TALAHI CARE CENTER

TITLE:Falls Risk Assessment

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APPROVED: EFFECTIVE DATE: 3/8/2010
REVIEWED:

REVISED:

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OBJECTIVE:

To provide a safe environment for resident care, reduce the number of falls, reduce the risk of injury resulting from falls, identify residents at risk for falls and provide close observation to prevent high risk residents from falling.

Procedure:

1) Upon admission, the nurse will complete the Fall Risk Assessment based on resident history, medications, cognitive status, general health and other fall risk factors.
2) A residents risk for falls will be measured based on a rating scale of Low risk, Medium risk and High risk.
3) The rating scale will be based on age, family history, balance, cognitive state, general health, vision, speech, medications, incontinence, chronic illness and days since admission.
4) A falls risk assessment will be completed at admission, 30 days from admission, 90+ days from admission, quarterly and whenever there is a significant change.
5) A safety level will be documented on the initial care plan and changed to reflect the specific needs of the resident.
6) Nursing will determine implement interventions per the safety fall levels assessment.
7) Staff providing direct care will be familiar with the interventions necessary to provide for the residents safety. Fall interventions will be noted on the initial care plan and care assignment cards that are utilized by the nursing assistants.
8) The fall risk level will be determined on a rating scale from 0-33. A Low risk scale will be 0-10; Medium risk scale 11-20 and High risk 21-33 measurement.
9) Interventions for each level will be implemented as follows:

Low Risk: All residents on a scale of 0-10

A. Place call light at reach and answer timely.
B. Maintain bed at lowest position with brakes locked when resident is unattended.
C. Keep room and living area free of obstacles and clean up spills immediately.

D. Orient to surroundings and instruct on use of call light.
E. Pain Management.
F. Check every two hours
G. Promote healthy sleep.
H. Ensure resident is wearing proper fitting shoes.
I. Attend to needs promptly such as toileting, pain, and positioning.
J. Encourage participation in activities.
K. Place a green leaf on door and equipment to alert staff.

Medium Risk: Rating scale of 11-20

A. All interventions listed above
B. Place a yellow leaf on patients' door and equipment to alert staff
C. Refer to OT and PT for strengthening
D. Instruct resident and family to ask for assistance with all activities
E. If resident has a fall or significant change will be re-assessed and appropriate interventions put in place.
F. Consider tab and bed alarm
G. Stay with resident in the bathroom.

High Risk: Rating scale of 21-33

A. All interventions listed above
B. Place a red leaf on residents' door and equipment to alert staff.
C. Proper lighting and noise control
D. Maintain close supervision of confused residents and close to desk within observation of staff.
E. Tabs alarm.
F Diversional activities and validation therapy.
G. Assist resident to bathroom every two hours and stay with resident in while in bathroom.

If a fall occurs, post fall procedure and policy will be implemented.

Approved_____

Side 1

Talahi Care Center
Falls Risk Assessment Tool

Admitting Diagnosis:

	Rating Scale				Date / /	Date / /	Date / /	Date / /
Categories	0	1	2	3	Score	Score	Score	Score
Days since Admission	90+ days	60+ days	30+ days	Admission- 29 days				
Age	0-19 years	20-59 years	60-70 years	>70 years				
Fall History	No falls in last year	Fall in last 6 months	Fall in last 3 months	Fall in last month				
Balance	Chair/ bedfast, stand & pivot with help	Needs assistive device & 2 person	Ambulates with assistive device &/or one person	Ambulates without assistance/device				
Mental State	Orientated to time, place, & person	Oriented to person & place	Oriented to person	Disoriented &/or impaired judgment &/or impulsive				
General Health	Well nourished, normal sleep pattern	Poor appetite &/or sleep disturbance	Severe sleep disturbance	Malnourished, weight loss				
Vision	Normal	Wears glasses	Blurred vision, cataract, glaucoma	Severe visual disturbance or blindness				
Speech	Normal	Speech defect but understood	Dysphasia/ language barrier	Severe defect or severe language barrier				
Medications	No effectors	CV effectors eg. Beta blockers, diuretics, anti-hypertensive's	CNS effectors eg. Tranquillizers, sedatives, psychotropic's	Both CV & CNS effectors				
Chronic Illness	None	1 chronic condition	>1 chronic condition	Multiple illnesses				
Incontinence	None	Increased frequency, Functional Incontinence	Nocturia, stress incontinence	Urge incontinence, indwelling catheter				
Score Assessment 0-10= Low Risk 11-20= Medium Risk 21-33= High Risk				Total Score:				
				Nurse Signature				

Name_____ **Room#**_____ **MR#**_____

Side 2

Low Risk: All residents on a scale of 0-10

A. Place call light at reach and answer timely.
B. Maintain bed at lowest position with brakes locked when resident is unattended.
C. Keep room and living area free of obstacles and clean up spills immediately.
D. Orient to surroundings and instruct on use of call light.
E. Pain Management.
F. Check every two hours
G. Promote healthy sleep.
H. Ensure resident is wearing non-skid socks and proper fitting shoes.
I. Attend to needs promptly such as toileting, pain, and positioning.
J. Encourage participation in activities.
K. Make sure walking aids are within reach.
L. Place a green leaf or tape on door and equipment to alert staff.

Medium Risk: Rating scale of 11-20

A. All interventions listed above
B. Place a yellow leaf or tape on patients' door and equipment to alert staff
C. Refer to OT and PT for strengthening
D. Instruct resident and family to ask for assistance with all activities (bathroom, walking to and from destinations.)
E. If resident has a fall or significant change will be re-assessed and appropriate interventions put in place.
F. Consider tab and bed alarm based on nurse assessment.
G. Use High/Low bed when available and use in lowest position.
H. Place a falls mat at bedside per nursing discretion.
I. Stay with resident in the bathroom.

High Risk: Rating scale of 21-33

A. All interventions listed above
B. Place a red leaf or tape on residents' door and equipment to alert staff.
C. Proper lighting and noise control
D. While awake, maintain close supervision of confused residents and place resident close to desk so that staff will be in appropriate distance to intervene if a resident falls.
E. Do not leave unattended in room while up in wheelchair.
F. Keep door closed when not in room unless directed by resident otherwise.
G. Tabs alarm and consider lap buddy for non-ambulatory residents based on nursing assessment.
F Engage in divers ional activities, group activities, and validation therapy.
G. Assist resident to bathroom every two hours and stay with resident in while in bathroom.
H. Consider a mat on floor based on nursing assessment.
I. Offer toilet every hour.

If a fall occurs, post fall procedure and policy will be implemented.