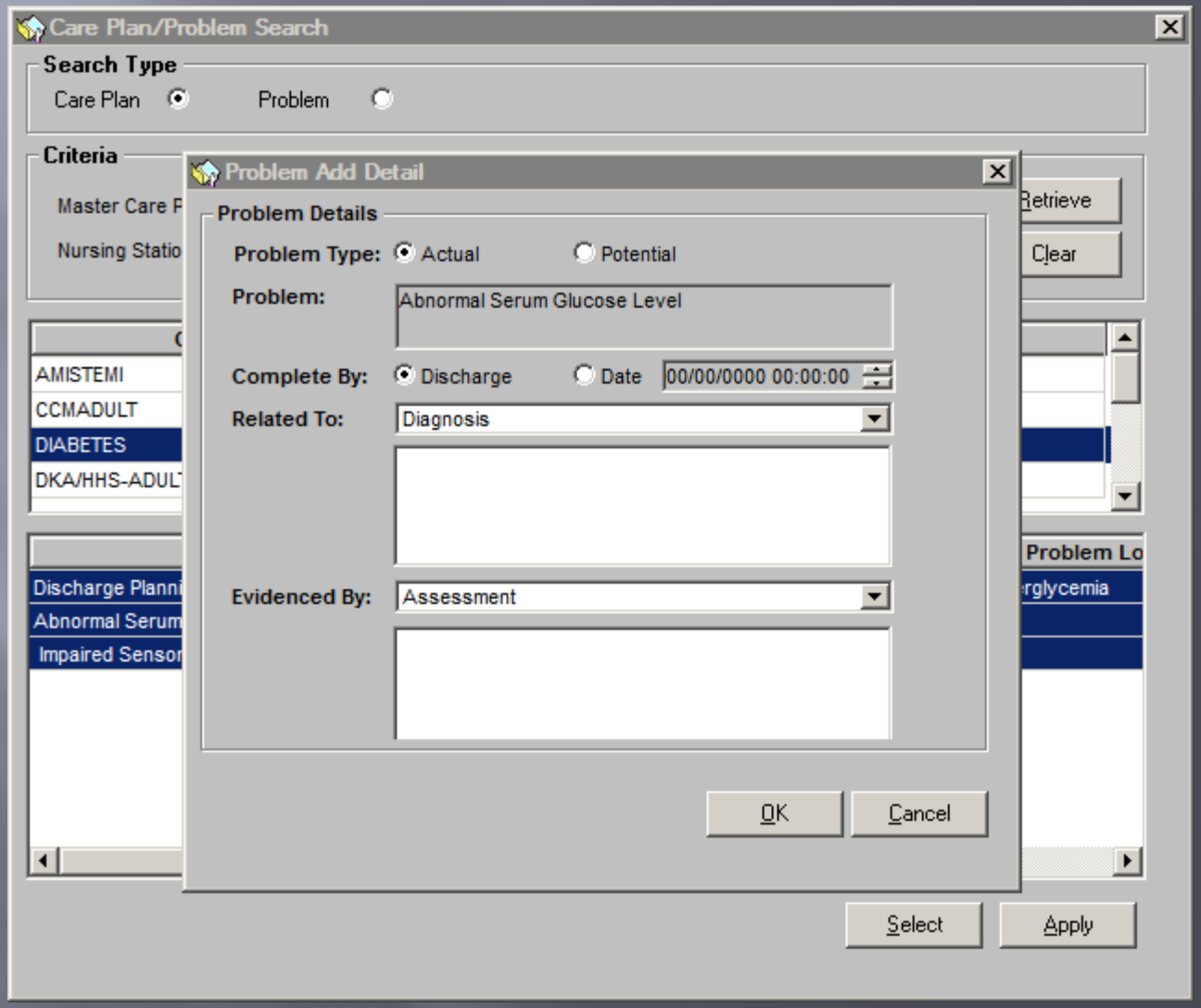
Nursing Process for Fall Prevention

- Assessment: Morse Fall Scale (admission and daily assessment tabs in McKesson)
- Diagnosis: Prevent Injury Utilizing Morse Fall Scale
- Outcomes/Planning - Goal :
  - Absence of Fall – Universal Fall Precautions – All Patients
  - Absence of Fall – Moderate Risk Score (this includes history of falls and secondary diagnosis)
  - Absence of Falls – High Risk Score
- Implementation - Interventions – based on score and nursing judgment

