Edmonson Fall Risk Assessment Tool Risk Factor Category Definitions and Directions:

RISK FACTOR CATEGORY	DEFINITION/ DIRECTIONS
AGE • Less than 50 • 50-79 • 80-over	Choose their age!
DIAGNOSIS	Use the physician's diagnosis. Some patients may have more than one diagnosis. Patient may score for each diagnosis, for example *Major Depressive Disorder* and *Alcohol Abuse.*
HISTORY OF FALLS	A reported or documented fall **within the last 3 months.**
MENTAL STATUS • Fully Oriented at all times • Agitation/Anxiety • Intermittently confused • Confusion/Disorientation	Patient may score for *Agitation/ Anxiety* **and** the other categories including *Fully oriented, Intermittently confused or Confused/ disorientation.* Scored components are dependent on your assessment including input from team members such as PCTs. A patient should score for *Confusion and Disorientation* if **1 or more abnormalities** are noted during assessment. For example, if the patient knows his name but not place or time he is scored as having *Disorientation/ Confusion.*
ELIMINATION • Independent with control of bowel/bladder • Catheter/Ostomy • Elimination with Assist • Altered elimination (incontinence, nocturia, frequency) • Incontinent but Ambulates Independently	*Elimination with assist* is defined by the patients' need for assistance with ambulating to the toilet or commode and assistance in getting the bedpan or urinal. A patient may score in more than one area of elimination. For example, a person can be *independent* and have *nocturia.*
AMBULATION • Independent/Steady gait/Immobile • Proper Use of Assistive Devices • Vertigo/Orthostatic Hypotension/Weakness	• *Independent/Steady gait/Immobile*= **a patient who's gait is balanced, steady and totally independent** • *Proper Use of Assistive Devices*= **a patient who uses his/her device properly 100% of the time**

• Unsteady/Requires Assist and Aware of Abilities • Unsteady but Forgets Limitations **Patient may **score in more than one category** for example: *Independent* **and** O*rthostatic hypotension.*	• *Vertigo/Orthostatic Hypotension/Weakness*= **c/o weakness or observation, *orthostatic drops by definition are included in our policy and reflect EBP and research findings.** • *Unsteady/Requires Assist and Aware of Abilities*= **calls for help and waits 100% of the time (don't see this much!!)** • *Unsteady but Forgets Limitations*= **includes patients whose <u>perception</u> of their abilities is different from their <u>actual</u> abilities (could be dementia, delirium, mania, struggles with powerlessness)**
NUTRITION • Has had very little food or fluids in the past 24 hours • No apparent abnormalities with appetite	Patient is scored as *very little food or fluids…* if **1 or more** of the following is present: • *Caregiver or patient report of decreased appetite and intake of food and fluids over the last 24 hours.* • *Documentation of patient meal/ supplement intake of **less than 50 % over the last 24 hours.*** • *Documentation of "poor fluid intake" within the last 24 hours by nurses and/or nursing technicians.* • *Physical assessment reveals signs of dehydration or poor fluid intake (for example poor skin turgor, dry mucous membranes, abnormal labs).*
SLEEP DISTURBANCE • No Sleep Disturbance • Report of Sleep Disturbance by patient, family or staff	A patient can be given a scored as having *sleep disturbance* for **any** of the following: 1. Patient, family or caregiver report of sleep disturbance (for example "not sleeping", "awake half the night"). 2. Documentation of **4hours** or less of consecutive sleep the night prior to assessment. Use the Nurses Notes or Admission Profile/ Intake, MD Notes or SP/EP sheets to obtain this information.

MEDICATIONS • No Medications • Cardiac Medications • Psychotropic Medications (Includes antipsychotics, benzodiazepines and antidepressants) **OR** • Increase in psych or cardiac medications and/or PRN (cardiac, psych, pain) medication received in the last 24 hours	*Cardiac, Psychotropic and Pain* medications included in the research study to develop the psychiatric fall risk assessment include: • Benzodiazepines • Antipsychotics • Narcotics • Nonnarcotic pain meds • Antidepressants • Antihypertensives • Antiarrhythmics **Please note that anticonvulsants and mood stabilizers are not included on this list. This is due to the lack of research available in publication at the time of instrument development. If your assessment findings reveal that these two medication classes appear to be correlated to an increase in your individual patient's fall risk, you may capture added risk in the other categories such as gait as always utilize your critical thinking skills to determine additional risk not captured in the instrument itself. Safety first!