

MINISTRY OF HEALTH MALAYSIA, NURSING DIVISION
DAILY MORSE FALL SCALE ASSESSMENT AND INTERVENTION CHART

BKJ-BOR-PPK-QAP-8

NAME :		REG NO :		WARD :		FALL RISK	UNIVERSAL FALLS PRECAUTION	Please tick			
DIAGNOSIS :		AGE :		ADMISSION DATE:						✓	
ITEMS	DATE					ALL RISK	Orientate patient to the environment Position call bell, urinal (if applicable) and bedside table/belongings within patient's reach Ensure patient wears non-skid footwear Ensure hearing aid and glasses are used Encourage proper use of assistive device				
	TIME										
History of fall		SCORE									
NO	0										
YES	25										
Secondary Diagnosis		SCORE						Provide health education on fall prevention to patients and caregivers			
If only 1 active medical diagnosis		0									
Secondary diagnosis ≥ 2 medical diagnosis in chart		15									
Ambulatory Aids		SCORE									
None/ Bed rest / Nurse Assist		0									
Crutches/ Cane/ Walker		15				MODERATE HIGH RISK (PLEASE ENSURE PATIENT AND BEDSIDE IS TAGGED)	Place bed in lowest position with brakes locked Determine the safest use of bed side rails				
Furniture (Patient clutched onto furniture for support)		30						Monitor for Orthostatic Hypotension if patient complain of dizziness and ensure patient rise slowly when getting out of bed			
IV therapy / Heparin Lock (IV devices)		SCORE						Encourage to call for help when mobilising			
NO		0						Assist patient in ambulation and toileting as appropriate			
YES		20						Evaluate effectiveness of medications that predispose patients to fall and consult with doctor and pharmacist as needed			
Gait		SCORE						Relocate patient's bed closer to nurse's station, if possible. Check patient hourly and maintain close supervision			
Normal/ bed rest/ immobile		0									
Weak		10									
Impaired		20					HIGH RISK (PLEASE ENSURE PATIENT AND BEDSIDE IS TAGGED)	Ensure patient's bed is in the lowest position and the 2 bedside rails are up (if required)			
Mental Status		SCORE							Place floor mat and padding beside patient if required		
Oriented to own ability		0						Reinforce activity limits and safety precautions with patient and family members			
Over estimates or forgets limitations		15									
Total Score :											
Signature of Staf :											

Patient Assessment **MUST BE DONE DAILY** and During **CHANGE OF PATIENT'S STATUS**

FALLS RISK	MFS SCORE	INTERVENTIONS
All patients		Standard/Universal Falls Prevention
Low risk	0-24	
Moderate risk	25-45	Standard/Universal Falls Prevention and Moderate Falls Risk Interventions
High risk	>45	All falls prevention interventions including Standard/Universal, Moderate and High Risk

Bed rails may be used as a safety barrier or as a support for transfer. They should be lowered by default and only be raised at the discretion of the staff. Bed rails are cautioned for confused but mobile patients because they may climb over them.