GVCC Fall Assessment and Reevaluation Tool

Resident name_____ MR # _____

		A	B	C	D	E	F	G	H	I			
Date	Assessment Type	Age	Fall Hx	Mental Status	Mobility	Communication	Elimination	Vitals	Medications	Behavior	Total Score	Fall Program	Initials

Variable	0	1	2	3
Age	18-30	31-60	61-75	>75
Hx of Falls	No history	➢ 6 months or unknown	1-6 months ago	Within 1 month
Mental Status	Alert & Oriented x3, follows instructions	Oriented to person/place	Oriented to person only, short term memory loss	Disoriented, unable to follow instructions
Physical Mobility	No physical impairment, no assistive devices to ambulate	Use assistive device **and/or** able to ambulate **and/or** needs standby assist	Assist of 1-2 or more to ambulate	Unable to ambulate
Communication/Sensory Impairment (vision, hearing, speech, neuropathy, language barrier	No deficits	1 deficit with correction	1 deficit without correction **or** 2 deficits with correction	3 or more deficits **or** onset of new problem
Elimination (nocturia, urgency, diarrhea, incontinence, retention, laxatives, bowel prep, UTI	No problem	1 problem **and/or** foley/ostomy	2 problems **or** removal of foley within 24 hours	3 or more problems **or** onset of 1 new problem
Vital Signs	No problem	Asymptomatic bradycardia <60, tachycardia>100, **or** Fever >102", **or** requires O2 to hold sats >90%, Systolic BP <90	2 Or more of the following Asymptomatic bradycardia <60, tachycardia>100: **or** Fever >102" **or** requires O2 to hold sats >90%	Symptomatic hypotension SBP <90, Orthostatic BP down 20 pts, Symptomatic bradycardia <60, Symptomatic tachycardia>100, Unable to maintain O2 sats >90%
Medications: CV or CNS Anesthesia within 24 hours	No CV or CNS meds	CV meds	CNS meds	>9 meds **or** CV and CNS meds **or** Anesthesia
Behavior: Combativeness, agitation and anxiety	No problems	Restless, occasionally abrasive	Repetitive behavior, calls out, threatening	Combative, paranoia, exhibits psychomotor behaviors

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Assessment Guidelines and Interventions

Assessment	Re-assessment	Interventions to be considered
Upon admit, all residents assessed for falls risk according to the Fall Assessment Tool	All residents are assessed on admit 1x/wk for 4 wks, after every fall , quarterly and with change of condition	Fall Protection for All Residents: • Call light within reach • Orientation to environment • Appropriate footwear • Personal items within reach • Clear pathway • Appropriate lighting • Sit up before standing up • Assistive devices to be used when care planned
Residents with Risk Score = or >9	All residents are assessed on admit 1x/wk for 4 wks, after every fall , quarterly and with change of condition	Fall Program for residents with a risk score of 9 or greater, consider more interventions: • Communicate fall risk with family, resident and staff, document communication • Identify fall risk on care plan and initiate red label under name on door • Chair alarm, bed alarm or motion detector in place • Relocate resident to highly visible area or one to one (family, staff or volunteer) • Frequent reorientation to environment and safety needs • 15 minute checks until RN completes fall risk assessment for further implementation • Pharmacy consult for medication review • PT/OT Consult or BESTAge recommendations • Increase assistance with transfer and/or ambulation • Review toileting needs and position changing needs • Address pain, food and fluid needs • Restraint (only last resort with MD order and family consent) • Bed in low position or cushioned floor mats in place • If a resident scores >24 they must be on 15 minute checks until their condition lessons

****Based off assessment by RN, interventions/fall program can be changed at any time if the RN feels current interventions may not be appropriate.****

RN Signature _____ Date completed _____
RN Signature _____ Date completed _____
RN Signature _____ Date completed _____
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