

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

Windows taskbar icons: [Icons for various applications and system utilities]

Patient Care Plan for TESTPATIENT, TESTPATIENT - Visit ID: 9008186882 - Location: z999 - DOB: 01/01/1901

Plan of Care Initiated: 02/06/2014 09:30

Care Plan/Problem Search

Search Type

Care Plan Problem

Criteria

Master Care Plan: [] Problem: [] Retrieve

Nursing Station: All Locations [v] Pattern: [] Clear

Care Plan	Description
Short Description	Long D
Prevent Injury Utilizing Morse Fall Scale	Prevent Injury Utilizing Morse Fall Scale

Select Apply

Buttons at bottom: [Dschr Criteria...] [Pat Guidelines...] [Review] [Evaluate] [Complete] [Inactivate] [Hold] [Reactivate] [Add...] [Initiate] [C]

Problem Add Detail

Care Plan/Problem Search

Search Type
Care Plan Problem

Criteria
Master Care P
Nursing Station

AMISTEMI
CCMADULT
DIABETES
DKA/HHS-ADUL

Discharge Plann
Abnormal Serum
Impaired Sensor

Retrieve
Clear

Problem Lo
rglycemia

Select Apply

Problem Add Detail

Problem Details

Problem Type: Actual Potential

Problem: Abnormal Serum Glucose Level

Complete By: Discharge Date 00/00/0000 00:00:00

Related To: Diagnosis

Evidenced By: Assessment

OK Cancel

Reviewing the Care Plan

TEST, CHRISTINA

Morse Falls Scale 2-All Patients

Absence of Fall- Universal Fall Precautions-All Patients

- Orient patient to the environment
- Educate patient/family on fall risks ("How to Avoid a Fall")
- Purpose and use of side rails and call light
- Non-skid green socks
- Instruction on purpose and use of assistive devices and mobility aids as needed
- Place articles within reach, including call light
- Lock wheels on chair/bed
- Provide adequate lighting (bathroom light @night)
- Floor free of clutter/spills/tripping hazards

Absence of Fall-Moderate Risk Score 45-44

- Room near nursing station
- 3 side rails up while in bed
- Instruct patient to call for assistance in ambulation, transfers
- Frequent verbal reminders to call for assistance in transfers/ambulation
- "Call Don't Fall" sign in room
- Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
- Bed/chair alarm- DO NOT leave alone in bathroom
- Bed alarm sign on door jam
- Commode chair at bedside
- Approach and transfer patient to stronger side
- Gait belt for assist with transfer and ambulation
- Individualized toileting schedule-define frequency in evaluation
- Minimum of hourly rounds day and night. Increase freq. PRN
- Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
- PT/OT referral-MD order required
- Check for orthostasis

..... Instruct patient to rise from bed/chair slowly

..... Pull-ups/Attends for incontinence

..... Monitor for abnormal lab values

..... Review medication doses

Absence of Fall- High Risk Score 45 and Higher- Additional Precautions based on Nursing J

..... Room near nursing station

..... 3 side rails up while in bed

..... Frequent verbal reminders to call for assistance in transfers/ambulation

..... "Call Don't Fall" sign in room

..... Alerts:yellow arm band, yellow socks, fall precaution sign on door jams

..... Bed/chair alarm- DO NOT leave alone in bathroom

..... Bed alarm sign on door jam

..... Gait belt for assist with transfer and ambulation

..... Individualized toileting schedule-define frequency in evaluation

..... Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes

..... Evaluate patient's safety with ambulatory aides

..... Obtain order for PT/OT

..... 1:1 monitoring

Modify Care Plan prior to Initiation

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 NURSING, SUPERUSER2 - Visit ID: 3009110341 - Location: 301-2 - DOB: 01/01/1960

Plan of Care Initiated: 02/20/2012 16:05 By:

