

Response

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I thank David Oliver for taking the time to respond to my article. But I view with dismay his position that we should move away from using risk assessment tools to identify the fall-prone patient. To revert to using certain symptoms — or even a fall itself — as the indicator for implementing fall prevention strategies is a mighty step backwards. I will address this issue after correcting some misperceptions Oliver has of my article.

First, the Morse Fall Scale (MFS) is not a checklist. Second, I do not recommend the 1997 STRATIFY (Oliver, Britton, Seed, Martin, & Hopper, 1997) but the version with weighted scores (Papaioannou et al., 2004). The MFS has been used extensively in many independent settings, is beyond the “trial” period, and the VA Hospital system in the United States will soon be introducing it in all of their 160 acute-care hospitals and thereafter, commencing in July 2006, in their other hospitals. Third, the variation in “success” of the performance of the MFS results not from differences in patient populations — of course these give different mean scores and ranges — but from misuse when scoring. One cannot rate a patient’s fall risk using the MFS and chart data — one *must* assess the patient. I recommend that patients be scored at least once per shift. We must move away from the ordinal categorization of scores as low/high, to using the actual MFS score — both item scores and total scores. Again, it is the interventions that prevent the fall; the MFS merely identifies patients at risk.

I am unable to support Oliver’s suggestions for future research:

1. Both the study by Haines, Bennell, Osborne, and Hill (2006) and the study by Fonda, Cook, Sandler, and Bailey (2006) identified patients at risk using fall assessments that included medical tests. This method of assessment is not quick nor easy. Rather, it is expensive, slow, and specialized, and should be used once patients have been scored at high risk of falling, as determined by an initial risk score. (It is of concern to note that in the study by Healey, Monro, Cockram, Adams, and Heseltine [2004] the number of *injuries* in the experimental group actually increased. As researchers are aware, it is the number of *injuries*, not the number of *falls*, that should be used as the significant outcome variable in fall research.)

2. The approach used by Healey et al. (2004) to assess only those patients who have fallen or who have a near miss is unethical and immoral. It is astonishing that such a study was approved by an ethics review committee and published in *Age and Ageing*. This study violates principles of prevention and would be an extremely costly approach in terms of morbidity and mortality — as well as placing the staff and the institution in legal jeopardy.

I am concerned about suggestions that fall assessments be completed following a fall, instead of triaging for fall risk on admission and implementing a fall protection program. There is a need to move beyond subjective evaluation of fall instruments. Further, there is a need for healthy debate on these issues, to ensure that the practices that we implement are those that provide the best ethically and scientifically grounded care for the patient.

References

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