

Morse Documentation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · September 2026 · Reproduces no scale items or weights

The Morse Fall Scale (Morse and colleagues, 1989) scores six weighted items for a total of 0 to 125, higher meaning higher fall risk. It is copyrighted, free to use with the author's permission, and required by no regulator; its risk categories are facility policy rather than the scale's rule, and the original study's positive predictive value was about 10 percent. Defensible charting names the trigger and version, the items that scored in plain words with the total, the category as policy, a measure for each scoring item, teaching and refusals, and the next reassessment.

Trigger, version, and rater why now, which build, who watched

Do: name admission, transfer, the policy interval, a change in condition, or a fall; the version or build; date, time, and rater.

Pitfall: a total time-stamped every shift with no trigger; the unit's every-shift habit written as a CMS rule.

Items that scored, then the total topics in plain words, never weights

Do: say which of the six items scored and what each rests on (fall date, aid, line, the walk you watched); total of 125.

Pitfall: "Morse 85" alone; a gait or self-appraisal item rated from the chart while the patient stayed in bed.

Facility risk category policy, not the scale's rule

Do: write the category your policy assigns and cite the policy; record any clinical judgment override and why.

Pitfall: "high risk per Morse" as if 45 were official; a bedbound, agitated patient called low risk with no override.

Intervention for each scoring item the item, not the tier, picks the measure

Do: for every item that scored, name the measure in place and how it is delivered; add the environment checks with the time.

Pitfall: "fall precautions maintained" or "bundle in place" with no measure answering a specific item; an alarm as the whole plan.

Teaching, preferences, refusals what was offered, what was declined

Do: teach-back with patient and family; preferences; any refusal with the offer, reason, education, alternatives, and who was told.

Pitfall: "refused bed alarm" standing alone; a relative at the bedside charted as if it lowered the score.

Reassessment and a changed total every changed item explained

Do: set the next reassessment and the triggers that bring it forward; when the total moves, say which item changed and why.

Pitfall: a total that fell because a line came out read as lower risk while new confusion went unrecorded.

After a fall: chart and report two documents, two purposes

Do: chart the injury check, notifications, a new score, contributing factors, and the revised plan; file the safety report separately.

Pitfall: the pre-fall score copied forward; the incident narrative pasted into the note; no revised plan.

Before the note is signed

- ☐ Trigger, version, and rater stated
- ☐ Scoring items named in plain words
- ☐ Total recorded against 125
- ☐ Facility category cited to its policy
- ☐ Each scoring item has a matched measure
- ☐ Teaching and refusals documented with alternatives
- ☐ Next reassessment and triggers set

Drafting with AI

Give it the facts: the trigger and version, which items scored and what each rests on, the total and any prior total, the facility category and policy, the measure in place for every scoring item, teaching and any refusal, notifications, and the reassessment plan.

"Draft Morse Fall Scale documentation: admission 09/14; items scoring: fall at home 08/22, active diagnoses, cane, IV line, weak gait; self-appraisal intact; total 85; high risk under policy NSG-207; hourly rounding, cane in reach, IV managed, gait belt, teach-back; bed exit alert declined, alternatives accepted."

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

Total 0 to 125

six weighted items, higher means riskier

Categories are policy

no regulator sets a cutoff

Items pick measures

the tier decides nothing alone

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free use, permission required

Morse Documentation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements. Contains no scale items or point values.

Setting: _____ Patient (initials): _____ Date: _____ Clinician: _____

Trigger (admission / transfer / interval / change / fall): _____ Version or build + policy cited: _____

Items that scored and total

Which of the six items scored, in plain words, and what each rests on (date of last fall, active diagnoses, aid used, line in place, how the patient walked, self-appraisal against observed ability) · total ____ of 125 · prior total and date

Facility risk category

Category assigned by the facility policy, with the policy name · categories are local conventions, not the scale's rule · clinical judgment override and its reason

Intervention for each scoring item

For every item that scored, the specific measure in place and how it is delivered: rounding and call light, medication review, aid within reach and assisted walking, line and pole management, footwear and gait belt, supervision and toileting schedule

Teaching, preferences, and refusals

Teach-back with patient and family · stated preferences · any refusal: what was offered, the reason given, education, alternatives accepted, who was notified, plan revised

Reassessment triggers and changed total

Next scheduled reassessment per policy · earlier for transfer, a new sedating or blood pressure medication, change in mobility or mentation, any fall · when the total moves, the item that changed and why

After a fall (clinical entry)

Injury check and vital signs, provider notified with time, a new score rather than a copied one, contributing factors, revised plan, family informed · safety report filed separately, not pasted here

Communication and handoff

Provider, pharmacy, therapy, and charge nurse notified with times · handoff and transfer summary carry the scoring items, the measures in place, and the next reassessment

Clinician (name and credentials): _____ Signature: _____ Date: _____