NURSING, SUPERUSER2

- Discharge Planning - Diabetes / Hyperglycemia
 - Patient verbalizes knowledge of diabetes self-management plan
 - (R) Assess healthcare knowledge
 - Educate on alcohol-use moderation
 - Educate on blood glucose self monitoring**
 - Expand Item
 - Fully Expand Item
 - Collapse Item
 - Educate on blood glucose self monitoring
 - Educate on body weight management
 - (R) Educate on diabetes management
 - Educate on diabetes management
 - Educate on diabetic diet
 - Educate on diabetic foot care
 - Educate on hyperglycemia management
 - Educate on medical management
 - Educate on post discharge management
 - Educate on when to seek medical attention
 - Educate on DKA/HH
- Abnormal Serum Glucose Level
 - Glucose level within specified parameters
 - Assess hyperglycemia signs and symptoms
 - Assess hypoglycemia signs and symptoms
 - Assess abnormal blood glucose risk
 - Educate on abnormal glucose level management
 - Educate on hyperglycemia signs and symptoms
 - Educate on hypoglycemia signs and symptoms
 - Consult to Diabetes Educator
 - Consult to Dietitian
 - Glucose management
 - Blood glucose monitoring

Expand the current item

02/20/2012 4:22

Initiate the Care Plan

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 NURSING, SUPERUSER2 - Visit ID: 3009110341 - Location: 301-2 - DOB: 01/01/1960

Plan of Care Initiated: 02/20/2012 16:05 By:

- NURSING, SUPERUSER2
 - Discharge Planning - Diabetes / Hyperglycemia
 - Patient verbalizes knowledge of diabetes self-management plan
 - (R) Assess healthcare knowledge
 - Educate on alcohol-use moderation - Inactivated 02/20/2012 16:26
 - Educate on blood glucose self monitoring
 - Educate on blood pressure monitoring
 - Educate on body weight control
 - (R) Educate on diabetes medication management
 - Educate on diabetes exercise
 - Educate on diabetic foot care
 - Educate on diabetic diet
 - Educate on hyperglycemia / hypoglycemia self management
 - Educate on medical alert identifications
 - Educate on post discharge follow-up
 - Educate on when to call provider
 - Educate on DKA/HHS signs and symptoms
 - Abnormal Serum Glucose Level
 - Glucose level within specified parameters
 - Assess hyperglycemia signs and symptoms
 - Assess hypoglycemia signs and symptoms
 - Assess abnormal blood glucose risk
 - Educate on abnormal glucose level management
 - Educate on hyperglycemia signs and symptoms
 - Educate on hypoglycemia signs and symptoms
 - Consult to Diabetes Educator
 - Consult to Dietitian
 - Glucose management
 - Blood glucose monitoring

Educate on alcohol-use moderation
Frequency: PRN

Mode
 Review Evaluate Complete Inactivate Hold Reactivate

Dischrg Criteria... Pat Guidelines... Add... **Initiate** Close

Ready 02/20/2012 4:26

Initiated Care Plan

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
- Abnormal Serum Glucose Level
- Impaired Sensory Perception

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Dischg Criteria... Pat Guidelines... Add... Initiate Close

Ready 02/03/2012 8:12

Care Plan Evaluation

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

Evaluate Outcome

Evaluate

Date: 02/03/2012 08:22 User: JANICE MACDONALD

Outcome: Glucose level within specified parameters

Evaluation:

Evaluation section

OK Close

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Dischg Criteria... Pat Guidelines... Add.. Initiate Close

Ready 02/03/2012 8:22

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

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Dischrg Criteria... Pat Guidelines... Add... Initiate Close

