HACKETTSTOWN REGIONAL MEDICAL CENTER
NURSING POLICY MANUAL
FALL RISK ASSESSMENT TOOLS: MORSE FALL SCALE and HUMPTY DUMPTY SCALE

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Effective Date: 11/1/2008	**Policy No: 8620.232A**
Cross Referenced:	**Origin: Division of Nursing**
Reviewed Date: 11/2010	**Authority: Chief Nursing Officer**
Revised Date: 11/2014,6/2015	**Page: 1 of 5**

SCOPE
All RNs in Inpatient areas

PURPOSE
To outline the process for completing a fall risk assessment using the Morse Fall scale and/or the Humpty Dumpty pediatric fall scale.

DEFINITIONS
Anticipated Physiological falls- These are falls that occur with the patients identified as fall-prone by scoring "at risk of falling"
Unanticipated physiological falls - These are falls that may be attributed to physiological causes but are created by conditions that cannot be predicted before the first occurrence.
Accidental Falls- These are caused by environmental hazards or errors of judgment by the patient (patient leaning against a curtain, thinking it was a supportive wall, misjudging the width of a doorway)
The Morse Fall Scale is an evidence-based scale designed to assess the patient's likelihood of falling. It predicts anticipated physiological falls for the adult patient.
The Humpty Dumpty fall scale is an evidence-based scale designed to assess the pediatric patient's level of fall risk. All pediatric patients are at risk to fall, and the Humpty Dumpty scale assist in identifying those twice as likely to fall.

POLICY
The Morse Fall Scale and the Humpty Dumpty Scale are completed by an RN on admission, upon transfer, daily and with change in condition regardless of original scoring.

PROCEDURE for MORSE Fall Scale
A. Procedure

The Morse Fall Scale consists of six variables: history of falling, secondary diagnosis, ambulatory aids, Intravenous therapy, gait and mental status. Patient scores with the Morse Fall Scale are from 0-125 points, with the higher the score the more likelihood of the patient falling while in the hospital;

1. Assess patient according to category.
2. Add all the values in each category to come up with a total score.
3. Document total score in appropriate area.

Low Risk	**0-24**	Standard interventions instituted
Moderate Risk	**25-44**	Fall protocol initiated and follow moderate risk interventions
High Risk	**>45**	High risk intervention

4. Document interventions and any reassessments of the scale in the nursing notes.
5. See Fall prevention protocol, PC 10 for details on pre and post fall care.

B. Assessment Categories

1. **History of falling-** This is scored as 25 if the patient has fallen during the present hospital admission, within the last year, or if there was an immediate history of physiological fall, such as from seizures or an impaired gait prior to admission . If the patient has not fallen, this is scored at 0.
2. **Secondary Diagnosis-** This is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score 0.

3. **Ambulatory aids-** This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheel chair or is on bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this items scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.
4. **Intravenous therapy-** This is scored as 20 if the patient has an intravenous apparatus or a saline lock inserted; if not score 0.
5. **Gait-** the characteristics of the three types of gait are evident regardless of the type of physical disability or underlying cause.
    a. A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side and striding unhesitantly. This gait scores 0.
    b. Weak gait (scores 10) patient is stooped but is able to lift the head while walking without losing balance. If support from furniture is required this is with a featherweight touch almost for reassurance, rather than grabbing to remain upright. Steps are short and the patient may shuffle.
    c. Impaired gait (scores 20) the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair and/or by bouncing. Head is down, and he/she watches the ground. Balance is poor; the patient grasps onto the furniture, a support person or a walking aid for support and cannot walk without this assistance. Patient takes short steps and shuffles.
    d. 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.
6. **Mental Status-** Check 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's reply judging his or her own ability is consistent with the ambulatory orders in the patient's record the patient is rated as normal (score 0). If the patient's response is not consistent with the nursing orders or if the patient's assessment is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations (scored 15).

