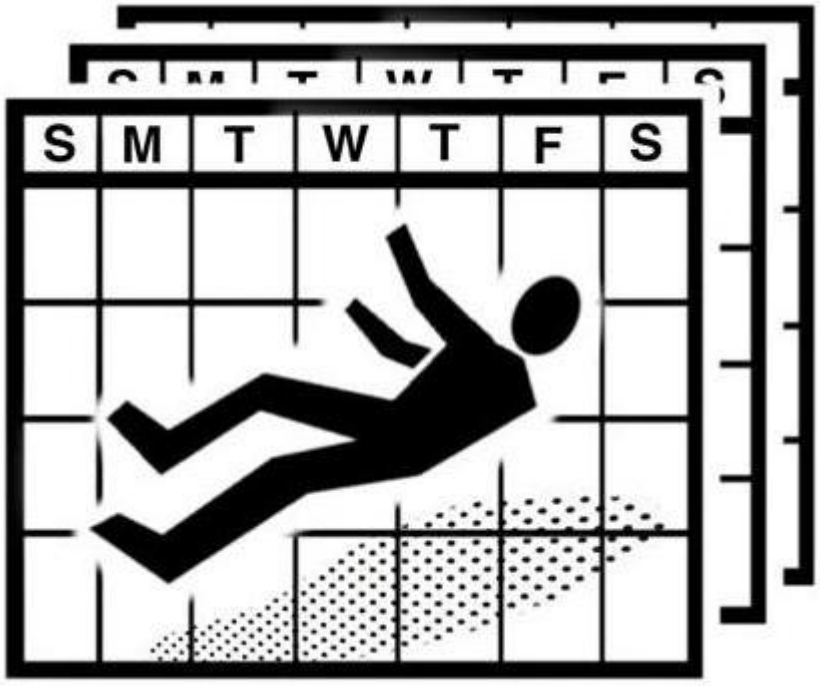
The Morse Fall Scale Training Module

Partners HealthCare System Fall Prevention Task Force



Based on J. Morse (1997). Preventing Patient Falls. CA: Sage Publishing Co.

Objectives

1. What is fall risk assessment?
2. What are the areas of fall risk that are identified by using the Morse Fall Scale (MFS)?
3. How do I use the MFS to plan interventions to prevent patients from falling?

What is Fall Risk Assessment?

- The Morse Falls Scale is a Fall Risk Assessment tool that predicts the likelihood that a patient will fall.
  - Should be done at least once a day and with change in patient status.
  - Provides the information needed to tailor interventions to prevent falls.

What are the areas of fall risk that are identified by the MFS?

- What are the areas of fall risk that are identified by the MFS?

  1. History of falling
  2. secondary diagnosis
  3. ambulatory aid
  4. IV therapy/heparin (saline) lock
  5. Gait
  6. Mental status

History of Falling

- **Score 0** if none of the following are true:
    1. Patient has fallen during this hospitalization.
    2. Patient has immediate history of falls within the past 3 months.
- **Score 25** if one or more of the above are true.

1. History of Falling	No Yes	0 25

Secondary Diagnosis

- **Score 0** if only 1 **<u>active</u>** medical diagnosis
- **Score 15** if more than 1 medical diagnosis is active for current admission

2. Secondary Diagnosis	No Yes	0 15

Ambulatory Aid

- **Score 0** if patient walks without a walking aid or uses a wheelchair or is on bed rest and does not get up at all.
- **Score 15** if patient uses crutches or a walker.
- **Score 30** if the patient walks clutching onto furniture for support (e.g., needs help, but does not ask or does not comply with order for bed rest).

3. Ambulatory Aid	None/bed rest/ nurse assist	0
	Crutches/cane/ walker	15
	Furniture	30

Intravenous/Heparin (Saline) Lock

- **Score 0** if the patient does not have an IV, heparin (saline) lock or is not attached to equipment.
- **Score 20** if the patient has an IV, heparin (saline) lock or is attached to equipment (e.g., monitoring equipment or Foley catheter.

4. IV/Heparin (Saline) Lock	No Yes	0 20

Gait

- **Score 0** if the patient has a normal gait.
  - Walks with head erect.
  - Arms swinging freely at the side.
  - Striding without hesitation
- **Score 10** if the patient has a weak gait.
  - Stooped, but able to lift head without losing balance.
  - If furniture required, uses as a guide (feather-weight touch).
  - Short steps, may shuffle.

Gait (Continued)

- **Score 20** if the patient has an impaired gait.
  - Difficulty rising from chair (needs to use arms; several attempts to rise.
  - Head down; watches ground while walking.
  - Cannot walk without assist; grabs at furniture or whatever available.
  - Short, shuffling gait.
  - Wheelchair: score according to gait used at transfer.

5. Gait	Normal Weak Impaired	0 10 20

Mental Status

- **Score 0** if the patient's mental status is normal.
- **Score 15** if the patient is considered to overestimate his/her abilities or is forgetful of limitations.
- <u>To test mental status:</u> Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?"
  - Normal: patient response is consistent with orders or kardex.
  - Overestimates/forgets limitations: patient response is inconsistent with ambulation order or unrealistic.

