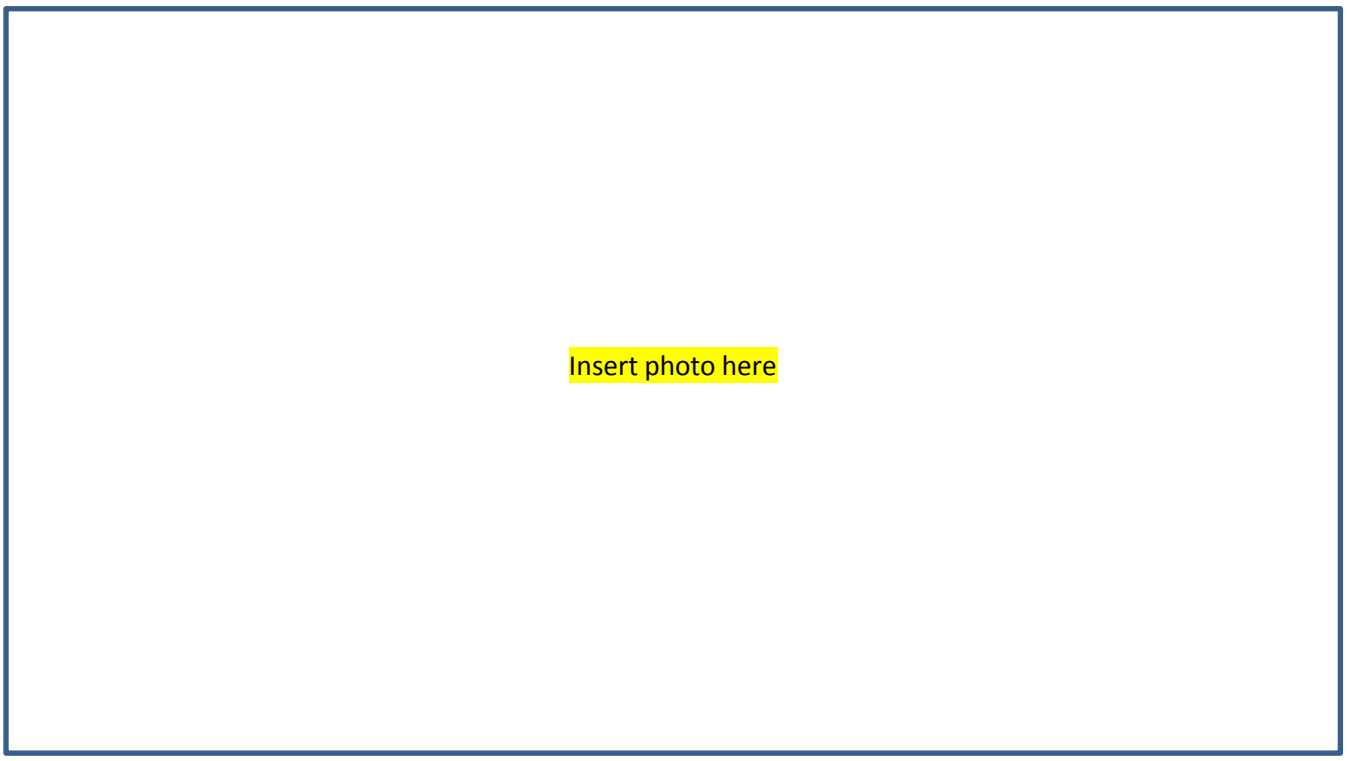


Fall: Inpatient

Instructor Information

Patient Name: Bernstein, John

Simulation Developer(s): Griselle Del Valle Rivera, Debra A. Mosley, LeAnn Schlamb, and Heather Thomas

Scenario Purpose:

- To effectively care for the patient who has sustained a fall

Learner(s):

- **Registered Nurses (RN), Licensed Practical Nurses (LPN), Unlicensed Assistive Personnel (UAP)**
- **Others as desired, depending on facility protocols**
- **Recommend no more than 6 learners (3 of which can be observers)**

Time Requirements:

- **Setup:** 5 minutes
- **Scenario:** 25 minutes
- **Debrief:** 25 minutes
- **Reset/Breakdown:** 5 minutes

Confederate(s):

- **Healthcare provider "Dr. Santana"- via telephone**
- **Unlicensed Assistive Personnel (UAP)**

Scenario Prologue:

