Falls and Injury Prevention Guideline (in Acute Care)

Site Applicability

All VCH Acute Care Sites

Practice Level

Basic skills for the following professions within their scope of practice and according to the team member's competencies and clinical decision making:

- RN, LPN, RPN, NP
- Occupational Therapist (OT)
- Social Work (SW)
- Pharmacist
- Respiratory Therapist (RT)
- Dietitian (RD)
- Physiotherapist (PT)
- Speech Language Pathologist (SLP)
- Recreation Therapist

Basic skills for unregulated healthcare workers under the supervision and direction of a regulated health care professional:

- Rehab Assistant (RA)
- Physical Therapy Assistant
- Activity Worker
- Medical Imaging Technologist
- Occupational Therapy Assistant
- Patient Care Aide
- Recreation Therapist Assistant

Quick Links:

- Fall Risk Screening & Assessment
  - Modified STRATIFY (CAMP-V) Fall Risk Screening Tool
  - Morse Fall Scale
- Fall Prevention Strategies & Interventions
- Post-Fall Algorithm Communication & Documentation Guideline
- Routine Fall Prevention Practices
- Multifactorial Fall Risk Assessment
- Patient/Family Education
- Care Planning & Fall Prevention
- Fall Risk Factors and Fall Prevention Strategies & Interventions (compiled table)

Policy Statement

The interdisciplinary team implements and evaluates strategies to minimize the frequency and impact of patient falls which:

- Supports the patient's right to optimal freedom of movement and choice as well as the right to make autonomous decisions that may result in living at risk
- Identifies the patients at risk for falls
  - All patients will be screened for fall risk within 24 hours of admission/ transfer to the unit, and with a change in health status by using the modified STRATIFY (CAMP-V) fall risk screening tool or the Morse Fall Scale (MFS).
  - All patients who are at risk for falls will receive a Multifactorial Fall Risk Assessment within 24 hours of admission / transfer to the unit.
  - All patients will have a mobility and transfer assessment within 24 hours of admission / transfer or prior to mobilization according to the SAFE Pre-Transfer Checklist (Appendix A).

All patients who are identified as being at risk for falls will have a fall prevention care plan developed, implemented, and (re)evaluated. The Fall Prevention Care Plan will be:

- implemented within 24 hours of admission / transfer for all patients identified as being at risk for falls
- reviewed each shift and whenever the patient's condition / risk factors change
- targeted towards fall risk factors identified in the Multifactorial Risk Assessment (section A.2)
- developed in partnership with the patient/caregiver and the interdisciplinary team, and
- communicated upon discharge or transfer to another unit, facility, or community program or agency.

All patients, not just those at risk, will have Routine Fall Prevention Practices* (**SAFE** Appendix D) implemented upon admission.

Need to Know

What is a Fall?

A fall is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without, injury.

Fall Prevention Strategies include three main approaches to reduce falls and fall-related injury:

1. fall risk screen and/or assessment
2. communication and patient/caregiver education about fall risk, and
3. implementation of individualized interventions for those at risk of falls and fall-related injury

Interdisciplinary Team Roles:

Nursing is usually the first discipline to perform fall risk screening/ assessment. Care planning for risk factors identified in the assessment includes making referrals to allied health professionals and physicians/ NPs for detailed assessment and implementation of fall prevention strategies and interventions within their scope of practice. Success of the fall prevention plan for each patient is dependent upon communication and collaboration between all members of the interdisciplinary team.

What are Routine Fall Prevention Practices?

The concept of Routine Fall Prevention Practices specifies the level of care that should be provided for **all patients every day**. For fall prevention, Routine Practices is a way of thinking and acting that forms the foundation for reducing falls, fall related injuries and fall risk factors in all health care settings. Routine Practices is the minimum standard of care for all patients/clients/residents. These include:

- ensuring a **S**afe environment
- providing **A**ssistance with mobility
- receiving patient and **F**amily centered care, and
- having appropriate **E**quipment

Fall Risk Screening Tool

Within VCH, there are two tools used to screen adult patients for fall risk:

- A modified version of STRATIFY (St. Thomas Risk Assessment Tool): this modified version of the tool is also known by the acronym CAMP-V. For more details see **Section A.1 and Appendix C**.
- Where education is provided and the tool is implemented, the Morse Fall Scale (MFS) is used for adult patients. For more details regarding the tool and workflow see Appendix K.

What is a multifactorial fall risk assessment?

A multifactorial fall risk assessment (also called a multifactorial risk assessment) is an assessment of all possible risk factors for falls that may contribute to a fall or fall-related injuries

Keeping Safe Questions: Ask patients the three Keeping SAFE Questions (Appendix H) every hour, while awake to reduces falls:

- Comfort: Do you have pain or discomfort?
- Toileting: Do you need to use the toilet?
- Equipment: Do you need anything else before I leave (water, mobility aid, call bell)?

Site Specific Practices:
Each acute care program/unit will develop a plan for post-fall communication** (Appendix G) with the most responsible physician (MRP) and/or Nurse Practitioner (NP) and family member/substitute decision maker (SDM).

Equipment & Supplies

See Section B.1 Fall Prevention Strategies and Interventions, for equipment recommendations.

Practice Guideline

A. ASSESSMENT

A.1 Falls Risk Assessment Screen

All patients will receive a fall risk assessment that includes a:

- Fall risk screen: Sites will use the appropriate fall risk screen tool that has been implemented at their site. See appendices for clinical guidance on these tools:
  - Appendix C: Modified STRATIFY (CAMP-V) tool
  - Appendix K: Morse Fall Scale
- Multifactorial fall risk assessment, if a fall risk is identified, and
- Fall prevention strategies and an individualized care plan as indicated.
- All patients will be screened for fall risk within 24 hours of admission/transfer, and with a change in health status.

A.2 Multifactorial Fall Risk Factor Assessment

All patients will have a mobility and transfer assessment **within 24 hours of admission/transfer or prior to mobilization** according to the **SAFE Pre-Transfer Checklist** (Appendix A)

All patients who are at risk for falls will receive a Multifactorial Fall Risk Assessment (see overview table below) to identify their individual fall risk factors

- within 24 hours of admission/transfer
- when there is a change in health status, and/or
- after a fall

When completing Multifactorial Fall Risk Assessment

- Obtain collateral information from patient/family/**chart** (including previous care settings if available) to determine:
  - history of falls
  - mobility, weight bearing and functional status prior to current admission
  - use of assistive aids (i.e. walker, cane, crutches, glasses, hearing aid)
- Identify patient's goals and expectations for fall prevention
- Communicate patient's risk for falls to interdisciplinary team members and patient/caregiver
- See additional information in Appendix I.

