



ALL patients are at risk to fall.

We need to identify those at high risk

Fall prevention starts with a fall assessment



Expense documentation is completed in **Worklist**

Fall Risk Screening

Refresh	Change View	Add	Not Done	View/ Edit	Detail	Document		
Filter	Include: Int, Out, Med; Look Ahead: 8 H							
Care Item			Last Done	Status/ Due	Today 08:30	Today 09:00	NOW	
Admission/Shift Assessment +	QSHIFT	A/I	4h	-3h				
Fall Risk Screening +	QSHIFT	A		-3h				✓
Hygiene Care +	DAILY			-3h				

Fall assessments are completed on **Every patient**

On Admission
Every Shift
Transfer between units
Change in caregivers
Change in patient condition
Immediately after a fall

Select your area of care Verify or change the time at the top to reflect the time the screening was done.

Fri Sep 18 12:25 by RN

Interventions

Fall Risk Screening + QSHIFT (A) ✓

Assessments

✓

✓

Fall Risk Screening

Fall Risk Tool Identifier

Fall risk tool identifier

☐ Adult inpatient/OB/ED
Morse Fall Scale - Adult ICU, PCU, med-surg, women's health, and ED

☐ Adult behavioral health
Wilson Sims Fall Risk Assessment Tool - Adult BH patients in a BH unit or facility

☐ Inpatient rehab
Fall Risk - Patients in a rehab unit or facility

☐ Newborn
Newborn Fall Risk - Newborn/NICU document in baby's chart

☐ Pediatric
CHAMPS - All pediatric patients less than 18 years (including BH)

****Sarasota Doctors Hospital** is piloting an initiative to ensure all patients are assessed and documented within 4 hours of assuming care.

Document Screening, Interventions, and Teach/Educate (if education was given)

✓ Morse Fall Scale

*History of falling (immediate or previous)

☒ 0-No ☐ 25-Yes

*Secondary diagnosis

☐ 0-No ☒ 15-Yes

Two or more medical diagnoses in chart

*Ambulatory aid

☐ 0-None/bedrest/nurse assist ☒ 15-Crutches/cane/walker ☐ 30-Furniture

*IV/heparin lock

☐ 0-No ☒ 20-Yes

*Gait/transferring

☐ 0-Normal/bedrest/immobile ☒ 10-Weak ☐ 20-Impaired

Weak: stooped stance, able to lift the head while walking, short shuffled steps

Impaired: difficulty rising from seated position, takes several attempts to stand, watches the ground while walking, support person / item is needed to steady oneself

*Mental status

☒ 0-Oriented to own ability ☐ 15-Forgets limitations

Morse Fall Scale score and risk level

60 - High Risk

*** For High Risk: update the Fall Precaution Special Indicator ***

Copyright

Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7. Morse, J.M. (2009). Preventing patient falls. (2nd ed). New York: Springer [End]

Active fall prevention interventions

☐ Assistive devices ☒ Slow position changes

☐ Bed/chair alarm ☒ Supervised/assisted ambulation

☒ Diversion techniques ☒ Supervised toileting

☒ Gait belt ☐ Virtual PSA

☐ Low bed ☐ Visual aids accessible

☐ Med review/timing optimization ☐ Other additional interventions

☐ Physical PSA

Additional fall prevention interventions

Fall Assessments (clickable):

[Morse Fall Risk](#)

[Wilson Sims Fall Risk](#)

[CHAMPS](#)

[Newborns](#)