



Fall Risk Assessment Tools

A fall risk assessment usually involves a scale used during the initial evaluation to predict the risk of a fall incidents. The nurse can then identify and implement the appropriate interventions for each patient. Nursing assessments which involve these tools prevent falls by; identifying patients with fall risks, minimizing risk factors, implementing strategies targeted to those most likely to fall, and targeting fall prevention resources appropriately

These scales are typically quick and easy to use since they are designed to be used by nurses as part of their normal shift.

Some nursing fall risk assessment tools include:

- The STRATIFY Risk Assessment Tool - Identifies a patient's risk for falling based on the following indicators; previous falls, agitation, impaired vision, frequent toileting, and Barthel Score for transfer and mobility.
- Reassessment is Safe Kare - Uses four indicators to asses for fall risk.
- Morse Fall Scale - Measures risk by evaluating a patient's history of falling, secondary diagnosis, use of ambulatory aids, intravenous therapy/ heparin lock, gait, mental status, and orientation to own ability.
- Hendrich Fall Risk Assessment - Assesses fall risk via recent history of fall, altered elimination, confusion/disorientation, dizziness/vertigo, poor mobility/ generalized weakness, and poor judgment.

Many organizations use various assessment tools; however there are assessment elements that are common. These elements include demographic, history, diagnosis, condition, mediations, and environmental factors. These are used most often since staff can easily assess this information and it can provide a comprehensive overall picture of fall risks. A patient's demographic and history includes age, sex, history of previous falls, fear of falling, and length of stay in the facility. These details provide insight into the patient's current health and physical functioning. Also, the past history data can help staff understand potential patient-specific falling trends. A patient's diagnosis and condition includes problems with mobility, lower-extremity strength, history of fractures, visual and auditory impairments, dizziness, dehydration, depression, stroke, and cardiac arrhythmias. It is also important to know if a patient has been prescribed certain medications, such as diuretics, analgesics, hypnotics, laxatives, or polypharmacy. Each facility must decide which tool or tools are best for their specific patients.

References: www.jointcommission.org