

Electronic Screening
Falls and Treatment Interference Risk
SBAR Tab Access

To be completed prior to transfer from
Critical Care

Step One – Choose SBAR from Menu

The screenshot shows a medical software interface. On the left is a 'Menu' sidebar with various options. The 'SBAR' option is highlighted with a red rectangular box. The main area displays a 'Recommendation' window. The window has a title bar with 'Recommendation' and a close button. Below the title bar, there is a list of recommendations. The first recommendation is 'No results found', followed by 'TESTING PRerelease', 'Psychiatry', 'ADT-A', '10/26/13', 'No results found', and 'No results found'. The 'No results found' text is highlighted in red. Below this list is a blue bar with the phone number '(519) 745-8888'. To the right of the recommendation list is a 'Patient Background' section with a 'Selected visit' field. Below this is a table with the following data:

Service:	Psychiatry
Isolation:	No results found
Activity Order:	No results found
Diet:	No results found
Assistive Devices (0)	No results found

Below the 'Patient Background' section is a 'Consolidated Problems' section with 'All Visits' and 'Classification: All'. There is also a field for 'Add new as: Active' and a search bar with a magnifying glass icon.

Step Two – Choose Assessment Tab

The screenshot shows a web browser window with a blue header bar containing a home icon and the text 'SBAR'. Below the header is a toolbar with various icons and a zoom level of '100%'. The browser's address bar shows three tabs: 'Situation/Background', 'Assessment' (highlighted with a red box), and 'Recommendation'. The main content area is divided into several sections:

- Patient Information**: A table with the following data:

Chief Complaint:	No results found
Reason For Visit:	TESTING PRerelease
Service:	Psychiatry
Room/Bed:	ADT-A
Admit Date:	10/26/13
Last Visit:	No results found
Code Status:	No results found
▾ Emergency Contact (1)	
BCDFG, Spouse:	(519) 745-8888
- Allergies (2) +**: A table with the following data:

All Visits	
meperidine	Hallucination, dry mouth
trimethoprim	Facial swelling
- Measurements and Weights (0)**: A section with a dropdown menu.
- Patient Background**: A section with the following data:

Selected visit	
Service:	Psyc
Isolation:	No n
Activity Order:	No n
Diet:	No n
▾ Assistive Devices (0)	
No results found	
- Consolidated Problems**: A section with the following data:

All Visits	
Classification: All	
Add new as: Active	
<input type="text"/>	
<hr/>	
Priority	Problem
This Visit (0)	

Step Three – Choose Screening Tool

The screenshot displays a series of data panels in a healthcare application:

- Flagged Events (0)**: Subtitle "Last 30 days for the selected visit". Content: "No results found".
- Home Medications (10)**: No visible content.
- Medications +**: Subtitle "Selected visit".
 - ▾ Scheduled (0) Next 12 hours
 - ▾ Continuous (0)
 - ▾ PRN/Unscheduled Available (0) Last 48 hours
 - ▶ Administered (0) Last 24 hours
 - ▾ Suspended (0)
 - ▶ Discontinued (0) Last 24 hours
- Screening Tools (1)** (highlighted with a red box): Subtitle "Selected visit".

Braden Risk Level	Very High	07/10/18 13:17
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- Documents (0)**: Subtitle "Last 7 days for all visits". Content: "No results found".

Step Four – Choose Tool

Screening Tools (2)

- Braden Risk Assessment
- Braden Q Risk Assessment
- CAM - Confusion Assessment Method for Delirium
- CSSRS - Suicide Severity Risk Screening Tool
- Fall Risk Assessment - Humpty Dumpty
- Fall Risk Assessment - Humpty Dumpty ED
- Fall Risk Assessment - Morse**
- ARI Screening Tool
- CSSRS - Suicide Severity Risk Screen Paediatrics

Selected visit	
Braden Risk Level	07/13/18 12:35
Braden Adjusted Risk Level	07/13/18 12:35

Documents (0)