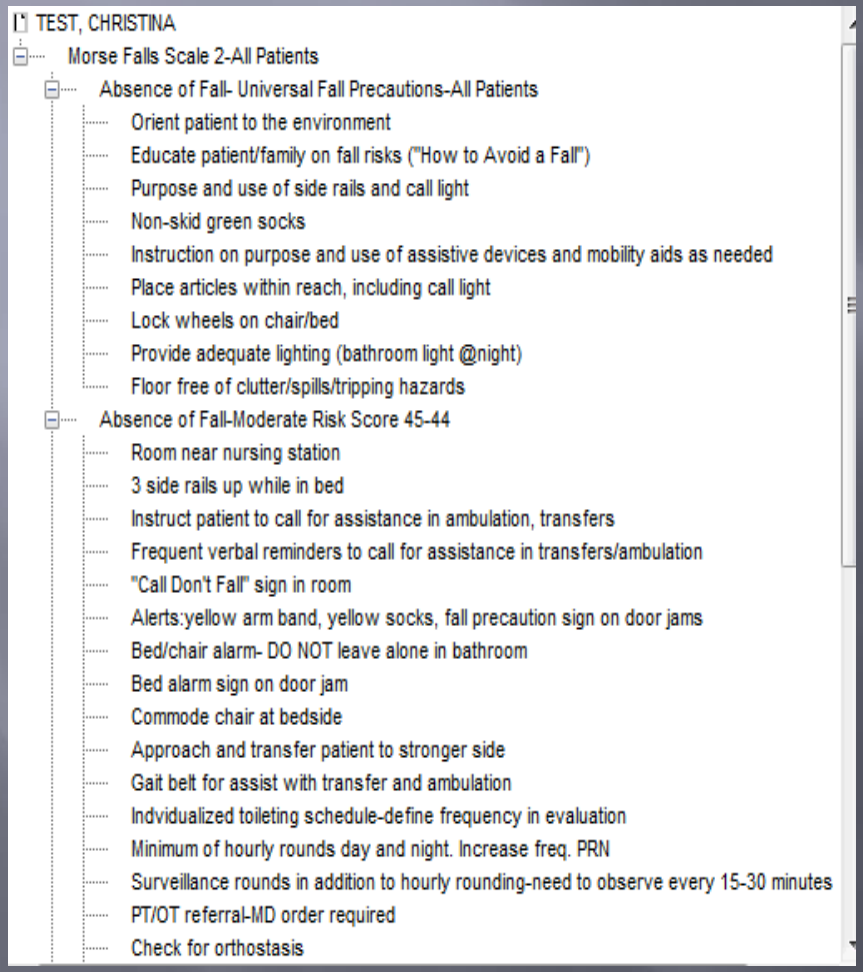
Problems from Assessment

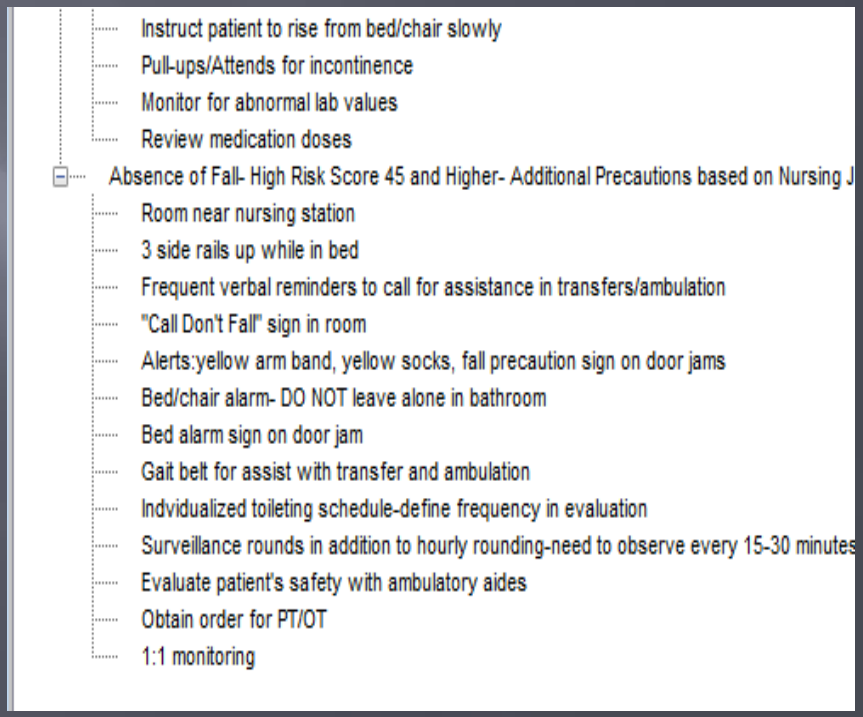


Problem Add Detail

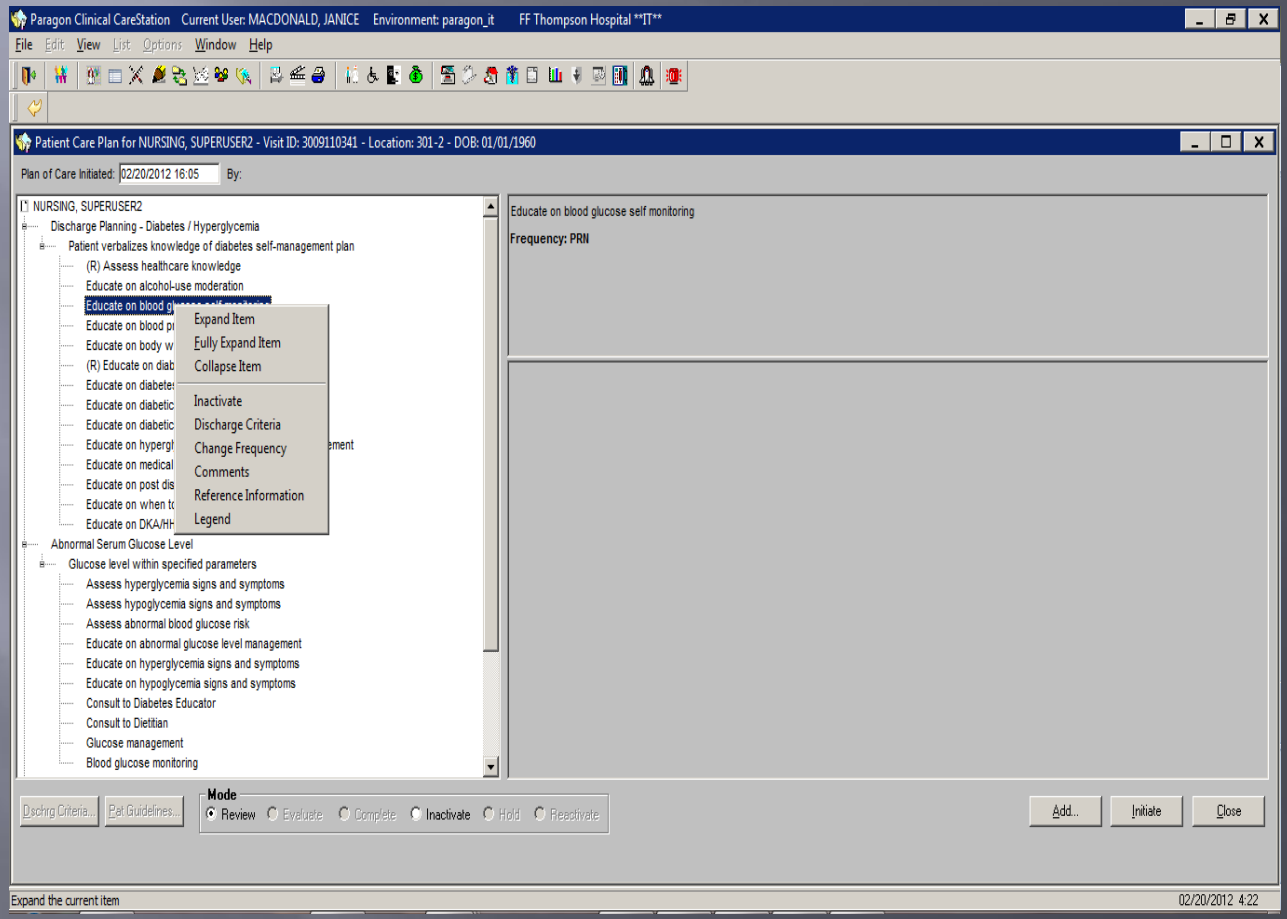


Reviewing the Care Plan

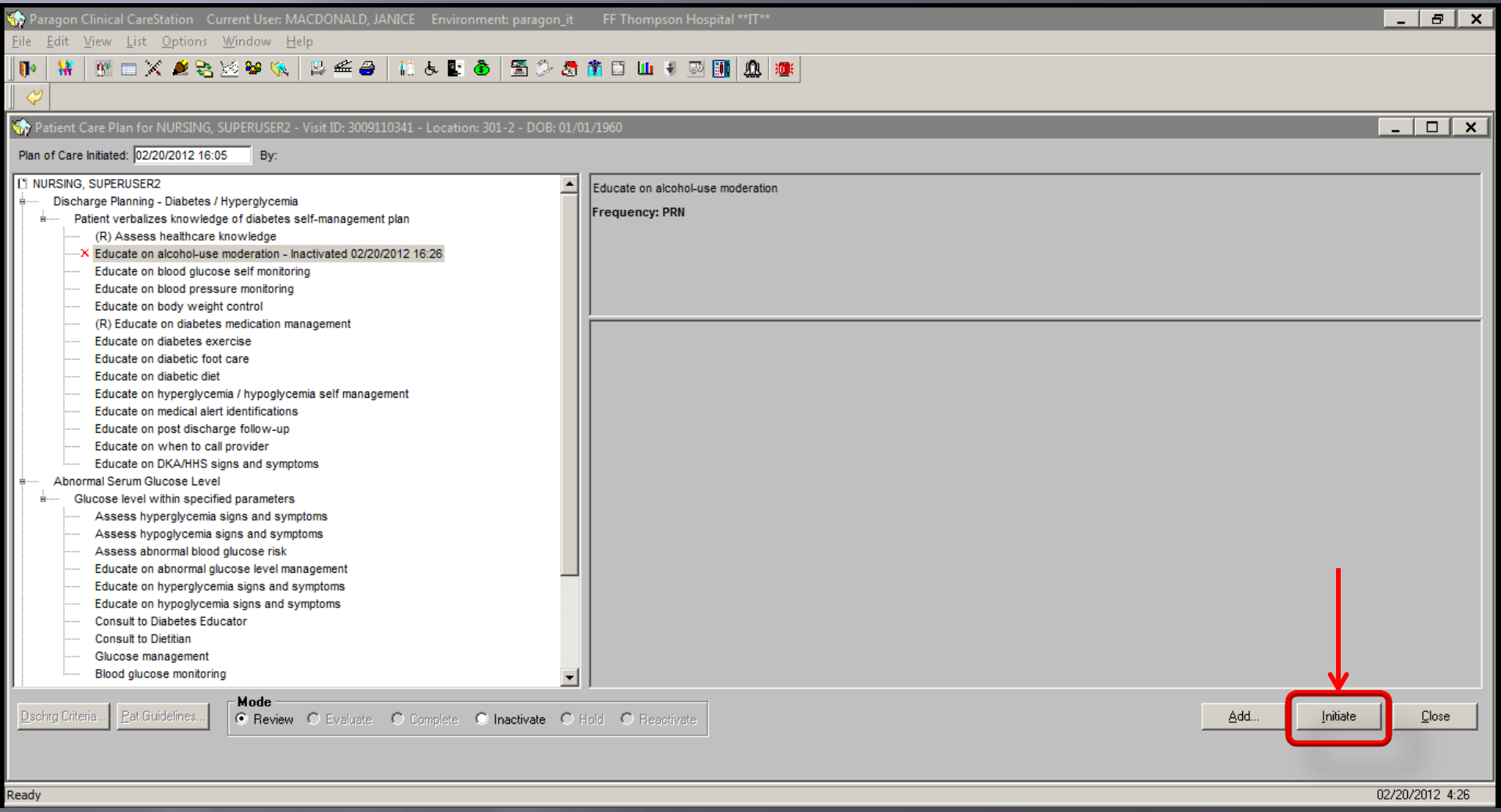




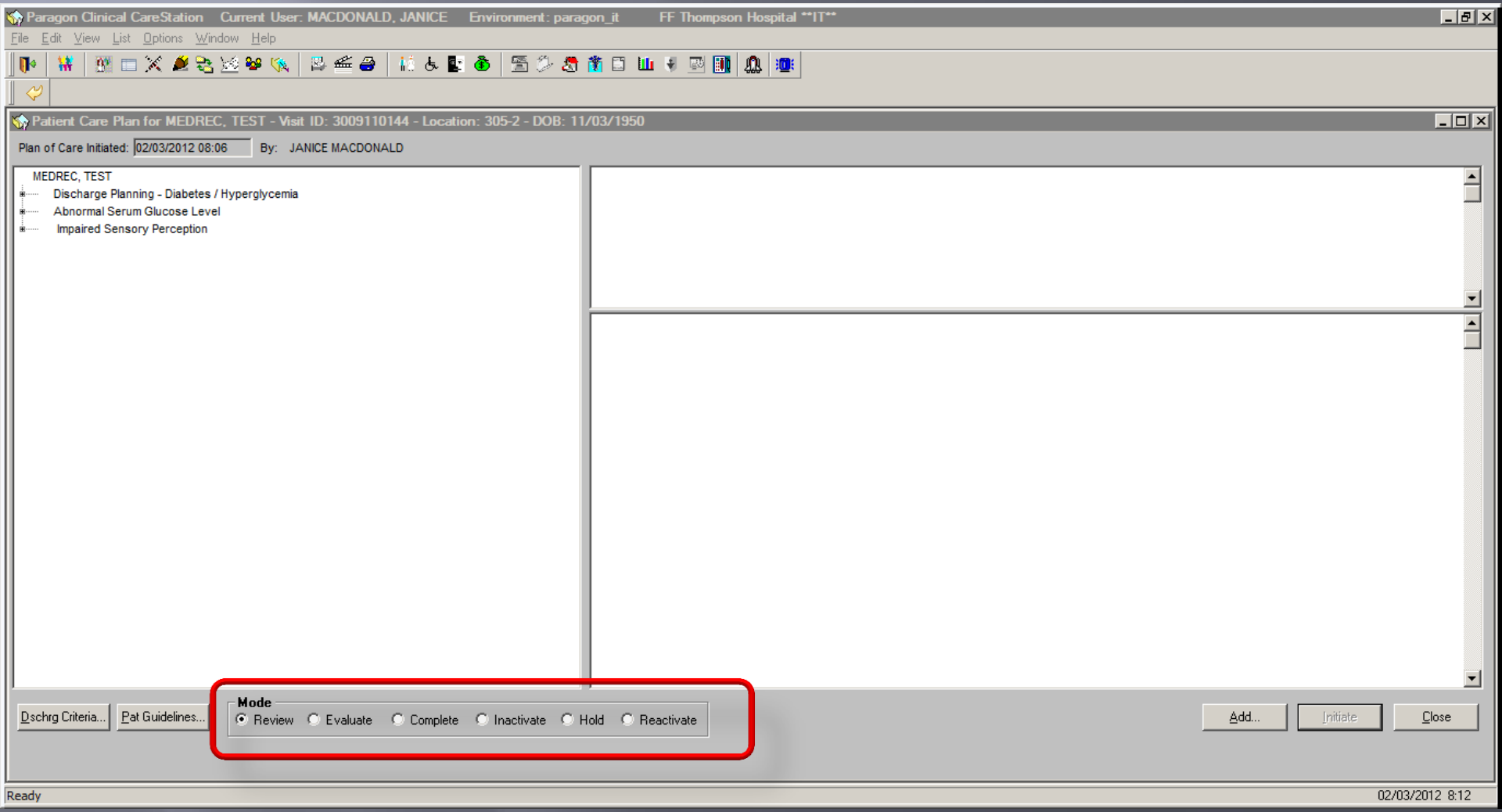
Modify Care Plan prior to Initiation



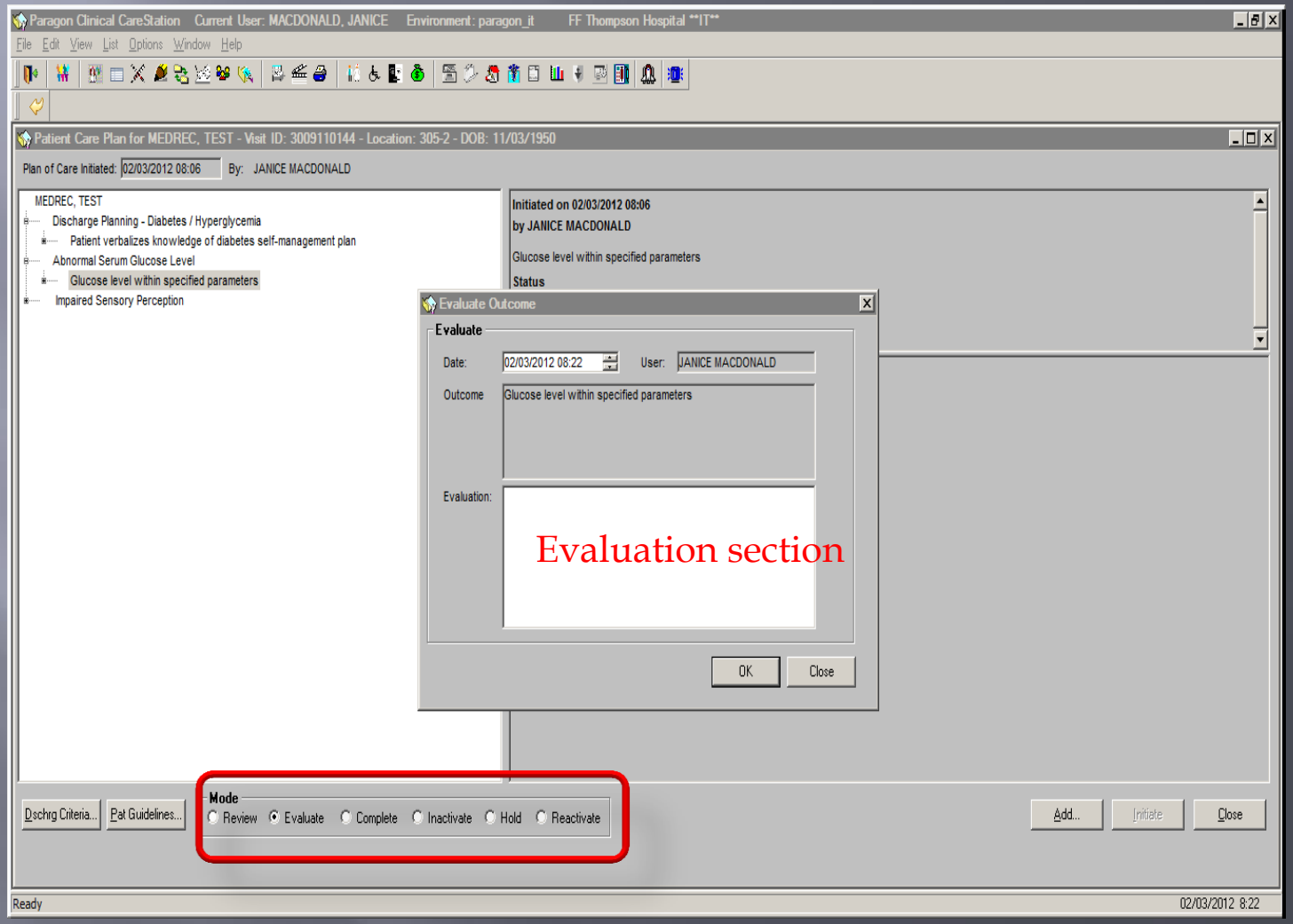
Initiate the Care Plan



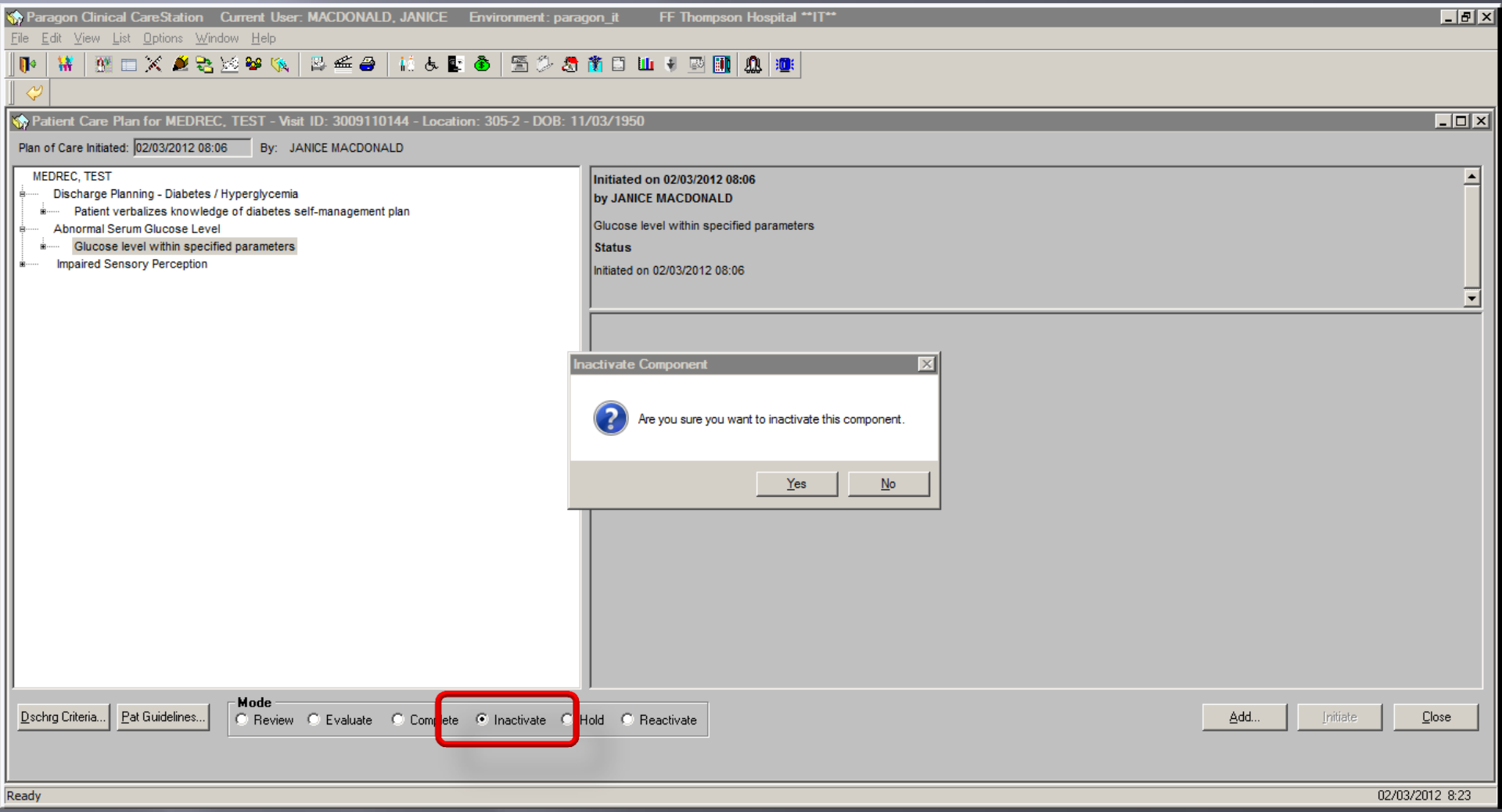
Initiated Care Plan



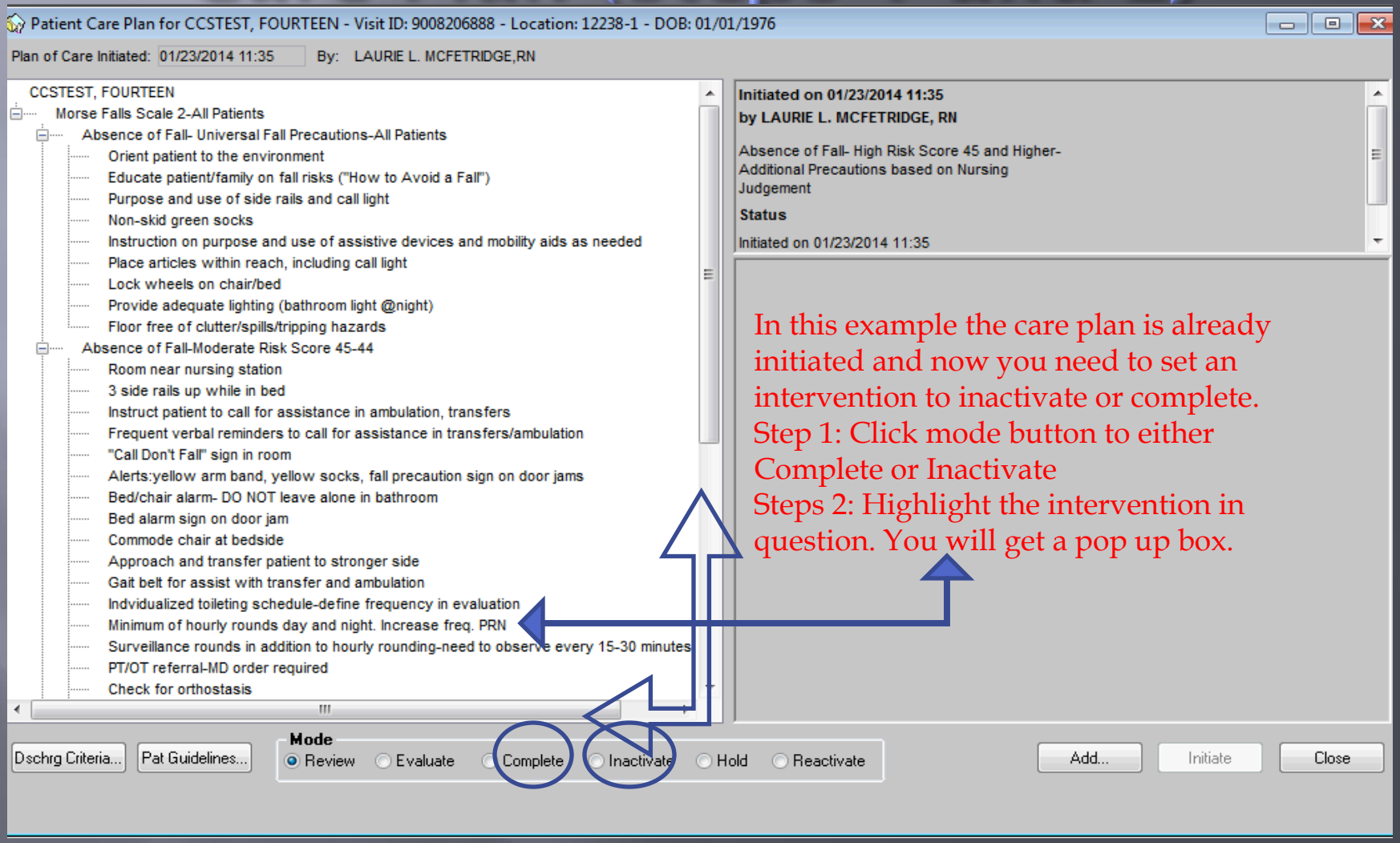
Care Plan Evaluation



