3H: 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.

Reference: Adapted from Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8:366-7. Reprinted with the permission of Cambridge University Press.

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 may be found at www.brighamandwomens.org/ Patients_Visitors/pcs/nursing/nursinged/Medical/FALLS/Fall_TIPS_Toolkit_MFS%20Training %20Module.pdf. 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 Tool 3I) 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

Item	Item Score	Patient Score
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 None/bedrest/nurse assist Crutches/cane/walker Furniture	0 15 30	_____
4. Intravenous therapy/heparin lock	No 0 Yes 20	_____
5. Gait Normal/bedrest/wheelchair Weak* Impaired[†]	0 10 20	_____
6. Mental status Oriented to own ability Overestimates/forgets limitations	0 15	_____
Total Score[‡]: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		_____

* 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.