THOMPSON
HEALTH

An Affiliate of the

UNIVERSITY of ROCHESTER
MEDICAL CENTER

Morse Fall Scale
It's all about patient safety!

Education 12/1/2013

Begin use 1/2/2014

Objectives

- Learn how to use the Morse Fall Scale (MFS)
- Learn when the scale will be completed
- Understand the variables and scoring process for MFS
- Develop standardized approach to implementing evidence-based prevention strategies for patients identified at risk to fall
  - Learn what constitutes low, medium, high fall risk scores
  - Attach risk scale score to interventions
  - Critically think about what other interventions might be required to keep your patient safe
- Know how your unit is doing in fall prevention

Types of Falls and Prediction Capability

- Anticipated physiological falls - constitute 78% of all falls
  - Falls that occur with the patient identified as "at risk of falling" on the MFS
- Unanticipated physiological falls – approx. 8% of falls
  - Falls attributed to physiological causes, but created by conditions that cannot be predicted before first occurrence.
  - Examples: seizures, 'drop attacks", fainting, pathological fracture of hip
  - Nursing concentrates on preventing injury or second fall
- Accidental falls – approx. 14% of falls
  - Caused by slipping, tripping, like slipping on wet floor

Morse Fall Scale (MFS)

- A reliable and simple method of assessing patient's likelihood of falling – anticipated physiological falls
- Consists of 6 variables quick and easy to score
- Provides consistent fall risk scale with accurate targeting of interventions
- Used widely in acute hospital and long term care settings
- Identifies up to 78% of patients who fall

Risk Assessment Tools

- Risk assessment tools do not prevent patient falls – they predict them
- Sensitivity is the ability of the tool to identify positive results - 79% compared to Hendrich II (77%)(Spoelstra,2011)
- Specificity is the ability of the tool to identify negative results – 82% compared to Hendrich II (72%)(Spoelstra,2011)
- Tools do not replace, but compliment nursing judgment
- These tools assist nursing in predicting <u>anticipated</u> physiological falls

Screening and Risk Assessment

- Risk assessment does not end with administration of the screening tool
- Falls risk assessment is a multi-step process:
  - Screening using a risk scale
  - In-depth multifactorial risk assessment
- Purpose of the screening and risk assessment is to identify patient's risk for falling in advance to correct problems and ultimately prevent falls

Frequency of Risk Assessment

- Admission
- Upon transfer from one unit to another
- Following a fall
- Once each shift
- With **<u>any</u>** status change – CRITICAL thinking a must!

Morse Fall Scale Six Variables

- History of falling
- Secondary diagnosis
- Ambulatory aids
- IV Therapy
- Gait
- Mental status

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

© Morse, JA. "Preventing Patient Falls" p. 41, Copyright 1997 by Sage Publications. Used with permission of Sage Publications, Inc.

Reference:

Double click (left) on the Morse scale for definitions for each variable.

History of Falling

- If patient has no history of falls
  - Score 0
  - Note: if patient falls for the first time, score immediately as 25
- Score 25 if patient has fallen during
  - Present hospital admission
  - Immediate history of physiologic al fall, i.e. seizure, impaired gait last 3 months

- Use clinical judgment
  - Differences between actual fall and not so graceful! (example: lost footing and slipped on wet grass with no prior history of falling)

Secondary Diagnosis

- If patient has only 1 diagnosis:
  - score 0
- If patient has more than 1 diagnosis:
  - score 15
  - Likely to have multiple medications, which increases risk of drug interactions
  - Medications contribute to fall risk as they relate to other variables, like gait and mental status
- Goal: review medications to reduce side effects and fall risk

Ambulatory Aids

- If patient walks without walking aid (even if assisted by caregiver) or is on bed rest or does not get out of bed – score 0
- If patient uses crutches, cane, or walker, score 15
- If patient ambulates clutching on to furniture, score 30

IV Therapy

- If patient has an IV line of any kind or a saline lock, score 20

Gait

- Normal – score 0
  - Patient walks with head erect, arms swinging freely at sides and stride unhesitating
- Weak – score 10
  - Patient is stooped, but able to lift head while walking, steps short, may shuffle, featherweight touch for support on furniture
- Impaired – score 20
  - Patient may have difficulty rising from the chair, attempting to rise by pushing on arms of chair and/or bouncing. Head is down, grasps furniture, support person or walking aid, can't walk without assist. Steps are short, may shuffle
- If wheelchair bound, score according to gait used for transfer w/c to bed