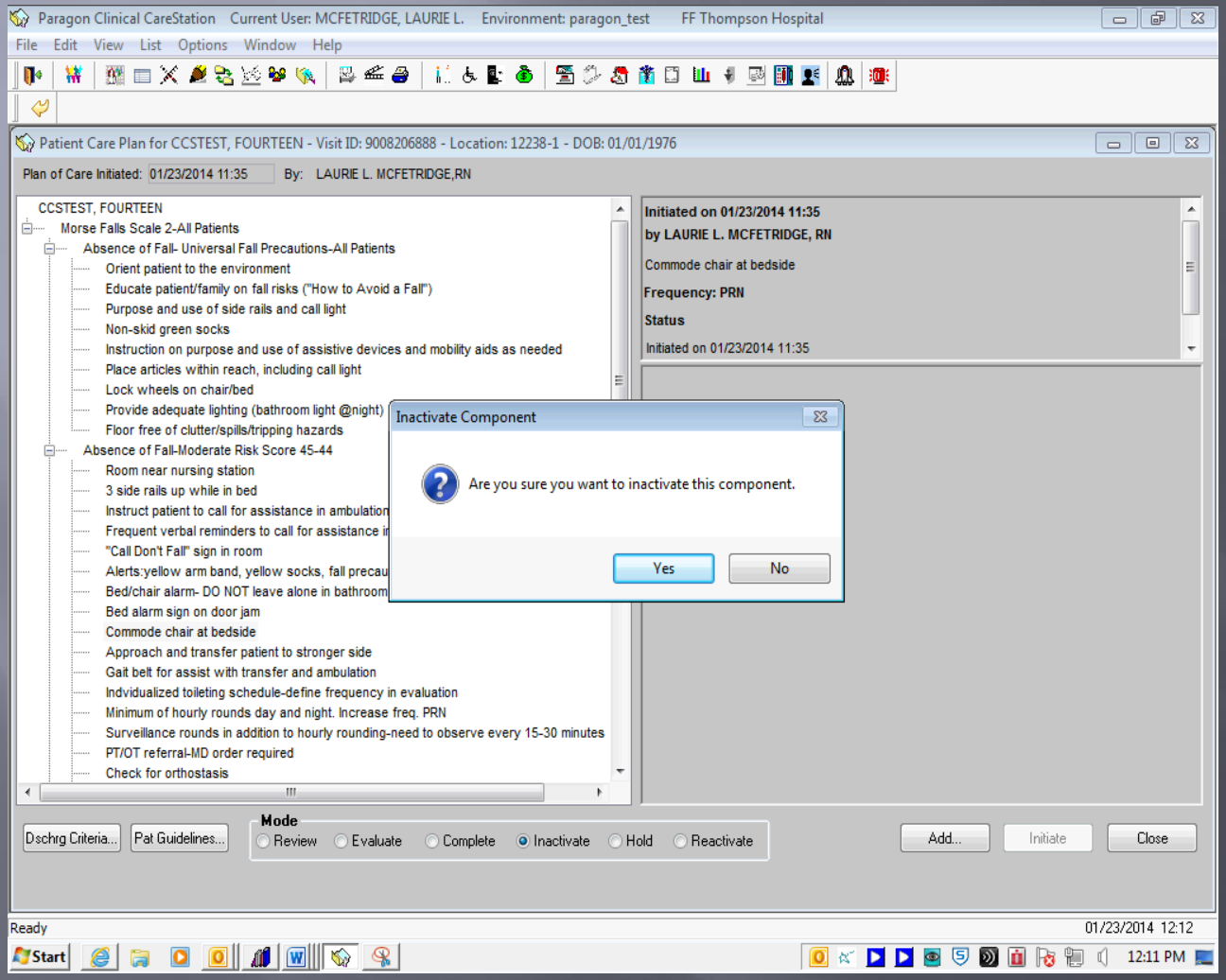
Inactivate


Paragon Clinical CareStation Current User: MACDONALD, JANICE Environment: paragon_it FF Thompson Hospital **IT**
File Edit View List Options Window Help
Patient Care Plan for MEDREC, TEST - Visit ID: 3009110144 - Location: 305-2 - DOB: 11/03/1950
Plan of Care Initiated: 02/03/2012 08:06 By: JANICE MACDONALD
MEDREC, TEST
Discharge Planning - Diabetes / Hyperglycemia
Patient verbalizes knowledge of diabetes self-management plan
Abnormal Serum Glucose Level
Glucose level within specified parameters
