GRAND RIVER HOSPITAL
your health, your hospital

FALL RISK ASSESSMENT TOOL

Patient Label

K-W Health Centre

To be completed on all patients over the age of 65 and/or:

1. **Patients who present with a fall or a history of falls**
2. **Patients with existing neurological disorder**
3. **After a patient fall**
4. **After improvement or deterioration in patient function**
5. **Transfer to new unit.**

Date: **Time:**

Use Universal Falls Precautions for all patients:

Mobility device within patient reach **Clear path with appropriate lighting**
Appropriate footwear/gripper socks **Call bell within reach**

MORSE FALL SCALE

Item			Score
1. History of falling (during or immediately prior to present hospital admission)	NO	0	
	YES	25	
2. Secondary diagnosis (more than one medical diagnosis listed on chart)	NO	0	
	YES	15	
3. Ambulatory aid			
None/bed rest/ nurse assist		0	
Crutches/walker/cane		15	
Relies on furniture		30	
4. Intravenous therapy (includes saline lock)	NO	0	
	YES	20	
5. Gait			
Normal/bedrest/wheelchair			
• Patient walks unhesitantly with head erect, arms swinging freely at the side		0	
• Patient is immobile (bedrest or wheelchair)			
Weak			
• Patient is stooped but able to lift head while walking without loosing balance. Steps are short and patient may shuffle.		10	
Impaired			
• Patient may have difficulty rising form chair, attempting to get up by pushing on arms of chair or by bouncing. Patients head is down and balance is poor. Patient relies on furniture or support of a person/walking aid and can not walk without assistance.		20	
6. Mental Status			
Patient aware of own ability		0	
Overestimates or forgets limitations		15	
Total Patient Score			

RISK LEVEL	SCORE	ACTION
Low Risk	**0-40**	**Implement Low Risk Interventions for fall prevention**
High Risk	**Greater than 40**	**Implement Low and High Risk Interventions for fall prevention**

Risk Factors for Falls in the Elderly:

- **Age 65 or older**
- **History of Falls/Fear of Falling**
- **Medical History**
- **Incontinence**
- **Central Nervous System Depressants**
- **Alcohol and Poor Diet**
- **Postural Hypotension**
- **Impaired vision/hearing**
- **Impaired gait/weakness**
- **Environment**
- **Confusion/Dimentia, Delireum, Depression**
- **Osteoporosis**

Staff Signature:

Turn over for high/low risk intervention

LOW RISK INTERVENTIONS (score 0-40):

- Utilize **falls prevention** pamphlet to teach patient and family/SDM falls prevention strategies
- Call bell within reach
- Bed in low position unless treatments are being done
- Lock wheels on wheelchairs, commodes, and stretchers
- Adequate lighting which may include light on in bathroom at night
- Clutter free floor with clear traffic area for patient
- Personal items are within easy reach
- Encourage use of nonskid footwear
- Encourage use of prescription eyeglasses/hearing aid if used at home

HIGH RISK INTERVENTIONS (score greater than 40):

- Bathroom light on during night
- Instruct patient to use grab bars in bathroom
- Nurse to assist to and from bathroom
- Move to room near nursing station, if possible
- Medication review by pharmacist
- Referral by RN for occupational therapy assessment
- Referral by RN for physiotherapy assessment
- Referral by RN for assessment by dietitian
- Consider mattress on floor

High Risk for Falls:

- ☑ **Place purple arm band on patient**
- ☑ **Place falls sign above bed**
- ☑ **Place purple dot on spine of chart**
- ☑ **Document high risk interventions on HED**
- ☑ **Initiate OT/PT referral (MD order)**