- Inpatient: Seventy five (75) year-old male admitted from the Emergency Department (ED) with pneumonia and dehydration. The patient has a history of frequent falls at home per the family member(s) who has gone home. He is also deaf in the right ear and refuses to wear his hearing aid.
- **The simulation begins when the learners are receiving report from the nurse**

Patient information:

- ***General:*** *Alert and oriented*
- ***Weight/Height:*** *80.5kg (190lbs) 177.8cm (70in)*
- ***Vital Signs:*** *BP 100/60, Temp 101.0, HR 108, RR 28, O2 Sat 92%*
- ***Pain:*** *0/10*
- ***Neurological:*** *Deaf in the right ear*
- ***Respiratory:*** *Rhonchi, tachypneic, productive cough (yellow sputum)*
- ***Cardiac:*** *Sinus tachycardia*
- ***Gastrointestinal:*** *Unremarkable*
- ***Genitourinary:*** *Unremarkable*
- ***Musculoskeletal:*** *Ambulates slumped over due to shortness of breath*
- ***Skin:*** *Unremarkable*
- ***Past Medical History:*** *Hypertension, pneumonia, and the patient is deaf in the right ear but refuses to wear his hearing aid. History of falls.*
  - ***Past Surgical History:*** *Cholecystectomy*

Medications:

- Metoprolol 100 mg two times daily

Allergies:

- No known drug allergies (NKDA)

Green Text Confederate

Red Text Physiology Change

Learning Objectives

Patient Name: John Bernstein
Simulation Developer(s): Griselle Del Valle Rivera, Debra A. Mosley, LeAnn Schlamb, and Heather Thomas
Scenario Purpose:

- To effectively care for the patient who has sustained a fall

Pre-Session Activities:

- Complete training on managing care for the patient risk for falls
- Review policies and protocols on the management of care for the patient who has sustained a fall

Potential Systems Explored:

- What standardized protocols help the patient at risk for falls?
- What risk factors are important to consider for the patient at risk for falls?
- What facility specific documentation is required for the patient who has sustained a fall?
- What interventions help reduce the incidence of falls?
- What complications are important to consider when caring for the patient who has sustained a fall?

Scenario Specific Learning Objectives (Knowledge, Skills, and Attitudes = K/S/A):
**The learner(s) will demonstrate ICARE principles throughout the scenario.
Learning Objective 1: Implement facility specific fall protocol

a. ***K***- *Discuss fall protocol*
b. ***S***- *Complete a post fall assessment*
c. ***S***- *Complete a fall risk assessment*
d. **S**- *Implement measures to prevent falls*
   A- *Elicit a sense of urgency with a composed demeanor*

Learning Objective 2: Demonstrate the use of Safe Patient Handling and Mobility (SPHM) equipment

a. ***K***- *Select the appropriate SPHM device to assist the patient back to bed (exam table if outpatient)*
   S- *Proceed with fall recovery by acquiring SPHM equipment and assist patient back to bed per facility protocol*

Learning Objective 3: Communicate effectively when managing care for the patient who has sustained a fall

a. ***S***- *Call for assistance*
b. ***S***- *Request or place a call to the healthcare provider*
c. ***S***- *Perform ISBAR communication to include pertinent information related to the fall*
d. ***S***- *Provide patient and family education in a way they can both understand*
e. ***K***- *Identify pertinent information to include in the documentation of a fall*
   S- *Complete facility specific documentation for falls*
   A- *Exhibit confidence when completing facility specific documentation*

Debriefing Overview:

- Ask the learner(s) how they feel after the scenario
- Have the learner(s) provide a summary of the scenario from a healthcare provider/clinical reasoning point of view
- Discuss the scenario and ask the learners what the main issues were from their perspective
- Ask what was managed well and why.
- Ask what they would want to change and why.