Impaired Sensory Perception
Initiated on 02/03/2012 08:06
by JANICE MACDONALD
Glucose level within specified parameters
Status
Initiated on 02/03/2012 08:06
Inactivate Component
Are you sure you want to inactivate this component.
Yes
No
Dschrg Criteria...
Pat Guidelines...
Mode
Review
Evaluate
Complete
Inactivate
Hold
Reactivate
Add...
Initiate
Close
Ready
02/03/2012 8:23

How to Inactivate Items From Care Plan (steps 1 and 2)

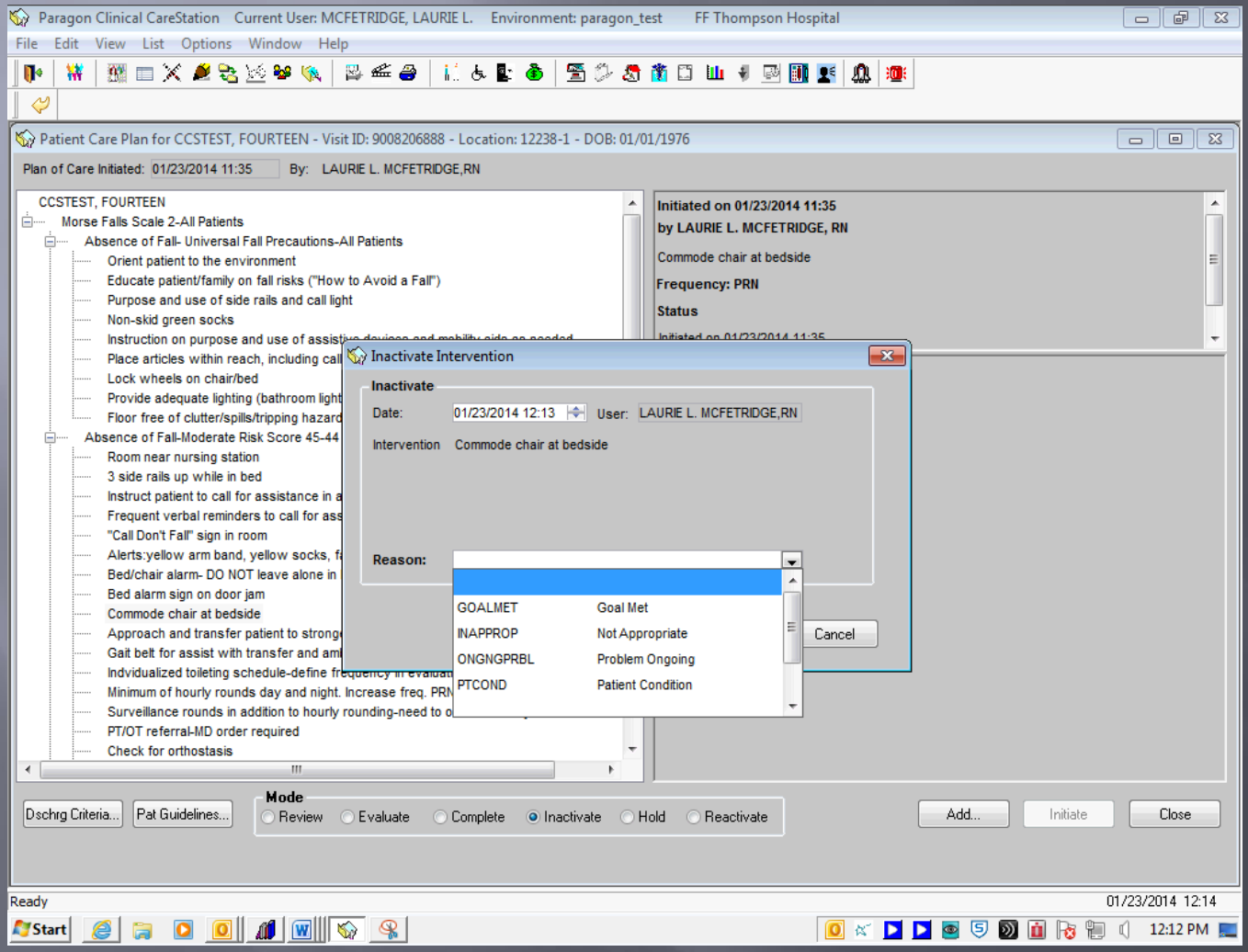


How to Inactivate Items From Care Plan (step 3)



