

### **INITIAL FALLS RISK ASSESSMENT ON ADMISSIONS**

The initial falls risk assessment is tasked in Care Compass within Basic Admission Information Adult.

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information
Current
Basic Admission Information Adult 10/01/24 12:08:00 EDT
Unscheduled (NO ACUVIDES)
13:00 (No Activities)
Interdisciplinary (No Activities)

Within task, there is a mandatory Falls Risk Assessment documentation highlighted in yellow:



Must complete all mandatory yellow fields. There is reference text available to aid with your documentation that can be found in any blue coloured text if selected.











If a patient is deemed a high falls risk from your assessment, you must document what interventions you have implemented.

X Activity View	व	Last 72 Hours		
Basic Admission Information     Vital Signs Basic Admission     Measurements	Find Item  Critical High	Low Abnormal Unauth Flag And		
Safety Management Basic Admission	Danuk Commanta Dan Data Dafarmad Du			
Falls Risk Assessment	03/Oct/2024/01/Oct/2024			
Braden Assessment	-   🗮 🔬	15:00 12:06		
	SpO2	%*High Risk Falls Interventions NH 🛛 🗙		
	Low Flow Oxygen Rate	memory Red dot posted (HDS)		
	Oxygen Therapy	Yellow falls risk sign posted (NHS)		
	⊿ Measurements	Orange falls risk sign posted (NHS)		
	Height/Length Measured	cm Universal Falls Precautions implemented		
	Weight Measured	kg Bed alarm calibrated and set, education provided		
	⊿ Safety Management Basic Admission	Bed in lowest position with brakes locked		
	Environmental Safety Implemented	Increase proximity to staff and safety checks		
	⊿ Falls Risk Assessment	Toileting routine established		
	*Falls: Within Past Year? NH	Physiotherapy (PT) consult		
	*Impaired balance? NH	Occupational Therapy (OT) consult		
	*Impaired cognition? NH	Geriatrician/NP consult for acute medical management		
	Cinica juoginene ini	Pharmacy Medication Review (FRAM)		
	*High Risk Falls Interventions NH	Falls risk communicated to patient and/or caregiver		
and A duile Outlette Manue	2 Diducti Assessment			

This documentation can be completed at any time during the patient's admission and can be found within the "Adult Systems Assessment" band located in your iView section.

## FALLS RISK ASSESSMENT OUTSIDE OF ADMISSIONS

In the situation when a patient is transferred between units, there is a change in patient status or in a post fall evaluation, a Falls Risk Assessment is needed to be completed as per policy. This can be found in Interactive iView and I&O band under the "Adult System Assessment" band.

🗙 Adult Systems Assessment		Find Item  Critical High Low	Abnormal
Pulses	^	A Regult Commonto Rag	Data
Edema Assessment		W.	
Gastrointestinal			03/Oct/2024
Genitourinary			15:20
Urinary Catheter		⊿ Falls Risk Assessment	
Genitalia Assessment		Falls: Within Past Year?	
Musculoskeletal		Impaired balance?	
Integumentary		Impaired cognition?	
Braden Assessment		Clinical judgement?	
Incision/Wound/Skin		2 Measurements	
Burn Assessment/Care		Height/Length Measured C	m
Psychosocial Assessment		Patient Stated Height/Length c	m
Falls Risk Assessment		Weight Measured	g
Post Fall Evaluation		Weight Dosing	g
Measurements		Scale Type	
Isolation Type/Activity		(B) Birth Weight	g
Critical Event		Patient Stated Weight	g
Provider Notification		Abdominal Circumference C	m
OB/GYN Assessment		Neck Circumference c	m
BSO-DOS Assessment		Bilateral Arm c	m







# **TIP SHEET** HOSPITAL INFORMATION SYSTEM (HIS)

### POST FALLS EVALUATION

When a patient has a fall in hospital, you must document the post falls assessment within the Adult Systems Assessment iView band:

