

INSTRUCTIONS: Recommend to be completed upon admission, following a fall and according to community policy. Assess the resident's condition and determine the most appropriate response. Steps should be promptly taken to reduce the risk associated with each clinical condition.

FALL RISK ASSESS AND INTERVENTIONS

For each assessment, document the date a device was started (S) or discontinued (D) during the assessment period.								Resident's Age			
	1	2	3	4		1	2	3	4		
Pacemaker					Side Bed Rails at Night						
Cane/Walker					Other _____						

ASSESSMENT DATES

CLINICAL CONDITION	RESIDENT STATUS	SCORE	ASSESSMENT DATES				
			1	2	3	4	
History of Falls	During the last 90 days the resident has had:	No falls 1-2 falls 3 or more falls	0 6 10				
	If fall(s) is indicated, record the date of the most recent fall in the appropriate assessment box.						
Cognitive Status/ Behavior Indicators	Has the resident's cognitive status changed in the last 90 days?	No Yes	0 2				
	Does the resident display any of the following behaviors: (✓ all that apply)						
	<input type="checkbox"/> Easily distracted <input type="checkbox"/> Periods of altered perception or awareness of surroundings <input type="checkbox"/> Episodes of disorganized speech <input type="checkbox"/> Periods of restlessness <input type="checkbox"/> Periods of lethargy <input type="checkbox"/> Mental function varies over the course of the day <input type="checkbox"/> Wanders <input type="checkbox"/> Abusive <input type="checkbox"/> Resists care		No to all Yes to any	0 2			
Vision Status	Resident's ability to see in adequate light and with glasses, if used: Adequate - sees fine detail, including regular print Moderately impaired - limited vision, but can identify objects Highly or Severely impaired - sees only lights, colors, etc... or no vision		0 2 4				
Continenence	Independent and continent Elimination with assistance Independent and incontinent		0 2 4				
Mobility	Ambulates without problem and without devices Ambulates without problem and with devices Ambulates with problems and with devices Confined to chair Uses bed rails		0 1 4 2 2				
Balance	Assess resident's balance while standing and sitting. Maintained position as required Unsteady, but able to rebalance without physical support Needs occasional physical support Always needs physical support		0 1 2 4				
Systolic Blood Pressure and Vitals	Measure systolic blood pressure while lying or sitting and 1-3 minutes after standing. No drop in pressure noted Less than 20mm Hg drop in pressure noted More than 20mm Hg drop in pressure noted		0 2 4				
	Indicate Temperature and Respiratory Rate						
Health Conditions	<ul style="list-style-type: none"> Cardiovascular (cardiac dysrhythmia, peripheral vascular disease) Neuromuscular or functional (loss of arm/leg movement, hypotension, Parkinson's, loss of sensation) Orthopedic (joint pain, hip fracture, missing limb, osteoporosis) Perceptual (impaired hearing, dizziness/vertigo) Psychiatric or cognitive (delirium, Alzheimer's disease, dementia) Nutritional factors (malnutrition, dehydration) None present 1-2 present 3 or more present		0 2 4				
Medications	To assess resident, consider the following medications taken during the last 7 days: antipsychotics, anti-anxiety, antidepressants, diuretics, anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cardiovascular meds, cathartics, hypoglycemics, narcotics, hypnotics. None of the above medications taken currently or within the last 7 days 1-2 of the above medications taken currently or within the last 7 days 3 or more of the above medications taken currently or within the last 7 days		0 2 4				
TOTAL SCORE	SCORE KEY : 1-3 = Lower Risk 4-6 = Moderate Risk 7+ = Higher Risk Consider ENVIRONMENTAL RISK factors in resident's interventions. (See slide two)						

The information contained herein is designed to serve only as a guide. It is the responsibility of health care professionals to use their professional judgement in determining accurate resident assessment and needs.

Initials	Signature	Date	Initials	Signature	Date
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ENVIRONMENTAL FACTORS

Consider the following environmental factors in assessing resident's risk of falls: glare; poor illumination; slippery floors; uneven surfaces; patterned carpets; foreign objects in walkway; new arrangement of objects; recent move into facility; proximity to aggressive resident; time of day; time since meal; type of activity; walking in crowded area; responding to bladder or bowel urgency.

Document interventions below and on the resident's service plan. Resident should be informed of the risk/benefits associated with each intervention.

1 INTERVENTION	Date Initiated	By:
Date Intervention Reviewed:	By:	Intervention effective? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:	Follow-up Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2 INTERVENTION	Date Initiated	By:
Date Intervention Reviewed:	By:	Intervention effective? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:	Follow-up Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3 INTERVENTION	Date Initiated	By:
Date Intervention Reviewed:	By:	Intervention effective? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:	Follow-up Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4 INTERVENTION	Date Initiated	By:
Date Intervention Reviewed:	By:	Intervention effective? <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:	Follow-up Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DATE	NOTES	INITIALS

Resident Name	Apt./Room #	Physician
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