Mental Status (self assessment of ambulatory ability)

- If patient's assessment is consistent with orders, rated as normal, score 0
- If patient's response is not consistent with orders or if assessment is unrealistic, he/she has overestimated his/her own abilities or forgetful of limitations, score 15

Identify Area of Risk - History of Fall

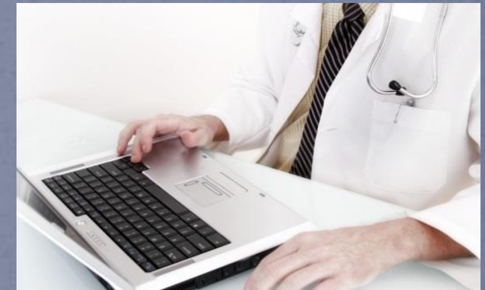
- If patient answers “yes” to history of falls, do further assessment by answering the following questions:
  - Did patient have any injury with prior fall?
    - No
    - Yes - injury with fracture
    - Yes - injury without fracture
    - Unknown history of injury(s)
  - If injury with fracture – ask location of fracture – hip, wrist, rib, other
  - If injury without fracture, what was the injury – describe

Identify Area of Risk – Secondary Dx

- If yes to Secondary Diagnosis, ask:
  - Is patient on multiple medications to manage co-morbidities? – yes or no
  - Is patient currently on medications that increase patient's risk for falling or increase risk of injury w/falls?
    - ☐Anti-hypertensives – observe for orthostasis
    - ☐Diuretics – consider toileting schedule
    - ☐Sedatives
    - ☐Analgesics
    - ☐Hypnotics
    - ☐Psychotropics
    - ☐Opioids
    - ☐none of the above

Document Risk Level

- The system will total the score at the bottom . i.e. Total Score: 49/125, patient score is 49 in this example
  - 0-24 - No or Low risk score
    - Universal fall precautions
  - 25-44 - Moderate risk score
    - Universal fall precautions
    - Additional interventions based on identified area of risk
  - 45 and higher – High risk score
    - Universal fall precautions
    - Additional interventions based on identified area of risk
    - Additional interventions based on further assessment/nursing judgment



Universal Fall Precautions – all Patients

- Patient/family education:
  - Orient to surroundings
  - Educate patient/family on fall risks (“How to Avoid a Fall”)
  - Purpose and use of side rails and call light
  - Use of non-skid green slippers
  - Purpose and use of assistive devices and mobility aids if needed
- Environment of care:
  - Place articles within reach, including call light
  - Lock wheels on chair/bed
  - Provide adequate lighting (night light/bathroom light @ night)
  - Floor free of clutter/spills/tripping hazards

Moderate Risk Score (25-44)

- Universal fall precautions
- Additional interventions based on history of fall:
  - Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
  - Room near nursing station, bed with 3 side rails
  - "Call Don't Fall" sign in room
  - Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
  - Bed/chair alarm – DO NOT leave alone in bathroom
  - Commode chair as needed
  - Approach and transfer patient to stronger side
  - Gait belt for assistance with transfer and ambulation
  - Individualized toileting schedule – define frequency
  - Request order for PT/OT
  - Minimum of hourly rounds day and night. Increase freq PRN

Moderate Risk Score (25-44)

- Universal fall precautions
- Additional interventions based on secondary diagnosis
  - Check for orthostasis
  - Instruct patient to rise from bed/chair slowly
  - Consider toileting scheduled at specified intervals
  - Consider use of pull-ups/attends if incontinent
  - Commode chair at bedside PRN
  - Frequent reminders to call for assistance for activity
  - Monitor abnormal lab values
  - Review dose of medication – greater than home dose?
  - Surveillance rounds hourly, increase frequency PRN

High Risk Score (45 and higher)

- Universal precautions
- Additional precautions based on identified areas of risk
- Additional precautions based on nursing judgment:
  - Is patient safe to have access to ambulatory aids at all times
  - Consider 1:1 sitter
  - Obtain order for PT/OT
  - Surveillance rounds in addition to hourly rounding –need to observe every 15-30 minutes
  - Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
  - Room near nursing station, bed with 3 side rails
  - “Call Don’t Fall” sign in room
  - Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
  - Bed/chair alarm – DO NOT leave alone in bathroom
  - Gait belt for assistance with transfer and ambulation
  - Individualized toileting schedule – define frequency