Overview of Risk Factors for Multifactorial Fall Risk Assessment		
Fall Risk Factors		**Fall Risk Assessment**
C	**Cognition**	• Agitation, aggression, pacing, impulsiveness, anxiety • Delirium, dementia, psychosis, neurological/brain injury • Developmental delay • Lack of insight and safety awareness
A	**Bowel / Bladder**	• Altered elimination, urgency, frequency, rushing to the toilet

M	**Functional Mobility**	• Gait, balance, mobility, transfer (e.g. Pre-Transfer Checklist – Appendix A) • Lower extremity muscle strength and joint function, ability to use mobility aid (cane/walker) and wheelchair safety • New assistive aids (i.e. walker, cane, crutches, brace), and/or change in weight bearing status • Activities of daily living including toileting and bathing • Identify specific mobility/turning approaches
P	**Previous Fall / Fall History**	• Recent falls, circumstances of falls, fall related injuries (fracture(s), hospitalizations, ED visits) • Ask: "Have you had a fall in the last 90 days?"
V	**Vision**	• Altered ability to see: macular degeneration, glaucoma, cataracts • Wears glasses, or uses magnifying glasses or other visual aids • Ask: "Have you had your vision checked in the last 2 years?"
Medications		• Medications that increase the risk of falling: ○ Psychotropics, sedatives, anticoagulants, antihypertensives, opioids, diuretics, laxatives etc (Appendix B) • Potentially inappropriate medications (2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults) • Anesthetics (spinal, general, peripheral nerve blocks) • Polypharmacy: Taking 5 or more medications
Communication		• Language barrier • Cognition – e.g. aphasia, illiteracy • Sensory impairments – poor vision or hearing
Environmental Barriers / Patient Care Equipment		• Lack of lighting including night lights • Bed rails • Lack of footwear/directional signage • Tripping hazards: Lines, tubes, drains, clutter • Monitor the patient's environment for safety hazards during all activities.
Fear of Falling		• Expressed fear of falling that compromises recovery
Health / Physical Status		• Heart rate and rhythm; oxygenation • Postural pulse and blood pressure: lying, sitting, standing • Underlying and/or exacerbation of chronic illness(es) (e.g. diabetes, angina, COPD) • Neurological (e.g. Parkinson's, multiple sclerosis, cerebral palsy CVA, history of seizure disorder) • Muscle weakness, decreased co-ordination • Poor proprioception (position of body parts) • Foot problems (e.g. deformities, calluses, ingrown nails)
Nutrition / Hydration		• Recent weight loss • History of poor or sub-optimal intake • History of poor fluid intake • History of osteoporosis
Pain		• Musculoskeletal/neurological conditions (i.e. diabetic neuropathy) that produce pain and limit mobility • Pain interfering with ADLs • Unidentified sources/symptoms of pain • Neurological conditions that limit the ability to express pain
Substance use		• Intoxication and withdrawal from alcohol, nicotine, and drugs

*** For a compiled table of Fall Risk Factors linked with Fall Prevention Strategies & Interventions see Appendix I.

B. CARE PLANNING & FALL PREVENTION INTERVENTIONS

The Fall Prevention Care Plan will be:

- implemented within 24 hours of admission / transfer from another unit for all patients identified as being at risk for falls
- reviewed each shift and whenever the patient's condition/risk factors change
- targeted towards fall risk factors identified in the Multifactorial Risk Assessment
- developed in partnership with the patient/caregiver and the interdisciplinary team
- communicated upon discharge or transfer to another unit, facility, or community program or agency.

B.1 Fall Prevention Strategies and Interventions

★ Interventions with a **'blue star'** are considered Standard Fall Precautions for all patients.

Fall Risk Factors		Fall Prevention Strategies & Interventions
C	**Cognitive Status**	• Familiarize patient to surroundings. For example the location of washroom, kitchen and telephone. • If appropriate, move patient closer to desk or suggest 1:1 • Implement treatment plans for recent changes in cognition (i.e. delirium due to infection, dehydration, brain injury) • Provide visual and verbal cues, and consistent daily routine • Keep information / directions simple. Check for understanding and repeat as needed. • Anticipate and minimize behavioral triggers to reduce fall risk • Initiate a Behavior Log (Appendix E) and/or Sleep and Agitation Log (Appendix F) to track impulsiveness and risk taking behaviors leading to fall risk as appropriate. • Use and activate bed and/or chair alarm as needed ★ Ensure bottom bed rails are down. • See Bed Height in Functional Mobility below ★ Use Keeping Safe questions (Appendix H) to increase supervision.
A	**Bowel/Bladder**	• Establish an individualized toileting plan • Review medications that cause urgency (i.e. diuretics and laxatives) • Implement strategies for urinary continence such as: ○ Fluid management; timed voiding schedule ★ Provide equipment to support safe toileting (i.e. commode/urinal, night light, loose clothing). Encourage patient to use toilet over bedpan whenever possible. ★ Identify a safe clutter-free pathway to access bathroom • Provide appropriate assistance for toileting, especially at night ★ Use Keeping Safe questions (Appendix H) to increase supervision.
M	**Functional Mobility**	• Monitor gait, balance, mobility and transfers (e.g. Pre-Transfer Checklist – Appendix A) • Assist transfers to/from bed/wheelchair/toilet/commode ★ Ensure bed/chair brakes are on for transfers ★ Ensure mobility aid (cane, walker, wheelchair) is appropriate and accessible ★ Encourage ambulation and/or exercises unless contraindicated. Provide supervision/ assistance as needed. ★ Provide adaptive equipment such as a shoe horn or reaching aid. ★ Ensure slippers or shoes fit well and are non-slip; try non-slip socks if patient does not have their own appropriate footwear • Address foot problems as needed ★ Educate patient on proper use of equipment ★ Encourage patient to use toilet over bedpan whenever possible ★ **Bed Height:** For high risk, patients ensure bed is at lowest height. For independently mobile patients, leave beds at knee height or slightly above (i.e. 1" to 2" above knee).

		★ Use Keeping Safe Questions (Appendix H) to increase supervision
P	**Previous Fall / Fall History**	• Ensure that modifiable risk factors are used to create an individualized care plan • Use Keeping Safe Questions (Appendix H) to increase supervision
V	**Vision**	• Enhance environment: increase contrast, improve lighting, reduce glare, remove physical hazards and clutter, use night lights • Ensure eye glasses are clean • Ensure patient has appropriate eye wear when ambulating. (Bifocal / progressive lens can affect depth perception and increase risk of falls.) • Refer for vision screening, if available. • Upon discharge, recommend that the patient see an optometrist if it has been more than 2 years since their last check up or if a problem has been identified. • Provide visual cues for the patient's room, toilet and bed

Fall Risk Factors	Fall Prevention Strategies & Interventions
Medications	• Assess medications known to increase fall risk and modify if possible (Appendix B & 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults) • Attempt to minimize total amount of medication (i.e. reduce polypharmacy) • Use the lowest effective dose. • Consider non-pharmacological strategies to improve sleep rather than using sedatives. • Consider timing of high risk medication given (i.e. laxatives, diuretics, hypnotics)
Communication	• Reduce anxiety/frustration due to the inability to communicate • Identify language barriers/communication disorders that contribute to falls • Identify specific precautions needed to ensure safety (i.e. translated signs) • Educate patients about hazardous activities and ways to call for help • Use pictures, pantomime, picture boards to communicate • For those with short term memory impairment: keep information / directions simple. Check for understanding and repeat as needed.
Environmental Barriers / Patient Care Equipment	★ Ensure the patient's room is free of obstacles and clutter ★ Assess the environment for tubes, lines, furniture, equipment that pose hazards to safe mobilization ★ Use high/low beds ★ Use well fitting shoes with an enclosed heel or non-slip socks ★ Ensure bed is in low position except when giving care ★ Place bottom bed rails down. ★ Place personal items, mobility/reaching aid and call bell within reach ★ Educate patient on use of call bell. ★ Use Keeping Safe Questions (Appendix H) to increase supervision
Fear of Falling	• Identify impact of fears on participating in daily activities. ★ Encourage safe physical activity whenever possible • Collaborate with patient and family to address fears ★ Use Keeping Safe Questions (Appendix H) to increase supervision
Health / Physical Status	★ After a period of bed-rest, encourage patient to sit for a few minutes prior to standing • If patient is dizzy or lightheaded consider checking blood pressure (lying, sitting and standing) and/or blood work • If systolic drops more than 20 mmHg from sitting to standing or lying to sitting (postural hypotension), notify NP/MD. • Monitor and manage chronic conditions, gait disorders, weakness, and dizziness, etc. • Consider recommending hip protectors, especially for those with osteoporosis