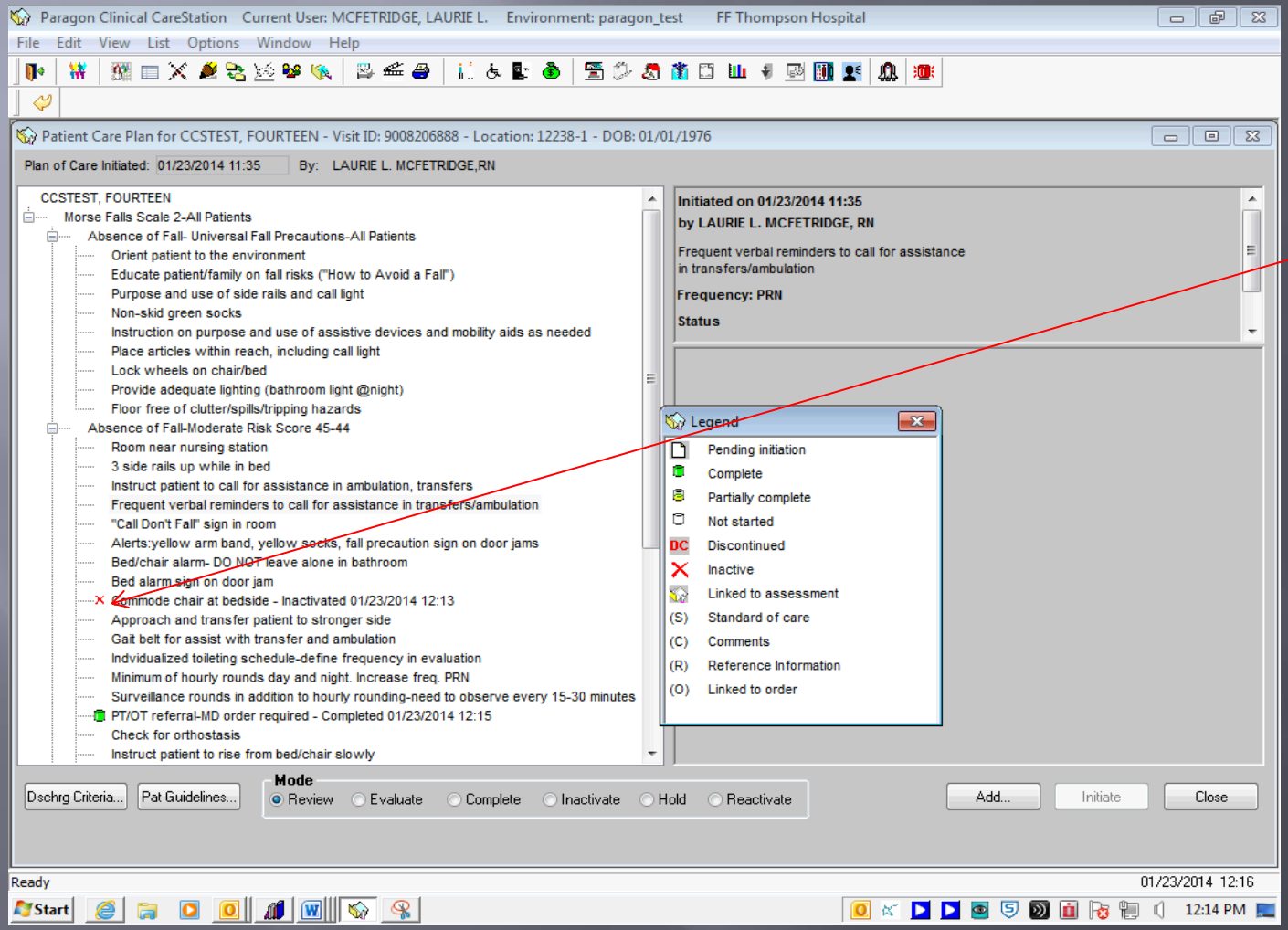
Step 3 It gives you a second chance to decide - Click YES if this is the action you want to take and click NO if not.

How to Inactivate Items From Care Plan (step 4)



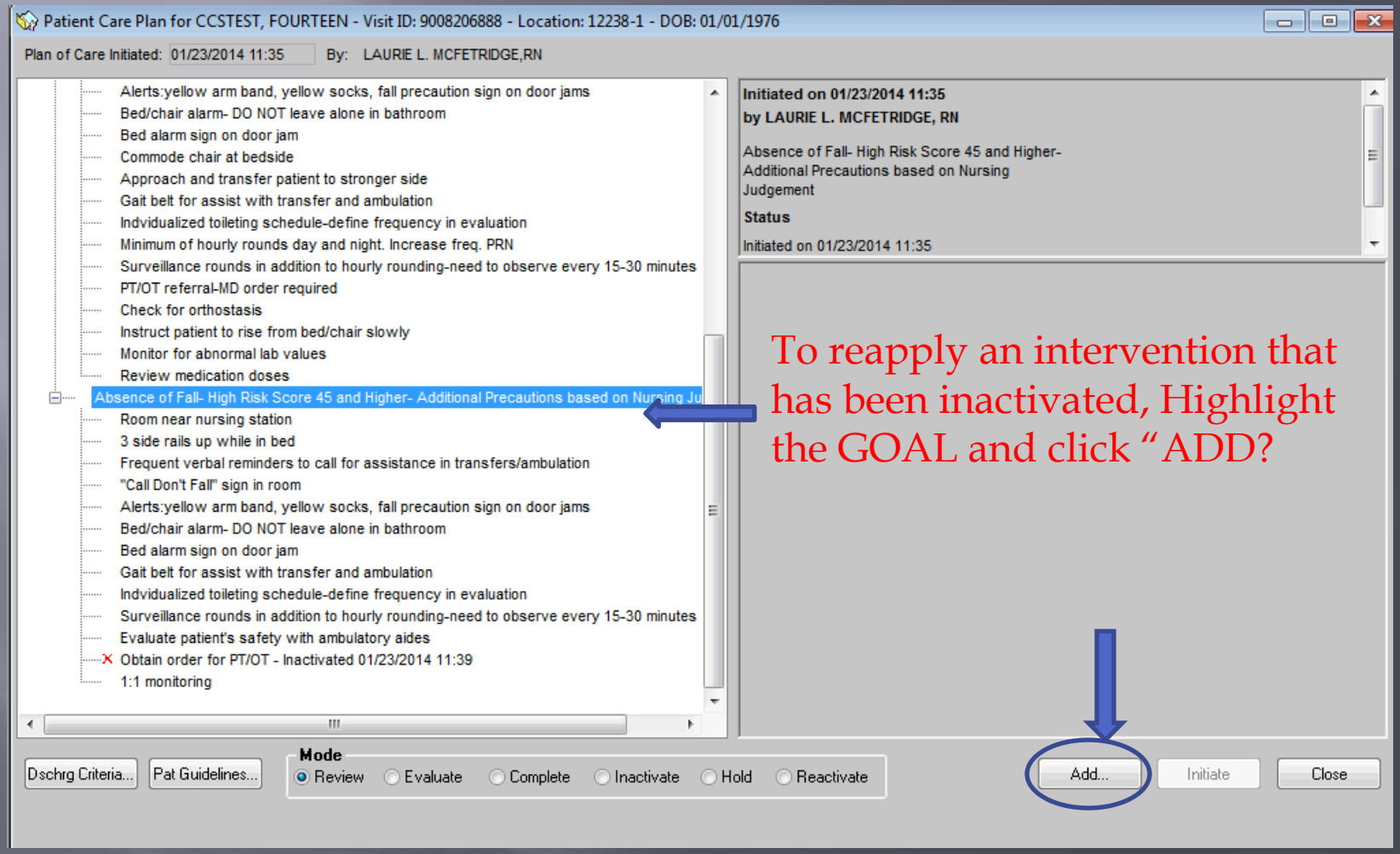
Step 4: Choose reason to inactivate or set as complete. Then click OK.

How to Inactivate Items From Care Plan (step 5)



An icon will appear next to the inactivated or completed item. If you are not sure what an icon means, right click in white space and chose legend.