X Activity View		•				Last 24 Ho
X Adult Quick View						
X Adult Systems Assessment		Find Item	Critical	🗌 High	Low	Abnormal
Pulses	^	Pooutt		Commor	to Do	n Data
Edema Assessment						
Gastrointestinal		1010 .				01/Oct/2024
Genitourinary		<b>R</b> 2				16:33
Urinary Catheter		Post Fall Evaluation	ation			
Genitalia Assessment		Date, Time of Fa	all			
Musculoskeletal		Provider Inform	ed			
Integumentary		Patient Story				
✓ Braden Assessment		Fall Witness				
Incision/Wound/Skin		Fall Assist				
Burn Assessment/Care		Fall Location				
Psychosocial Assessment		Activity at Time	of Fall			
Falls Risk Assessment		Position When	Found			
Post Fall Evaluation		Special Conditi	ons at Time of Fall			
Measurements		Fall Related Inj	ury			
Isolation Type/Activity		⊿ Measurements				
Critical Event		Height/Length	Measured			cm
Provider Notification		Patient Stated H	Height/Length			cm
OB/GYN Assessment		Weight Measur	red			kg
BSO-DOS Assessment		Weight Dosing				kg
	~	Scale Type				

After completing and signing your post fall evaluation, you must contact the MRP as per NH policy. To document this, you will navigate to the Provider Notification section within the Adult System Assessment band in iView.







After notifying the MRP, an order for Neurovitals may be ordered to be completed on the patient. These Neurovitals will be tasked to you in CareCompass. By selecting Neurovitals in CareCompass, it will bring you to activity view and the associated documentation needed for this task. Further reference text is available to aid in your documentation by selecting any blue hyperlinked text within iView.

A really rich	28-Sep	-2024 10:41 - 01-0ct-2024 1	8:00
Neurovitals			
Padiatric Coma Assassment			L Flag
Richmond Agitation Sedation Scale (RASS)	Roault Commonte Pag	Data	Dorfor
Punile Assessment			
Strength and Movement	👘 💐	01/Oct/2024	
Vital Signs		16:42 16:41 1	2:07
That orgine	Neurovitals		
	⊿ Glasgow Coma Assessment		
	Eye Opening Response Glasgow		
	Best Verbal Response Glasgow		
	Best Motor Response Glasgow		
	Glasgow Coma Score		
	Response to Stimuli Affected by (adult)		
	⊿ Pediatric Coma Assessment		
	Eye Opening Response Peds Coma		
	Best Verbal Response Peds Coma		
	Best Motor Response Peds Coma		
	Pediatric Coma Score		
	Response to Stimuli Affected by		
	⊿ Richmond Agitation Sedation Scale (RASS)		
Adult Ouick View	Richmond Agitation Sedation Scale (RASS)		
Adult Sustame Assessment	RASS Score		
Adult Systems Assessment	△ Pupils Assessment		
X Adult Lines - Devices	PERRLA		
Adult Education	Right Pupil Size mn	ð	
Vintake And Output	Left Pupil Size mn	a	
V Blood Broduct & dministration	△ Strength and Movement		
Contrologica Automistration	Strength and Movement		_
Early Warning - NEWS	△ Vital Signs		
💊 Peritoneal Dialysis Management	Temperature Axillary Deg C		

### **FALLS EDUCATION**

Pre/Post fall or with a good catch, you can document Falls Education at any time within the "Adult Education" band

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Activity View	Last 24	IIF JIILLI
Adult Quick View		
Adult Systems Assessment	Find Item V Critical High Low Abnormal	ΙΛΤΙΩΝΙ ΟΥΟΤΕΝΛ (ΠΙΟ)
Adult Lines - Devices		
Adult Education		
Learning Assessment General Education	01/Oct/2024 16:34	
Activities of Daily Living Education Discharge Planning Education Stroke Education		
Falls Education	Gait Aid Use	
Medication Education	Bed Height	
Nutrition Education - Topic	Call Rell Lice Conventional	
Nutrition Counseling Comprehensive	Call Bell Lise Special	
Pain Education	Caregiver Bounding	
Quality Measures Education	Encourage Assistive Device Item Use	
Safety Education	Eyeglasses Use	
Skin and Wounds Education	Handrail, Safety Bar Use	
Social Habits Education	Hearing Aid Use	
VIE Education	Night Light Use	
	Nonskid Footwear Use	
	Orthostatic Hypotension Precautions	
	Personal Article Availability	
	Remove Clutter	
	Side Rails for Mobility, Bed Control	
V Intake And Output	Do Not Lean On Tables With Wheels	
Second Product Administration	Ensure wheelchair/walker Brakes Used App	
av Fadu Warning NEWO	Deer Open	
Eany warning - NEWS	Door Open Datiant Specific Superillance	
🗙 Peritoneal Dialysis Management	Patient apecine adventance	



