
FALL RISK ASSESSMENT



Policy

STANDARD

The RN or designee will complete the Fall Risk Assessment located in the computer chart. The Fall Risk Assessment includes making a determination of a resident's risk of falls in order to determine appropriate interventions needed.

POLICY

- Upon admission and quarterly this assessment is done to determine, in addition to risk assessment score, whether the resident is deemed at high risk for falls so safety interventions can be considered for use to decrease the risk and/or occurrence of falls when possible.

PROCEDURES

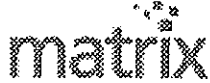
1. The RN case manager is responsible for coordinating the residents fall risk assessment upon admission, quarterly, annually, and for a change of condition.
2. If a score of 10 or more is assessed, fall interventions may be initiated by the RN and written on the care plan. Determination is then made for resident needs in relation to fall prevention and safety; i.e., side rails, tabs monitor, wheeled walker, transfers, and/or the need for ambulation assistance.
3. An occupational, physical and/or speech therapy evaluation may be sought for safety in ADL's, mobility, or other fall prevention techniques.
4. Residents deemed at risk may be referred to the BESTAge exercise program by the RN and/or therapy for continued strengthening.

WRITTEN: 8/01
REVISED: 5/03, 7/09
REVIEWED: 5/09

Our current policy

Facility: Annandale Care Center Welcome, Sondra Behrendt RN [Log off]

[E-Learning](#) | [Help](#)



Messages Resident Facility RAI

Add Observation

[REDACTED] Full Code

Type: Fall Risk Assessment
Fall Risk Assessment-Posey

Description

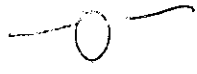
Observation Date Occurred:	01/26/2010	Observation Time Occurred:	10 : 14 AM
Short Description:			

RN OVER FALL RISK ASSESSMENT

Observation

Description	
Assessment Date Occurred:	
Assessment Time Occurred:	
Short Description:	
Mental Status/Level Of Consciousness	<input type="radio"/> 0 - Alert And Oriented At All Times -OR- Comatose <input type="radio"/> 4 - Intermittent Confusion <input type="radio"/> 2 - Disoriented x 3
Visual Impairment - Legally blind; Not wearing glasses or contacts as prescribed; Cataracts	<input type="radio"/> 0 - No Impairment <input type="radio"/> 1 - Visual Impairment
Balance And Gait - Have resident stand on both feet, without holding on to anything/ walk straight through a doorway, and make a turn.	<input type="checkbox"/> 0 - Gait And Balance Normal <input type="checkbox"/> 1 - Decreased Muscular Coordination <input type="checkbox"/> 1 - Balance Problem While Standing <input type="checkbox"/> 1 - Jerking Or Unstable When Making Turns <input type="checkbox"/> 1 - Balance Problem While Walking <input type="checkbox"/> 1 - Requires Use Of Assistive Devices - e.g. Cane, walker, wheelchair <input type="checkbox"/> 1 - Change In Gait Pattern When Waking Through Doorway
Activity Level	<input type="radio"/> 0 - Up Ad Lib <input type="radio"/> 3 - Confined To Chair, Totally Unable To Ambulate Without Assist; Wheelchair For Locomotion
Elimination	<input type="radio"/> 0 - Independent To/From, On/Off Toilet/Commode And Continent <input type="radio"/> 3 - Assistance To/From, On/Off Toilet/Commode For Elimination And/Or With Cares <input type="radio"/> 1 - Catheter/Ostomy <input type="radio"/> 5 - Independent To/From, On/Off Toilet/Commode And Incontinent Episodes
Medication Use - Does resident take any of the following types of medications?	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cathartics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Diuretics <input type="checkbox"/> Antiemetics <input type="checkbox"/> Hypoglycemics <input type="checkbox"/> Antihistamines <input type="checkbox"/> Narcotics Antihypertensives Sedative/Hypnotics (Benzodiazepines)

	<input type="checkbox"/> Antipsychotics/Neuroleptics <input type="checkbox"/> Anxiolytics	<input type="checkbox"/> Other [REDACTED] <input type="checkbox"/> None of above
Medication Use Scoring	<input type="radio"/> 0 - None Of These Medications Are/Were Taken In Last 7 Days <input type="radio"/> 2 - One - Two Of These Medications Are/Were Taken In Last 7 Days	<input type="radio"/> 4 - Three Or More Of These Medications Are/Were Taken In Last 7 Days
Has resident had a change of medications and/or change in dosage of medication in past 5 days?	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
If yes, describe further.	<input type="radio"/> Yes <input type="radio"/> No	
Systolic Blood Pressure - Measure while lying and standing.	<input type="radio"/> 0 - No Noted Drop Between Lying And Standing <input type="radio"/> 2 - Drop Of Less Than 20mm/Hg Between Lying And Standing	<input type="radio"/> 4 - Drop Of More Than 20mm/Hg Between Lying And Standing
Length Of Stay - How long has resident been in the facility?	<input type="radio"/> 0 - Over 3 Days	<input type="radio"/> 2 - Up To 3 Days
Does resident have a history of falls in last 3 months?	<input type="radio"/> 0 - No Falls <input type="radio"/> 2 - One or two Falls	<input type="radio"/> 4 - Three Or More Falls



CONTRIBUTING FACTORS		
Does resident have any of the following conditions?	<input type="checkbox"/> Cardiovascular - Cardiac Dysrhythmia <input type="checkbox"/> Perceptual - Impaired hearing; Impaired vision; Dizziness/Vertigo <input type="checkbox"/> Neuromuscular/Functional - Loss of limb movement, Decline in functional status; Incontinence; Hypotension, CVA; Hemiplegia/Hemiparesis; Parkinson's; Seizure Disorder; Syncope; Unsteady gait <input type="checkbox"/> Psychiatric Or Cognitive - Delirium; Decline in cognitive skills; Manic Depression; Alzheimer's Disease; Other Dementia <input type="checkbox"/> Orthopedic - Joint pain; Arthritis; Fracture of hip; Missing limb; Osteoporosis <input type="checkbox"/> None of above	
Contributing Factors Scoring	<input type="radio"/> 0 - None Present <input type="radio"/> 4 - Three Or More Present	<input type="radio"/> 2 - One - Two Present

EVALUATION	
Calculate Points and Record Total. Score of 10 or higher represents a high risk for falls.	[REDACTED]

REFERRALS	
Indicate what referrals are appropriate.	<input type="checkbox"/> Falls Prevention Program <input type="checkbox"/> Nursing Rehab. <input type="checkbox"/> OT
	<input type="checkbox"/> PT <input type="checkbox"/> Other [REDACTED] <input type="checkbox"/> No Referrals Necessary

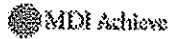
PLAN OF CARE	
Indicate Care Plan Action Taken	<input type="radio"/> Continue Current Plan of Care <input type="radio"/> Plan of Care Updated. Describe below if

	<input type="checkbox"/> Initiate Plan of Care necessary.
Describe if necessary.	<input type="text"/>

Additional Information

Additional Info:	<input type="text"/>
------------------	----------------------

Observation Complete: <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
--	----------------------	----------------------



[Contact Us](#) | [Help](#) | [E-Learning](#)
Matrix 6.3.1 © Copyright 2002-2010, MDI Achieve, Inc. All Rights Reserved.