6.Mental Status	Normal Overestimates abilities/ forgets limitations	0 15

Calculate Fall Risk Status

- Assess each area of risk using the MFS.
- Tally the patient score and record. (This calculation is done automatically in electronic documentation systems.)
- Fall risk can range from 0 to 125.
  - 0: No risk for falls
  - <25: Low risk
  - 25-45: Moderate risk
  - >45: High risk

The total MFS score provides an indication of the likelihood that a patient will fall. However, it does not identify how to protect the patient from falling.

An important goal of the MFS is to identify WHY a patient is at risk for falls. Focusing on the areas of risk identified by the MFS will help to recognize specific interventions to prevent patient falls.

Using the MFS data to plan interventions to prevent patient falls

- Review the areas of risk identified by the MFS for a specific patient.
- Select interventions to address **each** area of risk.
- Communicate the tailored fall prevention plan to the care team; nurses, nursing assistants, physical therapists, physicians, patients and their family members.

Fall prevention starts with the whole care team working from the same plan.

Using the MFS data to plan interventions to prevent patient falls

Area of Risk from MFS	Interventions
History of falling	• Safety precautions • Communicate risk status via plan of care, change of shift report and signage. • Document circumstances of previous fall.
Secondary diagnosis	• Consider factors which may increase risk for falls: illness/ medication timing and side effects such as dizziness, frequent urination, unsteadiness.
Ambulatory aid	• Ambulatory aid at bedside if appropriate. • Consider PT consult.
IV therapy/ heparin (saline) lock	• Implement toileting/rounding schedule. • Instruct patient to call for help with toileting. • Review side-effects of IV medications.
Gait	• Assist with out of bed. • Consider PT consult.
Mental status	• Bed alarm/chair alarm • Place patient in visible location • Encourage family presence • Frequent rounding

Competency

Instruction: Read the case study below. Complete the Morse Fall Scale based on the case study. Identify interventions to prevent falls based on the patient-specific areas of risk. **Return the completed competency to your nurse manager.**

An 82-year-old man with type 2 diabetes was admitted to the telemetry unit with chest pain and shortness of breath on exertion. On admission, the patient was found to be alert and oriented to place, person and time. He had a heplock in place and he was placed on a cardiac monitor. During the admission interview, the patient reported that he walks with his cane; he was independent with ambulation and transfers. However, the admitting nurse noted that the physician's order was for ambulation with cane and assistance only. After further questioning, the patient reported that he had several falls at home over the past year; most recently last month. As the nurse assisted the patient to the bathroom, she noted that initially he used the bedside table and other furniture as a guide and needed to be reminded to use his cane. Once he was given the cane, the patient walked with short, steady steps to the bathroom.

Name: _____ Unit: _____

Complete and return to your Nurse Manager.

Use the MFS to determine level of risk for this patient.

Morse Fall Scale		
Item	Select Areas of Risk	**Score**
1. **History of Falling**	□ No □ Yes	**0** **25**
2. **Secondary Diagnosis**	□ No □ Yes	**0** **15**
3. **Ambulatory Aid** • None/bed rest/nurse assist • Crutches/cane/walker • furniture	 □ □ □	 **0** **15** **30**
4. **IV Therapy/HepLock**	□ No □ Yes	**0** **20**
5. **Gait** • Normal/bed rest/wheelchair • Weak • Impaired	 □ □ □	 **0** **10** **20**
6. **Mental Status** • Oriented to own ability • Overestimates/forgets limitations	 □ □	 **0** **15**

Total Morse Fall Scale risk score = ____.

Patient is (select 1) □ Low □ Medium □ High Risk for falls.

Based on the areas of risk identified on the MFS, list 3 interventions that would prevent falls for this patient:

1. _____
2. _____
3. _____

Review the answers to the case study questions below. You may go back to the previous page to review your answers and to make corrections as needed.

- Use the MFS to determine level of risk for this patient. High Risk for falls. MFS Score = 115
  - History of falls: Yes (he fell within the past 3 months)
  - Secondary diagnosis: Yes (type 2 diabetes)
  - Ambulatory aid: Furniture (although the patient has a cane and is supposed to use it, the nurse saw him use furniture as he walked to bathroom)
  - IV/hep lock: Yes (he has a Heplock).
  - Gait: Weak (uses furniture as a guide, short, steady steps)
  - Mental status: Overestimates abilities/ forgets limitations (Although patient is alert and oriented x 3, he *thinks* he is independent to the bathroom and he is not.

Based on the areas of risk identified, what interventions should be implemented to prevent falls (list at least 3 interventions)?

All of the following are appropriate:

History of falls:	• Safety precautions • Communicate risk status via plan of care, change of shift report and signage. • Document circumstances of previous fall.
Secondary Diagnosis:	• Consider factors which may increase risk for falls: illness/ medication timing and side effects such as dizziness, frequent urination, unsteadiness.
Ambulatory Aid:	• Request order for PT consult • Provide Ambulatory aid
IV or Hep Lock Present:	• Implement toileting/rounding schedule. • Instruct patient to call for help with toileting. • Review side-effects of IV medications.
Gait	• Assist with out of bed. • Consider PT consult.
Mental Status:	• Bed alarm/chair alarm • Place patient in visible location • Encourage family presence • Frequent rounding

Bibliography

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