RESIDENT FALL RISK AND PREDICTION - DATA RETRIEVAL WORKSHEET

Date: _____ Nurse Completing Audit: _____

Unit: _____ Shift Completed: _____

Falls and fall risk can be symptoms of multiple disease processes and should be seriously considered with any assessment. A program that includes policies and procedures to identify residents who are at risk of falls immediately after admission and ongoing during their stay should be present in any formal care setting. Components include identification of risk level, areas of and reasons for increased risk. An interdisciplinary approach including the resident and direct care workers whenever possible must be used to design and implement individualized interventions based on assessment findings. Good ongoing communication, feedback and teamwork are essential to the success of any fall risk prevention program.

Observation=O, Record Review=RR, Interview=I, Assessment=A

Type of Data Retrieval	Monitoring Criteria	Y/N	N/A	Incomplete	Comments
A, O, RR, I	1. All residents are evaluated for fall risk on admission, quarterly, with new fall episode, and with change in status				
A, O, RR, I	2. Immediately on admission, quarterly, with fall or change, evidence based fall-risk scales are part of overall process to identify residents at risk, their areas of risk, and changes in risk factors/level. Use general tools for general information, specific tools for specific problems/information: a. Examples 1. Morse 2. RCCT 3. Tinetti Balance Subscale 4. Berg Balance Scale 5. MDS Section G0300 6. Hendrich II				
A, O, RR, I	3. Resident evaluation includes a. underlying conditions b. functional status c. neurological status d. psychological factors e. environmental factors				

	f. medications g. fall history				
A, O, RR, I	4. Underlying conditions that may contribute to fall risk are assessed. Some examples are: a. Age >80 b. Cardiovascular disease c. Dysrhythmias d. Anemia e. Vision/hearing problems f. Neurovascular disease g. Electrolyte imbalance h. Depression i. Diabetes j. Arthritis k. Foot/lower limb disorders l. Poor sitting balance or posture m. incontinence n. Infections (including C-Diff) o. Acute illness p. Mental status change q. Orthostatic hypotension r. Osteoporosis s. Involuntary movement disorders t. History of falls/fractures u. Dehydration v. General weakness w. Pain				
RR, I	5. Classes of medications that alone or in combination may contribute to falls are assessed. Consider all additions/changes in medications as a potential contributing factor. Some examples are: a. Antiarrythmics b. Antipsychotics c. Anti-hypertensives d. Antidepressants e. Opioid analgesics f. Anti-parkinsonian meds g. Diuretics h. Laxatives i. Vasodilators j. Anticholinergics k. Benzodiazepines l. Antiepileptics				
A, O, I	6. Areas of functional status are assessed.				

	a. Level of mobility b. Gait and standing/sitting balance c. Ability to get up and go d. Lower/upper extremity joint function/muscle strength e. Ability to properly use assistive devices (cane, walker) f. Activity tolerance g. De-conditioning h. Bowel/bladder continence, response to individualized toileting				
A, O, I	7. Neurological status is assessed a. Conditions that impair vision/hearing b. Impaired cognition c. sedation d. Sensory deficits, including peripheral neuropathies e. Muscle strength, proprioception, reflexes, motor and cerebellar function				
A, O, I, RR	8. Psychological status is assessed a. Impaired cognition b. Impaired Judgment c. Memory d. Safety awareness e. Decision making capacity f. Depression g. Fear of falling h. Concerned about bothering staff				
O, I	9. Environmental factors contributing to falls are assessed. Some examples are: a. Ill fitting or inappropriate footwear b. Excessive bed height c. Inadequate or broken assistive devices d. Poor/inconsistent lighting or glare e. Limited, inappropriate or uncomfortable seating f. Use of side rails or other g. Use of chair alarms				

	h. Incorrect glasses i. Loose/uneven flooring/ rugs j. Wet floors k. Highly polished floors				
A, I, RR	10. History of previous falls is assessed a. Time of day falls occurred b. Location of falls c. Doing usual or unusual activity d. Medications e. Proximity to most recent meal/fluid intake f. Standing still or walking g. Reaching up or down h. On way to toilet i. ID contributing factors/root cause if possible				
RR, I	11. Multidisciplinary approach is used to care plan resident's individual fall risk areas/ level a. Include resident/family members in discussion if possible b. Include front line staff who work with resident c. Review all resident assessment information d. Review MDS 3.0 Fall CAA (Appendix C No 11 of RAI manual) for items indicative of fall risk. e. Track/review previous falls f. Root cause analysis (what was resident trying to do?) g. Review areas of risk and resident needs h. Review/ discuss potential interventions that meet areas of risk				
A, RR, I, O	12. Potential interventions related to individual fall risk a. PT/OT consults for evaluation, strengthening of core, upper & lower extremities b. Encourage/enable regular resident ambulation and exercise c. Minimize potential for orthostasis or other S/Es				

	through regular review of new and current meds, adjustments, awareness and fluid intake programs d. Adequate pain management e. Confidence building to decrease fear f. Individualized toileting programs g. Meet individual needs for meaningful activity h. Repair/replace ill fitting or broken appliances/aides i. Management of depression j. Management of other disease processes that inhibit mobility or contribute to fall risk (see #4 - Underlying conditions)				
RR	13. Individualized care plan for resident fall risk/s is based on findings from thorough multidisciplinary assessment				
RR, I, O	14. Staff are educated routinely on resident's fall risk and interventions 15. Staff are routinely apprised of changes in status and care needs				
O, I	16. Appropriate general interventions are in place such as rounding on residents at risk of falls				
A, O, I	17. Staff working with resident are involved in ongoing evaluation of goals and interventions for efficacy and feasibility				

Resident Fall Risk and Prediction - Data Retrieval Worksheet

American Medical Directors Association. 2003. *Falls and Fall Risk: Clinical Practice Guidelines.*

Center for Medicare and Medicaid Services. January 2010. *Resident Assessment Instrument Manual, 3.0.*

Healthcare Association of New Jersey. 2007. *Fall Management Guideline*.

Kehinde, J. 2009. Instruments for measuring fall risk in older adults living in long-term care facilities. *Journal of Gerontological Nursing.* 35(10), 46-55.

Olsson, R, Wambold, S,Brock, B, Waugh,D, &Sprague, H. 2005. Visual spatial abilities and fall risk. *Journal of Gerontological Nursing.* 31(9), 45-53.

Sharaf,A, Ibrahim, H. 2008. Physical and psychosocial correlates of fear of falling among older adults in assisted living facilities. .*Journal of Gerontological Nursing*, 34(12), 27-35.

Taylor, J, Parmelee, P, Brown,H, & Ouslander, J. 2005. *The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities*. AHRQ #290-00-0011, Task order No. 3. Emory University.

Tideiksaar, R, 2007. How flooring can reduce fall risk and injury. *ECPN*, September 2007.

Wright, S, Goldman, B, & Beresin, N. 2007. Three essentials for successful fall management. *Journal of Gerontological Nursing*, 33(8), 42-48.