- For areas requiring direct feedback, provide relevant knowledge by stating "I noticed you *[behavior]…"* Suggest the behavior they might want to portray next time and provide a rationale. "Can you share with us?"
- Indicate closing of the debriefing but provide learners with an opportunity to voice one or two take-aways that will help them in future practice
- Lastly, ask for any outstanding issues before closing the debrief

Critical Actions/Debriefing Points:

1. Call for additional assistance
2. Request SPHM equipment
3. Request or place a call to the healthcare provider
4. Utilize Safe Patient Handling and Mobility (SPHM) equipment to assist the patient back to bed
5. Initiate fall protocol
6. Perform a post fall assessment
7. Perform ISBAR communication
8. Ensure fall prevention measures are implemented
9. Provide patient and family education in a way they both can understand
10. Complete facility specific documentation

Simulation Set-Up

Patient Name: John Bernstein **(ALS Mannequin or Standardized Patient)**
Simulation Developer(s): Griselle Del Valle Rivera, Debra A. Mosley, LeAnn Schlamb
Room Set-up:

- Set up like a hospital patient room or outpatient exam room
- The learners will be outside the patient's room receiving report from the nurse. The patient will yell for help and be on the floor with oxygen tubing tangled around his legs. The tubing will also be propped up on the patient's forehead.

Patient Preparation:

- Hospital gown
- Saline lock in the right antecubital space
- Monitoring device (3 Wave form):
    - ECG (Sinus tachycardia), O2 Sat 92%, BP 100/60, Temperature 101.0, HR 108, RR 28

Have the following equipment/supplies available:

- Telephone
- Gloves
- Hand sanitizer
- Oxygen source with nasal cannula
- Safe Patient Handling and Movement equipment-SPHM (facility specific)
- Blood pressure cuff
- Stethoscope

Note: 5.8 Simpad software update is required to load scenarios (http://cdn.laerdal.com/downloads/f4343/simpad-upgrade.vs2
Scenarios may be used with Laerdal or LLEAP software.
Scenario Supplements:

- Confederate scripts
- Confederate name tags
- Patient identification band
- Orders
- Fall risk assessment example
- Post fall checklist example
- Post Fall Huddle example
- ZZ test patient/Demo patient in CPRS (if desired)

Flowchart

Initial State:
- Mental Status: Alert and oriented
- Sp02: 92%
- BP: 100/60
- HR: 108
- RR: 28
- Lungs: Rhonchi
- ECG: Sinus tachycardia
- Eyes: Open
- Pain level: 0/10
- Skin: Unremarkable

Seventy-five (75) year-old male diagnosed with pneumonia and dehydration. He has a history of frequent falls per the family member(s) who has gone home. He is also deaf in the right ear and refuses to wear his hearing aid.

- ***The patient will be yelling for help as the learners approach the room.***
- ***The patient will be lying on the floor with his oxygen tubing tangled around his legs.***
- ***The patient states "I was trying to go to the bathroom, got tangled in this oxygen tubing and fell."***

***Did not … ***
- **…call for assistance**
- **…request SPHM equipment**
- **Patient states "How am I going to get up from here?"**

- ***Calls for assistance***
- ***Requests appropriate Safe Patient Handling and Movement (SPHM) equipment***
- ***Requests or places call to the healthcare provider***

Did not…
- **…perform post fall assessment**
- **Patient states "My back is killing me."**

- ***Patient states "I am alright. Can you help me to the bed?"***
- ***Utilizes SPHM to assist the patient back to bed***
- ***Performs facility specific post fall assessment***

- ***The phone will ring.***
- ***Provides Dr. Santana with ISBAR communication***
- ***Dr. Santana states "Go ahead and initiate fall protocol. I already entered the orders."***
- ***Initiates fall protocol***
- ***Provides patient /family education in a way they can both understand***
- ***Initiates facility specific fall prevention measures to ensure safety***
- ***Completes facility specific documentation***

Critical Actions/Debriefing Points:
- Call for additional assistance
- Request Safe Patient Handling and Mobility (SPHM) equipment
- Request or place a call to the healthcare provider
- Utilize SPHM equipment to assist the patient back to bed
- Initiate fall protocol
- Perform a post fall assessment
- Perform ISBAR communication
- Ensure fall prevention measures are implemented
- Provide patient and family education in a way they both can understand
- Complete facility specific documentation

