	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Kod Dokumen: HSAAS/NURS/BR124**	**Patient's sticker**
	MORSE FALL SCALE	

DIAGNOSIS:	**AGE:**	**DATE OF ADMISSION:**

ITEMS									
	DATE								
	TIME								
	SCALE								
1. History of falling ; immediate/ within 3 months	Yes = 25 No = 0								
2. Secondary Diagnosis	Yes = 15 No = 0								
3. Ambulatory aid	None, bed rest, wheel chair, nurse/carer = 0 Crutches, cane, walker = 15 Furniture = 30								
4. IV/Heparin Lock	Yes = 20 No = 0								
5. Gait/Transferring	Normal,bed rest, immobile =0 Weak = 10 Impaired =20								
6. Mental Status	Oriented to own ability = 0 Forgets limitations = 15								
	TOTAL SCORE								
	Name of Assessor								

Risk Level	**MFS Score**	**Signages Coding**	**Falls Prevention Protocol**
Low Risk	0-24	WHITE △	Standard
Moderate Risk	25- 45	YELLOW ▲	Standard + Moderate
High Risk	>45	RED ▲	Standard + Moderate +High

Patient assessment **MUST** be done **DAILY** and during :
1.Patient Fall
2.Change in clinical condition
3.Transfer to another unit/ward

Notes : If a patient aged 65 years old and above or based on your clinical judgment, you choose for further cognitive assessment, please use 4AT Delirium Rapid Assessment to identify any acute change in mental status.

1) **History of falling:**
   If the patient has fallen during the present admission or there was an immediate history of physiological falls, such as syncope or impaired gait within the past 3 months, **score 25**. If the patient has not fallen, **score 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.**

2) **Secondary Diagnosis:**
   If the patient has more than one medical diagnosis and is active for current admission, **score 15**; if only 1 active medical diagnosis or if not, **score 0**.

3) **Ambulatory Aids:**
   If a patient is clutching on the furniture for support**, score 30.** If the patient uses crutches, cane or walker, **score 15.** If the patient walks without walking aid or uses a wheelchair or is bed rest and does not get up at all, **score 0.**

4) **Intravenous Therapy/ IV devices:**
   If a patient has intravenous therapy attached to an equipment or IV devices inserted**, score 20;** if none **score 0.**

5) **Gait/Transferring:**
   If patient had an impaired gait; has difficulty rising from a chair, uses the arms of the chair to push off, head is down, eyes focus on the floor, uses moderate to heavy assistance for balance through use of furniture, persons or walking aids and steps are short or shuffled, **score 20**. If a patient walks with a weak gait; patient is stooped; unable to lift head without losing balance or support is required with limited assistance and steps are short and shuffled**, score 10.** If the patient walks with a normal gait, **score 0.** A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant.

6) **Mental Status**
   Identifying the patient's self assessment of his/her ability to walk. Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?" If the patient's answer overestimates his/her physical ability and is not consistent with the aboved assessment ,**score 15.** If the patient's assessment is consistent with his/her ability, **score 0.**

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Instruction: Tick √ for appropriate intervention task	
1.	**STANDARD RISK PROTOCOL (PATIENT EDUCATIONS)**
	Orient the patient to surroundings including bathroom, use of bed and call bell.
	Explain fall risk to patient /family/ carer *(Fall informations form)*
	Encourage patients and family to call for assistance- Do not leave patients unattended and nurses should be informed by relatives before leaving.
	Ensure call bell is functioning and keep call bell within patient's reach and answer promptly
	Keep frequently needed personal items within easy reach (drink, toiletries, telephone)
	Ensure bed rails are raised and keep bed at lowest positions
	Secure lock on bed. Wheel, stretchers and wheelchair.
	Keep floor and surroundings free from clutter and obstacles and clean all spills immediately
	Ensure adequate lighting and address sensory impairments (hearing aids, reading glasses)
	Advice patient to use proper non-slip footwear
	Tagged patient risk with Fall signages accordingly
	Safety and Comfort round every 4 hours-(**5 Bundle of FITS**)
	Fall Prevention Brochure given to patient/carer/family
2.	**MODERATE RISK PROTOCOL**
	All actions in Standard protocol.
	To remain with the patient while toileting.
	Supervise and assist bedside sitting, personal hygiene and toileting.(**use commode if necessary**)
	Transportation/transfer/ambulation of patient **MUST** be supervised by staff/trained carer Ensure walking aids are available in the ward to be used when appropriate
	Teach patient to use assistive device /grab bars, walking aids)
3.	**HIGH RISK PROTOCOL**
	All actions in standard and moderate protocol
	Evaluate the needs for the following starting with the least restrictive to the most restrictive measure in the following: i. Identify delirium and discuss with doctors on appropriate management ii. Move patient near to nurse's station (if required) iii. Encourage family/carer to stay with patient in the hospital iv. Restrain (Pharmacology/physical) if other methods are not successful,with consent from next of kin *to consult/discuss with doctor regarding pharmacology restraint-**REMIND DOCTOR FOR MEDICATION REVIEW**
	Monitor Postural Hypotension and Initiate/teach **" ABC"** for postural hypotension if indicated (**A**- Drink a cup of plain water, **B**-Head of the bed raise up to 15 degree, **C**- Calf maneuver)-Refer physio/OT if indicated
	Nurses to remain in the cubicle with high risk patients- do not leave patients more than 30 minutes without replacement.