UNIVERSAL FALL SCORE (0-24)
Date:________
Score:________
	Universal Fall Precautions – All Patients
	• Patient/family education:
	  • Orient to surroundings
	  • Educate patient/family on fall risks ("How to Avoid a Fall")
	  • Purpose and use of side rails and call light
	  • Use of non-skid green slippers
	  • Purpose and use of assistive devices and mobility aids if needed
	• Environment of care:
	  • Place articles within reach, including call light
	  • Lock wheels on chair/bed
	  • Provide adequate lighting (night light/bathroom light @ night)
	  • Floor free of clutter/spills/tripping hazards

MODERATE RISK SCORE (25-44)
Date:________
Score:________
	• Universal fall precautions
	• Additional interventions based on history of fall:
	  • Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
	  • Room near nursing station, bed with 3 side rails
	  • "Call Don't Fall" sign in room
	  • Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
	  • Bed/chair alarm – DO NOT leave alone in bathroom
	  • Commode chair as needed
	  • Approach and transfer patient to stronger side
	  • Gait belt for assistance with transfer and ambulation
	  • Individualized toileting schedule – define frequency
	  • Request order for PT/OT
	  • Minimum of hourly rounds day and night. Increase freq PRN

HIGH RISK SCORE (45 – 125)
Date:________
Score:________
	• Universal precautions
	• Additional precautions based on identified areas of risk
	• Additional precautions based on nursing judgment:
	  • Is patient safe to have access to ambulatory aids at all times?
	  • Consider 1 to 1 sitter
	  • Obtain order for PT/OT
	  • Surveillance rounds in addition to hourly rounding –need to observe every 15-30 minutes
	  • Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
	  • Room near nursing station, bed with 3 side rails
	  • "Call Don't Fall" sign in room
	  • Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
	  • Bed/chair alarm – DO NOT leave alone in bathroom
	  • Gait belt for assistance with transfer and ambulation
	  • Individualized toileting schedule – define frequency

Room Reminder

Place in each room for reminders. Include the patient initials, date and score. You may check appropriate interventions.

Universal Fall Score 0-24

UNIVERSAL FALL SCORE (0-24)
 	
Date:________
Score:________
	Universal Fall Precautions – All Patients
	• Patient/family education:
	  • Orient to surroundings
	  • Educate patient/family on fall risks (“How to Avoid a Fall”)
	  • Purpose and use of side rails and call light
	  • Use of non-skid green slippers
	  • Purpose and use of assistive devices and mobility aids if needed
	• Environment of care:
	  • Place articles within reach, including call light
	  • Lock wheels on chair/bed
	  • Provide adequate lighting (night light/bathroom light @ night)
	  • Floor free of clutter/spills/tripping hazards