Ready 02/03/2012 8:23

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

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

CCSTEST, FOURTEEN

- Morse Falls Scale 2-All Patients
 - Absence of Fall- Universal Fall Precautions-All Patients
 - Orient patient to the environment
 - Educate patient/family on fall risks ("How to Avoid a Fall")
 - Purpose and use of side rails and call light
 - Non-skid green socks
 - Instruction on purpose and use of assistive devices and mobility aids as needed
 - Place articles within reach, including call light
 - Lock wheels on chair/bed
 - Provide adequate lighting (bathroom light @night)
 - Floor free of clutter/spills/tripping hazards
 - Absence of Fall-Moderate Risk Score 45-44
 - Room near nursing station
 - 3 side rails up while in bed
 - Instruct patient to call for assistance in ambulation, transfers
 - Frequent verbal reminders to call for assistance in transfers/ambulation
 - "Call Don't Fall" sign in room
 - Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
 - Bed/chair alarm- DO NOT leave alone in bathroom
 - Bed alarm sign on door jam
 - Commode chair at bedside
 - Approach and transfer patient to stronger side
 - Gait belt for assist with transfer and ambulation
 - Individualized toileting schedule-define frequency in evaluation
 - Minimum of hourly rounds day and night. Increase freq. PRN
 - Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
 - PT/OT referral-MD order required
 - Check for orthostasis

Initiated on 01/23/2014 11:35
by LAURIE L. MCFETRIDGE, RN

Absence of Fall- High Risk Score 45 and Higher-
Additional Precautions based on Nursing
Judgement

Status
Initiated on 01/23/2014 11:35

In this example the care plan is already initiated and now you need to set an intervention to inactivate or complete. Step 1: Click mode button to either Complete or Inactivate Steps 2: Highlight the intervention in question. You will get a pop up box.

Mode
 Review Evaluate Complete Inactivate Hold Reactivate

Dschrg Criteria... Pat Guidelines... Add... Initiate Close

How to Inactivate Items From Care Plan (step 3)

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE, RN

CCSTEST, FOURTEEN

- Morse Falls Scale 2-All Patients
 - Absence of Fall- Universal Fall Precautions-All Patients
 - Orient patient to the environment
 - Educate patient/family on fall risks ("How to Avoid a Fall")
 - Purpose and use of side rails and call light
 - Non-skid green socks
 - Instruction on purpose and use of assistive devices and mobility aids as needed
 - Place articles within reach, including call light
 - Lock wheels on chair/bed
 - Provide adequate lighting (bathroom light @night)
 - Floor free of clutter/spills/tripping hazards
 - Absence of Fall-Moderate Risk Score 45-44
 - Room near nursing station
 - 3 side rails up while in bed
 - Instruct patient to call for assistance in ambulation
 - Frequent verbal reminders to call for assistance in ambulation
 - "Call Don't Fall" sign in room
 - Alerts:yellow arm band, yellow socks, fall precaution
 - Bed/chair alarm- DO NOT leave alone in bathroom
 - Bed alarm sign on door jam
 - Commode chair at bedside
 - Approach and transfer patient to stronger side
 - Gait belt for assist with transfer and ambulation
 - Individualized toileting schedule-define frequency in evaluation
 - Minimum of hourly rounds day and night. Increase freq. PRN
 - Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
 - PT/OT referral-MD order required
 - Check for orthostasis

Initiated on 01/23/2014 11:35 by LAURIE L. MCFETRIDGE, RN

Commode chair at bedside

Frequency: PRN

Status

Initiated on 01/23/2014 11:35

Inactivate Component

Are you sure you want to inactivate this component.

Yes No

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 01/23/2014 12:12

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)

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE, RN

CCSTEST, FOURTEEN

Morse Falls Scale 2-All Patients

- Absence of Fall- Universal Fall Precautions-All Patients
 - Orient patient to the environment
 - Educate patient/family on fall risks ("How to Avoid a Fall")
 - Purpose and use of side rails and call light
 - Non-skid green socks
 - Instruction on purpose and use of assistive devices and mobility aids as needed
 - Place articles within reach, including call light
 - Lock wheels on chair/bed
 - Provide adequate lighting (bathroom light)
 - Floor free of clutter/spills/tripping hazard
- Absence of Fall-Moderate Risk Score 45-44
 - Room near nursing station
 - 3 side rails up while in bed
 - Instruct patient to call for assistance in a timely manner
 - Frequent verbal reminders to call for assistance
 - "Call Don't Fall" sign in room
 - Alerts: yellow arm band, yellow socks, fall risk sign
 - Bed/chair alarm- DO NOT leave alone in room
 - Bed alarm sign on door jam
 - Commode chair at bedside
 - Approach and transfer patient to strong side
 - Gait belt for assist with transfer and ambulation
 - Individualized toileting schedule-define frequency in evaluation
 - Minimum of hourly rounds day and night. Increase freq. PRN
 - Surveillance rounds in addition to hourly rounding-need to observe
 - PT/OT referral-MD order required
 - Check for orthostasis

