Resident Observations 3.0 Introduces New Assessments: Resident Observations – Nursing Data Entry

Contents

Please note: Both the Facility and named Residents depicted in the following illustrations are fictitious.

LTC Fall Scale (introduced 2017)

This assessment looks at eleven variables, each having an individual score ranging from one through four. The individual scores are then tabulated and the resident is then placed into one of four groups - no risk (total = 0), low risk (total = 1 through 3), or high risk (total = 4 or higher). Types of factors include:

Gait disturbance (shuffling, jerking, swaying)

Dizziness / syncope in an upright position

Confused all the time

Nocturia / Incontinent

Intermittent confusion

Generalized weakness

'High Risk' drugs (diuretics, narcotics, sedatives, anti-psychotics, substance abuse withdrawal)

Previous falls within the last 12 months

Osteoporosis

Hearing and/or visually impaired

70 years old or greater

From the scores and your analysis, the facility can determine the type of intervention that is the best solution for assisting the resident, from basic nursing standards to high risk prevention. How you plan for care is left to your facility policy.

Suggestions for use – at admission, change of condition, transfer to a new unit, and after a fall. Some facilities may prefer to do this as part of their weekly or monthly documentation. Please refer to your facility policies.

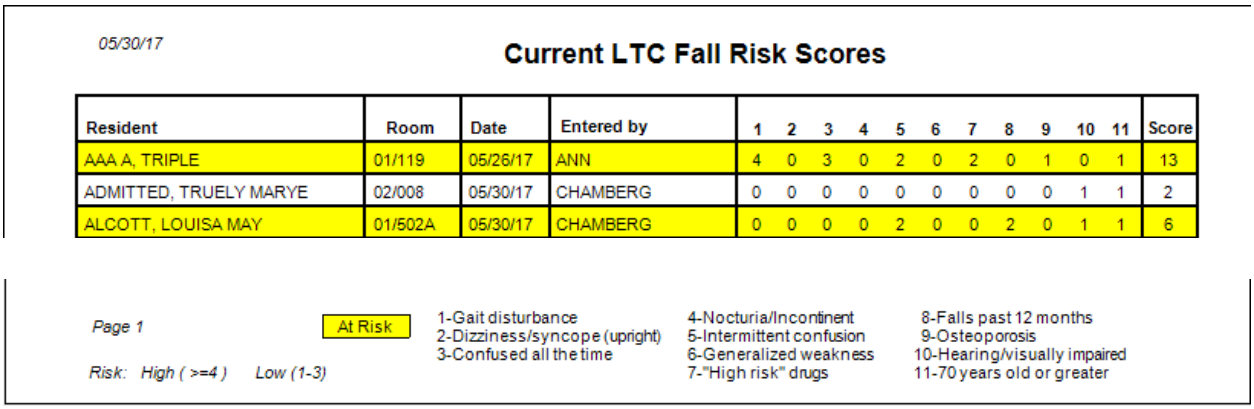
How to enter data

Select your resident and then click the LTC FALL SCALE button. You will be presented with a list of eleven variables. Either use a touchscreen, keyboard, or mouse to select the YES button whenever the condition exists for the resident you have displayed. At the bottom of the window, the total will be tabulated as you move down the list. The total will be identified as no risk, low risk, or high risk.

Reports

Reports – **Assessments** – **LCT Fall Risk** (Current Score, Score Compare or Score History)

Current Score – Allows you to select a single person, a single unit, or a group of residents. You will see the number assigned to each of the variables and the total score for each resident that you choose. Scores in the high risk group will be highlighted yellow.



05/30/17

Current LTC Fall Risk Scores

Resident	Room	Date	Entered by	1	2	3	4	5	6	7	8	9	10	11	Score
AAA A, TRIPLE	01/119	05/26/17	ANN	4	0	3	0	2	0	2	0	1	0	1	13
ADMITTED, TRUELY MARYE	02/008	05/30/17	CHAMBERG	0	0	0	0	0	0	0	0	0	1	1	2
ALCOTT, LOUISA MAY	01/502A	05/30/17	CHAMBERG	0	0	0	0	2	0	0	2	0	1	1	6