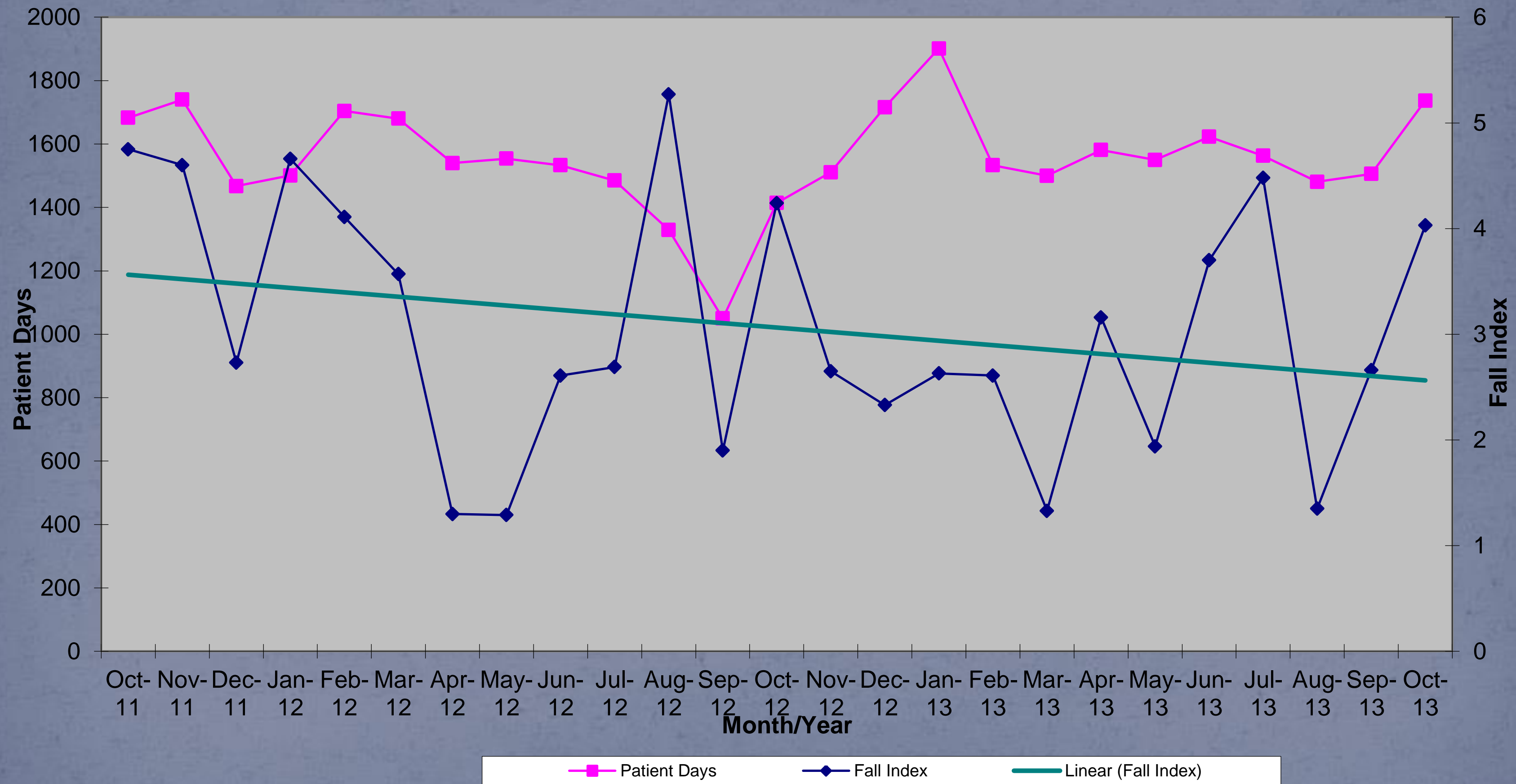
Moderate Risk Score 25-44

MODERATE RISK SCORE (25-44)
 	
Date:________
Score:________
	• Universal fall precautions
	• Additional interventions based on history of fall:
	  • Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
	  • Room near nursing station, bed with 3 side rails
	  • “Call Don’t Fall” sign in room
	  • Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
	  • Bed/chair alarm – DO NOT leave alone in bathroom
	  • Commode chair as needed
	  • Approach and transfer patient to stronger side
	  • Gait belt for assistance with transfer and ambulation
	  • Individualized toileting schedule – define frequency
	  • Request order for PT/OT
	  • Minimum of hourly rounds day and night. Increase freq PRN

