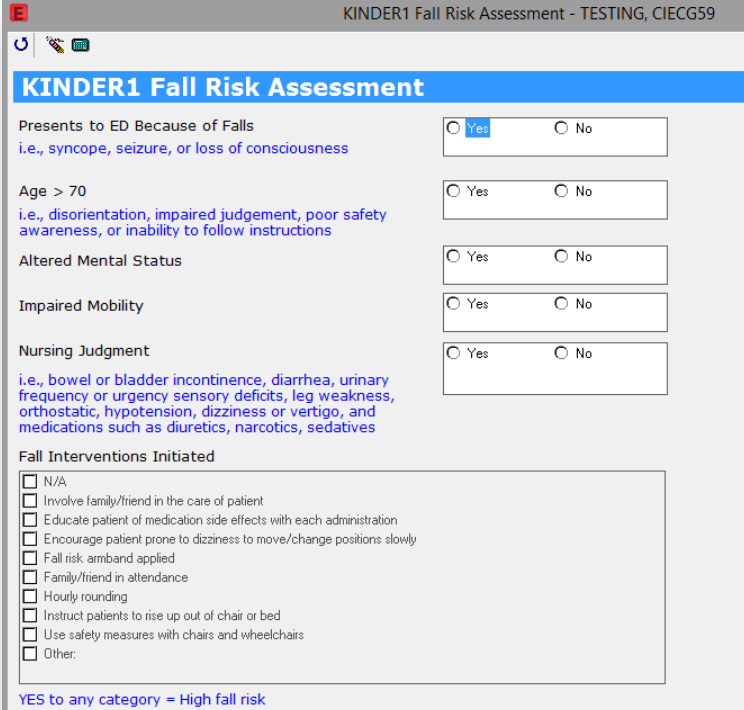

As part of the transition to the new ED Triage and Intake forms that focus on the essential elements required for collection during these processes, a new evidence-based fall risk assessment for adults receiving care in the ED setting is being implemented.

The Kinder1 Fall Risk Assessment is comprised of 5 questions, each with a Yes or No Response.

1. Presents to the ED because of falls (i.e. syncope, seizure, or loss of consciousness)
2. Age greater than 70 (i.e. disorientation, impaired judgement, poor safety awareness, or inability to follow instructions)
3. Altered Mental Status
4. Impaired Mobility
5. Nursing Judgement (i.e. bowel or bladder incontinence, diarrhea, urinary frequency or urgency, sensory deficits, leg weakness, orthostatic hypotension, dizziness or vertigo, and medications such as diuretics, narcotics, sedatives)



KINDER1 Fall Risk Assessment - TESTING, CIECG59

KINDER1 Fall Risk Assessment

Presents to ED Because of Falls
i.e., syncope, seizure, or loss of consciousness Yes No

Age > 70
i.e., disorientation, impaired judgement, poor safety awareness, or inability to follow instructions Yes No

Altered Mental Status Yes No

Impaired Mobility Yes No

Nursing Judgment
i.e., bowel or bladder incontinence, diarrhea, urinary frequency or urgency sensory deficits, leg weakness, orthostatic, hypotension, dizziness or vertigo, and medications such as diuretics, narcotics, sedatives Yes No

Fall Interventions Initiated

- N/A
- Involve family/friend in the care of patient
- Educate patient of medication side effects with each administration
- Encourage patient prone to dizziness to move/change positions slowly
- Fall risk armband applied
- Family/friend in attendance
- Hourly rounding
- Instruct patients to rise up out of chair or bed
- Use safety measures with chairs and wheelchairs
- Other:

YES to any category = High fall risk

A YES to any question classifies the patient as a HIGH FALL RISK