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

E-Learning | Help

matrix

Messages Resident Facility RAI

Add Event

[redacted] Full Code

Type: Falls
Falls

Description

Event Date Occurred:	01/26/2010	Event Time Occurred:	10 : 15 AM
Short Description:			

Observation

Location Of Fall	Day Room	Outside On Facility Grounds
	Dining Room	Resident Bathroom
	Hallway	Resident Room
	Outside, Not On Facility Grounds	Other
What was resident doing just prior to Fall?		
Was Fall Witnessed?	Yes No	

PAIN ASSESSMENT		
Does resident exhibit or complain of pain related to the fall? If so, describe location.	Yes (location)	No
On a scale of 0-10, how does resident rate intensity of pain if able or indicate based on observation.	0 - No Pain 1 - Mild Pain - Uncomfortable, Annoying - Usually able to carry on with daily routines, socialization or sleep. 2 3 4 - Moderate Pain - Distressing, Miserable 5 6 7 - Severe Pain - Horrible Intense 8 9 10 - Excruciating Pain - Worst Possible - Interferes with ability to carry on with daily routines, socialization or sleep.	

BODY ASSESSMENT	
Location Of Injury	
Note any injury to the	

Head, extremities, or trunk.	☐ Abnormal Alignment	☐ Redness
	☐ Abrasion	☐ Skin Tear
	☐ Bruising	☐ Swelling
	☐ Bump	☐ Other
	☐ Laceration	☐ No Injury Noted
Range Of Motion	☐ ROM X4 Without Pain/Limitations	☐ ROM Painful/Limited In Lower Extremity
	☐ ROM Painful/Limited In Upper Extremity	☐ Unable To Complete ROM
Positioning Of Extremities	☐ No Rotation/Deformity/ Shortening Noted	☐ Rotation/Deformity/Shortening Of Right Lower Extremity
	☐ Rotation/Deformity Of Upper Left Extremity	☐ Rotation/Deformity Of Upper Right Extremity
	☐ Rotation/Deformity/Shortening Of Left Lower Extremity	
Describe, if necessary.		

NEUROLOGICAL CHECK		
Level Of Consciousness	○ Alert Wakefulness - Perceives the environment clearly and responds appropriately to stimuli.	
	○ Lethargic/Drowsy - Does not perceive the environment fully; Responds to stimuli appropriately but slowly and with delay.	
	○ Stupor - Aroused only by intense stimuli.	
	○ Unresponsive/Coma - Does not perceive the environment and may not respond to intense stimuli.	
Facial Muscle Movement	○ Strong	○ Absent
	○ Weak	○ Other
	○ Asymmetrical	
Upper Left Extremity Movement/Grasps	○ Strong	○ Flaccid
	○ Weak	○ Rigid
	○ Absent	○ Unable To Do (describe)
Upper Right Extremity Movement/Grasps	○ Strong	○ Flaccid
	○ Weak	○ Rigid
	○ Absent	○ Unable To Do (describe)
Lower Left Extremity Movement	○ Strong	○ Flaccid
	○ Weak	○ Rigid
	○ Absent	○ Unable To Do (describe)
Lower Right Extremity Movement	○ Strong	○ Flaccid
	○ Weak	○ Rigid
	○ Absent	○ Unable To Do (describe)

Left Eye - Pupil Size	--Select Answer --
Left Eye - Pupil Response/Shape	○ Round/Brisk ○ Misshappen/Brisk ○ Round/Sluggish ○ Misshappen/Sluggish ○ Round/Non-Reactive ○ Misshappen/Non-Reactive
Right Eye - Pupil Size	--Select Answer --
Right Eye - Pupil Response/Shape	○ Round/Brisk ○ Misshappen/Brisk ○ Round/Sluggish ○ Misshappen/Sluggish ○ Round/Non-Reactive ○ Misshappen/Non-Reactive
Speech	○ Clear- Distinct, intelligible words ○ No Speech - Absence of spoken words ○ Unclear - Slurred, mumbled words
Does resident respond to the following?	☐ Name ☐ Other ☐ Pain ☐ Unresponsive ☐ Environment
Does resident exhibit or complain of any of the following since the fall?	☐ Dizziness/Lightheadedness ☐ Seizure ☐ Headache ☐ Other ☐ Nausea/Vomiting ☐ None of above
Describe, if necessary.	