Steps to Reapply Intervention(s) That Have Been Inactivated or to ADD Interventions to the Care Plan



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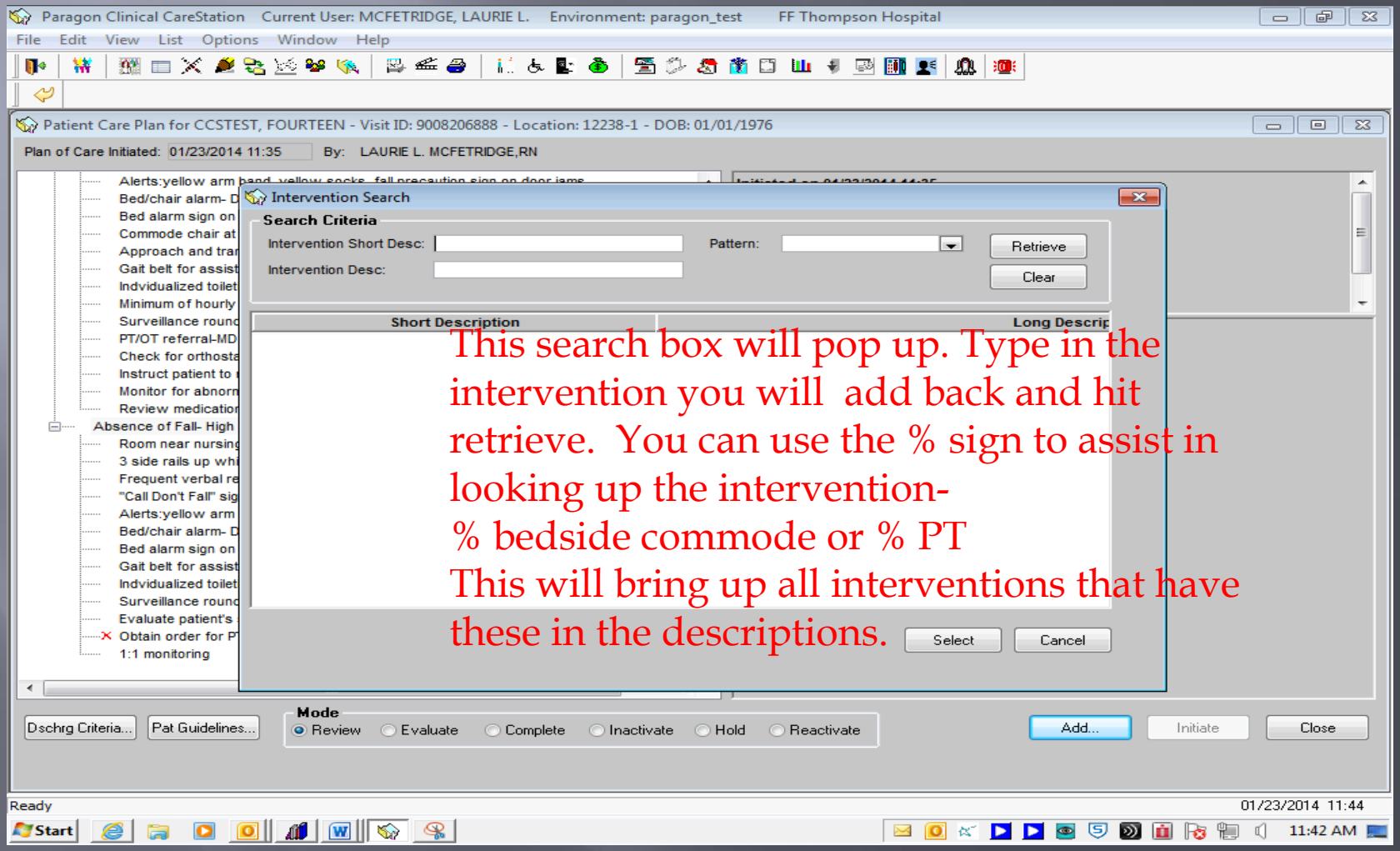

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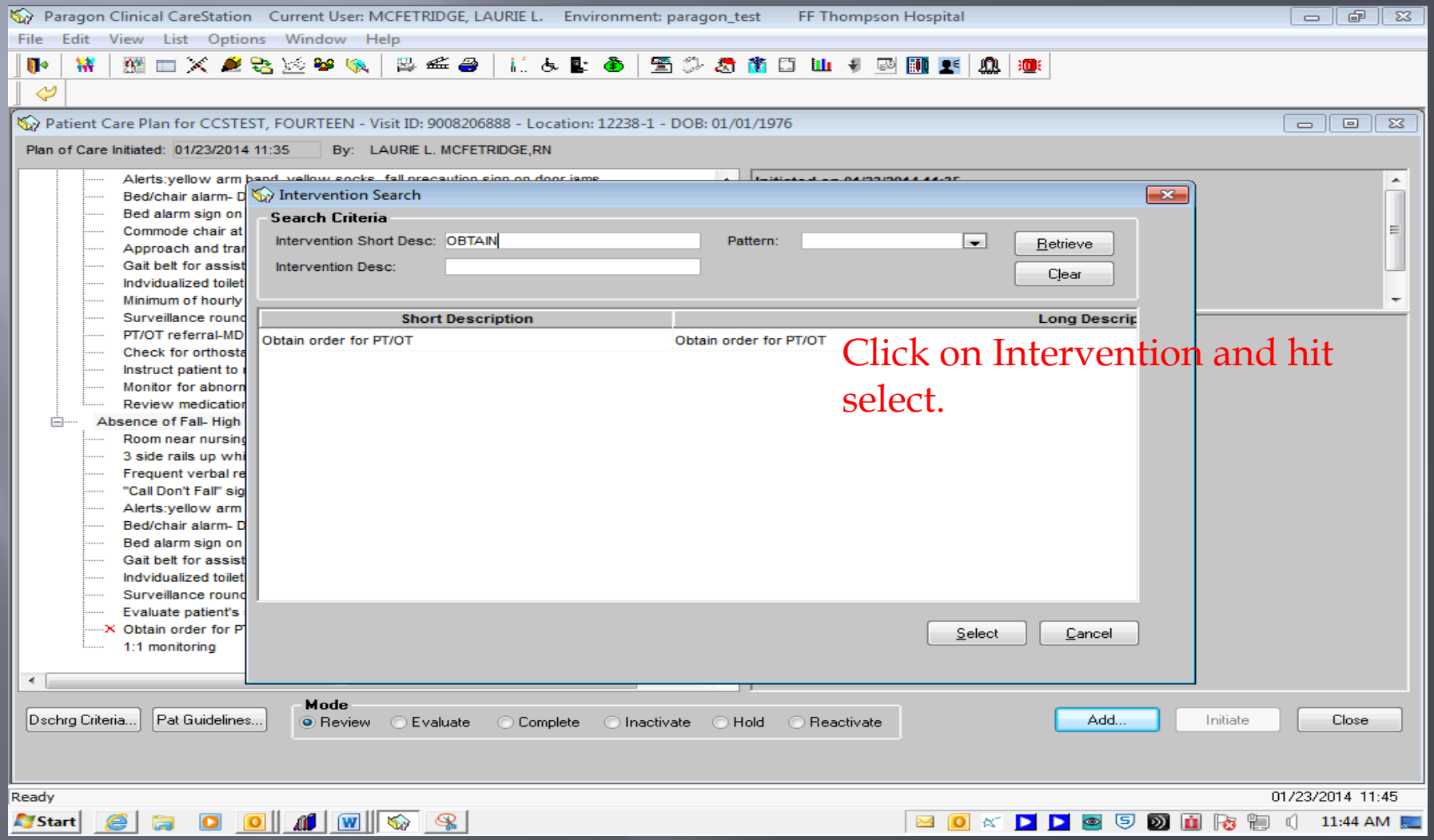

