“Evaluation of the Efficacy of Repeat Falls Risk Assessments Using the Morse Falls Scale”

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Disclosures

- Veterans Administration (VA) Boston HealthCare System
- No conflict of interest
- No sponsorship or commercial support
Objectives

- Examine variability of Morse Fall Scores (MFS) in an adult acute care population
- Evaluate sources of discrepancies in MFS assessments
- Develop recommendations for the frequency of MSF assessments
Hospital Falls in USA

- 3.5 falls per 1,000 patient days
- 1 injurious fall per 1,000 patient days
- The most commonly reported adverse events
Hospital Falls

- Potentially preventable
- Nurse sensitive
- First step in prevention is risk assessment
- Mandated by JCAHO in 2015
- Medicare denies reimbursement for care related to inpatient falls since 2008.
Impact

- Delayed recovery
- Physical impairment
- Psychological impact of fear of falling
- Average cost of an injurious fall - $14,000
Morse Fall Scale (MFS)

- Most commonly used assessment
- Extensively studied
- Good sensitivity and negative predictive ability
Morse Fall Scale

- History of falling
- Secondary diagnosis
- Ambulatory Aids
- IV or saline lock
- Gait
- Mental status
Morse Fall Scale

- Most research is based on a single MFS score, usually at time of admission
- Most hospitals have policies requiring repeat measurements during the patient’s stay
What is the evidence for repeat measurements of the Morse Fall Scale in hospitalized patients?
Population

- 50 patients who sustained a fall between October 1, 2014 and September 31, 2015
- Retrospective review of electronic health records
Variables

- Patient age and gender
- Date(s) of fall
- Date(s) of transfer between nursing units
- All MSF variables and scores with time and date
890 MSF assessments on 50 patients

Represents approximately 75 hours of nursing time
Any change in score was validated against progress notes.

In the case of a discrepancy:
- The progress notes were used as the standard.
- A corrected score was calculated.
Discrepancies

- Discrepancies in 41% of assessments
- 5.4% of discrepancies due to calculation errors
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Causes of Discrepancies

- Omitting history of falls
- Omitting comorbidities
- Omitting use of ambulatory aids
- Mental status changes (confusion)
- Variations in gait assessment
Corrected scores were dichotomized into above or below 45

Significant changes were defined as those which crossed the 45 point threshold
Changes in Fall Risk Category

- 38 (76%) patients with no significant change from initial assessment
Fall Risk by Avg

- Average
- MEAN
- Count

Fall Risk Score vs # Count Observations
Score Change to High Risk (>45)

- N = 5 (10%)
- All due to a fall
Score Change to Below 45

- 4 scores (8%) due to changes in gait assessment
- 1 (2%) score due to change in mental status
- 2 (4%) scores due to discontinuing IVs
- Changes were brief and quickly returned to High Risk status
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Conclusions

- Little change in the MSF score of adult patients during their hospitalization
- MSF assessment during the night shift is particularly problematic

Gait assessment is most variable
  - Actual change in patient gait?
  - Educational need?
  - Definition of bedrest?
Recommendations for Assessment

- Admission
- Once a patient is identified as high risk, should remain so
- For patients identified as low risk, assess;
  - On transfer
  - After a fall
  - With any change in mental status
Thank You.