TOOLKIT 3 · FALLS PREVENTION · TOOL 1 OF 5

Fall Risk Screening — On Admission and After Any Change

Six questions, two minutes, a score that drives the care plan. Repeat after any fall, transfer, new sedative or change in condition

Patient (name, DOB, no.)	
Ward · bed	
Date · time · assessor	

Item	Score 0	Score	Higher score	Points
1 · History of falling in the last 3 months	No — 0		Yes — 25	
2 · More than one active diagnosis	No — 0		Yes — 15	
3 · Walking aid	None / bed rest / nurse assists — 0	Crutches, cane, walker — 15	Holds on to furniture — 30	
4 · IV line or heparin lock in place	No — 0		Yes — 20	
5 · Gait	Normal / bed rest / wheelchair — 0	Weak (stooped, short steps) — 10	Impaired (cannot rise without help, unsteady) — 20	
6 · Mental status	Knows own limits — 0		Overestimates or forgets limits — 15	
Total: _____	**0–24 Low**	**25–44 Moderate**	**45 + High**	

Actions by risk band

Low (0–24)	Moderate (25–44)	High (45+)
Orientation to the room, call bell in reach, bed low and brakes on, non-slip footwear, night light.	All low-risk actions, plus: hourly rounding; assist to toilet; mobility aid within reach; review medicines with the doctor; falls-risk sign at the bed; family told.	All moderate actions, plus: bed alarm or sitter where available; bed nearest the station; no unsupervised walking; physiotherapy referral; pharmacist review of sedatives; re-screen daily.

Items adapted from the Morse Fall Scale as used in the AHRQ Preventing Falls in Hospitals toolkit. Screening is a prompt for action, not a prediction; every patient gets the low-risk actions.

ASF standards: Universal Floor — falls prevention (means of verification: completed screen in every chart)