Place Patient Form Label Here

MORSE
FALL RISK ASSESSMENT & CARE PLAN

* 7 3 8 0 *

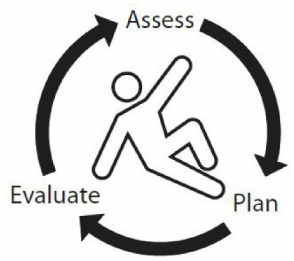
Interdisciplinary Care Plan

Morse Fall Scale: (circle score)

History of Falls (last 3 months)	No Yes	0 25
Secondary Diagnosis	No Yes	0 15
Ambulatory Aid	None/bed rest/lift/wheelchair Crutches/cane/walker Furniture	0 15 30
IV or IV lock (any lines/tubes)	No Yes	0 20
Gait	Normal/bed rest/immobile Weak Impaired	0 10 20
Mental Status	Oriented to own ability Forgets limitations	0 15
Morse Fall Score =		**/125**

Assessment on: (check one)

- ☐ Admission
- ☐ Transfer
- ☐ Significant Change in Status



If Morse Fall Score = 45 or more, patient is at high risk for falls, please complete the following:

	Detailed Fall Risk Assessment	Fall Prevention CARE PLAN
History of Fall in last 3 months	☐ Recent fall within 90 days?	☐ Increase supervision ☐ _____ ☐ _____
Secondary Diagnosis / Health Status	☐ Postural hypotension ☐ Exacerbation chronic illness ☐ Irregular heart rate/rhythm/oxygenation ☐ Muscle weakness/decreased coordination ☐ Poor proprioception ☐ Foot problems	☐ After period of bed-rest, patient needs to sit for a few minutes prior to standing ☐ Hip protectors needed ☐ If systolic drops more than 20mmHg from sitting to standing or lying to sitting, notify NP/MD ☐ _____
Gait / Functional Mobility / Ambulatory Aids	☐ Gait, balance, mobility, transfer impaired ☐ Lack of ability to use mobility aids &/or wheelchair safely ☐ Change in weight-bearing status &/or new assistive aids ☐ Requires assistance for toileting & bathing ☐ Lack of proper footwear	☐ Assistance for transfers to/from bed/wheelchair/toilet/commode ☐ Ensure bed/chair brakes are on for transfers ☐ Encourage ambulation with assistance/supervision ☐ Mobility aid needed & within reach ☐ Non-slip socks/well-fitting shoes with enclosed heel available ☐ Bed in lowest position ☐ Call bell within reach ☐ _____
IV or IV Lock/ Environmental Barriers	☐ Lack of lighting ☐ Tripping hazards (IV pole, clutter, lines, tubes)	☐ Personal items within reach ☐ Patient's room is free of obstacles & clutter ☐ Assess environment for tubes, lines, furniture, equipment hazardous to mobilization ☐ _____
Mental Status	☐ Agitation, aggression, pacing, anxiety ☐ Delirium, dementia, psychosis, ☐ Developmental delay ☐ Lack of insight &safety awareness ☐ Impulsiveness ☐ Neurological/brain injury	☐ Bottom bed rails are down ☐ Familiarize patient to surroundings ☐ Move patient closer to nursing station ☐ 1:1 supervision ☐ Bed/chair alarm ☐ _____ ☐ _____

See reverse

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MORSE
FALL RISK ASSESSMENT & CARE PLAN

7380

Interdisciplinary Care Plan

	Detailed Fall Risk Assessment	Fall Prevention CARE PLAN
Vision / Sensory Impairment	☐ Altered ability to see (macular degeneration, glaucoma, cataracts) ☐ Visually impaired to the extent that everyday function is affected ☐ Impaired hearing ☐ Uses hearing aids	☐ Remove clutter/physical hazards ☐ Patient has appropriate eyewear within reach ☐ Patient has hearing aids in, turned on and batteries are working ☐ _____
Bowel/Bladder	☐ Altered elimination, urgency, frequency, rushing to the toilet	☐ Individual Toileting schedule/plan in place ☐ Review medications that cause urgency ☐ Fluid management plan ☐ Clutter-free access to bathroom ☐ Assistance needed for toileting: ☐ Night ☐ Day ☐ Commode/urinal at bedside ☐ _____ ☐ _____
Communication	☐ Language barrier ☐ Sensory impairments - poor vision/ hearing	☐ Translator required: _____ ☐ Education on use of call-bell ☐ _____
Fear of falling	☐ Expressed fear of falling that compromises recovery	☐ Encourage safe physical activity as possible ☐ Collaborate with patient & family to address fears ☐ _____
Medications	☐ On medications that increase risk of falling (psychotropic, sedatives, anti-coagulants, antihypertensives, opioids, diuretics) ☐ Potentially inappropriate medication use	☐ Assess meds known to increase Fall risk & modify where possible ☐ Minimize total amount of medication ☐ Lowest effective dose used ☐ Non-pharmacological strategies to improve sleep ☐ Review timing of high-risk medication administration ☐ _____
Nutrition/Hydration	☐ Recent weight loss ☐ History of poor/sub-optimal intake ☐ Poor fluid intake ☐ History of osteoporosis	☐ Consult dietitian if patient is underweight or intake less than 75% for 3 consecutive meals ☐ Consultation with MD re: supplementation with calcium & vitamin D ☐ Offer minimum 1500 ml of fluids daily unless contraindicated ☐ _____
Pain	☐ Musculoskeletal/neurological condition(s) that produce pain & limit mobility (e.g., diabetic neuropathy) ☐ Pain interfering with ADLs ☐ Neurological conditions that limit ability to express pain	☐ Multifactorial pain assessment & treatment plan done ☐ Administer analgesics as needed to relieve pain & consider regular dosing ☐ Provide prn analgesic prior to mobilization & reassess ☐ _____
Substance Use	☐ Intoxication &/or withdrawal from alcohol, nicotine & drugs	☐ Monitor for drowsiness, dizziness & impaired balance/ gait/judgment ☐ _____

Date: _____ Signature: _____ Designation: _____