**Morse Falls Risk Screening**

Table 1-1 Morse Scoring Categories

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| 1. *History of falling; immediate or within 3 months* | No = 0  Yes = 25 |
| *2. Secondary diagnosis* | No = 0  Yes = 15 |
| 1. *Ambulatory aid*   *(Select current primary aid during assessment)* | None, bed rest, wheel chair, nurse = 0  Crutches, cane, walker = 15  Clutches Furniture = 30 |
| *4. IV/Heparin Lock* | No = 0                       Yes = 20 |
| *5. Gait/Transferring* | * Normal, bed rest, immobile = 0 * Weak = 10 – pt. is stooped but lifts head while walking w/o losing balance. Featherweight touch on furniture for reassurance, not support. Short steps and may shuffle. * Impaired = 20 – difficulty rising from chair, may take several attempts, or pushes/bounces up by using forearms of chair. Balance is poor. Grasps furniture, support person, or walking aide for support and cannot walk without this assistance. Steps are short and patient shuffles. |
| *6. Mental status* | Oriented to own ability = 0  Forgets limitations = 15 |

Table 1-2 Fall Precautions

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| **Precautions** | **Assess/Care/Teach/Manage** |
| **Standard Low (0-24)** | Orient to surroundings, use of call light, non-skid sock/shoes, requesting assistance for daily activities as needed.  Place personal, items, phone, and call light within easy reach, pathway clear & free of clutter, proper lighter (use night lights), bed in low position wheels locked. |
| **Moderate (25-44)** | **Standard + interventions based on risk factors**.  Examples: Monitor med side effects that increase fall risk. Non-skid footwear. Coordinate activities to maximize uninterrupted sleep. Assess for proper use of assist devices. Use transfer devices if appropriate. |
| **High (45+)** | **Moderate+ interventions** that alert team to risk (door signage, armband, yellow socks). Purposeful rounding. Remain with patient during toileting- provide bedside toileting devices if needed. Assist with ambulation and transfers. Where appropriate, bed exit alarm, move to room with best visual access. Consider protection or padding. Evaluate orthostasis and/or need for PT/OT referral. Have conversation with pt./family EVERY SHIFT about high fall risk and WHY they need to call for assistance before trying to get out of bed or bathroom (what makes them at risk?) |