Inpatient Fall Reassessment

To Be Completed After EACH Fall **Date:** ___________________

Identification of Fall Risk Factors Check ALL that apply	Interventions Check APPROPRIATE Interventions Implemented
☐ Orthostatic hypotension (≥20mmHg systolic dropper ≤ 90mm Hg standing) ☐ Urinary Tract Infection ☐ Vertigo/Syncope ☐ General Weakness ☐ Abnormal Blood Sugar ☐ Visual Disturbances/Deficits ☐ Lower extremity/foot pain/neuropathies	**Communication** **-- To Patient --** ☐ Use call light/ask for assistance ☐ Teach medication side effects ☐ Slow progressive change to standing position ☐ Patient condition relative to falls **-- To Family --** ☐ Notification ☐ Distribute Post Fall letter/Information **-- To Caregivers --** ☐ Discuss at Team ☐ Add to Kardex/Shift Report – Bee SAFE sticker ☐ Add to Transfers Forms/Hand-off Report ☐ Notify MD ☐ "Bee S.A.F.E." reminders Door Magnet and W/C Sticker
Gait/Balance ☐ Use of assistive devices ☐ Unsteady, swaying or ataxic gait ☐ Decrease in muscular coordination ☐ Loss of balance – standing or walking ☐ History of falls	**Equipment - Acquisitions** ☐ W/C - Accessories ☐ Bedside Commode ☐ Merri-Walker ☐ Walker ☐ Patient footwear
Medications ☐ Recent change in medications ☐ Currently on sedatives, antidepressants, psychotropics or anti-anxiety medications ☐ Recent Diuretics/Laxatives ☐ Currently on Antihypertensive/Cardiac Meds ☐ Change in analgesic	**Alarms** ☐ Bed alarm ☐ Chair alarm ☐ Pull cord alarm
Mental Status ☐ Change in cognition ☐ Dementia ☐ Agitation ☐ Unwillingness to accept limitations/assistance	**Increased Monitoring** ☐ Frequent Comfort/Bowel/Bladder rounds ☐ Ambulate/Reposition frequently ☐ Rearrange obstructive items/cords/furniture ☐ Assure assistive devices in reach ☐ Assure call light/personal items in reach
Environment ☐ Recent change in environment ☐ Call light/personal items not in reach ☐ Poor lighting ☐ Inadequate footwear ☐ Clutter in room	**Nursing Implementation** ☐ Monitor for Orthostatic Hypotension ☐ Consult Physical Therapy/Occupational Therapy ☐ Care Plan –Add fall prevention ☐ Consult Recreation Therapy ☐ Review medications ☐ Review medical status (infections, weakness) ☐ Evaluate potential – sitters
Mobility ☐ Unsteady transfers ☐ Max assist ☐ Recent increase/decrease in mobility ☐ Confined to chair/wheelchair ☐ Use of assistive devices	**Environment** ☐ Increase lighting ☐ Non slip mat ☐ Work order for repairs
Elimination ☐ Independent and incontinent ☐ Needs assistance ☐ Catheter and/or ostomy	

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Nurse Signature