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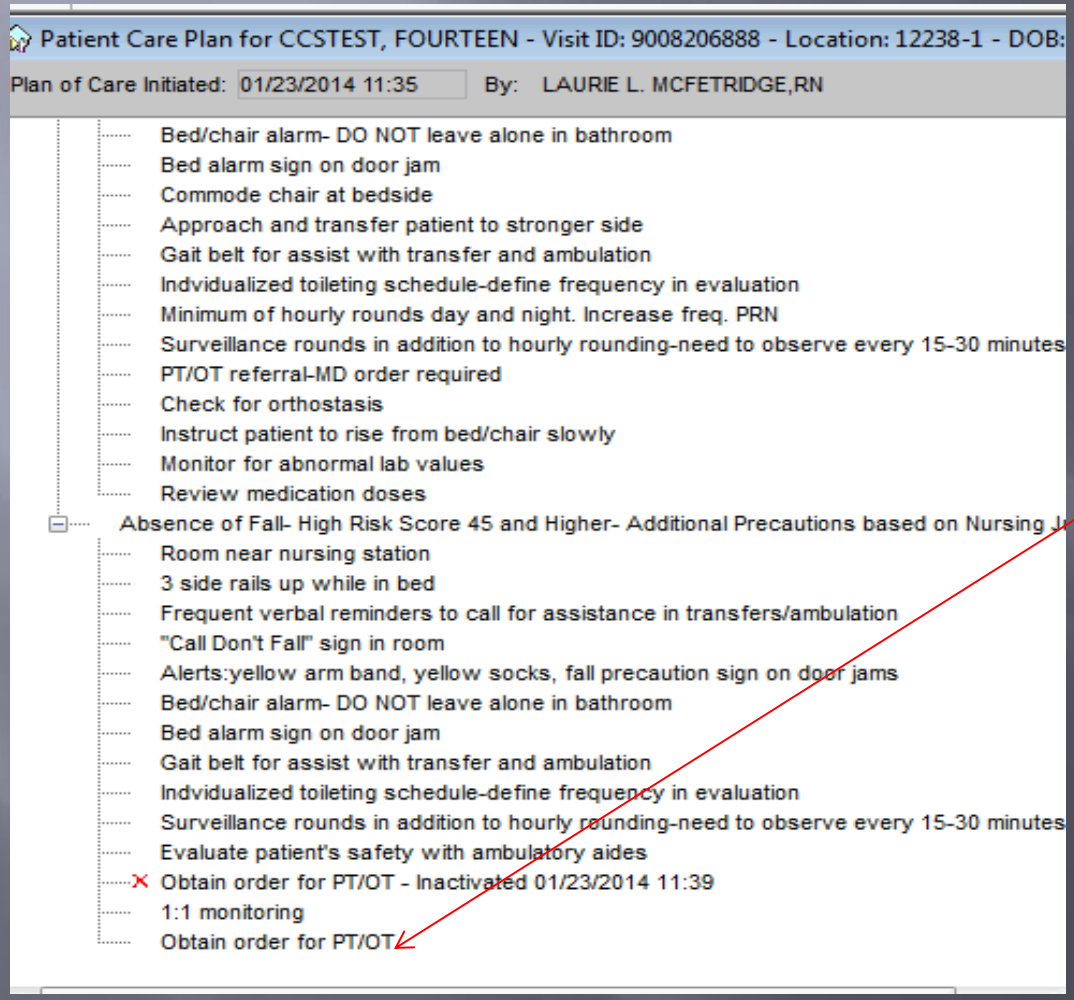
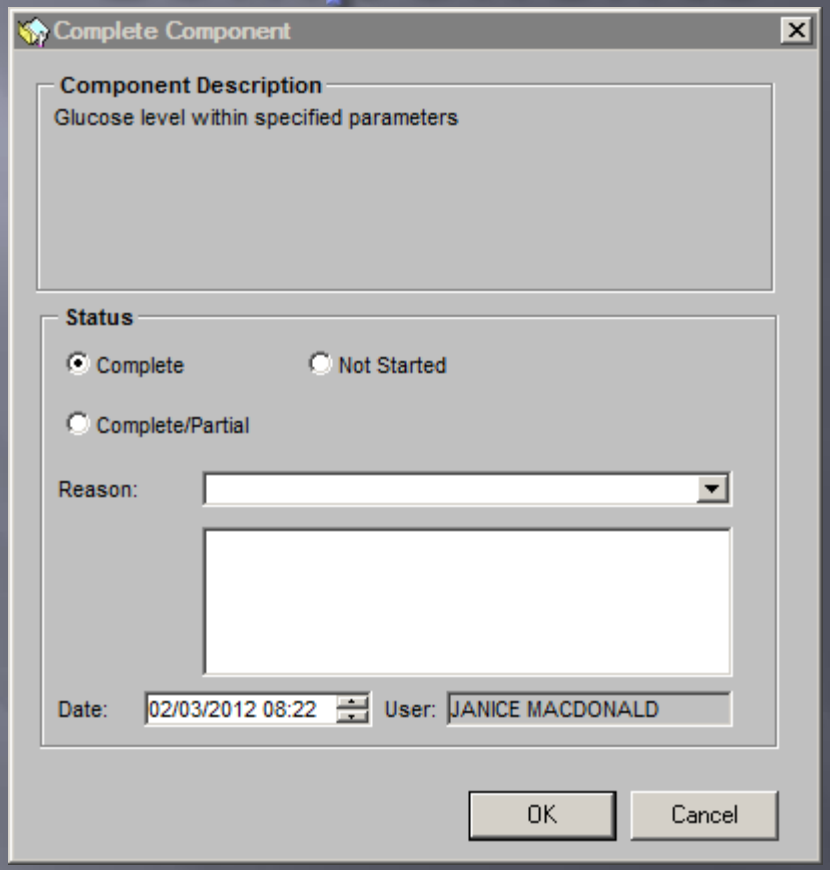
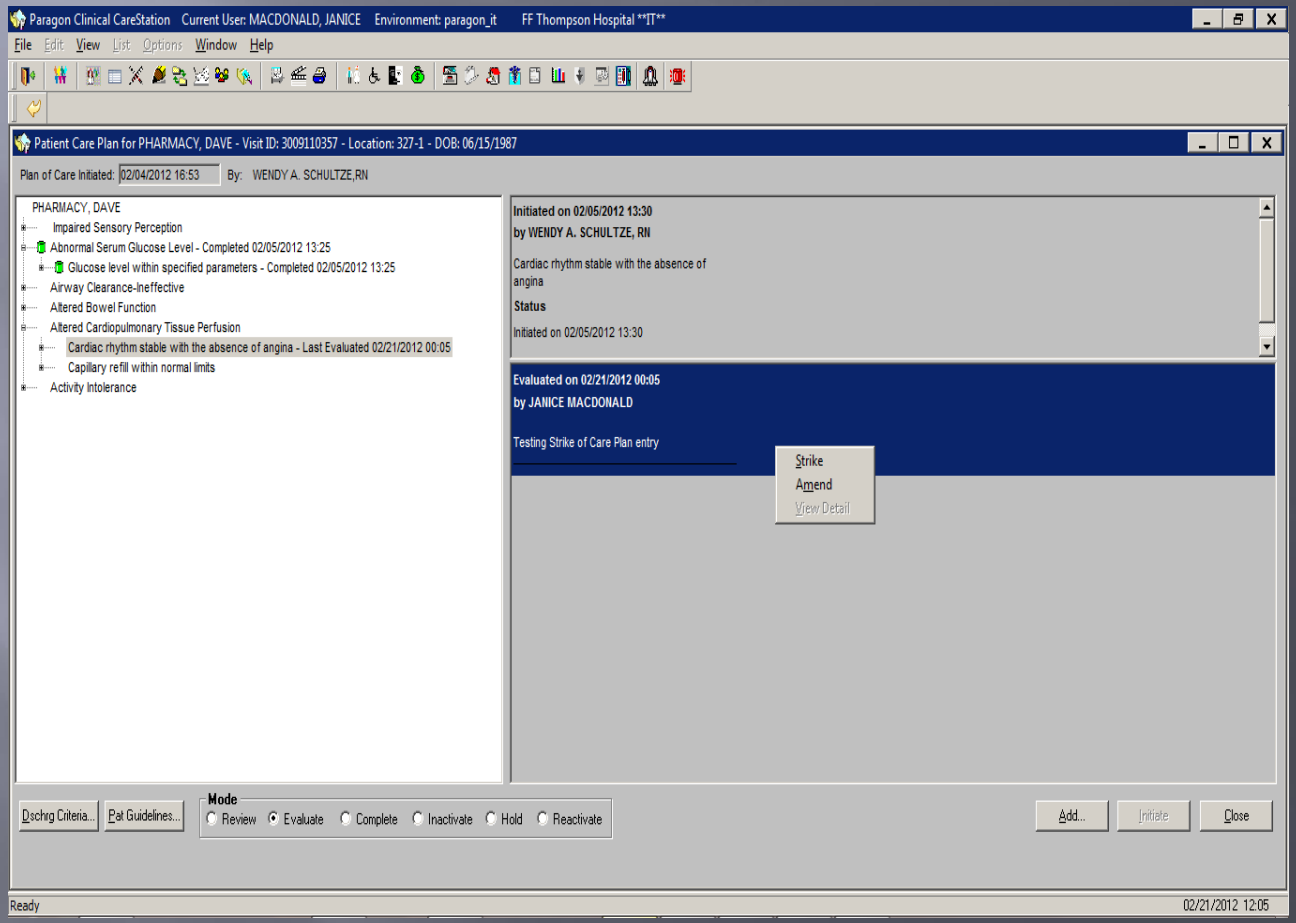


The Intervention will then be added to the bottom of that list under that goal.