Initiated on 01/23/2014 11:35 by LAURIE L. MCFETRIDGE, RN

Commode chair at bedside

Frequency: PRN

Status

Initiated on 01/23/2014 11:35

Inactivate Intervention

Inactivate

Date: 01/23/2014 12:13 User: LAURIE L. MCFETRIDGE, RN

Intervention: Commode chair at bedside

Reason:

- GOALMET Goal Met
- INAPPROP Not Appropriate
- ONGNGPRBL Problem Ongoing
- PTCOND Patient Condition

Cancel

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 01/23/2014 12:14

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

How to Inactivate Items From Care Plan (step 5)

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

CCSTEST, FOURTEEN

- Morse Falls Scale 2-All Patients
- Absence of Fall- Universal Fall Precautions-All Patients
 - Orient patient to the environment
 - Educate patient/family on fall risks ("How to Avoid a Fall")
 - Purpose and use of side rails and call light
 - Non-skid green socks
 - Instruction on purpose and use of assistive devices and mobility aids as needed
 - Place articles within reach, including call light
 - Lock wheels on chair/bed
 - Provide adequate lighting (bathroom light @night)
 - Floor free of clutter/spills/tripping hazards
- Absence of Fall-Moderate Risk Score 45-44
 - Room near nursing station
 - 3 side rails up while in bed
 - Instruct patient to call for assistance in ambulation, transfers
 - Frequent verbal reminders to call for assistance in transfers/ambulation
 - "Call Don't Fall" sign in room
 - Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
 - Bed/chair alarm- DO NOT leave alone in bathroom
 - Bed alarm sign on door jam
 - Inmode chair at bedside - Inactivated 01/23/2014 12:13
 - Approach and transfer patient to stronger side
 - Gait belt for assist with transfer and ambulation
 - Individualized toileting schedule-define frequency in evaluation
 - Minimum of hourly rounds day and night. Increase freq. PRN
 - Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
 - PT/OT referral-MD order required - Completed 01/23/2014 12:15
 - Check for orthostasis
 - Instruct patient to rise from bed/chair slowly

Initiated on 01/23/2014 11:35 by LAURIE L. MCFETRIDGE, RN

Frequent verbal reminders to call for assistance in transfers/ambulation

Frequency: PRN

Status

Legend

- Pending initiation
- Complete
- Partially complete
- Not started
- Discontinued
- Inactive
- Linked to assessment
- (S) Standard of care
- (C) Comments
- (R) Reference Information
- (O) Linked to order

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 01/23/2014 12:16

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

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

- Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
- Bed/chair alarm- DO NOT leave alone in bathroom
- Bed alarm sign on door jam
- Commode chair at bedside
- Approach and transfer patient to stronger side
- Gait belt for assist with transfer and ambulation
- Individualized toileting schedule-define frequency in evaluation
- Minimum of hourly rounds day and night. Increase freq. PRN
- Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
- PT/OT referral-MD order required
- Check for orthostasis
- Instruct patient to rise from bed/chair slowly
- Monitor for abnormal lab values
- Review medication doses
- Absence of Fall- High Risk Score 45 and Higher- Additional Precautions based on Nursing Judgement**
- Room near nursing station
- 3 side rails up while in bed
- Frequent verbal reminders to call for assistance in transfers/ambulation
- "Call Don't Fall" sign in room
- Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
- Bed/chair alarm- DO NOT leave alone in bathroom
- Bed alarm sign on door jam
- Gait belt for assist with transfer and ambulation
- Individualized toileting schedule-define frequency in evaluation
- Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
- Evaluate patient's safety with ambulatory aides
- ✗ Obtain order for PT/OT - Inactivated 01/23/2014 11:39
- 1:1 monitoring

Initiated on 01/23/2014 11:35
by LAURIE L. MCFETRIDGE, RN

Absence of Fall- High Risk Score 45 and Higher- Additional Precautions based on Nursing Judgement

Status
Initiated on 01/23/2014 11:35

To reapply an intervention that has been inactivated, Highlight the GOAL and click "ADD?"