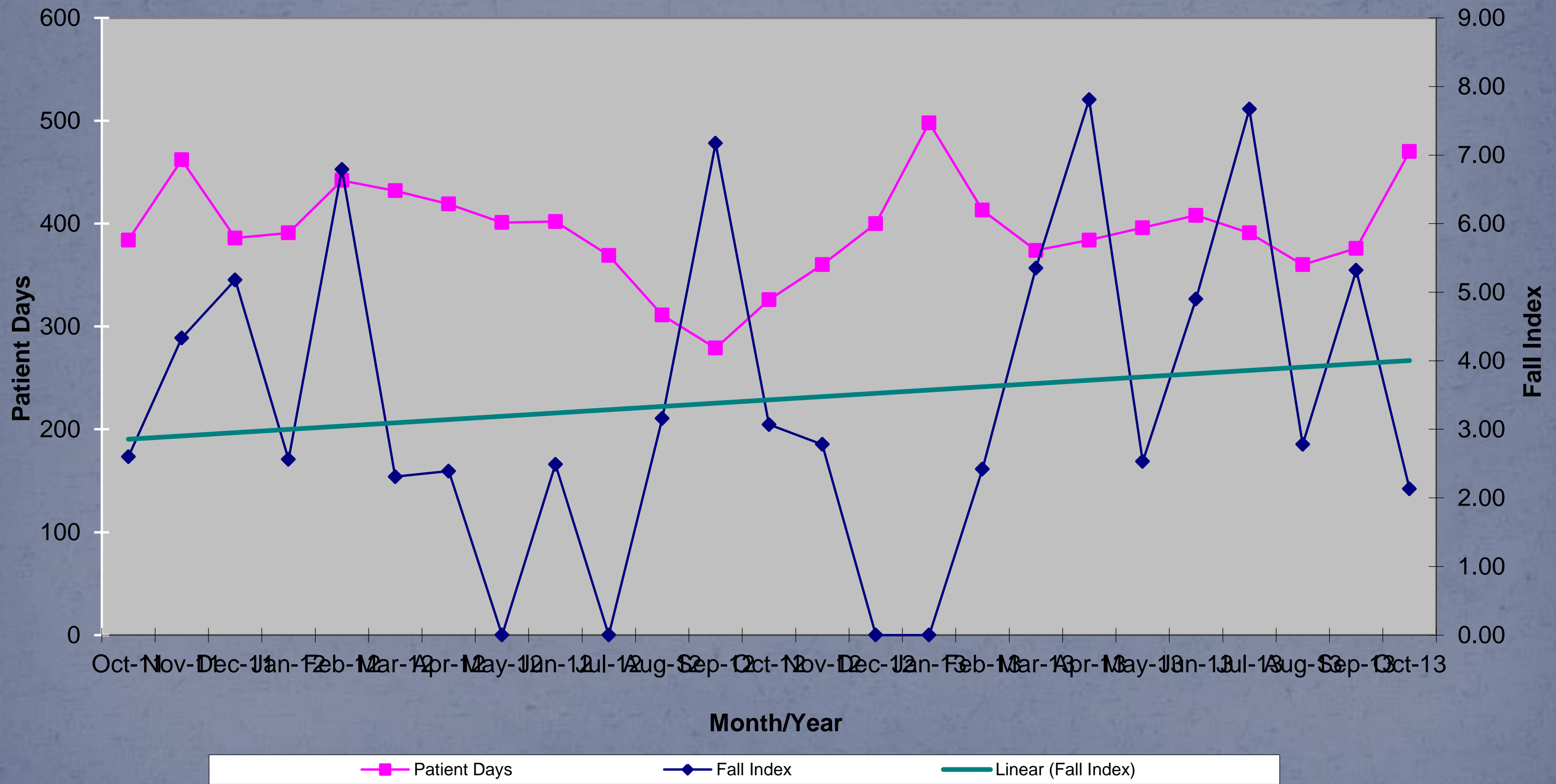
High Risk Score 45-125

HIGH RISK SCORE (45 – 125)
 	
Date:_____
Score:_____
	• Universal precautions
	• Additional precautions based on identified areas of risk
	• Additional precautions based on nursing judgment:
	  • Is patient safe to have access to ambulatory aids at all times?
	  • Consider 1 to 1 sitter
	  • Obtain order for PT/OT
	  • Surveillance rounds in addition to hourly rounding –need to observe every 15-30 minutes
	  • Frequent verbal reminders to call for help for activities (getting out of bed, toileting, transfers)
	  • Room near nursing station, bed with 3 side rails
	  • "Call Don't Fall" sign in room
	  • Alerts: yellow arm band, yellow socks, fall precaution and bed alarm signs on door jams
	  • Bed/chair alarm – DO NOT leave alone in bathroom
	  • Gait belt for assistance with transfer and ambulation
	  • Individualized toileting schedule – define frequency

