Adult Fall Prevention Reminders

Morse Fall Risk Assessment

- The Morse Fall Risk Assessment Tool is utilized to identify patients with greater fall risk at routine intervals in adult inpatient areas, surgical services, and emergency services.
- The Morse Fall Risk assessments should be documented each shift and appropriate interventions put in place based on the risk level.

Morse Fall risk should be documented at the following times in the adult inpatient setting:

1. **Upon Admission**
2. **Once per shift**
3. **PRN with change in patient status or level of care**

Morse Fall Risk Assessment

Risk Level	Score	Action
Low Risk	**0-24**	**Implement fall prevention interventions as needed according to individual patient risk factors and needs.**
Moderate Risk	**25-45**	
High Risk	**>45**	

Element	Responses
History of falling (Immediate or past 3 months)	No (0) Yes(25)
Secondary Diagnosis (>2 Diagnoses in chart)	No (0) Yes(15)
Ambulatory Aid	None/bedrest/nurse assist (0) Crutches/cane/walker (15) Furniture (30)
IV/Heparin Lock	No (0) Yes(20)
Gait/Transferring	Normal/bedrest/immobile (0) Weak (10) Impaired (20)
Mental Status	Oriented to own ability (0) Forgets limitations(15)

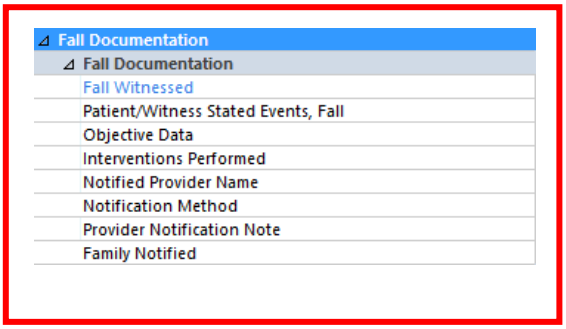
Fall Risk Interventions

- **The nurse should use clinical judgement when implementing interventions, even if score indicates a low fall risk. For example, a recent history of falls is a strong indication of increased risk.**
- **Fall prevention interventions should continue to be followed, even after a patient has a discharge order entered.**
- **Standard fall prevention interventions should be in place for all patients. These interventions include, but are not limited to:**
  - Bed locked and in low position
  - Clutter free room
  - Orientation to room and call light
  - Call light and telephone within reach
  - Dry Floor
  - Appropriate size gown
  - Adequate lighting
  - **Individualized fall prevention education to patient and family**
- **High risk interventions should include (Morse Fall risk >45):**
  - Yellow non-skid socks (appropriately sized)
  - Yellow Fall Risk Arm band
  - Bed Alarm activated (ensure that the bed alarm is functioning)
  - Frequent visualization
  - Fall risk indicator on the door
  - Open door
  - Remaining with the patient while toileting (within arm's reach)
  - Yellow Patient Gown (sized appropriately)
  - Use of CPO camera should be considered for patients that are considered high risk for falls and who are also confused and/or impulsive

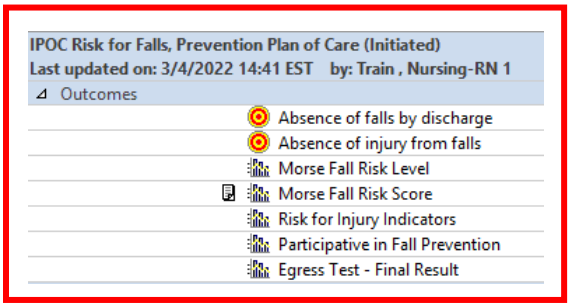
Following a patient fall:

- **Document a post-fall assessment**
- **Include vital signs** (IView→ Quick view→ Vital Signs & IView→ Assessment)
- **Document the fall and provider/family notification** (IView→ Notifications→ Fall Documentation)

*If family not notified, document why. (e.g. Patient alert and oriented and requested no family notification.)



- **Ensure Fall Risk IPOC is activated and updated to prevent future falls** (Orders→ Add and Initiate)



- **Enter a VigiLanz Report** (Report→ Patient Event→ Fall)
- **Complete the Fall Debrief Tool** with the Charge Nurse or Manager. The debrief tool can be accessed and printed from the below hyperlink located in the fall documentation band.