Fall Risk Factors	Fall Prevention Strategies & Interventions
Nutrition / Hydration	• Consult dietitian if patient is underweight or if intake is less than 75% for three consecutive meals • Ensure proper diet to meet nutritional needs is provided; consider supplementation with calcium and Vitamin D if necessary • Offer a minimum 1500 mL of fluids per day unless contraindicated
Pain	• Ensure patients with musculoskeletal/neurological conditions that produce pain receive a multifactorial pain assessment and treatment plan • For nonverbal cognitively impaired: use behavioral indicators to identify pain • Use appropriate pain scale to assess pain levels before/after activity • Administer analgesics as needed to relieve pain. Consider regular dosing • Provide PRN analgesic prior to mobilization. Reassess effectiveness
Substance Use	• Ongoing assessment and management of intoxication and/or withdrawal symptoms from alcohol, nicotine and/or substance use • Monitor for drowsiness, dizziness and impaired balance/ gait/ judgment • Provide resources and support to reduce or stop use

****For a compiled table of Fall Risk Factors linked with Fall Prevention Strategies & Interventions see Appendix I.*

B.2 Discharge Planning

For all identified risk factors consider appropriate referral upon discharge to:

- home and community care for OT / PT or out-patient fall prevention programs as appropriate
- appropriate community resources such as balance and mobility classes (e.g. SteadyFeet®, Get Up & Go, and Tai Chi)
- optometrist if vision has not been checked in the last 2 years, and
- family physician for ongoing monitoring of health-related risk factors.

C. POST FALL ASSESSMENT AND MANAGEMENT

See Post Fall Algorithm Communication & Documentation Guidelines (Appendix G)

Evaluation

- Monitor and document the patient's response to interventions intended to prevent and reduce falls and fall related injuries. Evaluate change in patient's health, outcome measure or functional status after implementing intervention(s):
- Re-assessment data: e.g. balance and functional mobility assessments such as SAFE Pre-Transfer Checklist or specific assessments such as Timed Up and Go (TUG) with appropriate training.

Documentation

Sites that have received the education on Morse fall scale, will use the Morse fall scale for fall risk assessment. Otherwise, continue to use CAMP+V:

For sites using the modified STRATIFY (CAMP-V) fall risk screening tool :

- Document the results of the modified STRATIFY (**CAMP-V**) fall risk screening tool
- Document initial assessment including the identification of fall risk factors (Multifactorial Risk Assessment)
- For paper charts, enter *Fall Risk on the Patient Risk Profile Alert Form* (Form #M-17C) or related document used by site.

For sites using the Morse fall scale:

- Complete the MFS.
- Tally up the score on form or in Cerner.
- If identified as fall risk: (score of 45 or more)
  - Will be prompted to complete the "fall prevention interventions".
  - Apply "Process Alert - Fall Risk" under PM conversation (registration field.)

- Develop/revise a Patient Care Plan that includes individualized and universal interventions to address fall risk factors (VCH.0571)
- Place a Fall Risk Alert icon (Appendix J) close to the patient and/or bedside in a clearly visible location
- Place a large 8.5x11 laminated Fall Risk Alert Icon sign at the entrance to the Inpatient Unit
- If patient had a fall, complete the "post fall evaluation" under adult system assessment.
- Complete a Fall Incident Report if the patient falls (in SLS or per site practices)

***It is the responsibility of the individual Inpatient Unit to educate all staff and volunteers working on, or visiting the Inpatient Unit as to which of these visual tools are in use.

Patient Education

- Educate patient/caregiver about the patient's risk factors for falls and possible fall prevention strategies.
- Orient patient and caregiver to new surroundings as needed.
- Educate patient about the importance of staying active.
- Discuss with patient/caregiver alternatives to restraint use and the dignity of individual choices related to living at risk (i.e. interdisciplinary team meeting with patient/caregiver) and document outcomes of discussion.
- Review current patient/caregiver educational materials. e.g. "What to do if you fall" and the "Stay on your Feet" booklet. Available in four languages: English, Chinese, Punjabi and Persian. To order copies of this and other educational materials go to the Patient Health Education Materials Resource Catalogue.

Expected Patient/Client/Resident Outcomes

- All potential risk factors related to falls will be identified and appropriate interventions will be implemented.
- Patients will experience a decreased risk of falls and fall related injuries.
- Each patient's care plan will reflect fall risk factors and interventions to reduce the risk of falling.
- Each patient's functional level will be maintained and their number of falls will be reduced or eliminated.
- Each patient/caregiver will be well informed about their risk of falls and how to reduce their risk factors as appropriate.

Related Documents/Resources

- Safe Patient Handling Standard *(Formerly No Manual Lift Policy)*
- Musculoskeletal Injury Prevention Standard
- Least Restraint Clinical Practice Document: Vancouver Acute

Forms:

- Falls Risk Assessment & Care Plan (VCH.0267)
- Morse Fall Risk Assessment & Care Plan (VCH.0571)
- Acute Care Post-Fall Algorithm Tracking (VCH.0274)
- Falls Prevention Monthly Chart Audit Tool for Acute Care (VCH.0278)
- Falls Prevention Monthly Audit Feedback notepad – great job (VCH.0281)
- Falls Prevention Monthly Audit Feedback notepad – missing information (VCH.0282)
- Falls Prevention Monthly Audit Results Chart (VCH.0285)
- Fall Prevention Icon – 8,.5 x 11 (VCH.0270)
- Fall Prevention Icon label for spine of chart (VCH.0273)
- VA Mental Health Falls Risk Review (VCH.VA.0088)
- VA Patient Care Flowsheet (VCH.VA.0041)
- VGH Special Care Nursing Assessment Record (VCH.VA.VGH.0479)
- VGH STAT Centre Interdisciplinary Flowsheet (VCH.VA.VGH.0061)
- VA Falls Prevention Program Clinician Workflow & Responsibilities poster (VCH.VA.0083)
- VA Falls Improvement Lane – True North Goal – form 1 in set VCH.VA.0074 (VCH.VA.0079)
- VA Falls Improvement Lane – Daily Tracking Chart – form 2 in set VCH.VA.0074 (VCH.VA.0080)
- VA Falls Improvement Lane – Falls Reasons Chart – form 3 in set VCH.VA.0074 (VCH.VA.0081)
- VA Falls Improvement Lane – Action Communications Chart – form 4 of set VCH.VA.0074 (VCH.VA.0082)

Patient Health Education Materials: (To order copies, go to Patient Health Education Materials website)

- Stay on your Feet booklet (Catalogue # BE.250.5798)
- Stay On Your Feet: Parkinson's (Catalogue # FM.495.S73)
- SAFE Pre-Transfer Checklist (badge card) (Catalogue # BD.800.S241)
- SAFE Questions (poster) (Catalogue # BE.250.S24)
- Stay on your Feet (brochure) (Catalogue # BE.250.S73)
- What to do if you Fall (Catalogue # EB.470.G48)
- Stay on your Feet: Exercises (Catalogue # EB.470.G48)

