## MORSE FALL SCALE

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falling (past year)</td>
<td>No 0</td>
<td>Yes 25</td>
</tr>
<tr>
<td>2. Secondary Diagnosis (any diagnosis)</td>
<td>No 0</td>
<td>Yes 15</td>
</tr>
<tr>
<td>3. Ambulatory aid</td>
<td>Bed rest/nurse assist 0</td>
<td>Crutches/cane/walker 15</td>
</tr>
<tr>
<td>4. IV/Heparin Lock</td>
<td>No 0</td>
<td>Yes 20</td>
</tr>
<tr>
<td>5. Gait/Transferring</td>
<td>Normal/bedrest/immobile 0</td>
<td>Weak 10</td>
</tr>
<tr>
<td>6. Mental Status</td>
<td>Oriented to own ability 0</td>
<td>Forgets limitations 15</td>
</tr>
</tbody>
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Fall Prevention interventions will be implemented according to identified risk level of patient population in individual outpatient settings (see attachment B)

**TOTAL POINTS**

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### Fall Prevention Interventions - Check as appropriate for the patient

- Escort or offer wheelchair assistance to a patient who is at risk for falls
- Place Fall Risk ID on patient
- Identify patient's room, stretcher, chart for fall risk
- Provide adequate lighting
- Bed/stretcher in low position with brakes locked
- While on stretcher all rails are to be raised for patient safety
- If high risk, do not place patient on examination table without 1:1 attendance
- Provide non-slip footwear when transferring from bed, chair, wheelchair
- Toilet patient regularly, especially prior to procedure. Instruct patient to use emergency call bell in restroom and keep path to bathroom clear
- While in recovery area - patient to be visible and not left alone
- All moderate sedation patients must be monitored according to hospital policy
- Review patient medications and correlate to pharmacy list for medications that place a patient at risk for falls. Educate patient if on medications that increase risk for falls.
- Provide patient/family with pamphlet on fall safety.

Morse Fall Risk Scale and Interventions initiated by: ___________________________ Date _____ Time _____