Fall Risk Nursing Care Plan

Patient Information and Assessment

Name:	**Age:**	**Date:**

Brief Summary of Medical History

Assessment Guide

- Conduct comprehensive fall risk assessment using validated tools, including the Morse Fall Scale.
- *Identify risk factors such as history of falls, impaired mobility, medication side effects, and environmental factors.*

Morse Fall Scale

History of Falls:

- ☐ No falls - 0 points
- ☐ Falling once in the past three months - 10 points
- ☐ More than once in the past three months - 25 points

Ambulatory Aid:

- ☐ Independent - 0 points
- ☐ Ambulatory aid (cane, crutch, etc.) - 15 points
- ☐ Partial weight-bearing - 30 points
- ☐ Non-ambulatory - 40 points

Secondary Diagnosis:

- ☐ No secondary diagnosis - 0 points
- ☐ Any diagnosed condition - 15 points

Gait:

- ☐ Normal or mild impairment - 0 points
- ☐ Weak, impaired, or absent - 15 points

Intravenous Therapy:

- ☐ No intravenous therapy - 0 points
- ☐ Hep-locked or saline lock - 20 points
- ☐ Multiple intravenous medications - 25 points

Mental Status:

- ☐ Oriented to own ability - 0 points
- ☐ Forgetful - 15 points
- ☐ Confused - 30 points

Total Score:

Morse Fall Scale Guide	
0-24	**Low Risk**
25-50	**Moderate Risk**
51 or more	**High Risk**

Fall Risk Diagnosis

May include impaired mobility, history of falls, medication side effects, and environmental hazards.
Please include any and all risk factors.

Goals

1. Reduce the risk of falls within the next month by _____ %.
2. Improve patient's mobility and strength.

Additional goals:

Interventions

General Interventions:

- Implement bed alarms and encourage the use of call bell.
- Conduct hourly rounds to assist with toileting needs and mobility.
- Review and adjust medications to minimize side effects affecting balance.
- Provide mobility aids as necessary.

Additional Interventions Needed:

Applied Interventions and Results

Environmental Modifications

General Guide:

- **Lighting:**
  - Ensure adequate lighting in all areas, especially corridors and bathrooms.
  - Install motion-sensor lights to illuminate pathways during nighttime.
  - Encourage the use of nightlights in the patient's room.
- **Flooring:**
  - Use non-slip flooring or add non-slip mats in high-risk areas.
  - Repair or replace any damaged flooring promptly.
  - Eliminate or secure rugs that could cause tripping.
- **Handrails and Grab Bars:**
  - Install handrails along corridors and stairways.
  - Place grab bars in bathrooms and near the bed for support during transfers.
- **Furniture Arrangement:**
  - Ensure furniture is arranged to provide clear pathways.
  - Remove clutter to reduce the risk of tripping.
- **Footwear:**
  - Encourage the use of non-skid, well-fitting footwear.
  - Regularly assess and replace worn-out or slippery shoes.
- **Assistive Devices:**
  - Provide and encourage the use of mobility aids like walkers or canes.
  - Ensure these devices are in good condition and properly adjusted.

Additional necessary modifications:

Monitoring and Evaluation:

General guide for monitoring and evaluation:

- Regularly assess and document the patient's fall risk status.
- Review and update the care plan as needed based on patient progress

Additional Notes for Monitoring and Evaluation:

Communication and Patient Education

- Openly communicate with the team about any changes in the patient's condition.
- Document all interventions, patient responses, and outcomes accurately.
- Educate patient and family on fall risks, prevention strategies, and environmental modifications.
- Emphasize the importance of using assistive devices and calling for assistance.

Additional Notes for Communication and Patient Education:
Write contact persons, contact details, schedules, and other notes here.

Follow-Up

- Schedule regular follow-up assessments to reassess fall risk.
- Adjust the care plan based on the patient's evolving needs.

Follow-Up Schedule:

Additional Notes for Care Team