Other Resources:

- Safer Healthcare Now! Reducing Falls and Injuries from Falls
- AGS Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2012)
- The Activities-specific Balance Confidence (ABC) Scale
- **Need Help Stat: Falls.** Available at: Consult GeriRN.org. Hartford Institute for GeriatriHartc Nursing.
- **Senior Friendly Hospitals - Fall Resources:** Available at: Ontario Senior Friendly Hospitals website

References

See References

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http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf July 28th (had different scoring)

https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html July 28th, 2017 (created the Morse into a word document from this site)

From https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html

One other version:
http://www.primaris.org/sites/default/files/resources/Restraints%20and%20Falls/falls_morse%20fall%20scale%20final.pdf

Sample learning pack for electronic documentation.

https://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/Morse_Fall_Scale-all.doc

Pocket/badge card

https://www.patientsafety.va.gov/docs/fallsToolkit/morse_falls_pocket_card.pdf

Adapted from: Partners HealthCare System Fall Prevention Task Force. (n.d.) The Morse Fall Scale Training Module. Retrieved June 7, 2017 from:
http://www.brighamandwomens.org/Medical_Professionals/nursing/nursinged/Medical/FALLS/Fall%20TIPS%20Toolkit_MFS%20Training%20Module.pdf

Appendix A: Pre-Transfer Checklist

Appendix B: Drugs and the Risk of Falling

Medications and the Risk of Falling

Which drugs can increase the risk of falls?

In theory ANY drug that causes one of the following effects can increase the risk of falling:

- Drowsiness
- Dizziness
- Hypotension
- Parkinsonian effects
- Ataxia/gait disturbance
- Vision disturbance

As well, theoretically ANY drug that causes the following effects can increase the risk of a serious outcome if an individual falls:

- Osteoporosis or reduced bone mineral density: Increased risk of fracture if a fall occurs
- Bleeding risk: Increased risk of a cerebral hemorrhage if a fall occurs

What can be done if you are taking a drug that can increase the falls risk?

Individualize treatment. Drugs are just one of many factors that can increase the risk of falling.

Assessment: Are you at high risk?

- ☐ **Have you had a slip, trip, near fall or fall in the last 6 months?**
- ☐ Are you **taking a drug that can cause the effects listed above** (see attached list of drugs)
- ☐ Are you taking a **high dose of the drug?**
- ☐ Are you **displaying any of the adverse effects listed above**, such as drowsiness?
- ☐ Are you over the age of 65? Elderly patients may be more sensitive to adverse drug effects because of alterations in the way that the body absorbs, distributes or eliminates the drug.
- ☐ Are you **taking more than one drug that increases the falls risk**?
- ☐ Are you at **high risk of falling for other, non-drug reasons**?
- ☐ Is it **difficult for you or your doctor to monitor** for an adverse drug effect?

Consider intervention, especially if you have assessed the patient as high risk:

- Consider risk/benefit ratio: Does the benefit of the drug outweigh a possible risk of falling?
- Is there a safer drug or non-drug alternative?
- Is it possible to minimize the dose without losing the benefit of the drug?

Medications and the Risk of Falling

Examples of drugs that can increase the risk of falling, or of a serious outcome if a fall occurs (and possible mechanisms)

ACE Inhibitors (3)
Benazepril
Captopril
Cilazapril
Enalapril/enalaprilat
Fosinopril
Lisinopril
Perindopril
Quinapril
Ramipril
Trandolapril

Alcohol (1,5)

Alpha Receptor Blockers (2,3, especially initial doses)
Alfuzosin
Doxazosin
Prazosin
Tamsulosin
Terazosin

Anticoagulants (8)
Dalteparin
Danaparoid
Enoxaparin
Heparin
Nadroparin
Nicoumalone
Tinzaparin
Warfarin

Anticonvulsants (1,2,5,6,7)
Carbamazepine (1,2,6)
Ethosuximide (1,2,5)
Fosphenytoin (1,2,5,7)
Gabapentin (1,2,5,6)
Lamotrigine (1,2,6)
Levetiracetam (1,2,5)
Methsuximide (1,2,5)
Oxcarbazepine (1,2,5,6)
Phenobarbital (1,2)
Phenytoin (1,2,5,7)
Primidone (1,2)
Topiramate (1,2)
Valproic acid (1,2,5)
Vigabatrin (1,2)

Antidepressants (1,2,3,6)
Amitriptyine
Bupropion
Citalopram
Clomipramine
Desipramine
Doxepin
Escitalopram
Fluoxetine
Fluvoxamine
Imipramine
Maprotiline
Mirtazapine
Moclobemide
Nortriptyline
Paroxetine
Phenelzine 1,2,3
Sertraline
Tranylcypromine 2,3
Trazodone
Trimipramine
Venlafaxine

Antihistamines, sedating (1)
Cold Medications that contain sedating antihistamines (1)
Azatadine
Brompheniramine
Cetirizine
Chlorpheniramine
Clemastine
Cyproheptadine
Diphenhydramine
Hydroxyzine
Meclizine
Promethazine
Trimeprazine

Antipsychotics (1,3,4)
Chlorpromazine
Clozapine
Flupenthixol
Fluphenazine
Haloperidol
Loxapine
Methotrimeprazine
Olanzapine
Paliperidone
Perphenazine
Pimozide
Pipotiazine
Prochlorperazine
Quetiapine
Risperidone
Thioproperazine
Thiothixene
Trifluoperazine
Zuclopenthixol

Corticosteroids, oral (7)
Corticosteroids, inhaled, high-dose (7)
Beclomethasone
Betamethasone
Budesonide
Cortisone
Dexamethasone
Fludrocortisone
Fluticasone
Hydrocortisone
Methylprednisolone
Prednisolone
Prednisone
Triamcinolone

Digoxin (mechanism unknown)

Eye drops (6)

Herbal and Natural health products
Natural sleep aids
Natural products for sexual enhancement (possible adulteration with undeclared drugs)

Metoclopramide (1,2,4)

Muscle Relaxants (1,2)
Baclofen
Carisoprodol
Chlorzoxazone
Cyclobenzaprine
Dantrolene
Methocarbamol
Orphenadrine
Tizanidine

Nitrates (2,3)
Isosorbide dinitrate
Isosorbide mononitrate
Nitroglycerin

NSAIDs
ASA/acetylsalicylic acid (8)

Opiates/narcotics (1,2,3)
Alfentanil
Butorphanol
Codeine
Fentanyl
Hydromorphone
Meperidine
Methadone
Morphine
Oxycodone
Oxymorphone
Nalbuphine
Pentazocine
Propoxyphene
Sufentanil

Proton Pump Inhibitors (9)
Esomeprazole
Lansoprazole
Omeprazole
Pantoprazole
Rabeprazole

Sedative/ hypnotics
Benzodiazepines
Barbiturates (1,2,5)
Alprazolam
Bromazepam
Chloral hydrate
Clorazepate
Diazepam
Diphenhydramine
Doxylamine
Flurazepam
Lorazepam
Midazolam
Nitrazepam
Oxazepam
Pentobarbital
Phenobarbital
Temazepam
Triazolam
Zopiclone

Thiazolidinediones (7)
Pioglitazone
Rosiglit

Possible mechanisms (often unclear): (1) Drowsiness; (2) Dizziness; (3) Hypotension; (4) Parkinsonian effects; (5) Ataxia/gait disturbance; (6) Vision disturbance; (7) Osteoporosis or reduced bone mineral density increases the fracture risk if a fall occurs; (8) Risk of serious bleeding if a fall occurs. Drugs are listed by generic (chemical) name under each drug group. For Brand (manufacturer's) names, check in the CPS to find the generic name. This list includes only those drugs for which there is evidence of increased risk of falls or their consequences. There may be other drugs that increase this risk in certain patients.