Mode
 Review Evaluate Complete Inactivate Hold Reactivate

Dschrg Criteria... Pat Guidelines... Add... Initiate Close

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

The screenshot displays the Paragon Clinical CareStation interface. The main window shows a patient care plan for 'CCSTEST, FOURTEEN' with a visit ID of 9008206888. A list of interventions is visible on the left, including 'Alerts:yellow arm band', 'Bed/chair alarm- D', and 'Absence of Fall- High'. An 'Intervention Search' dialog box is open in the center, featuring search criteria fields for 'Intervention Short Desc' and 'Intervention Desc', a 'Pattern' dropdown, and 'Retrieve' and 'Clear' buttons. Below the search criteria is a table with columns for 'Short Description' and 'Long Description'. A red text overlay explains the search process: 'This search box will pop up. Type in the intervention you will add back and hit retrieve. You can use the % sign to assist in looking up the intervention- % bedside commode or % PT This will bring up all interventions that have these in the descriptions.' The dialog box also includes 'Select' and 'Cancel' buttons. At the bottom of the main window, there is a 'Mode' section with radio buttons for 'Review', 'Evaluate', 'Complete', 'Inactivate', 'Hold', and 'Reactivate', along with 'Add...', 'Initiate', and 'Close' buttons. The Windows taskbar at the bottom shows the system time as 11:42 AM on 01/23/2014.

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

Alerts:yellow arm band,yellow socks, fall precaution sign on door jams
Bed/chair alarm- D
Bed alarm sign on
Commode chair at
Approach and tra
Gait belt for assist
Individualized toilet
Minimum of hourly
Surveillance round
PT/OT referral-MD
Check for orthost
Instruct patient to
Monitor for abnorm
Review medication
Absence of Fall- High
Room near nursing
3 side rails up wh
Frequent verbal re
"Call Don't Fall" sig
Alerts:yellow arm
Bed/chair alarm- D
Bed alarm sign on
Gait belt for assist
Individualized toilet
Surveillance round
Evaluate patient's
Obtain order for P
1:1 monitoring

Intervention Search

Search Criteria

Intervention Short Desc: Pattern: Retrieve

Intervention Desc: Clear

Short Description	Long Description
-------------------	------------------

This search box will pop up. Type in the intervention you will add back and hit retrieve. You can use the % sign to assist in looking up the intervention- % bedside commode or % PT This will bring up all interventions that have these in the descriptions.

Select Cancel

Mode

Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 01/23/2014 11:44

11:42 AM

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

The screenshot displays the Paragon Clinical CareStation interface. The main window shows a patient care plan for 'CCSTEST, FOURTEEN' with a visit ID of 9008206888. The plan was initiated on 01/23/2014 at 11:35 by Laurie L. MCFETRIDGE, RN. A list of interventions is visible on the left, including 'Alerts:yellow arm band', 'Bed/chair alarm-D', and 'Obtain order for PT/OT'. An 'Intervention Search' dialog box is open in the foreground, allowing for searching by short description or pattern. The search criteria are set to 'OBTAIN'. A table of search results is shown below the criteria, with one entry: 'Obtain order for PT/OT'. A red text overlay reads 'Click on Intervention and hit select.' The software interface includes a menu bar (File, Edit, View, List, Options, Window, Help), a toolbar with various icons, and a status bar at the bottom showing the system time as 11:44 AM on 01/23/2014.

