Morse Falls Scale Assessment for Long Term Care Facilities

Procedure:

Obtain a Morse Fall Scale Score by using the variables and numeric values listed in the "Morse Fall Scale" table below. (Note: Each variable is given a score and the sum of the scores is the Morse Fall Scale Score. Do not omit or change any of the variables. Use only the numeric values listed for each variable. Making changes in this scale will result in a loss of validity. The "Total" value obtained must be recorded in the patient's medical record.

MBB MOORE BALANCE BRACE

Morse Fall Scale

MBB This icon indicates primary consideration for the Moore Balance Brace.

Variables	Numeric Values	Score
1. History of falling	No - 0 Yes - 25	_____
2. Secondary diagnosis: Dizziness, Parkinsons, Neuropathy, Osteoarthritis, Hypertension MBB	No - 0 Yes - 25	_____
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture MBB	 0 15 30	_____
4. IV or IV Access	No - 0 Yes - 20	_____
5. Gait Normal/bed rest/wheelchair Weak Impaired MBB	 0 10 15	_____
6. Mental status Oriented to own ability Overestimates or forgets limitations	 0 15	_____
Total:		

1. History of falling
This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

2. Secondary diagnosis
This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.

3. Ambulatory aid
This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this variable scores 15; if the patient ambulates clutching onto the furniture for support, score this variable 30.

4. IV or IV Access
This is scored as 20 if the patient has an intravenous apparatus or a saline/heparin lock inserted; if not, score 0.

5. Gait
The characteristics of the three types of gait are evident regardless of the type of physical disability or underlying cause.

a. A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitation. This gait scores 0.

b. With a weak gait (score10), the patient is stooped but is able to lift the head while walking without losing balance. If support from furniture is required, this is with a featherweight touch almost for reassurance, rather than grabbing to remain upright. Steps are short and the patient may shuffle.

c. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair and/or bouncing (i.e., by using several attempts to rise). The patient's head is down, and he or she watches the ground. Because the patient's balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance. Steps are short and the patient shuffles.

d. If the patient is in a wheelchair, the patient is scored according to the gait he or she used when transferring from the wheelchair to the bed.

6. Mental status
When using this Scale, mental status is measured by checking the patient's own self assessment of his or her own ability to ambulate. Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?" If the patient's reply judging his or her own ability is consistent with the activity order on the Kardex, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the activity order or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and is scored as 15.

Fall Risk

- Use the Morse Fall Scale Score to see if the patient is in the low, medium or high risk level. (See the "Fall Risk Level" table below to determine the level and the action to be taken.)
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- Implement the interventions that correspond with the patient's fall risk level. (See "Fall Risk Prevention Interventions" on back.)

Fall Risk Level

0 – 24 Low risk	25 – 44 Medium risk	>45 High risk
Implement Low Risk Fall Prevention Interventions	Implement Medium Risk Fall Prevention Interventions	Implement High Risk Fall Prevention Interventions

See back of sheet for fall prevention intervention details

Fall Risk Prevention Interventions

Intervention	Low	Med	High
1. All Patients Implement low risk interventions for all hospitalized patients.	yes	no	no
2. Communication • Orient patient to surroundings and hospital routines ▪ Very important to point out location of the bathroom ▪ If patient is confused, orientation is an ongoing process ▪ Call light in easy reach – make sure patient is able to use it ▪ Instruct patient to call for help before getting out of bed.	yes	yes	yes
• Patient/Family Education ▪ Verbally inform patient and family of fall prevention interventions.	yes	yes	yes
• Shift Report ▪ Communicate the patient's "at risk" status.	yes	yes	yes
• Plan of Care ▪ Collaborate with multi-disciplinary team members in planning care. ▪ Healthcare team should tailor patient-specific prevention strategies. It is inadequate to write "Fall Precautions".	yes	yes	yes
• Post a "Falls Program" sign at the entrance to the patient's room.	prn	yes	yes
• Make "comfort" rounds every 2 hours and include change in position, toileting, offer fluids and ensure that patient is warm and dry.	prn	yes	yes
• Consider obtaining physician order for Physical Therapy consult.	prn	prn	yes
3. Toileting • Implement bowel and bladder program.	yes	yes	yes
• Discuss needs with patient.	yes	yes	yes
• Provide a commode at bedside (if appropriate).	prn	prn	yes
• Urinal/bedpan should be within easy reach (if appropriate).	prn	prn	yes

Intervention	Low	Med	High
4. Medicating • Evaluate medications for potential side effects.	yes	yes	yes
• Consider peak effect that affects level of consciousness, gait and elimination when planning patient's care.	yes	yes	yes
• Consider having a Pharmacist review medications and supplements to evaluate medication regimen to promote the reduction of fall risk.	prn	prn	yes
5. Environment • Bed ▪ Low position with brakes locked, document number of side rails.	yes	yes	yes
• Bedside stand/bedside table ▪ Personal belongings within reach.	yes	yes	yes
• Room "clutter" - Remove unnecessary equipment and furniture ▪ Ensure pathway to the bathroom is free of obstacles and is lighted. ▪ Consider placing patient in the bed that is close to the bathroom.	yes	yes	yes
• Use a night light as appropriate.	prn	yes	yes
6. Safety • Nonskid (non-slip) footwear.	yes	yes	yes
• Moore Balance Brace	yes	yes	yes
• Do not leave patients unattended in diagnostic or treatment areas.	prn	yes	yes
• Consider placing the patient in a room near the nursing station, for close observation, especially for the first 24–48 hours of admission.	prn	prn	yes
• Consider patient safety alarm (tab alarm &/or pressure sensor alarm). ▪ Communicate the frequency of alarms each shift.	prn	prn	yes
• If appropriate, consider using protection devices: hip protectors, a bedside mat, a "low bed" or a helmet.	prn	prn	yes