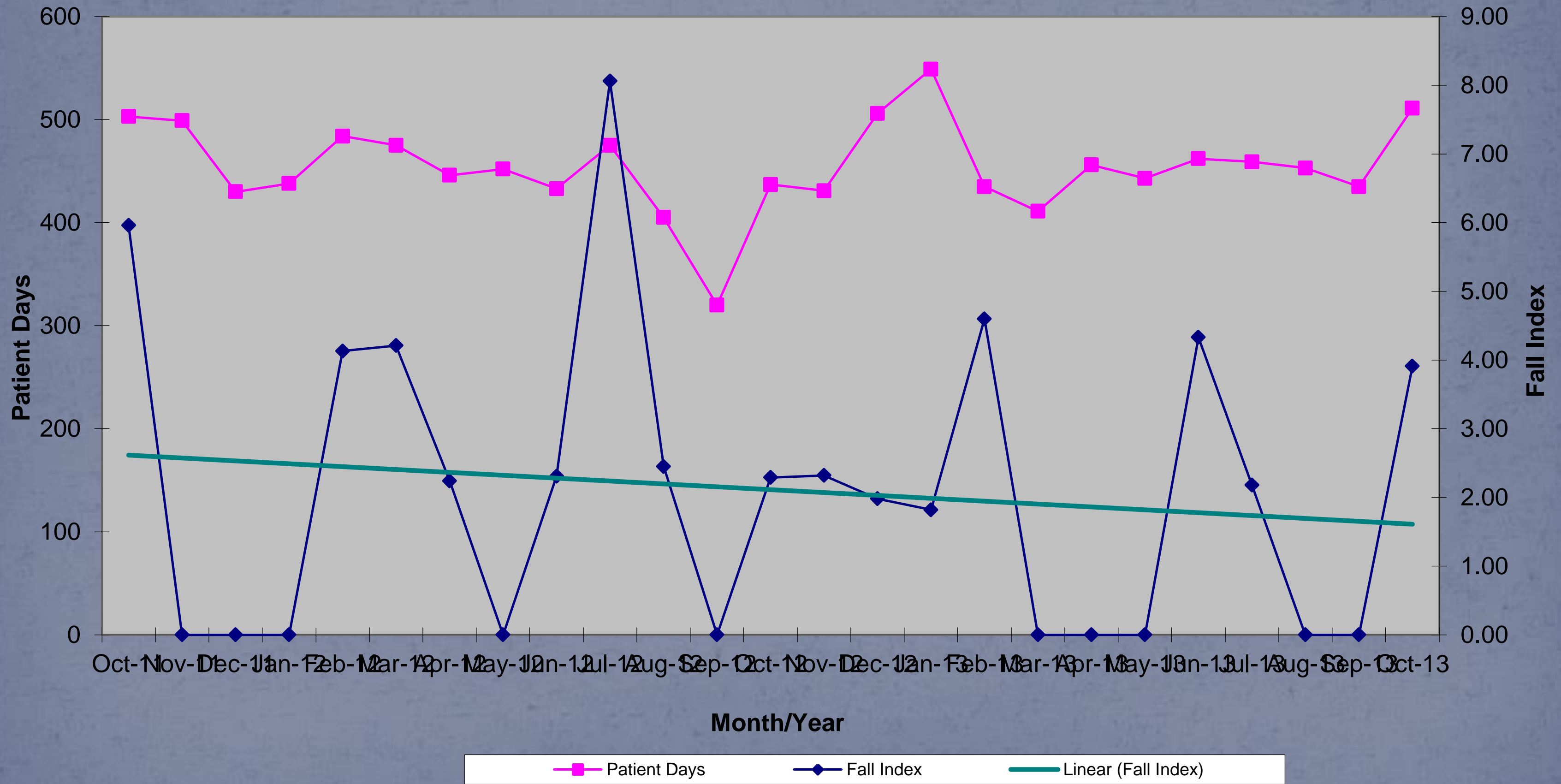
Fall Index Med-Surg/ICU



2W



3E



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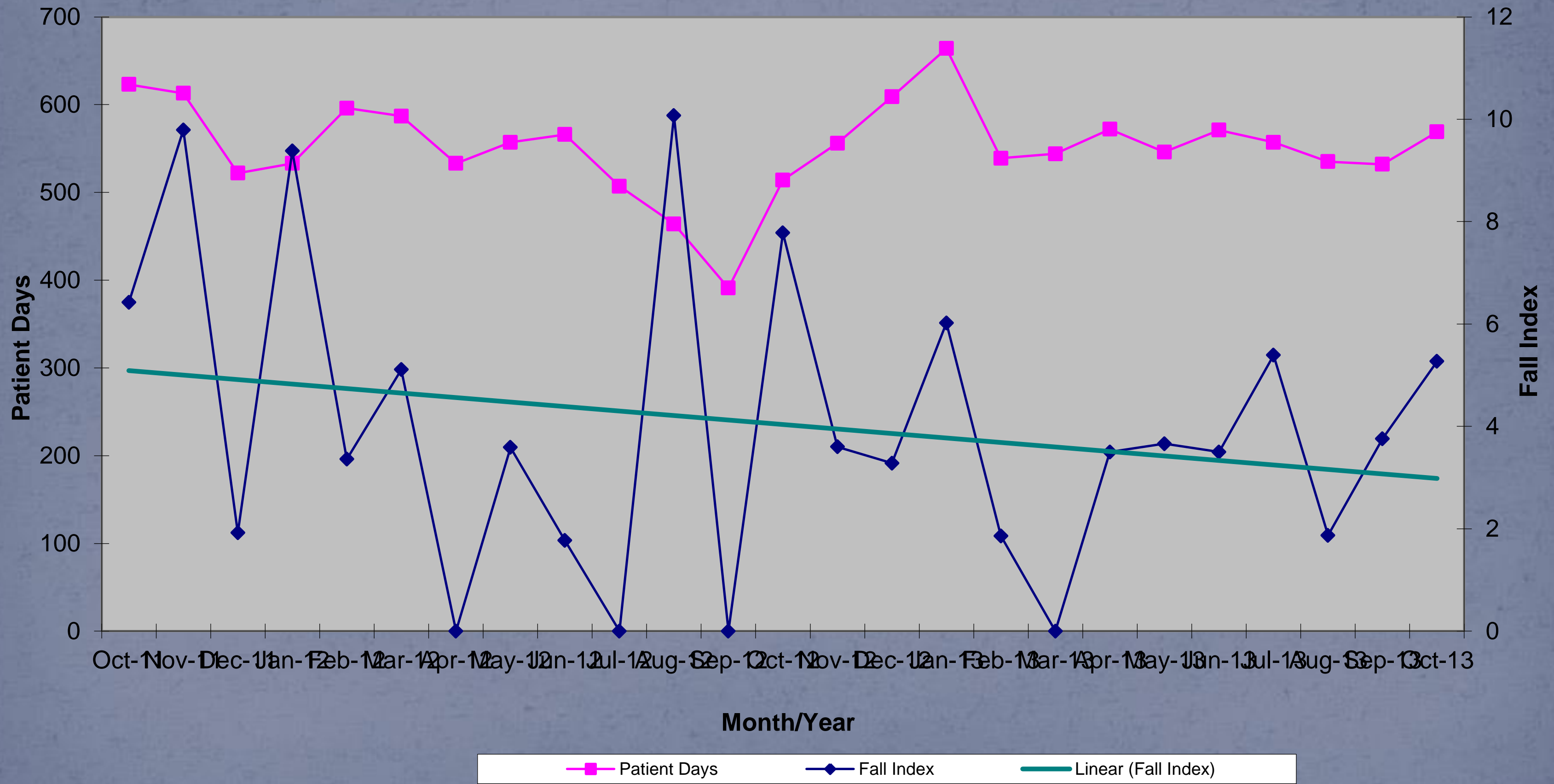


Fall Awareness on Your Unit

- Graphs of fall index
- Graphs of falls with moderate or greater injury as defined by NDNQI (the National Database for Nursing Quality Indicators)
  - No injury
  - Minor: application ice, dressing, limb elevation, pain, bruise or abrasion.
  - Moderate: sutures, steri-strips, splint, muscle joint strain
  - Major: surgery, cast, traction, any fracture, required neuro consult
  - Death as a direct result of the fall
- White boards for falls on your units
- Annual calendars in your break areas with number of falls monthly

Burden for Fall Prevention

- "The burden of preventing falls has been placed firmly on your shoulders. Your wisdom and judgment, your observational skills, and your past experiences provide an excellent background for your to develop a repertoire of innovative and creative ways to prevent patients from falling."

