Minnewaska Lutheran Home
605 Main St PO Box 40
Starbuck, MN 56381

Resident Label

Fall Assessment & Reevaluation Tool

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, Quarterly & with change in condition.	**Fall Protection for <u>all</u> Residents:** * Call light within reach or resident under direct supervision * Orientation to environment * Bed or chair in low position/brakes on * Appropriate footwear (non-skid) * Personal items within reach * Clear pathway * Appropriate lighting * Sit before standing * Assistive devices will be used as appropriate
Residents with Risk Score equal to or greater than 9		**Fall Program for patient with risk score of 9 or greater:** * Identify Fall Protection on Care Plan and Kardex * Communicate risk level * Share with patient/family education regarding fall program and document in medical record * Bilat 1/2 SR * Family present or 1:1 (nursing) * Chair alarm * Floor alarm * **Restraints (required MD order)** * Relocate patient to highly visible area * 4Ps-Pain,Potty,Position,Plalate-every 2 hrs * Frequent re-orientation * Pharmacy consult for medical review * **PT/OT consult (requires MD order)** * Ambulate with assist

Using grid at bottom of page, score each variable and tally Total Score.

	Date	Time	A Age	B Hx of Falls	C Mental Status	D Physical Mobility	E Commun-ication	F Elimination	G Vital Signs	H Medications	Total Score (if>9)		Fall Program	Initials
Admit														
Reevaluation												If nurse feels patient is at risk (even if score<9) implement Fall Program		

Score of 9 or greater or fall during admission = At Risk... Place on Fall Program.

Variable	0	1	2	3
A. Age	18-30	31-60	61-75	>75
B. Hx of Falls	No history	> 6 months or unknown	1-6 months ago	Within 1 month
C. Mental Status	Alert & Oriented x3 , follows instructions.	Oriented to person/place	Oriented to person only, Short Term Memory loss	Disoriented, unable to follow instructions
D. Physical Mobility	No physical impairment, no assistive devices to ambulate	Use assistive device and/or able to ambulate and/or needs stand-by assist	Assist of 1-2 or more to ambulate	Unable to ambulate
E. Communcation/Sensory Impairment (vision, hearing, speech, neuropathy, language barrier)	No deficits	1 deficit w/correction	1 deficit w/out correction or 2 deficits with correction	3 or more deficits or onset of 1 new problem
F. Elimination (nocturia, urgency, diarrhea, incontinence, retention, laxative, bowel prep, UTI)	No problem	1 problem and/or Foley/ostomy	2 problems or removal of Foley within 24 hrs	3 or more problems or onset of 1 new problem
G. Vital Signs	No problem	Asymptomatic bradycardia <60, tachycardia >100, OR Fever >102°, OR Requires O2 to hold stats at >90%, Systolic <90	2 or more of the following: *Asymptomatic bradycardia <60, tachycardia >100 *Fever >102° *Requires O2 to hold stats at >90%	Symptomatic hypotention SBP <90%, Orthostatic BP down >20 pts, Symptomatic bradycardia <60, Symptomatic tachycardia >100, Unable to maintain O2 sats >90%
H. Medications (CV: antihypertensive, diuretics, antiarrhythmics) (CNS: narcotics, psychotropics, anti-convulsants, benzodiazepine) (Anesthesia: within 24 hrs)	No CV or CNS meds	CV meds	CNS meds	>9 medications **OR** CV and CNS meds **OR** Anesthesia