

Fall Risk Assessment & Care Plan

Site: _____

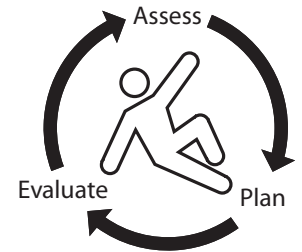
Date: _____ Signature: _____ Designation: _____

Fall Risk Screen: (check all that apply)

- Cognition impaired?
- Altered elimination?
- Mobility impaired?
- Previous fall (last 90 days)?
- Vision Impaired?

Assessment on: (check one)

- Admission
- Transfer
- Significant Change in Status



/5 = Fall Risk (CAMP+V) Score

If "At risk" (Score = 2 or more), please complete the following:

	Fall Risk Factors	Multi-factorial Fall Risk Assessment	Fall Prevention Strategies & Interventions CARE PLAN
C	Cognitive Status	<input type="checkbox"/> Agitation, aggression, pacing, anxiety <input type="checkbox"/> Delirium, dementia, psychosis, <input type="checkbox"/> Developmental delay <input type="checkbox"/> Lack of insight & safety awareness <input type="checkbox"/> Impulsiveness <input type="checkbox"/> Neurological/brain injury	<input type="checkbox"/> Bottom bed rails are down <input type="checkbox"/> Familiarize pt to surroundings <input type="checkbox"/> Move patient closer to nursing station <input type="checkbox"/> 1:1 supervision <input type="checkbox"/> Bed/chair alarm <input type="checkbox"/> _____ <input type="checkbox"/> _____
A	Bowel/Bladder	<input type="checkbox"/> Altered elimination, urgency, frequency, rushing to the toilet	<input type="checkbox"/> Individual Toileting schedule/plan in place <input type="checkbox"/> Review medications that cause urgency <input type="checkbox"/> Fluid management plan <input type="checkbox"/> Clutter-free access to bathroom <input type="checkbox"/> Assistance needed for toileting: <input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Commode/urinal at bedside <input type="checkbox"/> _____ <input type="checkbox"/> _____
M	Functional Mobility	<input type="checkbox"/> Gait, balance, mobility, transfer impaired <input type="checkbox"/> Lack of ability to use mobility aids &/ or wheelchair safely <input type="checkbox"/> Change in wt-bearing status &/ or new assistive aids <input type="checkbox"/> Requires assistance for toileting & bathing <input type="checkbox"/> Lack of proper footwear	<input type="checkbox"/> Assistance for transfers to/from bed/wheelchair/toilet/ commode <input type="checkbox"/> Ensure bed/chair brakes are on for transfers <input type="checkbox"/> Encourage ambulation with assistance/supervision <input type="checkbox"/> Mobility aid needed & within reach <input type="checkbox"/> Non-slip socks/well-fitting shoes with enclosed heel available <input type="checkbox"/> Bed in lowest position <input type="checkbox"/> Call bell within reach <input type="checkbox"/> _____
P	Previous Fall/Fall History	<input type="checkbox"/> Recent fall within 90 days?	<input type="checkbox"/> Increase supervision <input type="checkbox"/> _____ <input type="checkbox"/> _____
V	Vision	<input type="checkbox"/> Altered ability to see (macular degeneration, glaucoma, cataracts) <input type="checkbox"/> Visually impaired to the extent that everyday function is affected	<input type="checkbox"/> Remove clutter/physical hazards <input type="checkbox"/> Pt has appropriate eyewear within reach <input type="checkbox"/> _____ <input type="checkbox"/> _____

Most current plan in Kardex

Fall Risk Assessment & Care Plan

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Fall Risk Factors	Multi-factorial Fall Risk Assessment	Fall Prevention Strategies & Interventions CARE PLAN
Medications	<input type="checkbox"/> On medications that increase risk of falling (psychotropic, sedatives, anti-coagulants, antihypertensives, opioids, diuretics) <input type="checkbox"/> Potentially inappropriate medication use	<input type="checkbox"/> Assess meds known to increase Fall risk & modify where possible <input type="checkbox"/> Minimize total amount of medication <input type="checkbox"/> Lowest effective dose used <input type="checkbox"/> Non-pharmacological strategies to improve sleep <input type="checkbox"/> Review timing of high-risk medication administration <input type="checkbox"/> _____
Communication	<input type="checkbox"/> Language barrier <input type="checkbox"/> Sensory impairments—poor vision/hearing	<input type="checkbox"/> Translator required: _____ <input type="checkbox"/> Education on use of call-bell <input type="checkbox"/> _____
Environmental Barriers	<input type="checkbox"/> Lack of lighting <input type="checkbox"/> Tripping hazards (clutter, lines, tubes)	<input type="checkbox"/> Personal items within reach <input type="checkbox"/> Pt's room is free of obstacles & clutter <input type="checkbox"/> Assess environment for tubes, lines, furniture, equipment hazardous to mobilization <input type="checkbox"/> _____
Fear of falling	<input type="checkbox"/> Expressed fear of falling that compromises recovery	<input type="checkbox"/> Encourage safe physical activity as possible <input type="checkbox"/> Collaborate with patient & family to address fears <input type="checkbox"/> _____
Health/Physical Status	<input type="checkbox"/> Postural hypotension <input type="checkbox"/> Exacerbation chronic illness <input type="checkbox"/> Irregular heart rate/rhythm/oxygenation <input type="checkbox"/> Muscle weakness/decreased coordination <input type="checkbox"/> Poor proprioception <input type="checkbox"/> Foot problems	<input type="checkbox"/> After period of bed-rest, patient needs to sit for a few minutes prior to standing <input type="checkbox"/> Hip protectors needed <input type="checkbox"/> If systolic drops more than 20mmHg from sitting to standing or lying to sitting, notify NP/MD <input type="checkbox"/> _____
Nutrition/Hydration	<input type="checkbox"/> Recent weight loss <input type="checkbox"/> History of poor/sub-optimal intake <input type="checkbox"/> Poor fluid intake <input type="checkbox"/> History of osteoporosis	<input type="checkbox"/> Consult dietitian if pt is underweight or intake less than 75% for 3 consecutive meals <input type="checkbox"/> Consultation with MD re: supplementation with calcium & Vit D <input type="checkbox"/> Offer minimum 1500 ml of fluids daily unless contraindicated <input type="checkbox"/> _____
Pain	<input type="checkbox"/> Musculoskeletal/neurological condition(s) that produce pain & limit mobility (e.g., diabetic neuropathy) <input type="checkbox"/> Pain interfering with ADLs <input type="checkbox"/> Neurological conditions that limit ability to express pain	<input type="checkbox"/> Multifactorial pain assessment & treatment plan done <input type="checkbox"/> Administer analgesics as needed to relieve pain & consider regular dosing <input type="checkbox"/> Provide prn analgesic prior to mobilization & reassess <input type="checkbox"/> _____
Substance Use	<input type="checkbox"/> Intoxication &/or withdrawal from alcohol, nicotine & drugs	<input type="checkbox"/> Monitor for drowsiness, dizziness & impaired balance/gait/judgment <input type="checkbox"/> _____

Date: _____ Signature: _____ Designation: _____