Morse Fall Scale for Identifying Fall Risk Factors

Background: This tool can be used to identify risk factors for falls in hospitalized patients. The total score may be used to predict future falls, but it is more important to identify risk factors using the scale and then plan care to address those risk factors.


How to use this tool: A training module on proper use of the Morse Fall Scale developed by the Partners HealthCare Fall Prevention Task Force is also found in the LAMMICO Tips and Tools section. In addition to completion of the module, training should include real cases where the provider conducts an assessment. Mental status and gait parameters require actual assessment of a real patient (as opposed to solely a chart review).

This tool can be used by staff nurses. Use this tool in conjunction with clinical assessment and a review of medications (see Medication Assessment Tool also located in the Tips and Tools section) to determine if a patient is at risk for falls and plan care accordingly. Note that this scale may not capture the risk factors that are most important on your hospital ward, so consider your local circumstances.

If your hospital uses an electronic health record, consult your hospital's information systems staff about integrating this tool into the electronic health record.

Morse Fall Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Score</th>
<th>Patient Score</th>
</tr>
</thead>
</table>
| 1. History of falling (immediate or previous) | No = 0  
Yes = 25 | |
| 2. Secondary diagnosis (≥ 2 medical diagnoses in chart) | No = 0  
Yes = 15 | |
| 3. Ambulatory aid | 0  
15  
30 | |
| 4. Intravenous therapy/heparin lock | No = 0  
Yes = 20 | |
| 5. Gait | 0  
10  
20 | |
| 6. Mental status | 0  
15 | |
| Total Score‡: Tally the patient score and record. | <25: Low risk  
25-45: Moderate risk  
>45: High risk | |

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(Customize this form by using your logo if desired and removing the instructions below)
* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).
† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.
‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

**History of falling:** This is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. If the patient has not fallen, this is scored 0. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

**Secondary diagnosis:** This is scored as 15 if more than one medical diagnosis is listed on the patient’s chart; if not, score 0.

**Ambulatory aids:** This is scored as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all. If the patient uses crutches, a cane, or a walker, this item scores 15; if the patient ambulates clutching onto the furniture for support, score this item 30.

**Intravenous therapy:** This is scored as 20 if the patient has an intravenous apparatus or a heparin lock inserted; if not, score 0.

**Gait:** A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores 0. With a weak gait (score as 10), the patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. With an impaired gait (score 20), the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The patient’s head is down, and he or she watches the ground. Because the patient’s balance is poor, the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance.

**Mental status:** When using this Scale, mental status is measured by checking the patient’s own self-assessment of his or her own ability to ambulate. Ask the patient, “Are you able to go the bathroom alone or do you need assistance?” If the patient’s reply judging his or her own ability is consistent with the ambulatory order on the Kardex®, the patient is rated as “normal” and scored 0. If the patient’s response is not consistent with the nursing orders or if the patient’s response is unrealistic, then the patient is considered to overestimate his or her own abilities and to be forgetful of limitations and scored as 15.

**Scoring and Risk Level:** The score is then tallied and recorded on the patient’s chart. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

**Important Note:** The Morse Fall Scale should be calibrated for each particular healthcare setting or unit so that fall prevention strategies are targeted to those most at risk. In other words, risk cut off scores may be different depending on if you are using it in an acute care hospital, nursing home or rehabilitation facility. In addition, scales may be set differently between particular units within a given facility.
Sample Risk Level

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>MFS Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Risk</td>
<td>0 - 24</td>
<td>Good Basic Nursing Care</td>
</tr>
<tr>
<td>Low Risk</td>
<td>25 - 50</td>
<td>Implement Standard Fall Prevention Interventions</td>
</tr>
<tr>
<td>High Risk</td>
<td>≥ 51</td>
<td>Implement High Risk Fall Prevention Interventions</td>
</tr>
</tbody>
</table>


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