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

Alerts:yellow arm band, yellow socks, fall precaution sign on door jams

Bed/chair alarm-D

Bed alarm sign on

Commode chair at

Approach and transfer

Gait belt for assist

Individualized toilet

Minimum of hourly

Surveillance round

PT/OT referral-MD

Check for orthostatic

Instruct patient to

Monitor for abnormal

Review medication

Absence of Fall- High

Room near nursing

3 side rails up wh

Frequent verbal re

"Call Don't Fall" sig

Alerts:yellow arm

Bed/chair alarm-D

Bed alarm sign on

Gait belt for assist

Individualized toilet

Surveillance round

Evaluate patient's

Obtain order for PT/OT

1:1 monitoring

Intervention Search

Search Criteria

Intervention Short Desc: OBTAIN Pattern: Retrieve Clear

Intervention Desc:

Short Description	Long Description
Obtain order for PT/OT	Obtain order for PT/OT

Click on Intervention and hit select.

Select Cancel

Mode: Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 01/23/2014 11:45

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

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB:

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

- Bed/chair alarm- DO NOT leave alone in bathroom
- Bed alarm sign on door jam
- Commode chair at bedside
- Approach and transfer patient to stronger side
- Gait belt for assist with transfer and ambulation
- Individualized toileting schedule-define frequency in evaluation
- Minimum of hourly rounds day and night. Increase freq. PRN
- Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
- PT/OT referral-MD order required
- Check for orthostasis
- Instruct patient to rise from bed/chair slowly
- Monitor for abnormal lab values
- Review medication doses
- ☐ Absence of Fall- High Risk Score 45 and Higher- Additional Precautions based on Nursing J
 - Room near nursing station
 - 3 side rails up while in bed
 - Frequent verbal reminders to call for assistance in transfers/ambulation
 - "Call Don't Fall" sign in room
 - Alerts:yellow arm band, yellow socks, fall precaution sign on door jams
 - Bed/chair alarm- DO NOT leave alone in bathroom
 - Bed alarm sign on door jam
 - Gait belt for assist with transfer and ambulation
 - Individualized toileting schedule-define frequency in evaluation
 - Surveillance rounds in addition to hourly rounding-need to observe every 15-30 minutes
 - Evaluate patient's safety with ambulatory aides
 - X Obtain order for PT/OT - Inactivated 01/23/2014 11:39
 - 1:1 monitoring
 - Obtain order for PT/OT

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

Completing Care Plan Components

Complete Component [X]

Component Description
Glucose level within specified parameters

Status

Complete Not Started

Complete/Partial

Reason:

Date: User:

OK Cancel

Strike and Amend Care Plan Entries

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 PHARMACY, DAVE - Visit ID: 3009110357 - Location: 327-1 - DOB: 06/15/1987

Plan of Care Initiated: 02/04/2012 16:53 By: WENDY A. SCHULTZE, RN

PHARMACY, DAVE

- Impaired Sensory Perception
- Abnormal Serum Glucose Level - Completed 02/05/2012 13:25
 - Glucose level within specified parameters - Completed 02/05/2012 13:25
- Airway Clearance-Ineffective
- Altered Bowel Function
- Altered Cardiopulmonary Tissue Perfusion
- Cardiac rhythm stable with the absence of angina - Last Evaluated 02/21/2012 00:05
- Capillary refill within normal limits
- Activity Intolerance

Initiated on 02/05/2012 13:30
by WENDY A. SCHULTZE, RN

Cardiac rhythm stable with the absence of angina

Status

Initiated on 02/05/2012 13:30

Evaluated on 02/21/2012 00:05
by JANICE MACDONALD

Testing Strike of Care Plan entry

Strike
Amend
View Detail

Dischg Criteria... Pat Guidelines... Mode
 Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 02/21/2012 12:05

Strike/Amend Reason

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 PHARMACY, DAVE - Visit ID: 3009110357 - Location: 327-1 - DOB: 06/15/1987

