Fall
- Unintentional change in position coming to rest on the ground or onto the next lower surface.

Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300
- Resident unable to eat or drink

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Initial Nursing Evaluation for injury and/or Mental Status Changes
- DO NOT move off floor until a complete exam has been performed
- Suspected fracture or new bone deformity
- Head trauma
- Altered mental status (decreased LOC, unresponsiveness, suspicion of seizure, new or worsened cognitive impairment)
- Laceration requiring sutures/staples

Notify MD / NP / PA

Eval Signs and Symptoms for immediate Notification
- Abnormal lung sounds
- New irregular pulse
- Chest Pain
- Acute decline in ADLs
- New/worsened incontinence
- Signs or symptoms suggestive of a stroke

Consider Contacting MD/NP/PA for the following Orders
- CBC
- Xray (if needed)
- BMP
- UA/C&S
- EKG

Tests Ordered

Manage in Facility¹
- Document Fall per facility policy
- Monitor VS (including orthostatic) x 24-72²
- Monitor Neuro checks x 24-72
- Check for pain level
- Check for new bruising or other evidence of injury
- Review of orders for medications associated with increased fall risk³

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

¹ See link to Fall Management Program at http://interact.fau.edu
² Obtain only if symptoms of urinary tract infection
³ Neuro Checks should be according to your facility policy and procedure
⁴ Many classes of medications can increase risk of falls