MENTAL STATUS	
Does resident exhibit any of the following as a change in mental status of new onset?	☐ Agitation ☐ Restlessness ☐ Anxiety ☐ Sleepiness ☐ Confusion ☐ Slurred Speech ☐ Lethargy ☐ Other ☐ Resistiveness ☐ No Changes
Describe, if necessary.	

POSSIBLE CONTRIBUTING FACTORS	
Are any the following factors present?	☐ Cardiac / Respiratory Disease ☐ Recent Change In Appetite ☐ Dehydration ☐ Recent Change In Medications ☐ Fever ☐ Recent Decline In ADL Abilities ☐ Neurological Disorder - e.g. Seizures, Parkinson's Disease ☐ Other ☐ Orthopedic Condition ☐ None of above
Were restraints /	Yes (describe) No

adaptive equipment in use at the time of the fall?	○ [ ] ○
Did resident complain of or experience any of the following PRIOR to the fall?	☐ Change In Vision ☐ Seizure Activity ☐ Dizziness/Lightheadedness ☐ Tinitus (Ringing in the ear) ☐ Discomfort/Pain ☐ Tripping ☐ Feeling Faint ☐ Other [ ] ☐ Headache ☐ None of above ☐ Nausea/Vomiting
Describe, if necessary.	[ ]
Drug Review - Does resident use any of the following types of medications?	☐ Analgesics ☐ Diuretics ☐ Anticonvulsants ☐ Narcotics ☐ Antihypertensives ☐ Sleeping medications ☐ Antipsychotics ☐ Other [ ] ☐ Anxiolytics ☐ None of above
Accidents (Check all that apply) J4	☐ a. Fell in past 30 days ☐ d. Other fracture in last 180 days ☐ b. Fell in past 31-180 days ☐ e. None of above ☐ c. Hip fracture in last 180 days
Describe, if necessary.	[ ]

INTERVENTIONS - Immediate measures taken.	
Indicate measures taken.	☐ Adaptive Equipment ☐ First Aid ☐ Anaglesics ☐ Immobilize/Splint Area ☐ Bed Alarm - i.e. bed pad, TAB Alarm ☐ Personal Alarm - i.e. Motion Detector ☐ Chair/Wheelchair Alarm - i.e. seat pad, TAB Alarm ☐ Rest ☐ Cold ☐ Restraint ☐ Direct Pressure to Wound ☐ Other [ ] ☐ Elevate Edematous/Affected Extremity ☐ None of above
Describe measures, if necessary.	[ ]
Outcome Of Interventions	○ Interventions Effective, describe below if necessary. ○ Interventions Ineffective, describe below. ○ Interventions Somewhat Effective, describe below. ○ No Interventions Used
Describe, if necessary.	[ ]

NOTIFICATION GUIDELINES	
Notify MD/NP/PA	BP - Systolic >180, <90; Diastolic >110 Abnormal alignment/positioning, e.g.

immediately by phone or beeper for any of the following.	☐	☐ shortening of lower limb with external rotation.
	☐ Pulse - >110; < 55 resting, unless values are within the resident's baseline parameters.	☐ Change in Mental Status of new onset.
	☐ Respirations - >28; <10, unless values are within resident's baseline parameters.	☐ Hip/Joint pain with palpation or ROM, or inability/unwillingness to bear weight.
	☐ Temperature - 2.4 degrees or > above resident baseline OR >100.4 Oral/Tympanic; >102 Rectal	☐ Laceration with uncontrolled bleeding.
	☐ Oxygen Saturation - < 90%	☐ New onset of moderate to severe pain.
	☐ Orthostatic BP - Systolic changes ≥ 20	☐ Suspected head injury/abnormal neuro checks from resident baseline.
	☐ If Diabetic - FSBS >300; <70	

Additional Information

Additional Info:	

Notifications

Notify Attending Physician:	Physician does not receive system pages ☐ Fax Attending				
Physician Notified:	☐	Date Notified:		Time Notified:	:
Family Notified:	☐	Date Notified:		Time Notified:	:
Care Plan reviewed and revised as needed:	☐	Date Reviewed:		Time Reviewed:	:

Observation Complete: ☐