**FALL RISK PREDICTIVE FACTORS ASSESSMENT**

INSTRUCTIONS: Assess the resident status in the eight clinical condition parameters listed below (A-H) by assessing the corresponding score which best describes the resident in the appropriate assessment column, Add the column of numbers to obtain the Total Score. If the total score is 10 or greater, the resident may be considered HIGH RISK for potential falls. If indicated, initiate a plan of care to reduce the likelihood of a fall and/or severity of fall related injury. (SEE OTHER SIDE FOR OPTIONAL PLAN OF CARE)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MENTAL STATUS** | PARAMETER | | SCORE | ASSESSMENT | | 1 | 2 | 3 | 4 |
| A  Level of Consciousness / Mental Status | | 0 | ALERT, ORIENTED, RLIABLE SAFETY AWARENESS; OR COMATOSE | |  |  |  |  |
| 2 | DIMINISHED SAFETY AWARENESS | |  |  |  |  |
| 4 | POOR RECALL, JUDGEMENT, SAFETY AWARENESS | |  |  |  |  |
| **MOBILITY / CONTINENCE** | B  Ambulatory Elimination Status 2 or higher may assess for continence protocol | | 0 | AMBULATORY / CONTINENT | |  |  |  |  |
| 2 | IMPAIRED MOBILITY / CONTINENT (assist with toileting) | |  |  |  |  |
| 4 | AMBULATORY / INCONTINENT | |  |  |  |  |
| C  Gait / Balance  If total is greater than 1, refer to Rehab Department for screening | | To assess the resident’s Gait / Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; make a turn. Score each area of enter N/A | | | | | | |
| 0 | GAIT / BALANCE normal | |  |  |  |  |
| 1 | Balance problem while standing | |  |  |  |  |
| 1 | Balance problem while walking | |  |  |  |  |
| 1 | Decreased muscular coordination | |  |  |  |  |
| 1 | Change in gait pattern when walking through doorway | |  |  |  |  |
| 1 | Jerking or unstable when making turns | |  |  |  |  |
| 1 | Requires use of assistive device (cane, w/c, walker, furniture, etc.) | |  |  |  |  |
| MEDICAL STATUS / HISTORY | D  Vision Status | | 0 | ADEQUATE (with or without glasses) | |  |  |  |  |
| 2 | POOR (with or without glasses) | |  |  |  |  |
| 4 | LEGALLY BLIND | |  |  |  |  |
| E  Orthostatic Blood Pressure (Systolic) | | 0 | NO NOTED DROP between lying and standing | |  |  |  |  |
| 2 | Drop LESS THAN 20mm Hg between lying and standing | |  |  |  |  |
| 4 | Drop MORE THAN 20mm Hg between lying and standing | |  |  |  |  |
| F  Falls History  (past 3 Months) | | 0 | NO FALLS in past 3 months | |  |  |  |  |
| 2 | 1 – 2 FALLS in the past 3 months | |  |  |  |  |
| 4 | 3 OR MORE FALLS in the past 3 months | |  |  |  |  |
| G  Medications  If total is greater than 2, may refer to Physician or Pharmacy Consultant for assessment | | Respond below based on the following types of medications: Anesthetics, Antihistamines, Anti-hypertensives, Anti-seizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemic, Narcotics, Psychotropic, Sedative / Hypnotics | | |  |  |  |  |
| 0 | NONE of these medications taken currently or within the last 7 days | |  |  |  |  |
| 2 | TAKES 1-2 of these ,medications currently and/or within the last 7 days | |  |  |  |  |
| 4 | TAKES 3-4 of these medications currently and/or within the last 7 days | |  |  |  |  |
| 1 | If resident has had a change in medication and/or change in dosage in the past 5 days – score 1 additional point | |  |  |  |  |
| H  Predisposing Diseases / Conditions | | Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson’s Disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures, Dementia, Delirium, Anemia, Wandering, Anger | | |  |  |  |  |
| 0 | NONE PRESENT | |  |  |  |  |
| 2 | 1-2 PRESENT | |  |  |  |  |
| 4 | 3 OR MORE PRESENT | |  |  |  |  |
| Total score of 10 or higher may represent HIGH RISK | | | | TOTAL SCORES |  |  |  |  |
| □ Admission Assessment □ Quarterly □ Post fall | | | | |  |  |  |  |
| ADDRESSORS | Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| RESIDENT | | Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

