

Name: _____

Date: _____

Score: _____

RN Falls (True or False)

1. If my patient falls or is found on the floor, I need to reassess for fall risk, document fall risk score in narrative, Evaluate the Care Plan and initiate new interventions as indicated. T F
2. Being comatose places the patient at high risk for falls T F.
3. Assessment for fall risk should be performed on admission, at least daily, after a fall, after change in level of care, and as needed. T F
4. During the assessment of the Adult Patient for falls, a nurse must use his/her Nursing judgment if a patient is a fall risk –regardless of the Schmid or ABCS scores. T F
5. If a patient has a Schmid score <3, but meets ABCS criteria, it would be appropriate to document "ABCS" in the Care Plan, and update with interventions reflecting the 3 vital behaviors. T F