

To be effective, assessment tools need to be sensitive (correctly identify high risk patients/residents) and specific (correctly identify patients/residents not at risk) and, perhaps most importantly, be easy for nurses to use (embedding the fall risk assessment tool into existing nursing assessments helps with "buy-in" and acceptance of the tool/process).

Purpose of Fall Risk Assessment

- Identify patient/resident problems (rational basis for deciding whether risk exists)
- Identify those patients/residents most likely to fall
 Trigger further fall-related assessments (multidisciplinary)
 Identify interventions (guide patient/resident care planning)
 Raise staff awareness of fall/injury risk

When to Conduct Fall Risk Assessments

- Upon admission
- Post-fall
- Upon change of health condition (including medication changes)
 Daily/every shift (confused patients/residents; patients/residents taking sedatives, recent fall, etc.)

COMPONENTS	FALL RISK FACTORS
Diseases/Conditions	 History of falls Impaired vision/hearing Urinary problems (toileting needs) Muscle weakness Gait/balance impairment Dizziness Orthostatic hypotension Mobility impairment (impaired bed, chair and/or toilet transfers) Uses cane/walker
Medications	 Polypharmacy (>5 medications) Psychotropics Diuretics Antihypertensives Antiseizure Benzodiazepines Hypoglycemics Sedative/hypnotics
Mental Status	 Dementia Depression Delirium Impaired 'safety' judgment Disruptive behaviors Non-English speaking Exhibits unsafe behavior Lacks understanding of mobility limitations
Situational Conditions	 New admission Floor-to-floor transfer Post-fall Change of condition and/or starting fall risk medication

Most Commonly Used Fall Risk Assessment Tools

The Morse Fall Scale The STRATIFY tool The Hendrich II Fall Risk Model tool The Schmid Fall Risk Assessment Tool

Tideiksaar, R. Falls in Older People: Prevention and Management. 4th Edition. Health Professions Press, Baltimore, MD 2010