Last 7 days for all visits

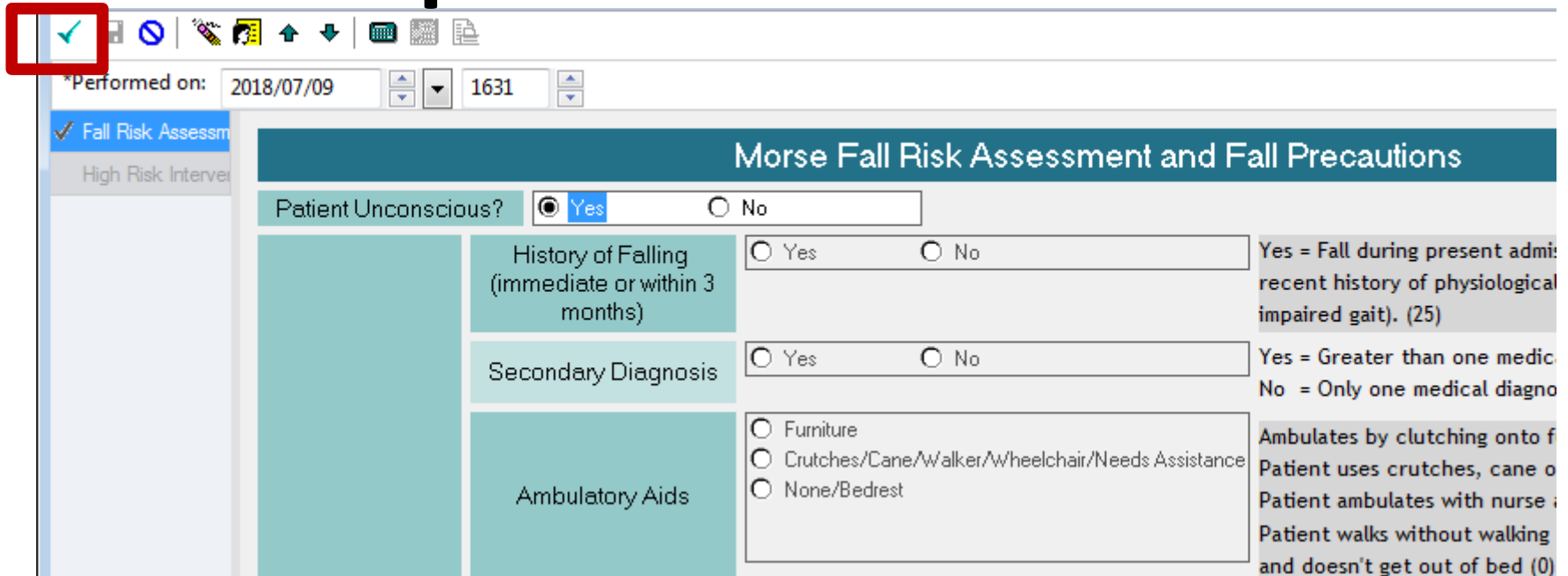
No results found

Step Five – Identify Consciousness

Morse Fall Risk Assessment and Fall Precautions		
Patient Unconscious?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
History of Falling (immediate or within 3 months)	<input type="radio"/> Yes <input type="radio"/> No	Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)
Secondary Diagnosis	<input type="radio"/> Yes <input type="radio"/> No	Yes = Greater than one medical diagnosis listed on the chart. (15) No = Only one medical diagnosis listed on the chart. (0)
Ambulatory Aids	<input type="radio"/> Furniture <input type="radio"/> Crutches/Cane/Walker/Wheelchair/Needs Assistance <input type="radio"/> None/Bedrest	Ambulates by clutching onto furniture for support (30) Patient uses crutches, cane or walker (15) Patient ambulates with nurse assistance consistently (0) Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)

Identify whether the patient is unconscious or conscious.

Step Five – Unconscious



*Performed on: 2018/07/09 1631

Morse Fall Risk Assessment and Fall Precautions

✓ Fall Risk Assessment
High Risk Intervention

Patient Unconscious? Yes No

History of Falling (immediate or within 3 months)	<input type="radio"/> Yes <input type="radio"/> No	Yes = Fall during present admission or recent history of physiological impairment (e.g., impaired gait). (25)
Secondary Diagnosis	<input type="radio"/> Yes <input type="radio"/> No	Yes = Greater than one medical diagnosis No = Only one medical diagnosis
Ambulatory Aids	<input type="radio"/> Furniture <input type="radio"/> Crutches/Cane/Walker/Wheelchair/Needs Assistance <input type="radio"/> None/Bedrest	Ambulates by clutching onto furniture Patient uses crutches, cane or walker Patient ambulates with nurse or other staff Patient walks without walking aids and doesn't get out of bed (0)

If the patient is unconscious at the time of transfer, choose “Yes”, then confirm completion by selecting:

 (top left corner)

Step Five – Conscious

Morse Fall Risk Assessment and Fall Precautions

Patient Unconscious? Yes No

History of Falling (immediate or within 3 months) Yes No
Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)

Secondary Diagnosis Yes No
Yes = Greater than one medical diagnosis listed on the chart. (15)
No = Only one medical diagnosis listed on the chart. (0)

Ambulatory Aids
 Furniture
 Crutches/Cane/Walker/Wheelchair/Needs Assistance
 None/Bedrest
Ambulates by clutching onto furniture for support (30)
Patient uses crutches, cane or walker (15)
Patient ambulates with nurse assistance consistently (0)
Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)

If patient is conscious, select “No” and answer the questions on the screen.