Barbara Cadario and BC Falls and Injury Prevention Coalition. Drugs and the Risk of Falling: Guidance Document. Revised August 2011.

Appendix C: Modified STRATIFY – St. Thomas Risk Assessment Tool (CAMP-V)

St. Thomas's risk of assessment tool is used to identify clinical fall risk factors in the elderly and to predict the chance that they will have a fall. A risk assessment score (range 0 – 5) is derived by rating 1 for presence or 0 for absence of 5 fall risk factors. The transfer and mobility score section has been modified from its original form to make the tool faster and easier to administer by front-line staff. All patients will be screened for fall risk within 24 hours of admission/transfers, and with a change in health status by using the modified STRATIFY also known as **CAMP-V**, fall risk screening tool:

1. Cognition impaired? Is the patient agitated, confused, or disoriented? e.g. Consider history of dementia, delirium, lack of insight and judgment	No = 0 Yes = 1
2. Altered elimination? Does the patient require frequent toileting? e.g. urgency, frequency, incontinence	No = 0 Yes = 1
3. Mobility impaired? Does the patient ambulate or transfer with an assistive device or assist? Or does the patient ambulate with an unsteady gait or no assistance?	No = 0 Yes = 1
4. Previous fall? Did the patient fall in the last 90 days?	No = 0 Yes = 1
5. Vision impaired? Is the patient visually impaired to the extent that everyday function is affected? e.g. blurred vision, impaired peripheral vision. Consider history of glaucoma, cataracts, macular degeneration	No = 0 Yes = 1
*****Medications can affect each of these factors. Consider this when completing this fall risk screen.** **Total:**	**/5**

Risk Level	Score	Action
Low/ Moderate Risk	0 - 1	Universal / Standard Fall Precautions
High Risk	2 or more	Complete Multifactorial Risk Assessment and develop individualized fall prevention care plan

If the patient scores 2 or more on the modified STRATIFY, or **CAMP-V**, fall risk screening tool:

- complete Multifactorial Risk Assessment
- develop and initiate fall prevention care plan, and
- initiate **Fall Risk Alert**:
  - Enter Fall Risk on the Patient Risk Profile Alert Form (Form #M-17C) (site specific practices),
  - Place a Fall Risk Alert icon sticker (Appendix J) on the spine of the Health Record and in the Kardex
  - Choose one or more of the following options:
    - Place a Fall Risk Alert icon (Appendix J) close to the patient and/or bedside in a clearly visible location.
    - Place a large 8.5x11 laminated Fall Risk Alert Icon sign at the entrance to the Inpatient Unit.
    - Place a generic sign at the entrance to the Inpatient Unit stating that all Staff and Visitors Must Report to the Nursing Station.

  ***It is the responsibility of the individual Inpatient Unit to educate all staff and volunteers working on, or visiting the Inpatient Unit as to which of these visual tools are in use.

Appendix D: Routine Fall Prevention Practices

Appendix E: Behaviour Assessment Log (sample)

PCIS Label

BEHAVIOR ASSESSMENT LOG

INSTRUCTIONS: Please check (✔) the time when and location where each behavior(s) occurred.
Location Key: **PR**: Patient's Room **BR**: Bathroom **H**: Hallway **O**: Other (state)

TYPE OF VERBAL &/OR DISRUPTIVE BEHAVIOR	DATE									
	TIME									
	Calling Out									
	Crying									
	Screaming									
	Banging									
	Verbal Abuse Swearing									
	Trying to Leave									
	Other (state)									
TYPE OF AGGRESSIVE &/OR RESISTIVE BEHAVIOR	Striking									
	Punching									
	Grabbing									
	Pushing Away									
	Slapping									
	Biting									
	Resists care									
	Other (state)									
PERSON(S) AFFECTED	Staff									
	Other Patient									
	Visitor/Family									
LOCATION	(See Key)									
RELATED FACTORS	Personal Care									
	Transfers									
	Taking VS, Tests									
	When Alone									
	With Others									
	Other (state)									
INITIALS										

M. Shaw, 2010R

Appendix F: Sleep & Agitation Log (sample)

PCIS Label

SLEEP & AGITATION RECORD

Instructions: Each hour, check (✔) the appropriate box.

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Date:																								
Agitated																								
Calm																								
Asleep																								
Date:																								
Agitated																								
Calm																								
Asleep																								
Date:																								
Agitated																								
Calm																								
Asleep																								
Date:																								
Agitated																								
Calm																								
Asleep																								

Appendix G: Post Fall Algorithm Communication & Documentation Guidelines

DO NOT MOVE THE PATIENT

Prior to Transfer into Bed/Chair Determine Severity of Injury:

- Call for assistance.
- Assess level of consciousness (LOC), airway, breathing, and circulation.
- Complete quick head-to-toe assessment for injuries, including pain, fractures and bleeding.
- Assess VS (BP, HR, RR, O_2 sat) and NVS.
- Activate appropriate emergency response team* (ERT), as required for serious injury.**

If neck pain or weakness, numbness and/or tingling in limbs present:

- ➔ Manually immobilize the head/neck in the position patient was found
- ➔ **Notify the most responsible physician (MRP) / NP immediately.**
- ➔ Call emergency response team*, as required.**
- ➔ **Do not move the patient** until directed as safe to be moved by MRP/NP and/or ERT.

Falls & Hits Head / Unwitnessed Fall:	**Falls & Does Not Hit Head / Witnessed Fall:**
• Nurse to assess VS / neurovitals ➔ q30min x 2 times, then ➔ q1h x 4 times, then ➔ q4h x 8 times & PRN. • Observe for change in LOC, headache, amnesia or vomiting	• Nurse to assess VS ➔ q1h x 2 times, then ➔ q4h x 6 times & PRN

Patient may require more frequent assessment –
Be responsive and inform MRP/NP of changes from baseline

1. **Suspected Limb / Neurovascular Injury**
   - Assess CWMS q2h until assessed by MRP/NP
   - Assess limb function/weakness, external rotation of legs or difference in leg length
2. **Soft Tissue Injuries / Pain / Mobility Impairment**
   - Assess q12h x 48 hrs (minimum)
   - Assess for bruising, lacerations, swelling, pain and mobility impairment

- **Notify:** Charge Nurse. MRP/NP; family/SDM **
- **Document**: Fall, assessments, interventions, notifications**; SLS report
- **Revise**: Fall prevention care plan

* **Emergency Response Team (ERT):** e.g. Code Blue, Nursing Assessment Response (NAR) team or 911

**Site specific Practices

Appendix G: Post Fall Algorithm Communication & Documentation Guideline

POST FALL PATIENT CARE

1. **Immediate Post Fall Care**
   Prior to moving the patient, complete a head-to-toe assessment in the position the patient was found starting with airway, breathing, circulation and level of consciousness to identify location and severity of injury.
2. **If injury is serious**
   - *RN to inform most responsible physician (MRP) or nurse practitioner (NP) immediately.*
   - Call emergency response team (e.g. Code Blue, Nursing Assessment Response team or 911), as required.**
   - If a head/neck injury is suspected, do not move the patient, instead immobilize head/neck and call MRP/NP and/or emergency response team for direction.
   - Monitor patient as per algorithm (e.g. vital signs, neurological vital signs, and CWMS - color, warmth, movement, and sensation - of injured limb or body area).

