FALL RISK ASSESSMENT

COPY

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]

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Messages Resident Facility RAI

RN Quick fall risk assessment

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:			

Observation

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

	☐	☐
	☐ Antipsychotics/Neuroleptics	☐ Other
	☐ Anxiolytics	☐ None of above
Medication Use Scoring	○ 0 - None Of These Medications Are/Were Taken In Last 7 Days	○ 4 - Three Or More Of These Medications Are/Were Taken In Last 7 Days
	○ 2 - One - Two 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?	☐ 0 - No	☐ 1 - Yes
If yes, describe further.	○ Yes ○ No	
Systolic Blood Pressure - Measure while lying and standing.	○ 0 - No Noted Drop Between Lying And Standing	○ 4 - Drop Of More Than 20mm/Hg Between Lying And Standing
	○ 2 - Drop Of Less Than 20mm/Hg Between Lying And Standing	
Length Of Stay - How long has resident been in the facility?	○ 0 - Over 3 Days	○ 2 - Up To 3 Days
Does resident have a history of falls in last 3 months?	○ 0 - No Falls	○ 4 - Three Or More Falls
	○ 2 - One or two Falls	

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

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

REFERRALS		
Indicate what referrals are appropriate.	☐ Falls Prevention Program	☐ PT
	☐ Nursing Rehab.	☐ Other
	☐ OT	☐ No Referrals Necessary

PLAN OF CARE		
Indicate Care Plan Action Taken	○ Continue Current Plan of Care	○ Plan of Care Updated. Describe below if

	necessary. Initiate Plan of Care
Describe if necessary.	

Additional Information

Additional Info:	

Observation Complete: ☐ [redacted] [redacted]