Step Six – Complete Screen

Morse Fall Risk Assessment and Fall Precautions		
Patient Unconscious?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Morse Fall Scale Risk Factor	History of Falling (immediate or within 3 months)	<input type="radio"/> Yes <input type="radio"/> No Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)
	Secondary Diagnosis	<input type="radio"/> Yes <input type="radio"/> No Yes = Greater than one medical diagnosis listed on the chart. (15) No = Only one medical diagnosis listed on the chart. (0)
	Ambulatory Aids	<input type="radio"/> Furniture <input type="radio"/> Crutches/Cane/Walker/Wheelchair/Needs Assistance <input type="radio"/> None/Bedrest Ambulates by clutching onto furniture for support (30) Patient uses crutches, cane or walker (15) Patient ambulates with nurse assistance consistently (0) Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)
	IV/Saline Lock	<input type="radio"/> Yes <input type="radio"/> No IV apparatus or saline lock (20)
	Gait/Transferring	<input type="radio"/> Impaired <input type="radio"/> Weak <input type="radio"/> Normal/Bedrest/Immobile Impaired = Difficulty rising from chair, may use several attempts or "bounces". Patient keeps head down focuses on ground, loses balance easily, clutches tightly to objects, air or nurse. Cannot walk without assistance of aids/nurse. (20) Weak = Patient stooped, may shuffle, but keeps heads up, does not lose balance, may featherweight touch objects or aids for support. (10) Normal/Bedrest/Immobile = Head erect, strides without hesitation, arms swing freely at side; OR is immobile, on bedrest and doesn't get out of bed; uses lift aid, or transfers safely to wheelchair. (0)
	Mental Status	<input type="radio"/> Forgets limitations <input type="radio"/> Oriented to own ability Ask patient, "Are you able to go to the bathroom alone, or do you need assistance?" Compare patient's answer with your clinical judgement. Overestimates abilities, or forgetful of limitations. (15)
	Total Fall Risk Score	<input type="text"/>
Fall Risk Level	<input type="radio"/> Low <input type="radio"/> Moderate - High "Low"= score of 0 - 24 "Moderate-High"= score of 24 or higher	

Answer the screening questions.

Step Seven – Low Risk

Low Risk - Universal Fall Precautions		Yes	No	Comment
	Call bell in reach & operational			
	Adequate lighting			
	Oriented to unit, room, bathroom			
	Bed at lowest level, brakes on			
	Ensure secure, non-slip footwear			
	Walking aids, commode, urinal accessible			
	Assess need for frequent toileting			
	Pathway clear of obstacles			
	Ensure bed exiting/equipment/items on pt's strong side			
	Education & Fall prevention brochure given to pt/family			
	Evaluation of current medication			
	Other Precaution #1			
	Other Precaution #2			

Considerations

- * Consider placement in room near nursing station or in an area of high visibility
- * Consider assistance from family members
- * Consider observation care with leadership approval
- * Consider referrals as specific risk factors are identified to reduce risk of fall or repeat falls
- * Consider need for medication review by team
- * Communicate risk for fall status at shift report and upon patient transfer to other unit (RNAO, 2007,p9)
- * The use of bedrails to prevent falls is not recommended (RNAO, 2011)
- * Never underestimate the power of clinical judgement

Risk will be calculated automatically. If Low Risk Interventions populate, select the interventions that are in place.