PROCEDURE for Humpty Dumpty

A. Procedure

The Humpty Dumpty Scale consists of 7 categories: Age, gender, diagnosis, cognitive impairments, environmental factors, response to surgery/sedation/anesthesia and medication usage. The problem of fall-related injuries in the pediatric population is closely linked to the developmental stage of the child. Humpty Dumpty Scale is from 7 to 23, with 12 points or more indicating higher risk of falling.

1. Assess patient according to category.
2. Add all the values in each category to come up with a total score.
3. Document total score in appropriate area.

Low Risk	**7-11**	Standard interventions instituted
High Risk	**>12**	High risk intervention

4. Document interventions and any reassessments of the scale in the nursing notes.

B. Assessment Categories

1. **Age-** This is scored from 1 to 4 with the patient getting more points (higher risk) the younger they are.
2. **Gender-** allocates appropriate points based upon female or male gender.
3. **Diagnosis-** review patient reason for admission along with relative past history and allocate appropriate points.
4. **Cognitive Impairments-** Check 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's reply

judging his or her own ability is consistent with the ambulatory orders in the patient's record the patient is rated "oriented to own ability". If the patient's response is not consistent with the nursing orders or if the patient's assessment is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations, score is as "forgets limitation". If unable to verbalize limitations, score "not aware"

5. **Environmental factors-** Observe patients mobility and review patient's current reason for visit, past medical history and interview patient and parents to determine environmental factors.
6. **Response to surgery/sedation/anesthesia-** Assess whether the patient has had any surgery, sedation or anesthesia in the past 48 hours and allocate appropriate points.
7. **Medication usage-** evaluate patient current medication usage for the following medications: sedatives, hypnotics, barbiturates, phenothiazines, antidepressants, laxatives, diuretics and narcotics

REFERENCES

Preventing Patient Falls. Janice M. Morse. Sage Publications, International Educational and Professional Publisher. 1997.

Preventing Patient Falls: Assessing Risk, Educational CD-Rom. Hill-Rom Professional Program Group, Hill-Rom Services, Inc. 2003

The Humpty Dumpty Fall Scale: A Case Controlled Study.Deborah Hill-Rodriguez, Patricia R. Messmer, Phoebe D. Williams, Richard A. Zeller, Arthur R. Williams, Maria Wood, and Marianne Henry, 2008, The Authors Journal of Compilation, Wiley Periodicals, Inc.

http://www.jointcommission.org/national quality forum
http://www.patientsafety.gov/fall prevention

Appendix: Humpty Dumpty Scale

Parameter	Criteria	Score
Age		
	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years old and above	1
Gender		
	Male	2
	Female	1
Diagnosis		
	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments		
	Not Aware of Limitations	3
	Forget Limitations	2
	Oriented to own Ability	1
Environmental Factors		
	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant Toddler in Crib or Furniture/Lighting (Tripled Room)	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia		
	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage		
	Multiple Usage of: Sedatives(excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives /Diuretics Narcotics	3
	One of the Meds listed above	2
	Other Medications/None	1
	Total	

Appendix: Morse Fall Scale

Morse Fall Risk Assessment

Risk Factor	Scale	Points	Patient's Score
History of Falls	Yes	25	
	No	0	
Secondary Diagnosis (Two or more medical Diagnoses)	Yes	15	
	No	0	
Ambulatory Aid	Furniture	30	
	Crutches/Walker/Cane	15	
	None/Bedrest/Wheelchair/Nurse	0	
IV/Saline Lock	Yes	20	
	No	0	
Gait/Transferring	Impaired	20	
	Weak	10	
	Normal/Bed Rest/ Immobile	0	
Mental Status	Forgets limitations	15	
	Oriented to own ability	0	

Total Score: _____

High Risk = 45 and higher
Moderate Risk = 25-44
Low Risk = 0-24

(From Morse, J. M. (1997). Preventing Patient Falls. Thousand Oaks: Sage.)