Plan of Care Initiated: 02/04/2012 16:53 By: WENDY A. SCHULTZE, RN

PHARMACY, DAVE

- Impaired Sensory Perception
- Abnormal Serum Glucose Level - Completed 02/05/2012 13:25
- Glucose level within specified parameters - Completed 02/05/2012 13:25
- Airway Clearance-Ineffective
- Altered Bowel Function
- Altered Cardiopulmonary Tissue Perfusion
- Cardiac rhythm stable with the absence of angina - Last Evaluated 02/21/2012 00:08
- Capillary refill within normal limits
- Activity Intolerance

Initiated on 02/05/2012 13:30 by WENDY A. SCHULTZE, RN

Cardiac rhythm stable with the absence of angina

Strike Evaluation

Strike Details

Evaluation:
Testing Strike of Care Plan entry

Reason Comments:

Date: 02/21/2012 00:08 User: JANICE MACDONALD

OK Close

Dischg Criteria... Pat Guidelines... Mode

Review Evaluate Complete Inactivate Hold Reactivate

Add... Initiate Close

Ready 02/21/2012 12:08

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

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Daily Focus Assessment: for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976 - Unit Type: MEDICAL SURGICAL

CENTRAL LINE DAILY PROC SAWS RESTRAINTS TEACH IMMUNIZATIONS HYPOGLYCEMIA TRANSFER RESP TX RT ASSESSMENT RT MISC D/C PLAN EXPIRED

GENITO FOLEY INTEG LESIONS WOUND 1-2 WOUND 3-4 WOUND 5-6 PAIN PCA EPIDURAL PSYCH VAL/INFO DRAINS/TUBES IV CENTRAL LINE

ROUNDING ADLs FALLS/SAFETY NEURO STROKE NEURO/MUSC EENT CARDIO VASC UPPER VASC LOWER RESP TRACH GASTRO NUTRITION DYSPHAGIA

CO-SIGN SBAR **FALLS**

Entry For Date: 01/23/2014 12:21

Morse Falls Scale	
History of Falling Score: 25	
0 No	25 Yes
Secondary Diagnosis Score: 15	
0 No	15 Yes
Ambulatory Aid Score: 15	
0 None / Bedrest / Nurse Assist	15 Crutches / Cane / Walker
15 Furniture	30 Furniture
IV Therapy/Heparin Lock Score: 20	
0 No	20 Yes
Gait Score: 10	
0 Normal / Bedrest / Wheelchair	10 Weak
20 Impaired	
Mental Status Score: 0	
0 Oriented to own ability	15 Overestimates / Forgets Limitations
Total Score: 85/125	

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If Pt. Has History of Falls, Answer Additional Falls Screening Question

Did Pt. Have Any Injury With Prior Fall?

No

Yes-Injury With Fracture

Yes-Injury Without Fracture

Unknown History of Injury(s)

If Injury With Fracture-Location

If Injury Without Fracture-Describe Injury

bruise on knees

If Yes To Secondary Diagnosis, Ask:

Is Pt. Currently on Medications That Increase Patients Risk of Falling?

Anti-Hypertensives-Observe for Orthostasis

Diuretics-Consider Toileting Schedule

Analgesics

Hypnotics

Opioids

Psychotropics

Sedatives

Other

All Patients Universal Fall Precautions

25-44 Moderate Risk Score Additional Interventions Based on Hx of Fall

45-125 High Risk Score All Above-Plus Additional Precautions based on Area of Risk_Nursing Judgement

Document All Interventions in Care Plan

Is Pt. Currently on Medications That Increase Patients Risk of Falling? 01/23/2014 12:22

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

Paragon Clinical CareStation Current User: MCFETRIDGE, LAURIE L. Environment: paragon_test FF Thompson Hospital

File Edit View List Options Window Help

Patient Care Plan for CCSTEST, FOURTEEN - Visit ID: 9008206888 - Location: 12238-1 - DOB: 01/01/1976

Plan of Care Initiated: 01/23/2014 11:35 By: LAURIE L. MCFETRIDGE,RN

CCSTEST, FOURTEEN
Morse Falls Scale 2-All Patients

Highlight patient's name and right click on the blue to "fully expand" care plan. Document needed information and yellow arrow back to 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!