Step Seven – Moderate or High Risk

High Risk Interventions (Morse) - Dummy, Dummy Baby

Moderate - High Fall Risk Precautions
(includes Low Risk - Universal Fall Precautions)

	Yes	No	Comment
Call bell in reach & operational			
Adequate lighting			
Oriented to unit, room, bathroom			
Bed at lowest level, brakes on			
Ensure secure, non-slip footwear			
Walking aids, commode, urinal accessible			
Assess need for frequent toileting			
Pathway clear of obstacles			
Ensure bed exiting/equipment/items on pt's strong side			
Education & Fall prevention brochure given to pt/family			
Evaluation of current medication			
Assess for contributing factors (vision, UTI, delirium)			
Inform pt/family/team of fall risk status			
Fall Risk sign posted			
"Call Don't Fall" armband applied			
Activate bed/chair exit alarm			
Assist with mobilization			

Risk will be calculated automatically. If Moderate or High Risk Interventions populate, select the interventions that are in place.

Step Seven – Comments if Relevant

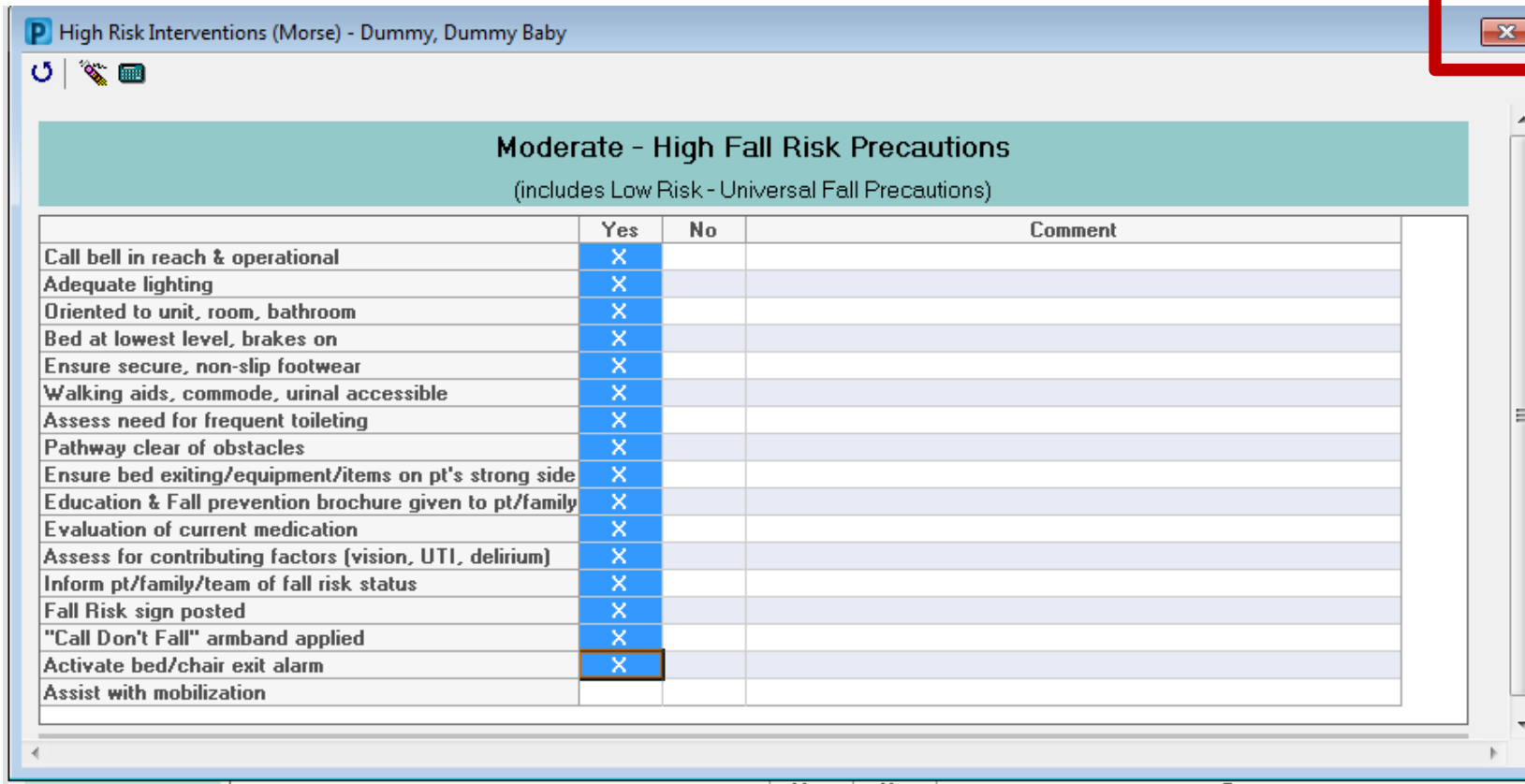
High Risk Interventions (Morse) - Dummy, Dummy Baby

