

Post Fall 72-Hour Monitoring Report

This assessment should be completed at the following intervals for follow up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician.

- Initial assessment (B*); followed by q15 min x 4; q30 min x 2; every hour x 2; once per shift for 72 hours

Resident name: _____ Room #: _____ Date: _____ Time of fall: _____

Description	B*	q15 x 4				q30 x 2		q1 x 2		24 hours			48 hours			72 hours		
Date																		
Time																		

Vital Signs

Assess blood pressure for increase or decrease.
 Assess pulse for slowing or widening pulse, then increased rate.
 Assess respirations for change in rate, rhythm and pattern.

Blood Pressure																		
Pulse																		
Respirations																		

Orientation

Place																		
Person																		
Date/Time																		

Skin

Bruising																		
Skin tear																		
Clear																		
Other																		
Pain																		

Circle YES or NO. If YES, record site here: _____

Range of Motion/Strength of Extremities: Check if right/left responses are the same. It is necessary to know the baseline ability for each. Range of motion F for full, L for limited.

	4 = Normal power	3 = Mild weakness	2 = Severe weakness	1 = No response	Scoring example: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>F</td><td>3</td></tr></table>	F	3
F	3						
Right Hand	/	/	/	/	/		
Left Hand	/	/	/	/	/		

*B = Baseline

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Description	B*	q15 x 4	q30 x 2	q1 x 2	24 hours	48 hours	72 hours		
Range of Motion/Strength of Extremities (Cont.): Check if right/left responses are the same. It is necessary to know the baseline ability for each. Range of motion F for full, L for limited.									
4 = Normal power	3 = Mild weakness	2 = Severe weakness	1 = No response	Scoring example: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>F</td><td>3</td></tr></table>				F	3
F	3								
Right arm									
Left arm									
Right leg									
Left leg									

Eye Responses: A) Eyelid Response

- 4 = Opens eyes spontaneously and purposely
- 3 = Opens eyes only in response to speech ("Please open your eyes.")
- 2 = Opens eyes only in response to pain (apply blunt pressure with an object such as a pencil to the fingernail where it enters the skin of the finger)
- 1 = Does not open eyes when painfully stimulated
- U = Untestable

Eye Score																	
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B) Pupils: Assess size, equality, reaction to light, and unilaterally dilated pupils. Some residents will have unequal pupils as their normal.

(+) = Reactive (-) = Non-reactive (c) = Closed In Millimeters



Right size																	
Right reaction																	
Left size																	
Left reaction																	

Notifications: Yes or N/A (Document notification time, name, outcome in Nurse's Notes)

Physician notified if change in status																	
Family notified if change in status																	

Nurse's initials with signature

***B = Baseline**

Document available at www.primaris.org

MO-08-40-REST July 2008 This material was prepared by Primaris, the Medicare Quality Improvement Organization for Missouri, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