COMMUNICATION POST FALL (WITH/WITHOUT INJURY)

1. **Calling the MRP/NP**

   ➢ **Fall with Injury**
   - RN to inform MRP/NP immediately
   - Use SBAR to report.
   - State whether fall was witnessed / unwitnessed.
   - Describe injury & location(s).
   - Liaise for appropriate care (e.g. diagnostics, consults, exams).
   - Plan for anticoagulation/antiplatelets.

   Special Consideration:
   Patients on anticoagulants and/or anti-platelets and/or with a known disorder where blood is too slow to clot (coagulopathy). Alcoholic patients are coagulopathic.

   ➢ **Fall without Injury**
   - Notify MRP/NP at end of shift or within 24 hours or as per site specific practices.**

2. **Calling the Family / Substitute Decision Maker (SDM)**

   ➢ **Fall with Injury**
   - Discuss notification of family/SDM with MRP/NP.
   - After discussion with MRP/NP, RN must notify the family/SDM immediately.
   - Document notification and response in progress notes**

   ➢ **Fall without Injury**
   - Nurse may inform the family.
   - Falls between 0800 and 2200, inform family/SDM immediately.
   - Falls after 2200, notify family/SDM in morning or as per site policy.
   - Document notification and response in progress notes**

** SITE SPECIFIC PRACTICES

DOCUMENTATION AND FOLLOW UP

- Document communication with MRP/NP and family/SDM as appropriate.
- Complete a fall incident report (in SLS or per site practices).
- Notify Charge Nurse and Interdisciplinary team.
- Document a description of the fall, assessments & new interventions.
- Revise post fall plan of care (see CPD for details).

** **Site specific Practices**

Appendix H: Keeping SAFE Questions

Appendix I: Fall Risk Factors and Fall Prevention Strategies & Interventions

	Fall Risk Factors	Fall Prevention Strategies & Interventions
C	**Cognitive Status** • Agitation, aggression, pacing, impulsiveness, anxiety • Delirium, dementia, psychosis, neurological/brain injury • Developmental delay • Lack of insight and safety awareness	• Familiarize patient to surroundings. For example, the location of washroom, kitchen, and telephone. • If appropriate, move patient closer to nursing desk or suggest 1:1 • Implement treatment plans for recent changes in cognition (i.e. delirium due to infection, dehydration, brain injury) • Provide visual and verbal cues, and consistent daily routine • Keep information/directions simple. Check for understanding and repeat as needed. • Anticipate and minimize behavioral triggers to reduce fall risk • Initiate a Behavior Log (Appendix E) and/or Sleep and Agitation Log (Appendix F) to track impulsiveness and risk taking behaviors leading to fall risk as appropriate. • Use and activate bed and/or chair alarm as needed ★ Ensure bottom bed rails are down • See Bed Height in Functional Mobility below ★ Use Keeping Safe Questions (Appendix H) to increase supervision
A	**Bowel / Bladder** • Altered elimination, urgency, frequency, rushing to the toilet	• Establish an individualized toileting plan • Review medications that cause urgency (i.e. diuretics and laxatives) • Implement strategies for urinary continence such as: ○ Fluid management; timed voiding schedule • Provide equipment to support safe toileting (i.e. commode/urinal, night light, loose clothing). Encourage patient to use toilet over bedpan whenever possible. ★ Identify a safe clutter-free pathway to access bathroom • Provide appropriate assistance for toileting, especially at night ★ Use Keeping Safe Questions (Appendix H) to increase supervision
M	**Functional Mobility** • Gait, balance, mobility, transfer • Lower extremity muscle strength and joint function, ability to use mobility aid (cane/walker) and wheelchair safety • New assistive aids (i.e. walker, cane, crutches, brace), and/or change in weight bearing status • Activities of daily living including toileting and bathing • Identify specific mobility/ turning approaches	• Monitor gait, balance, mobility and transfers (e.g. Pre-Transfer Checklist Appendix A) • Assist transfers to/from bed/wheelchair/toilet/commode • Ensure bed/chair brakes are on for transfers • Ensure mobility aid (cane, walker, wheelchair) is appropriate and accessible • Encourage ambulation and/or exercises unless contraindicated. Provide supervision / assistance as needed. • Provide adaptive equipment such as a shoe horn or reaching aid. • Ensure slippers or shoes fit well and are non-slip; try non-slip socks if patient does not have their own appropriate footwear • Address foot problems as needed • Educate patient on proper use of equipment • Encourage patient to use toilet over bedpan whenever possible • **Bed Height:** For high risk, patients ensure bed is at lowest height. For independently mobile patients, leave beds at knee height or slightly above (i.e. 1'' to 2" above knee). • Use Keeping Safe Questions (Appendix H) to increase supervision
P	**Previous Fall / Fall History** • Recent falls, details of falls, fall-related injuries (fracture(s), hospitalizations, ED visits) • Ask: "Have you had a fall in the last 90 days?"	• Ensure that modifiable risk factors are used to create an individualized care plan ★ Use Keeping Safe Questions (Appendix H) to increase supervision
V	**Vision** • Altered ability to see: macular degeneration, glaucoma, cataracts • Wears glasses, or uses magnifying glasses or other visual aids • Ask: "Have you had your vision checked in the last 2 years?"	• Enhance environment: increase contrast, improve lighting, reduce glare, remove physical hazards and clutter, use night lights • Ensure eye glasses are clean • Ensure patient has appropriate eye wear when ambulating. (Bifocal / progressive lens can affect depth perception and increase risk of falls.) • Refer for vision screening, if available. • Upon discharge, recommend that the patient see optometrist if it has been more than 2 years since their last check up or if a problem has been identified. • Provide visual cues for the patient's room, toilet and bed

★ Interventions with a **'blue star'** are considered Standard Fall Precautions for all patients.

Appendix I: Fall Risk Factors and Fall Prevention Strategies & Interventions (cont'd)

