Nurse Delegation Program
Fall Scale

The items in the scale are scored as follows:

***History of falling*:** This is scored as **5** if the person has fallen during the 3 months prior to admission or within the last 3 months at your facility or if there was an immediate history of physiological falls, such as from seizures or an impaired gait.
If the person has not fallen, this is scored **0**. Note: If a person falls for the first time, then his or her score immediately increases by **5**.

***Secondary diagnosis*:** This is scored as **5** if **more than one medical diagnosis** is listed on the person's chart; if not, score **0**. (Example: Cerebral Palsy and Epilepsy)

***Ambulatory aids*:** This is scored as **0** if the person does not use any assistive devices.
If they walk **with** a walking aid, use a wheelchair, crutches or hold onto the furniture, are on a bed rest this is a score of **10**. (Note: only ***one score*** even if multiple devices)

***Two or More sedation meds*:** This is scored as **5** if the person has **two or more** medications that cause sedation; if not, score **0**.

***Gait*:** A *normal gait* is characterized by the person walking with head erect, arms swinging freely at the side, and striding without hesitant. This gait scores **0**.

With a *weak gait* (score as **5**), the person is stooped but can lift the head while walking without losing balance. Steps are short and the person may shuffle.

With an impaired gait (**score 10**), the person may have difficulty rising from the chair, attempting to get up by pushing on the arms of the chair/or by bouncing (i.e., by using several attempts to rise). The person's head is down, and he or she watches the ground. Because the person's balance is poor, the person grasps onto the furniture, they require a support person, or a walking aid for support and cannot walk without this assistance.

***Mental status*:** When using this Scale, mental status is measured by **checking the person's own self-assessment of his or her own ability to ambulate**. Ask the person (when applicable), "Are you able to go the bathroom alone or do you need assistance?" **If the person's reply judging his or her own ability is consistent with what the nurse views during the assessment scored 0.**

If the person's response is **not consistent** with the nursing orders or if the person response is **unrealistic**, then the patient is considered to **overestimate his or her own abilities and to be forgetful of limitations and scored as 10.**

Assessment is repeated after any new fall.

***Scoring and Risk Level*:** The score is then tallied and recorded on the persons. Risk level and recommended actions (e.g. no interventions needed, standard fall prevention interventions, high risk prevention interventions) are then identified.

Item	*Scale*	*Scoring*
History of falling; immediate or within 3 months	No = 0 Yes = 5	
Secondary Medical diagnosis	No = 0 Yes = 5	
Ambulatory aid Bed rest/nurse assist Crutches/cane/walker Furniture	None = 0 One or more = 10	
Two or more medications that cause sedation	No = 0 Yes = 5	
Gait/Transferring Normal/bedrest/immobile Weak Impaired	None = 0 Weak = 5 Gait impaired = 10	
Mental status Oriented to own ability. Forgets limitations	None = Forgets, Altered reality = 10	
	Total	

Risk Level	Score	Action
No Risk	0 - 4	Good Basic Nursing Care
Moderate Risk	5 - 15	Implement Standard Fall Prevention Interventions
High Risk	≥ 15	Implement High Risk Fall Prevention Interventions