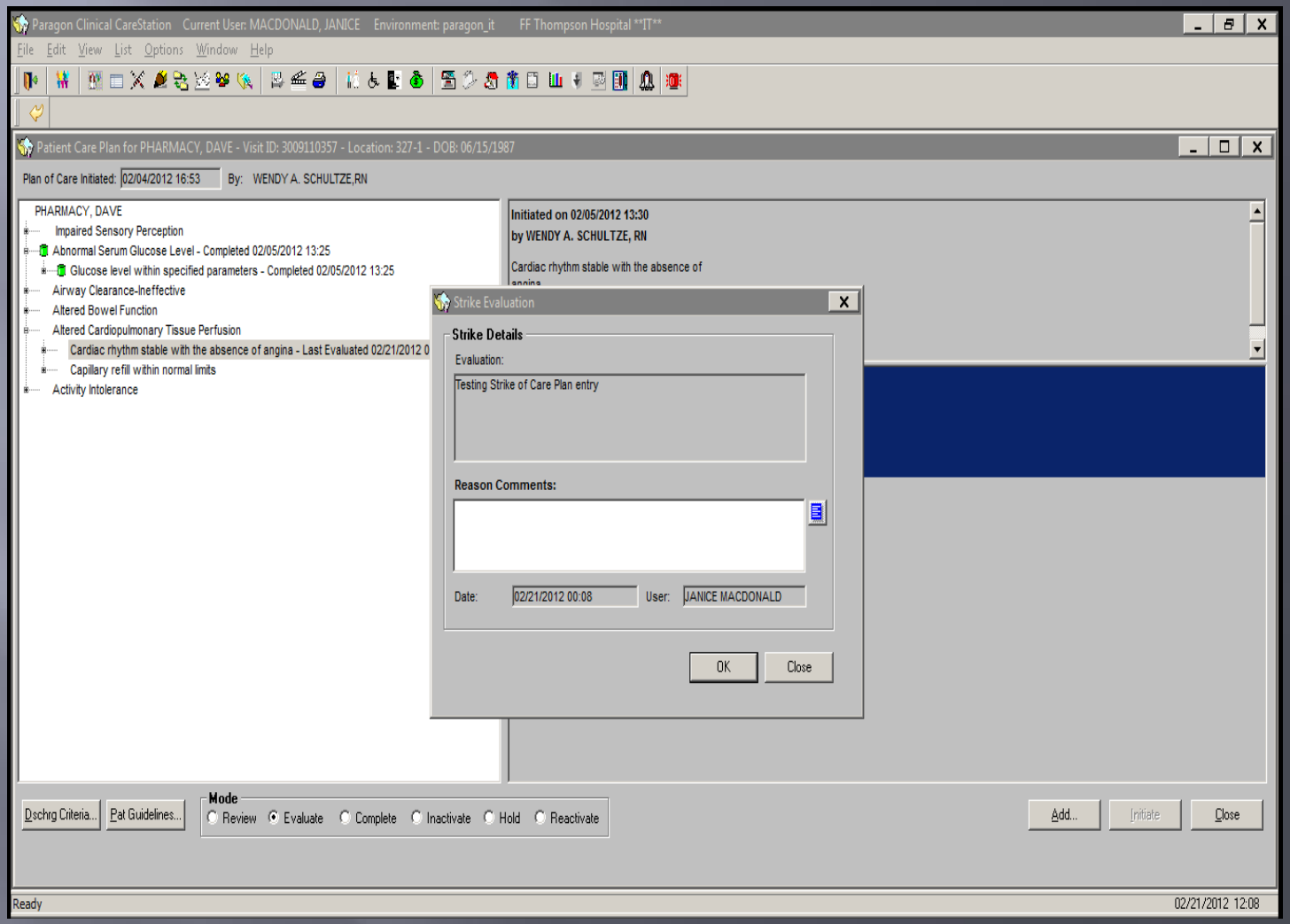
Completing Care Plan Components



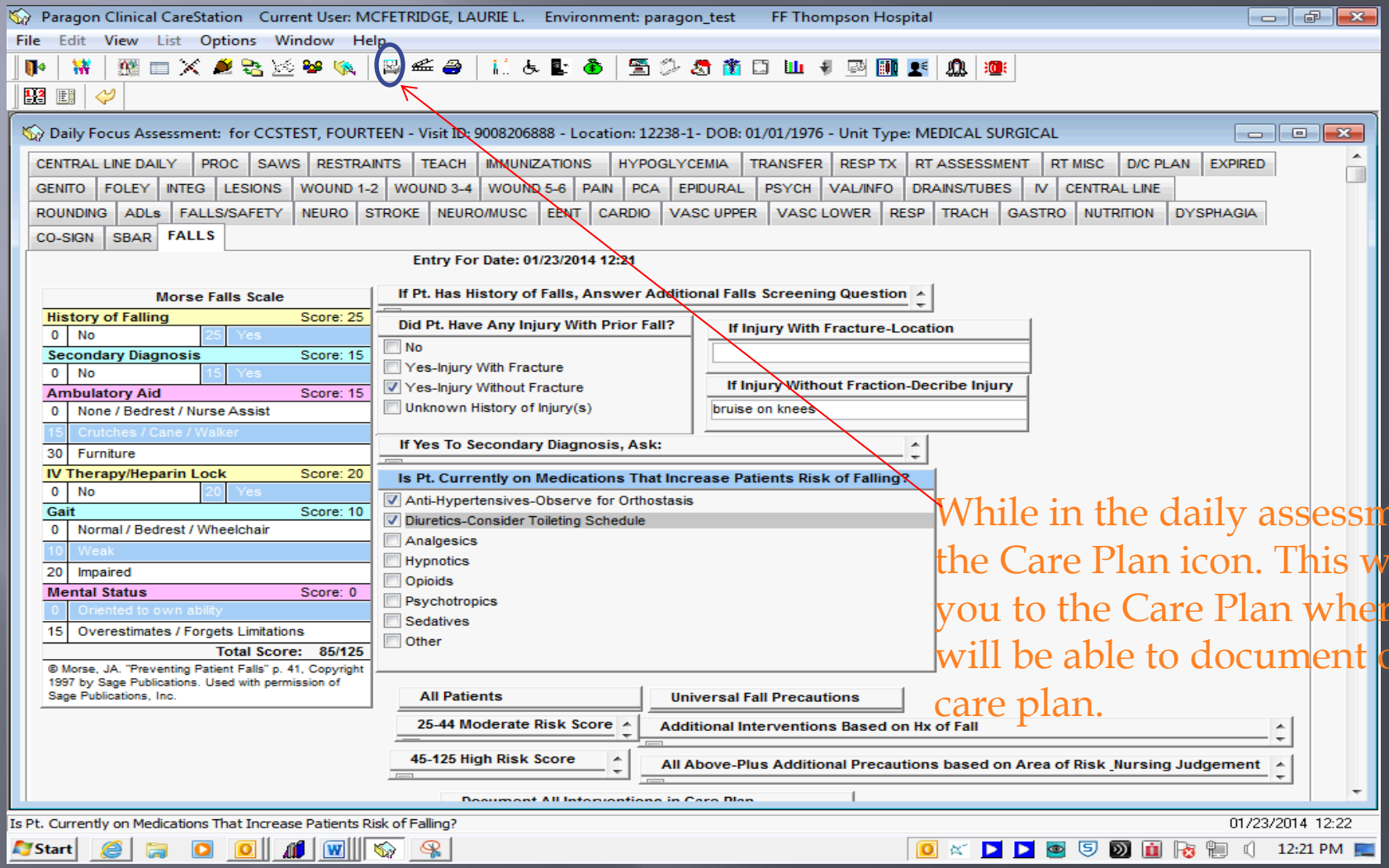
Strike and Amend Care Plan Entries



Strike/Amend Reason

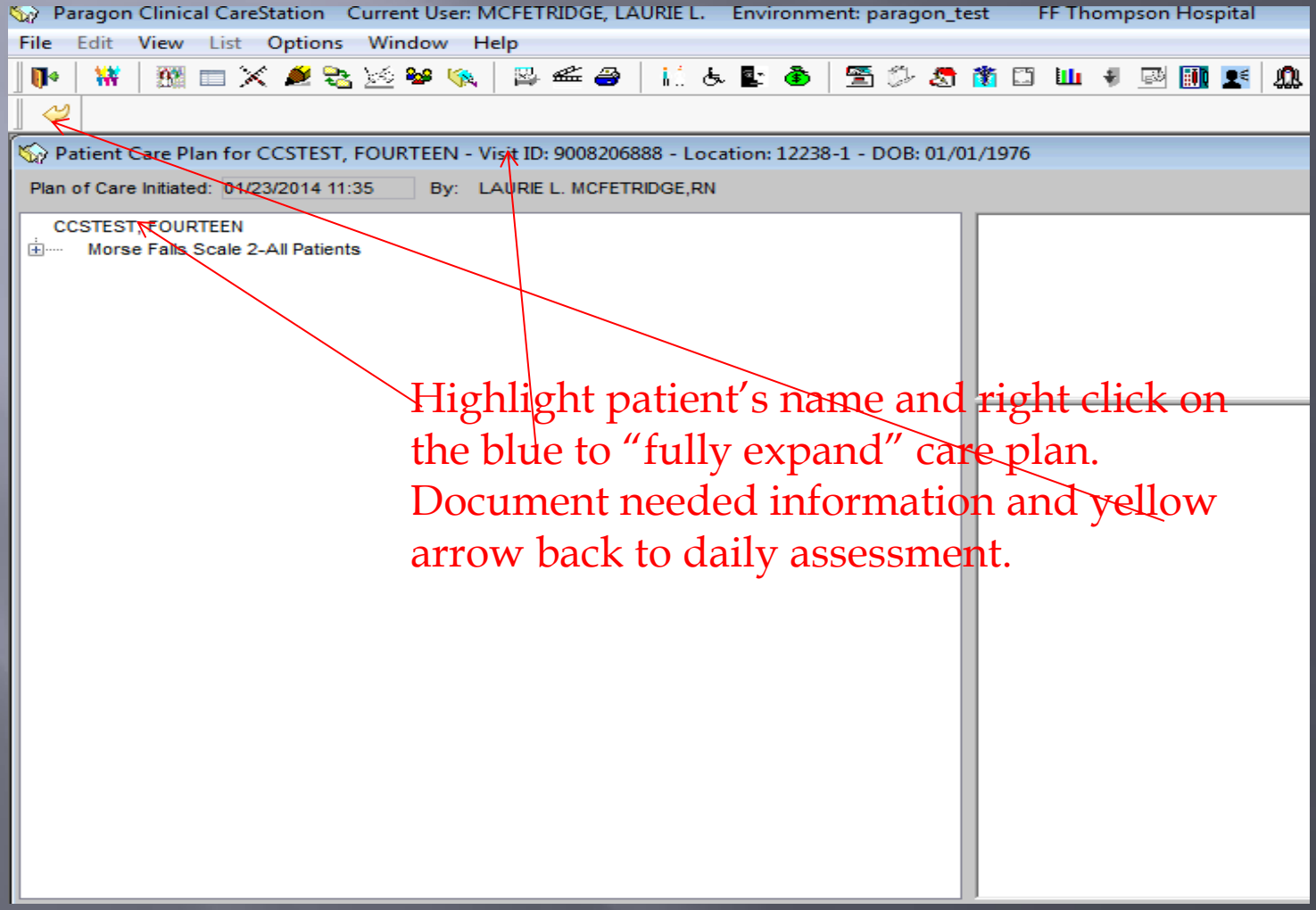


How to Navigate From Falls Screen in Admission or Daily Assessment to the Care Plan



While in the daily assessment click the Care Plan icon. This will take you to the Care Plan where you will be able to document on the care plan.

How to Navigate From Falls Screen While Documenting in Daily Assessment



Care Plan – update

1) An individual intervention can be added to the care plan any time you determine it is necessary.

2) It is only necessary to evaluate the goals of the care plan. If you have evaluated the goal it is implied that the interventions are still applicable.

Care Plan update continued

- Care Plan should be initiated by admitting nurse.
- All patients should have a problem/goal related to falls and safety
- When evaluating the care plan it is only necessary to document the evaluation of the goal.
- Complete, inactivate interventions as appropriate when evaluating the goal but it is not necessary to document the evaluation of each intervention separately, though you can if there is something specific to that intervention.

Care Plan - reviews

Using Nursing Standards of Care to determine care plan reviews (not location):

ICU, Telemetry, Non-Tele
Medical/Surgical – q12h

Comfort Care and Hospice – require Fall/Safety and Pain problems ONLY and may be reviewed Daily.

SNF – Reviewed weekly on Wednesdays

IMPORTANT: in addition to these time the care plan is to be reviewed on change in condition!

Review

- The documentation for fall prevention will be done in the care plan
- This is the first of many pieces of the documentation that will be moved to the plan of care
- This process will be audited and feedback will be provided as needed.
- We know the process and the Morse care plan that has been built will require ongoing review and tweaking to achieve optimal results in decreasing falls and injuries to our patients.

Questions and Thoughts for Ongoing Revisions

- Please call Diana Ellison at extension 6923 or Laurie McFetridge at extension 6579
- Thank-you!