**FALLS MANAGEMENT: INITIAL PLAN OF CARE**

NOTE: Interventions includes general standards of care that should be considered facility /program/unit specific protocols and environmental safety features. The medical record documents – physician’s orders, progress notes, therapy notes, nurses notes, and consultation reports may include additional interventions that are intended to manage underlying conditions and circumstances that are predictive of falls. The below, resident-specific interventions are a guide. Actual care and services may vary in accordance with specific circumstances. DIRECTIONS: COMPLETE ALL INTERVENTION CATEGORIES THAT APPLY.

**GOALS (on-going, may not be date specific)**

|  |  |
| --- | --- |
| 1 | To reduce incidence of falls and severity of fall related injury |
| 2 |  |
| 3 |  |

**SELECTED INTERVENTIONS**

|  |  |
| --- | --- |
| **Mental Status** | 1. **Level of Consciousness / Mental Status** |
| □ Behavioral management / modifications:\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Movement sensor alarm:  □ bed alarm □ chair alarm □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ alarm test and battery check per protocol |
| □ Least restrictive restraint  □ bed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Chair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Assistive devices  □ wheelchair □ walker □ meri-walker  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ increase assistance and surveillance:  □ locate near station /staff when out of bed  □ toilet per B & B assessment  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Proactive promote comfort  □ pain medication □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Review Medications: □ Yes, date \_\_\_\_/\_\_\_\_/\_\_\_\_ □No |
| □ Medical Consultation: □ Yes, date \_\_\_\_/\_\_\_\_/\_\_\_\_ □No  □Psychiatric Consultation: □Yes, date\_\_\_\_/\_\_\_\_/\_\_\_\_ □No |
| **Mobility / continence** | 1. Ambulatory Elimination Status 2. Gait / Balance |
| □ PT / OT assessment and treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Restorative Nursing(exercise / ambulation)\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Increase help with ADLs (activities of daily living) \_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Assistive Devices  □ Cane □ Crutches □ Walker □ Meri-walker □ W/C  □ Adjust height of: □ bed □chair  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Protective Devices  □ hip protector □ head helmet protector  □ in bed protector □ out of bed protector  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Transfer:  □ no assistance □ one person □ two person □ other\_\_\_  □ sliding board □other device \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Medical Status / History** | **Environmental Modifications**  □ instruct resident to call for help before getting out of bed  □ bed in lowest position and wheels locked  □ bedrails up: □ left side □ right side  □ brighter lighting □ night light  □ personal care items within arm length (cordless telephone,  Optical / hearing devices, mobility aids and assistive  devices)  □ Footwear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Vision and Hearing Status |
| □ Vision intervention:  □ Corrective eyewear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Eyewear within arms reach  □ Encourage resident to wear glasses  □ modify lighting  □ modify contrast colors  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Orthostatic Blood Pressure (Systolic) |
| □ Low Blood Pressure  □ Instruct to change position slowly  □ Instruct to sit on edge of bed and dangle feet before  Standing  □ Instruct to use dorsiflexion (flexion of the foot in an  upward direction) before standing  □ instruct not to tilt backwards  □ If medication change  □ monitor blood pressure while lying to sitting: sitting to  standing. Inform physician  □ Other interventions:  □ TED hose (thromboembolic disease support hose)  □ Promote adequate hydration  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Falls History (Past 3 months) 2. Medications 3. Predisposing diseases / conditions |
| □ Monitor and report changes in behavior (anxiety, sleep, patterns, behavior, mood, etc.)  □ Monitor and report drug side effects (see mental status)  □ Monitor Routines:  □ No caffeine after 4 pm  □ Up at night with supervision  □ Comfort measures, good hygiene  □ pain management  □ irregular exercise routine  □ limit napping  □ relaxing bed routine  □ individualized toileting at night  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Who completed this Section | Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| RESIDENT | Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room #: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FALLS MANAGEMENT: ACTUAL FALL PLAN OF CARE**

NOTE: Interventions includes general standards of care that should be considered facility /program/unit specific protocols and environmental safety features. The medical record documents – physician’s orders, progress notes, therapy notes, nurses’ notes, and consultation reports may include additional interventions that are intended to manage underlying conditions and circumstances that are predictive of falls. The below, resident-specific interventions are a guide. Actual care and services may vary in accordance with specific circumstances.

