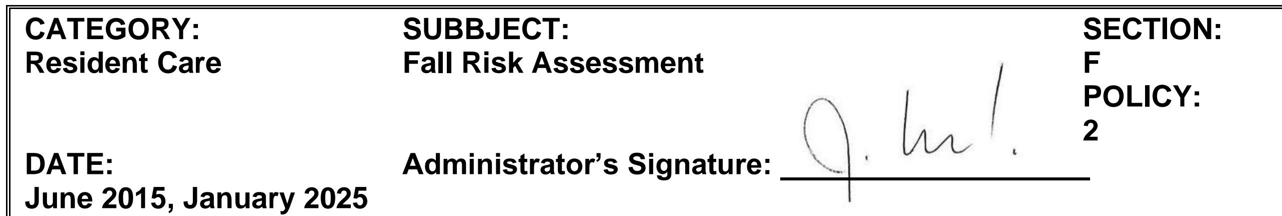
Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE



CATEGORY: Resident Care	SUBBJECT: Fall Risk Assessment	SECTION: F POLICY: 2
DATE: June 2015, January 2025	Administrator's Signature: ________________	

FALL RISK ASSESSMENT

PURPOSE:

To provide an assessment for each resident to determine the level of risk for falls.

PROCEDURE:

The Fall Risk Assessment is completed upon admission, with quarterly assessments, when there is a change in status, upon return from hospitalization, or if there are reported falls such as 2 in 24 hours or 3 falls in 7 days.

The Registered Staff will evaluate the resident by the score produced through the Fall Risk Assessment.

The Registered Staff (and multidisciplinary team) using clinical judgement will determine the risk level interventions. This shall be reviewed by the DNPC with communication of high-risk residents to the DNPC within 24 hours.

- The resident will be placed in a Fall Risk Category through the completed Fall Risk Assessment and Risk Calculation.

Morse Fall Scale Risk Assessment Score	Risk for Falls Level
0-24	Low
25-44	Medium
45 and higher	High

- Outline interventions on the Care Plan of the resident as needed.
- Outline use of Hi Lo Beds.

<u>Suggested interventions:</u>

Low Risk

- Orientate resident to surrounding/staff
- Call for assistance before getting out of bed – call bell use
- Personal care items within reach
- Toileting schedule/raised toilet seat – or commode
- Evaluation of BM pattern
- Proper footwear – nonslip shoes/slipper/socks
- Environmental safety – clutter/cords/equipment
- Placement/adequate lighting
- Bed location for exiting on prominent side
- Bed maintained in height appropriate level
- Proper utilization of hearing aids/glasses
- Food/fluid intake
- Assess mobility equipment – referral to OTA
- Refer to LMH restorative program
- Encourage exercise/participation in activities/stimulation
- Medication review by nurse

Moderate Risk

- As above as indicated.
- DOS to evaluate behaviours – refer to LMH BSO team
- Distraction/relaxation activities: music/videos/iPad
- Comfort rounds: repositioning/offering fluids/snacks/ensuring warmth
- Verbal/written/visual cues
- Wheelchair alarm with Falling Star logo on the wheelchair
- Bed maintained in lowest position with wheels locked
- Bed alarm
- Fall mat
- Use of grab bars/railings etc.
- Every 2 hour and comfort routine toileting schedule
- Evaluate bowel pattern for daily or every other day defecation
- PT referral
- Pharmacy/Physician review of medication

High Risk

- Hi/Low Bed with crawl out mats
- Falling Star symbol above the over bed All about sign
- Referral to Lead BSO team/Geriatric Outreach program
- Review previous interventions and evaluate need to adjust to new situation

All interventions are then communicated to the multidisciplinary staff, utilizing the updated Care Plan, the over the bed All About Sign; Nursing report and E notes, Change to Care Sheet known as the “brown sheet.”