Confederate

Change in physiology

Red border incorrect action

Supplements

Confederate Scripts

Confederate Name Tags

Patient Identification Band

Orders

Fall Risk Assessment Example

Post Fall Checklist Example

Post Fall Huddle Tool Example

Confederate Scripts

Dr. Santana (healthcare provider)- via telephone

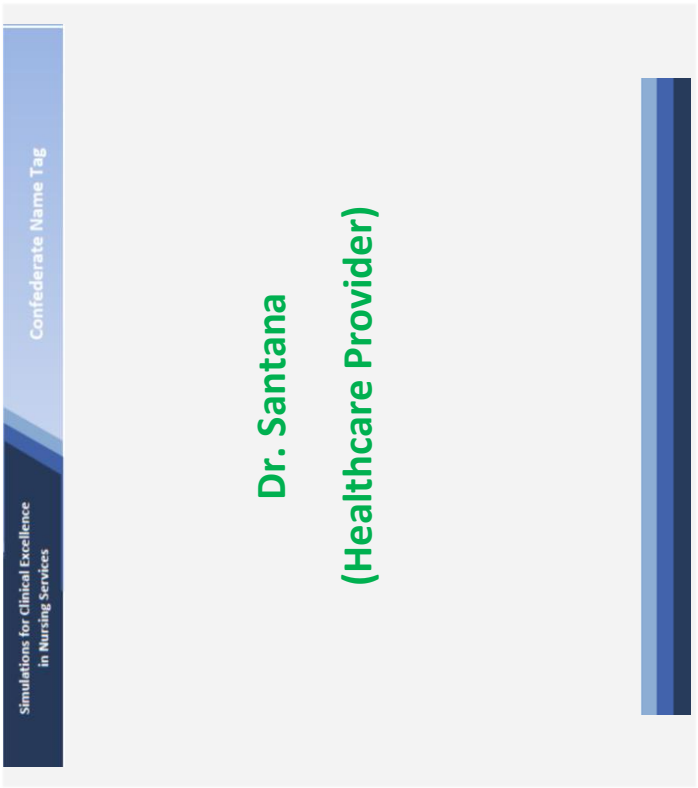
- Learner(s) requests a call to notify healthcare provider of fall
- The phone will ring
- Learner(s) provides Dr. Santana with ISBAR communication
- Dr. Santana states "Go ahead and initiate fall protocol. I already entered the orders."

John Bernstein: Patient (ALS Mannequin)

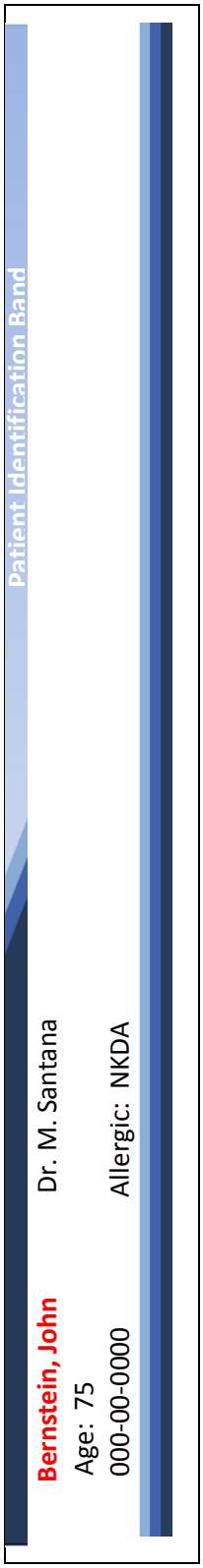
- Medical/Surgical History: Hypertension, pneumonia, and deaf in the right ear; cholecystectomy
- Meds: Metoprolol 100 mg two times daily
- Allergies: NKDA

- The nurses and learners are outside the patient's room
- The patient will be yelling for help as the learners approach the room.
- The patient will be lying on the floor with his oxygen tubing tangled around his legs.
- If the learner(s) do not call for assistance, the patient states "How am I going to get up from here?"
- The patient will state "I am alright. Can you help me back to bed?"
- The patient is assisted back to bed with the SPHM equipment
- The learner(s) will perform post fall assessment
- If learner(s) do not perform post fall assessment, the patient will say "My back is killing me."
- The phone will ring
- The learner(s) provides Dr. Santana with ISBAR communication
- Fall protocol will be initiated
- Fall prevention interventions are implemented
- Documentation is completed
- End of scenario

Confederate Name Tags



Patient Identification Band



Orders

Patient Information

Bernstein, John
Dr. M. Santana
Age: 75
Social Security #: 000-00-0000
Allergies: NKDA
Weight: 80.5kg (190lbs)
Height: 177.8cm (70in); BMI 25.5