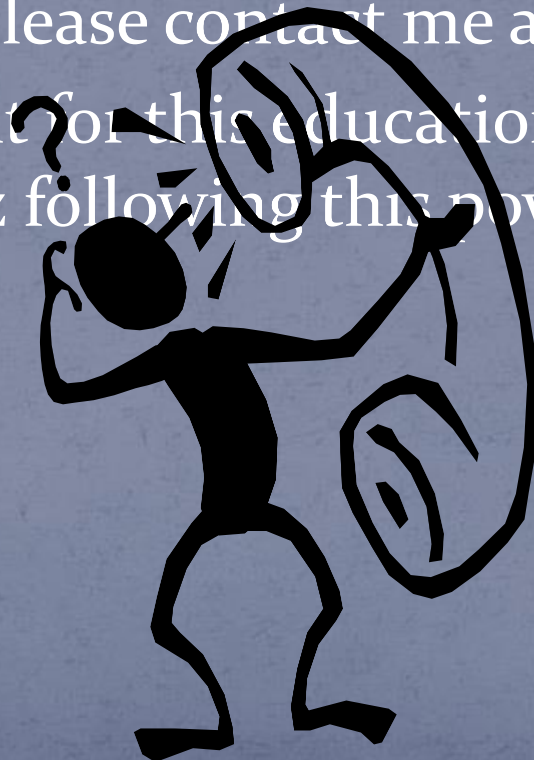
References

- Morse, Janice M. Preventing Patient Falls: Establishing a Fall Intervention Program. Second edition, 2009. Springhouse Publishing Company.
- Quigley, Patricia. Via a telephone conversation and use of her educational materials for a fall risk assessment template. Retrieved from the internet November 2013.
- Spoelstra, S., Given, B., Given, C. Fall prevention in Hospitals: An Integrative Review. Clinical Nursing Research 2012.

Questions??

- We may need to make adjustments in the interventions at some point, but let's try this for 6 months.
- If you have questions, please contact me at 396-6923.
- In order to receive credit for this education ,please complete the short quiz following this power point.

- Thank-you!



Quiz

- 1. If a patient has fallen during his/her present hospital stay or if there is a history of a fall within the past 3 months, what score should be used for the "History of Falling"?
  - A. 20
  - B. 25
  - C. 30
  - Answer is b. 25

- 2. When is a fall assessment or reassessment required?
  - A.
  - B.
  - C.
  - D.
  - E.

  - Answer is on admission, after a fall, once a shift, upon transfer to another unit, with any patient status change.

- 3. A patient scores 15 for “Secondary diagnosis” when__________________________?
  - A. The patient has another condition, regardless of whether the condition is related to the reason for admission.
  - B. The condition for which the patient was admitted results from a diagnosed underlying condition.
  - C. A patient’s primary diagnosis or a secondary diagnosis is a known indicator of fall risk.

  - Answer: A

- 4. A patient walks with head erect and arms swinging freely at their side. What score should the patient receive for the variable of “Gait”?
  - A. 0
  - B. 10
  - C. 20

Answer: A

- 5. When administering the Morse Fall Scale, the phrase "Mental status" is defined in terms of the ________________________________.
  - A. Patient's orientation to person, place and time
  - B. Presence or absence of mild-to-moderate dementia
  - C. Patient's orientation to his/her own ambulatory capabilities
  - Answer: C

- 6. An "impaired gait" receives a score of _____ based on the patient having difficulty rising from a chair, with head down and watching the ground. The patient's balance is poor, he/she grasps onto the furniture, a support person, or a walker for support and cannot walk without assistance.
  - A. 10
  - B. 15
  - C. 20

  - Answer: C

- 7. What score should the patient receive for the "Ambulatory aid" variable if he/she is stooped with the walker?
  - A. 0
  - B. 15
  - C. 30
  - Answer: B

- 8. The purpose of fall risk assessment using the Morse Fall Scale is to identify ____________________.
  - A. Those patients for whom a fall prevention plan is required.
  - B. The underlying cause of a patient's fall risk.
  - C. Risk prevention methods for a facility or unit.

  - Answer: 8

- 9. When there is a change in the patient's fall risk score, ________________________________.
  - A. The patient's fall prevention interventions should be reviewed and revised if needed.
  - B. The physician should be notified immediately.
  - C. The nursing staff no longer need to score the patient.
  - Answer: A

- If you forget exactly what the definitions are or need clarification on the 6 variables for the Morse scale, how can you find these? _
  - A. Look it up on line
  - B. Ask another nurse
  - C. Right click while on the Morse scale in McKesson
  - D. Double click (left) while on the Morse scale in McKesson

Answer: D. Double click (left) while on the Morse scale in McKesson.