Kennedy Krieger Institute

KKI 12-19-03 14797150
AL YASIN, HAYA
JHH
6/09/03 X F
7/07/08 Alyasin, Haya

Fall Risk Assessment Tool

Instructions: Assess on admission, then every week with Goal Note and Wee Fim scores. If "no", score is 0; if "yes", score total number of points for risk factor. Score for behaviors presented during the past week.

Risk Factors	Points	Score
•Physical Activity Intolerance (lack of endurance)	10	10
•Age less than 13	5	5
•Agitation	20	
•Altered elimination patterns (incontinent, cic, foley catheter)	10	10
•Communication deficits	10	10
•Diuretics and/or drugs that increase GI motility	5	
•Episodes of dizziness/seizures	10	10
•History of previous falls (past 3 months)	20	
•Impaired cognition	20	20
•Impaired mobility	20	20
•Impulsiveness	20	20
•Sensory deficits (hearing, sight, touch, smell)	5	
•Special medications (narcotics, psychotropic, hypnotic, antidepressants etc.)	5	
•Unilateral neglect (lack of awareness on either side of the body)	10	
	Total =	105

	Risk Level (Check Level)	Fall Risk Scale	Action
	Standard Risk	≤ 59	See Standard Fall Prevention Interventions
X	High Risk	> 60	See High Risk Fall Prevention Interventions

Falls Prevention Program

Standard Fall Prevention Interventions

- Orient patient to environment as appropriate.
- Check patient minimally every two hours
- Ensure patient wears eyeglasses (if applicable).
- Keep the patients feet covered with socks, shoes, or slippers when out of bed.
- Place patient in a bed that will afford maximum safety and least restrictive environment.
- Keep bed in low position.
- Keep side rails be up at all times unless patient is attended by staff/parents/caregiver.
- If the patient can crawl or stand, the tops of the crib must be down and locked when in the crib.
- Adolescents may have bedrail down with a physician's order.
- Young children (i.e toddlers) may ambulate if they are supervised by an adult.
- Accompany patients during ambulation as determined by the professional nurse/physical therapist.
- Adhere to patient-specific protocol for ambulation.
- Lock wheels/brakes on all wheelchairs, beds, commodes, and stretchers.
- Clean up spills immediately.
- Provide adequate lighting at night.
- Make certain nurse call system/telephone is accessible to the patient at all times.

High Risk Fall Prevention Interventions

- Implement Standard Fall Prevention Interventions
- Identify the patient is high risk for falls in their Plan of Care under "safety" section
- Assess elimination needs every two hours
- Assess need of bedside commode or bedpan
- Assess need for assistive or protective device; implement if needed: high-climber crib, Posey bed
- Consider moving patient close to nurses' station
- Assess need for 1:1 supervisions
- Evaluate medication administration times, i.e. Lasix in AM instead of PM
- Report High Risk for Falls patient to charge nurse and physician
- Other

RN Signature: Cust Bafld RN Date: 7/7/08 Time: 1030