Fall Risk Factors	Fall Prevention Strategies & Interventions
Medications • Medications that increase fall risk: ○ Psychotropics, sedatives, anticoagulants, antihypertensives, opioids, diuretics, laxatives etc • Potentially inappropriate medications • Anesthetics (spinal, general, peripheral nerve blocks) • Polypharmacy: taking 5 or more medications	• Assess medications known to increase fall risk and modify if possible (Appendix B & 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults) • Attempt to minimize total amount of medication (i.e. reduce polypharmacy) • Use the lowest effective dose. • Consider non-pharmacological strategies to improve sleep rather than using sedatives. • Consider timing of high risk medication administration (i.e. laxatives, diuretics, hypnotics)
Communication • Language barrier • Cognition – e.g. aphasia, illiteracy • Sensory impairments – poor vision or hearing	• Reduce anxiety/frustration due to the inability to communicate • Identify language barriers/communication disorders that contribute to falls • Identify specific precautions needed to ensure safety (i.e. translated signs) • Educate patients about hazardous activities and ways to call for help • Use pictures, pantomime, picture boards to communicate • For those with short term memory impairment: keep information / directions simple. Check for understanding and repeat as needed.
Environmental Barriers / Patient Care Equipment • Lack of lighting including night lights • Bed rails • Lack of footwear/directional signage • Tripping hazards: Lines, tubes, drains, clutter • Monitor patient's environment for safety hazards during all activities.	★ Ensure the patient's room is free of obstacles and clutter ★ Assess environment for tubes, lines, furniture, equipment that pose hazards to safe mobilization ★ Use high/low beds ★ Use well fitting shoes with an enclosed heel or non-slip socks ★ Ensure bed is in low position except when giving care ★ Place bottom bed rails down ★ Place personal items, mobility/reaching aid and call bell within reach ★ Educate patient on use of call bell. ★ Use Keeping Safe Questions (Appendix H) to increase supervision
Fear of Falling • Expressed fear of falling that compromises recovery	• Identify impact of fears on participating in daily activities. ★ Encourage safe physical activity whenever possible • Collaborate with patient and family to address fears ★ Use Keeping Safe Questions (Appendix H) to increase supervision
Health / Physical Status • Heart rate and rhythm; oxygenation • Postural pulse and blood pressure: lying, sitting, standing • Underlying and/or exacerbation of chronic illness(es) (e.g. diabetes, angina, COPD) • Neurological (e.g. Parkinson's, multiple sclerosis, cerebral palsy CVA, history of seizure disorder) • Muscle weakness, decreased co-ordination • Poor proprioception (position of body parts) • Foot problems (e.g. deformities, calluses, ingrown nails)	★ After a period of bed-rest, encourage patient to sit for a few minutes prior to standing • If patient is dizzy or lightheaded consider checking blood pressure (lying, sitting and standing) and/or blood work • If systolic drops more than 20 mmHg from sitting to standing or lying to sitting (postural hypotension), notify NP/MD. • Monitor and manage chronic conditions, gait disorders, weakness, and dizziness, etc. • Consider recommending hip protectors, especially for those with osteoporosis
Nutrition / Hydration • Recent weight loss • History of poor or sub-optimal intake • History of poor fluid intake • History of osteoporosis	• Consult dietitian if patient is underweight or if intake is less than 75% for 3 consecutive meals • Ensure proper diet to meet nutritional needs is provided; consider supplementation with calcium and Vitamin D if necessary • Offer a minimum 1500 mL of fluids per day unless contraindicated
Pain • Musculoskeletal/neurological conditions (i.e., diabetic neuropathy) that produce pain and limit mobility • Pain interfering with ADLs • Unidentified sources/symptoms of pain • Neurological conditions that limit ability to express pain	• Ensure patients with musculoskeletal/neurological conditions that produce pain receive a multifactorial pain assessment and treatment plan. • For nonverbal cognitively impaired: use behavioral indicators to identify pain • Use appropriate pain scale to assess pain levels before/after activity • Administer analgesics as needed to relieve pain. Consider regular dosing. • Provide PRN analgesic prior to mobilization. Reassess effectiveness.
Substance Use • Intoxication and withdrawal from alcohol, nicotine, and drugs	• Ongoing assessment and management of intoxication and/or withdrawal symptoms from alcohol and/or substance use • Monitor for drowsiness, dizziness and impaired balance/gait/judgment • Provide resources and support to reduce or stop use

Appendix J: Fall Risk Alert Icon/Visual identifier

The Fall Risk Alert Icon is available in 3 sizes:

1. 1.25 inches by 1.75 inches – sticker
   - This is the size used for the spine of the Health Record and the Kardex
2. 3 inches by 1.75 inches - sticker
   - This size can be used outside of patient rooms, at the bedside or to mark equipment
3. 8.5 inches by 11 inches – letter size paper
   - This size can be printed off and laminated to be used at the entrance to the inpatient unit, outside of patient rooms or at the bedside.

Appendix K: Morse Fall Scale

The Morse Fall Scale is an internationally recognized tool for falls risk assessment, shown to have predictive validity and interrater reliability. It assesses six areas of falls risk: history of falling, secondary diagnosis, ambulatory aid, IV therapy/Heparin (Saline) lock, gait, and mental status. This tool indicates the likelihood of a patient falling.

A score equal to 45 or higher indicates the patient is at risk and all patients who are at risk for falls will receive a **Multifactorial Fall Risk Assessment** to identify their individual fall risk factors.

A Morse Fall Scale is to be completed:

- within 24 hours of admission/transfer
- when there is a change in health status
- reviewed each shift and/or
- after a fall

How to Use:

Tab	Score	Documentation and Definitions
History of falling in last 3 months	0	No history of falling.
	25	Fallen during current hospital admission. Immediate history of falls within the past 3 months.
Type of fall	NA	*Anticipated physiological* - falls occur with patients identified as at risk for falls on the MFS.
	NA	*Unanticipated physiological* - falls that may be attributed to physiological causes that cannot be predicted before the first fall event. This type of fall is not predicted using MFS. e.g. seizure, drop attack, fainting
	NA	*Accidental* - falls caused by environmental hazards or errors in judgement regarding the environment. This type of fall is not predicted using MFS. These falls are not due to physical factors e.g. wet floor, IV pole, bed left in high position, patient tries to use furniture for support but it rolls away
Activity at Time of Fall	N/A	Options: ambulating, bathing, dressing/undressing/fall from (arms, bed, chair, commode, play device, rehab therapy device, stretcher/exam table), transferring, undergoing diagnostic procedure, and unknown.
Secondary diagnosis	0	One Active Medical Diagnosis
	15	More than one active medical diagnosis for current admission.
Use of Ambulatory Aids	0	Requires no walking aid. On bed rest Does not get up at all
	15	Uses crutches or walker
	30	Walks holding onto furniture for support. Non-compliant with bed rest order. Unsteady, but has no awareness/insight or denies help.
IV or IV Lock	0	No IV. Not attached to equipment. (i.e. Feeding tube, monitor devices.)
	20	Has IV, attached to equipment (i.e. Foley, suction.)
Gait	0	**Normal Gait:** Walks with head erect. Arms swinging freely at the side. Striding without hesitation.
	10	**Weak Gait:** Stooped, but able to life head without losing balance. If furniture required, uses as a guide. Short steps, may shuffle.
	20	**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. If uses wheelchair: score according to gait used at transfer.
Mental Status	0	**Oriented to own ability**
	15	**Forgets limitations**

Total score: Out of 125 (score is automatically tallied in Cerner.)