Moderate - High Fall Risk Precautions
(includes Low Risk - Universal Fall Precautions)

	Yes	No	Comment
Call bell in reach & operational		X	No call bell available, in process of transfer
Adequate lighting	X		
Oriented to unit, room, bathroom			
Bed at lowest level, brakes on			
Ensure secure, non-slip footwear			
Walking aids, commode, urinal accessible			
Assess need for frequent toileting			
Pathway clear of obstacles			
Ensure bed exiting/equipment/items on pt's strong side			
Education & Fall prevention brochure given to pt/family			
Evaluation of current medication			
Assess for contributing factors (vision, UTI, delirium)			
Inform pt/family/team of fall risk status			
Fall Risk sign posted			
"Call Don't Fall" armband applied			
Activate bed/chair exit alarm			
Assist with mobilization			

Use comments box to identify interventions that cannot be met or are not appropriate.

Step Eight – Complete Risk Reduction Entry



High Risk Interventions (Morse) - Dummy, Dummy Baby

Moderate - High Fall Risk Precautions
(includes Low Risk - Universal Fall Precautions)

	Yes	No	Comment
Call bell in reach & operational	X		
Adequate lighting	X		
Oriented to unit, room, bathroom	X		
Bed at lowest level, brakes on	X		
Ensure secure, non-slip footwear	X		
Walking aids, commode, urinal accessible	X		
Assess need for frequent toileting	X		
Pathway clear of obstacles	X		
Ensure bed exiting/equipment/items on pt's strong side	X		
Education & Fall prevention brochure given to pt/family	X		
Evaluation of current medication	X		
Assess for contributing factors (vision, UTI, delirium)	X		
Inform pt/family/team of fall risk status	X		
Fall Risk sign posted	X		
"Call Don't Fall" armband applied	X		
Activate bed/chair exit alarm	X		
Assist with mobilization			

Select "X" top right corner when risk reduction strategies have been entered.

Step Nine – Submit Screen Results

Fall Risk Assessment - Morse - Dummy, Dummy Baby

*Performance on: 2018/07/09 1710 By: Morgan, Brenda (RN)

Morse Fall Risk Assessment and Fall Precautions

Patient Unconscious?	<input type="radio"/> Yes <input checked="" type="radio"/> No	
History of Falling (immediate or within 3 months)	<input checked="" type="radio"/> Yes <input type="radio"/> No	Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)
Secondary Diagnosis	<input checked="" type="radio"/> Yes <input type="radio"/> No	Yes = Greater than one medical diagnosis listed on the chart. (15) No = Only one medical diagnosis listed on the chart. (0)
Ambulatory Aids	<input type="radio"/> Furniture <input checked="" type="radio"/> Crutches/Cane/walker/wheelchair/Needs Assistance <input type="radio"/> None/Bedrest	Ambulates by clutching onto furniture for support (30) Patient uses crutches, cane or walker (15) Patient ambulates with nurse assistance consistently (0) Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)
IV/Saline Lock	<input checked="" type="radio"/> Yes <input type="radio"/> No	IV apparatus or saline lock (20)

Submit screen results by selecting:

 (top left corner)

Step Ten – View Previous Entries

The screenshot displays the 'Results Review' interface. The 'Assessments/Interventions View' is selected in the Flowsheet dropdown menu. The main display shows a table of assessment results for three dates: 2018/07/09 17:01, 2018/07/09 16:31, and 2018/07/09 12:25. The table includes various assessment categories like 'Fall Risk', 'Operational', 'Bathroom', etc., with 'Yes', 'No', and 'No, Intervention' as possible outcomes.

Assessments/Interventions View	2018/07/09 17:01	2018/07/09 16:31	2018/07/09 12:25
nt			
is	Yes	Yes	Yes
	Furniture	Furniture	Crutches/Ca
	Yes	Yes	Yes
	Impaired	Impaired	Impaired
	Forgets limi	Forgets limi	Forgets limi
	125	125	110
	Moderate -	Moderate -	Moderate -
cautions			
operational	No, none a	No, Interv	No, No call
	Yes	Yes	Yes
om, bathroom	Yes	No	
brakes on	Yes		
-slip footwear	Yes		
node, urinal accessible	Yes		
quent toileting	Yes		
stacles	Yes		
ent on pt strong side	Yes		

From the Results Review section, choose Assessment/Intervention View from the Flowsheet drop box (remember to refresh screen for recent results)