NURSING SERVICE GUIDELINES
INPATIENT BEHAVIORAL HEALTH

Guideline: **Fall prevention**

Policy Number Superseded:

Responsibility: All patient care personnel

Purpose of Guideline: To prevent patient falls using proactive interventions.

Equipment: Fall ID stickers, bed monitoring devices, patient mobility devices, nursing assessment-fall risk assessment section, Morse fall scale

Effective Date:
April 2026

Initial Effective Date:
May 2008

(A) General information.

A fall is defined as any unplanned descent to the floor, with or without injury (National Database of Nursing Quality Indicators [NDNQI], 2015). A fall may be either unassisted or assisted (where someone helps to 'break' the fall by helping the patient to the floor) and the NDNQI definition also includes falls where a patient lands on a surface where you would not expect to find the patient.

University of Toledo Medical Center's (UTMCs) fall injury level categories:

(1) None.
(2) Minor (dressing, ice, cleaning, or elevation).
(3) Moderate (suturing, splinting, or steri-strips/skin glue).
(4) Major* (surgery, casting, traction, or neuro consult).
(5) Death* (died as a result of injuries sustained from the fall).

* If a patient's fall has a major injury level or results in a death, the department manager or house supervisor and Quality Management need to be notified immediately.

(B) Tools used.

(1) The Morse Fall Scale: This tool is used to identify risk factors for falls in hospitalized patients. The total score may be used to predict future falls,

but it is more important to identify risk factors using the scale and then plan care to address those risk factors.

(2) Short Portable Mental Status Questionnaire: Patients found to have impaired mental activity as a risk factor for falls require further evaluation. The Short Portable Mental Status Questionnaire is designed to help determine if the patient has delirium.

(3) Applying Fall Risk Interventions:

Begin your patient assessment with the Morse Fall Scale (see attachment). The patient will automatically be deemed a high fall risk (see intervention chart) if any of these three red flags are noted:

(a) They score 70 or greater
(b) They have had a physiological fall in the past 90 days
(c) They score 15 on question #6 (they forget limitations and overestimate abilities)

If none of the above flags exist for your patient, proceed with assessing fall risk, using the other three tools, medication fall risk, short portable mental status questionnaire, and mobility zone. If the patient scores in the red zone on two or more of the four assessment tools the patient will be deemed a high fall risk and high fall risk interventions will be implemented. All other patients will have universal fall interventions implemented.

Tool #1: Morse Fall Scale.

The Morse Fall Scale uses six different patient risk factors that give an indication of the patient's probability of falling by assigning a numerical score. The total possible scoring on the scale is 125.

(1) History of falling: Scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiologic falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. If the patient falls for the first time in-house, it is scored as 25.

(2) Secondary diagnosis: Scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, scored as 0.

(3) Ambulatory aid: Scored as 0 if patient walks without a walking aid even if assisted by a nurse, uses a wheelchair, or is on bedrest and does not get out of bed. If the patient uses crutches, a cane, or a walker, this item scores 15; if patient ambulates clutching onto the furniture for support, score this item 30.

(4) IV therapy: Scored as 20 if the patient has an intravenous apparatus or a heparin/saline lock inserted; if not, score 0.

(5) Type of gait: If the patient is in a wheelchair, the patient is scored according to the gait he or she used when transferring from the wheelchair to the bed.

(a) Normal: Characterized by the patient walking with head erect, arms swinging freely at the side, and striding unhesitant. This gait scores 0.
(b) Weak: Characterized by the patient having a stooped gait but can lift the head while walking without losing balance. If support from furniture is required, steps are short, and patient may shuffle, this gait is scored as 10.
(c) Impaired: Characterized by the patient having difficulty rising from the chair, attempting to get up by pushing on the arms of the chair, and/or bouncing several attempts to rise. Also, the patient's head is down, they watch the ground while grasping onto furniture for support, utilize a walking aid for support, or they cannot walk without assistance. This gait is scored as 20.

(6) Mental status: Measured by checking the patient's own self-assessment of his or her own ability to ambulate. Ask the patient, "are you able to go to the bathroom alone or do you need assistance?" If the patient correctly judges his or her own ability to ambulate and this is consistent with the ambulatory orders in the EHR, the patient is rated as "normal" and scored 0. If the patient's response is not consistent with the mobility order or if the patient's assessment is unrealistic, then the patient is considered to overestimate his or her own ability and to be forgetful of limitations and scored as 15 (ahrq.gov; 2016).

Tool #2: Short Portable Mental Status Questionnaire.

(1) A proper evaluation for delirium requires both standardized testing and direct observation of the patient's behavior. Mental status will be assessed upon admission and daily with nursing assessments by performing the Short Portable Mental Status Questionnaire. This

information will then be used in conjunction with other tools to judge fall risk.

(2) This tool should be used with any patient whose mental status is unclear on admission, or transfers to another unit, or whose mental status has acutely declined.

(3) The tool will allow multidisciplinary staff to determine if a patient is delirious and therefore requires further medical evaluation for delirium. This tool is important to distinguish delirium from behavioral symptoms of dementia.

(4) The Senior Behavioral Health (SBH) nursing unit will utilize a more in-depth mental status assessment in determining patient fall risk and fall risk interventions.

Guideline: Fall Prevention

Interventions

HIGH **Morse score is 70 or >** **or** **history of fall 90 days prior to admission** **or** **scores "15" on "overestimates abilities and forgets limitations"** **or** scores in the red zone on two or more of the four assessment tools	**Universal-all patients**
• Bed in low and locked position • Bed/Chair locked • Nonskid slippers on when up • Call system in reach • Hourly rounding (Q15 on psych units) • Use of gait belt whenever patient is up with assistance, walker available at each bedside • Patient in room near nurses' station when able • Bed/chair alarm in place • Yellow wrist band • Fall risk card outside the room • Continuous assist when toileting or bathing, toileting regimen every 2-4 hours	• Bed in low and locked position • Bed/Chair locked • Nonskid slippers on when up • Call system in reach • Hourly rounding (Q15 on psych units) • Use of gait belt whenever patient is up with assistance, walker available at each bedside
• Consider use of floor mats when patient in bed • Consider distraction or self-soothing activities	

(C) References.

Agency for Healthcare Research and Quality (2016). Morse Fall Scale for Identifying Fall Risk Factors. Retrieved on February 16, 2016, from http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html

Vassallo, M., Poynter, L., Sharma, J. C., Kwan, J., & Allen, S. C. (2008). Fall risk-assessment tools compared with clinical judgment: An evaluation in a rehabilitation ward. *Age and Ageing, 37*, 277-281

Bok, A., Pierce, L. L., Gies, C., & Steiner, V. (2016). Meanings of falls and prevention of fall according to rehabilitation nurses: A qualitative descriptive study. *Association of Rehabilitation Nurses, 41*, 45-53.

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