DIRECTIONS: COMPLETE ALL INTERVENTION CATEGORIES THAT APPLY.

**GOALS (on-going, may not be date specific)**

|  |  |
| --- | --- |
| 1 | To reduce incidence of falls and severity of fall related injury |
| 2 |  |
| 3 |  |

**SELECTED INTERVENTIONS**

|  |  |
| --- | --- |
| **Mental Status** | 1. **Level of Consciousness / Mental Status** |
| □ Behavioral management / modifications:\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Movement sensor alarm:  □ bed alarm □ chair alarm □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ alarm test and battery check per protocol |
| □ Least restrictive restraint  □ bed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Chair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Assistive devices  □ wheelchair □ walker □ meri-walker  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ increase assistance and surveillance:  □ locate near station /staff when out of bed  □ toilet per B & B assessment  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Proactive promote comfort  □ pain medication □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Review Medications: □ Yes, date \_\_\_\_/\_\_\_\_/\_\_\_\_ □No |
| □ Medical Consultation: □ Yes, date \_\_\_\_/\_\_\_\_/\_\_\_\_ □No  □Psychiatric Consultation: □Yes, date\_\_\_\_/\_\_\_\_/\_\_\_\_ □No |
| **Mobility / continence** | 1. Ambulatory Elimination Status 2. Gait / Balance |
| □ PT / OT assessment and treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Restorative Nursing(exercise / ambulation)\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Increase help with ADLs (activities of daily living) \_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Assistive Devices  □ Cane □ Crutches □ Walker □ Meri-walker □ W/C  □ Adjust height of: □ bed □chair  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Protective Devices  □ hip protector □ head helmet protector  □ in bed protector □ out of bed protector  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Transfer:  □ no assistance □ one person □ two person □ other\_\_\_  □ sliding board □other device \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Medical Status / History** | **Environmental Modifications**  □ instruct resident to call for help before getting out of bed  □ bed in lowest position and wheels locked  □ bedrails up: □ left side □ right side  □ brighter lighting □ night light  □ personal care items within arm length (cordless telephone,  Optical / hearing devices, mobility aids and assistive  devices)  □ Footwear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Vision and Hearing Status |
| □ Vision intervention:  □ Corrective eyewear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Eyewear within arm’s reach  □ Encourage resident to wear glasses  □ modify lighting  □ modify contrast colors  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Orthostatic Blood Pressure (Systolic) |
| □ Low Blood Pressure  □ Instruct to change position slowly  □ Instruct to sit on edge of bed and dangle feet before  Standing  □ Instruct to use dorsiflexion (flexion of the foot in an  upward direction) before standing  □ instruct not to tilt backwards  □ If medication change  □ monitor blood pressure while lying to sitting: sitting to  standing. Inform physician  □ Other interventions:  □ TED hose (thromboembolic disease support hose)  □ Promote adequate hydration  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Falls History (Past 3 months) 2. Medications 3. Predisposing diseases / conditions |
| □ Monitor and report changes in behavior (anxiety, sleep, patterns, behavior, mood, etc.)  □ Monitor and report drug side effects (see mental status)  □ Monitor Routines:  □ No caffeine after 4 pm  □ Up at night with supervision  □ Comfort measures, good hygiene  □ pain management  □ irregular exercise routine  □ limit napping  □ relaxing bed routine  □ individualized toileting at night  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Who completed this Section | Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assess. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| RESIDENT | Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room #: \_\_\_\_\_\_\_\_\_\_\_\_\_ |