SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

Name:

MR#:

Service:

Physician:

ADULT RISK / FALL ASSESSMENT TOOL

MORSE SCALE

Date:_____

Location / NS.: _____

- Adult Patients to be Assessed on Admission, and Reassessed Every Shift, and After a Fall or any Other Change in Status.
- See Reverse Side for Low, Medium and High Risk Fall Prevention Protocols.

RISK FACTORS	Assigned Score	Tour I Initial Score	Tour II Initial Score	Tour III Initial Score	12 hr Day Initial Score	12 hr Night Initial Score	Remarks
1. Age 65 or Older	2						
2. History of Falls (6 Months – One Year)	15						
3. Unsteady Gait / Balance Problem	15						
4. Vertigo	3						
5. Osteoporosis	2						
6. Seizure Disorders	3						
7. Weakness / Multiple Myeloma	2						
8. Degenerative Joint Disease	2						
9. Paresis / Paralysis	3						
10. Hearing Impairment	2						
11. Sight Impairment	3						
12. Mental Status / Confusion-Impaired Judgment	15						
13. Drugs that Have Diuretic Effect	3						
14. Drugs that Suppress Thought Processes and Create a Hypotensive Effect, i.e., Narcotics, Sedatives, Psychotropics, Hypnotics, Tranquilizers, Anti-depressives, Anti-hypertensives	3						
15. Drugs that Increase G.I. Motility, i.e., Laxatives, Enemas	3						
16. **Amputees:** Single Above Knee	7						
Below Knee	4						
Double Above Knee	9						
Below Knee	7						
17. **Assisting Device:** Wheelchair	4						
Crutches	4						
Cane	4						
Walker	4						
Orthopedic Cast	4						
TOTAL SCORE							

	Tour I	Tour II	Tour III	12 hr. Day	12 hr. Night
NURSES NAME (Print)					
NURSES SIGNATURE					
NAME OF PHYSICIAN NOTIFIED of Fall Risk Score 9 or Above					

Scores: A. Score of 2 – 8 - Patient at Low Risk for Falling (Initiate Low Risk Protocol).*
B. Score of 9 – 15 - Patient at Moderate Risk for Falling (Initiate Moderate Risk Protocol).*
C. Score of 16 – Above - Patient at High Risk for Falling (Initiate High Risk Protocol).*

***See back of form for Protocol**

If Fall Risk Score is 9 or Above, Document Above that MD was Notified of Score and Risk Factors.

FALL PREVENTION PROTOCOLS*

A. LOW RISK FOR FALLS: Score 2-8

Nursing interventions

1. Keep bed in low position at all times.
2. Call light to be kept within easy reach of the patient, and instruct to call for assistance when needed.
3. Turn on night light at bed time.
4. Instruct patient to sit up slowly prior to ambulation
5. Instruct patient to use hand rails in bathrooms, showers and hallways.
6. Recommend the use of non-skid slippers or shoes when ambulating
7. Instruct patient to call for assistance prior to ambulating, if necessary.
8. Apply breaks to bed and wheelchairs.
9. Regardless of score, side rails must be kept in upward position to provide protection for patients who are: over 65, receiving narcotics or sedation, or who require the use of protective devices.

B. MODERATE RISK FOR FALLS – Score 9-15 (Nursing DX and plan of care required)

Nursing Interventions

1. All of the above.
2. Position all equipment and supplies required for personal care (water pitcher, bed pan, urinal) within easy access for the patient.
3. Assist the patient when getting OOB.
4. Interact with patient every 2 hours to see that personal needs are being met.
5. Document implementation of Protocol B on the Intervention Record at the end of each shift.

C. HIGH RISK FOR FALLS – Score 16 and above (Nursing DX and plan of care required).

Nursing Interventions

1. All of the above.
2. Orient patient to environment every shift.
3. Keep side rails up at all times
4. Document the implementation of Protocol C on the Intervention Record at the end of each shift.
5. Assess patient every 30-60 minutes to ensure that personal needs are met.
6. Place high risk for fall sign on the patient's door, place high risk for fall arm band on the patient's wrist, and place high risk for fall red slippers on the patient's feet.

* ***These are generic protocols. Individual patients may require additional interventions or modifications of the generic protocol.***