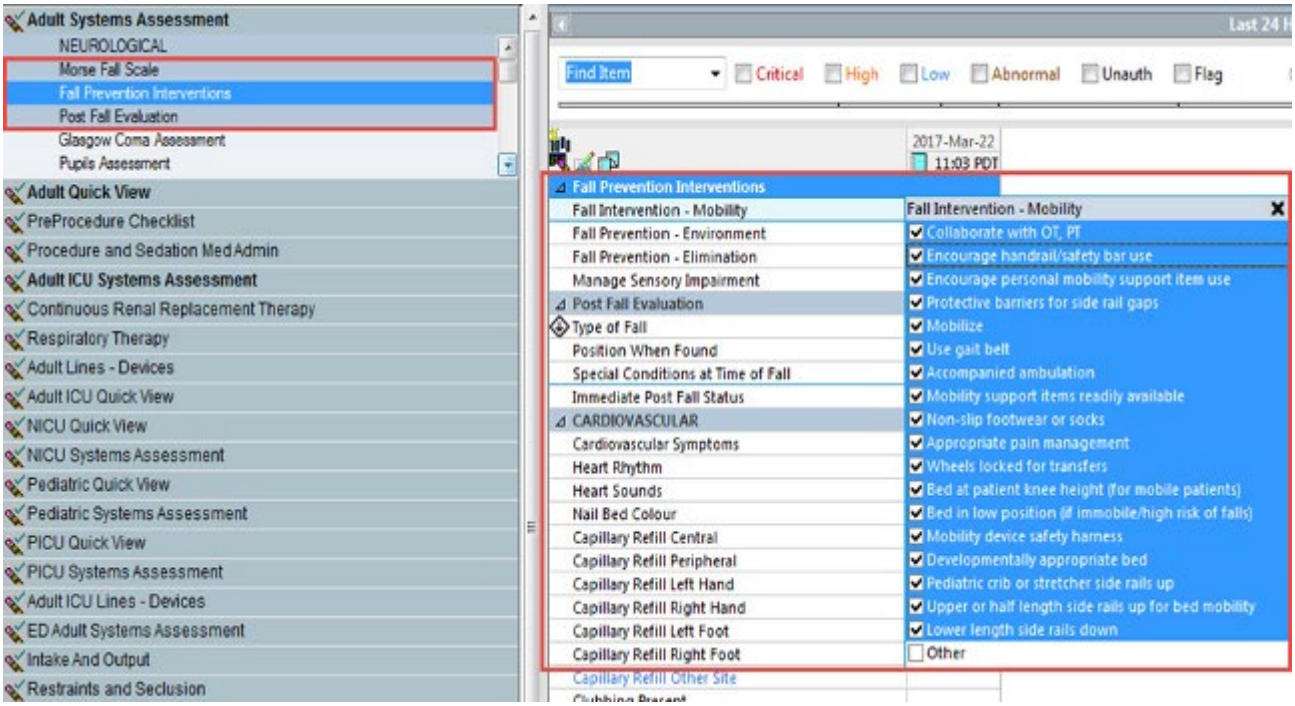
Interpretation of Morse Fall Score:

Score	Rating	Action
0-44	Low/Medium Risk	Universal fall precautions (B.1, Appendix D)
Equal to 45 and higher	High Risk	Complete multifactorial risk assessment (A.2) and develop individualized fall care plan available in the print shop VCH.0571

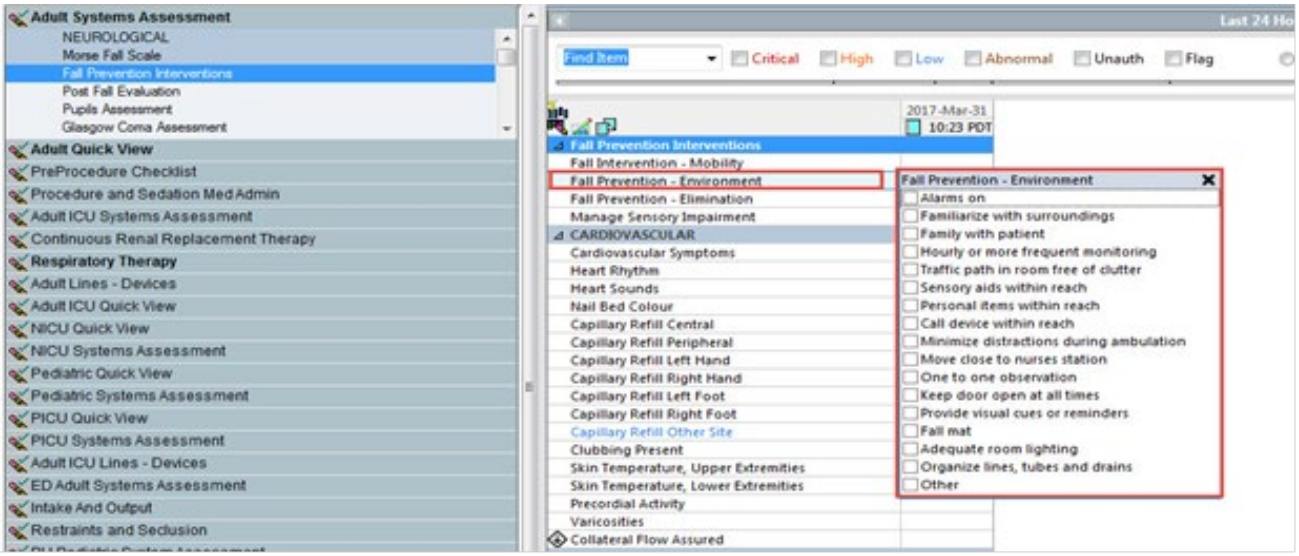
Fall Prevention Interventions:

For Cerner sites, you will find fall prevention interventions under the four categories

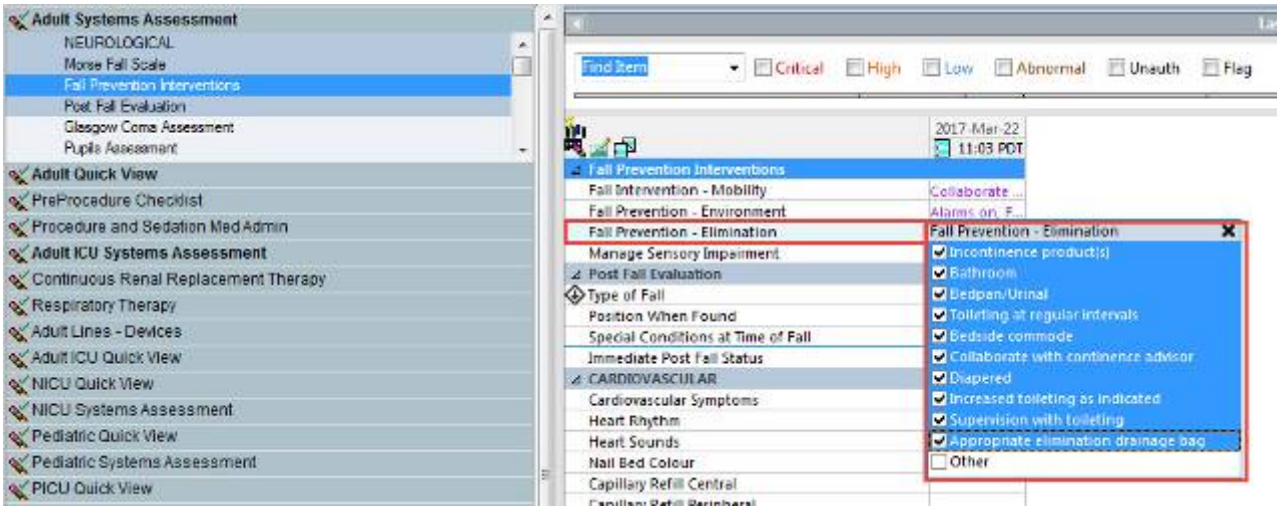
1. Fall Intervention-Mobility
   Choose all interventions that are applicable for the patient/client.



2. Fall Prevention-Environment
   Choose all interventions that are applicable for the patient/client.



3. Fall Prevention-Elimination
   Choose all interventions that are applicable for the patient/client.



4. Fall Intervention: manage sensory impairment
   Choose all interventions that are applicable for the patient/client.