Admit to	Medical Surgical unit
Diagnosis	Pneumonia Dehydration
Condition	Stable
Diet	2 Gm Na
Activity	Bathroom privileges
IV Therapy	Saline lock
Medications (routine)	Metoprolol tartrate 100mg by mouth twice daily Cefazolin sodium 1 Gm IV every 8 hours
Medications (prn)	Albuterol nebulizer treatment unit dose every 4 hours as needed for wheezing
Diagnostics	Chest x-ray in the morning
Code Status	Full code
Respiratory Therapy Orders	Oxygen 4 liters via nasal cannula continuously
Miscellaneous Orders	High risk fall protocol

DO NOT WRITE IN THIS SPACE

Fall Risk Assessment Example

Patient Name:_____ Date/Time: _____

Fall Scale

Low Risk 0-24
Moderate Risk 25-50
High Risk 51-74
Very High Risk > 75

Classification of Falls

1. Accidental Fall
2. Anticipated Physiological Falls
3. Unanticipated Physiological Falls
4. Near Miss

Morse Fall Scale

Fall Risk is based upon Fall Risk Factors and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, at change of condition, transfer to new unit, and after a fall.

Variables		Score	
History of Falling	no	0	
	yes	25	_____
Secondary Diagnosis	no	0	
	yes	15	_____
Ambulatory Aid	None/bed rest /nurse assist	0	
	Crutches/cane/ walker	15	_____
	Furniture	30	
IV or IV access	no	0	
	yes	20	_____
Gait	Normal/bed rest/ wheelchair	0	
	Weak	10	_____
	Impaired	20	
Mental status	Knows own limits	0	
	Overestimates or forgets limits	15	_____
		Total	_____

Safety Factors
- Maintain bed in low position, bed alarm when needed
- Call bell, urinal and water within reach. Offer assistance with elimination needs routinely
- Buddy system
- Wrist band identification
- Ambulate with assistance
- Do not leave unattended for transfers / toileting
- Encourage patient to wear non-skid slippers or own shoes
- Lock bed, wheelchairs, stretchers and commodes

Assessment
- Assess patient's ability to comprehend and follow instructions
- Assess patient's knowledge for proper use of adaptive devices
- Need for side rails: up or down
- Hydration: monitor for orthostatic changes
- Review meds for potential fall risk (HCTZ, Ace inhibitors, Ca channel blockers, B blockers)
- Evaluate treatment for pain

Family/Patient Education
- PT consult for gait techniques
- OT for home safety evaluation
- Family involvement with confused patients
- Sitters
- Instruct patient/family to call for assistance with out-of-bed activities
- Exercise, nutrition
- Home safety (including plan for emergency fall notification procedure)

Environment
- Room close to nurses station
- Orient surroundings, reinforce as needed
- Room clear of clutter
- Adequate lighting
- Consider the use of technology (non-skid floor mats, raised edge mattresses)

Post Fall Assessment Example

Patient Name:_____ Date/Time of Fall: _____

___Complete blood glucose if diabetic

___Obtain vital signs (orthostatic vital signs if Veteran complains of dizziness before fall)

___Notify the provider/MOD regarding patient fall and let them know need for a PT consult for gait and balance evaluation if indicated

___Notify Manager or Immediate Supervisor of fall

___Conduct a post fall huddle including the Veteran, any staff who witnessed the fall, the primary nurse, the physician on duty, and either the manager or supervisor if available.

___Complete post fall note, ensure to include added fall interventions in note

___Review and update the care plan

CLC ONLY:

___Add provider and restorative RN or LPN as an additional signer on the post fall

Post Fall Huddle Tool Example

Patient Name:_____ Date/Time of Fall: _____

This is a tool and is not a permanent part of the patient's chart

1. Coordinate a time within two hours of the fall to have all the necessary people present for the post fall huddle. Remember to list the people involved and time of the huddle in the post fall note in CPRS.
2. Review history of falls.
3. Review interventions currently in place to reduce falls.
4. Evaluation of Environment/patient's physical ability.
5. Ask for the Patient's account of event (if able to share) and witness account.
6. Was the bed and/or chair alarm set (if ordered or charted it was on)? If so, did it alarm properly?
7. Why did this patient fall? (root cause)
8. Was the patient at the correct Morse Fall Score Level? Were appropriate interventions in place?
9. How could the same outcome be avoided next time?
10. What is the follow up plan (interventions)?
11. Veteran re-educated if needed/response to education.
    a. *Remember to document in CPRS.

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