Assessment of Falls

Review medical record

Look for diseases

Look for functional limitations/ADL's

Look at medications, new and old medication

Look for recent labs

Assessment of Falls ~ Continued

- Examine the patient
  - Vital signs; sitting and standing BP/pulse, O2 Sat
  - Neurological exam; Alert and oriented X's 3 or confused, able to follow 2-3 step command, balance when sitting/standing,
  - Muscular/skeletal exam: Upper and lower extremity strength, tremor, rigidity, pain with movement, ability to roll in bed, sit on side of bed, stand up from bed/chair/toilet/commode, ability to walk assisted/unassisted, with or without adaptive equipment

Physical Examination/Assessment

- ADL's WATCH & DO;
  - Roll side to side in bed (*draw sheet, grab bars, bed level height?)*
  - Transfer onto the toilet (*gaitbelt, grab bars, floor surface, space?)*
  - Transfer in and out of bed (*bed height, floor surface, transfer pole?)*
  - Observe walking (*furniture grabbing, limp, walker placement)*
  - Observe dressing: (*bra, buttons, socks and shoes)*

Physical Examination/Assessment cont.

- Listen/look/touch
  - Listen for crepitus, sounds of pain, caregiver's instructions
  - Look at joints, posture, gait, body alignment, caregiver's technique and attitude
  - Touch skin, back, joints, limbs for heat, cold, swelling, range of motion

Physical Examination of Falls ~ Continued

- Pain assessment
- Vision, general ability to see object in environment with or without glasses
- Foot exam
- Caregiver's ability to assist with transfers, walking

Fall Prevention Strategies ~ Adaptive Equipment

- Wheelchairs

Fall Prevention Strategies ~ Adaptive Equipment

- Lift Stick

Fall Prevention Strategies ~ Adaptive Equipment

- Walkers