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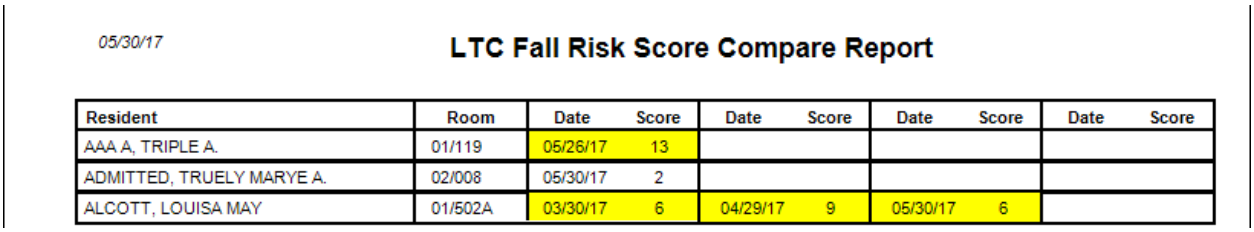
At Risk

Risk: High (>=4) Low (1-3)

1-Gait disturbance
2-Dizziness/syncope (upright)
3-Confused all the time
4-Nocturia/Incontinent
5-Intermittent confusion
6-Generalized weakness
7-"High risk" drugs
8-Falls past 12 months
9-Osteoporosis
10-Hearing/visually impaired
11-70 years old or greater

Score Compare – You also have the option of selecting a single person, a single unit, or a group of residents. You will see the total score from the four most recent assessments. Scores in the high risk group are highlighted yellow.

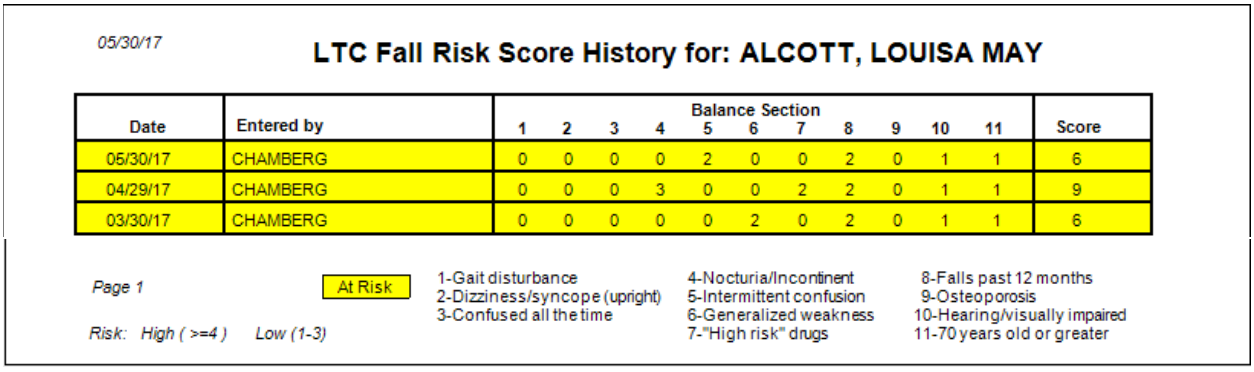


05/30/17

LTC Fall Risk Score Compare Report

Resident	Room	Date	Score	Date	Score	Date	Score	Date	Score
AAA A, TRIPLE A.	01/119	05/26/17	13						
ADMITTED, TRUELY MARYE A.	02/008	05/30/17	2						
ALCOTT, LOUISA MAY	01/502A	03/30/17	6	04/29/17	9	05/30/17	6		

History – Again, select a single person, a single unit, or a group of residents. Enter a date range for the history. You will see the number for each variable and the total score for each assessment generated in that time period.



05/30/17

LTC Fall Risk Score History for: ALCOTT, LOUISA MAY

Date	Entered by	Balance Section 1	2	3	4	5	6	7	8	9	10	11	Score
05/30/17	CHAMBERG	0	0	0	0	2	0	0	2	0	1	1	6
04/29/17	CHAMBERG	0	0	0	3	0	0	2	2	0	1	1	9
03/30/17	CHAMBERG	0	0	0	0	0	2	0	2	0	1	1	6

Page 1

At Risk

Risk: High (>=4) Low (1-3)

1-Gait disturbance
2-Dizziness/syncope (upright)
3-Confused all the time
4-Nocturia/Incontinent
5-Intermittent confusion
6-Generalized weakness
7-"High risk" drugs
8-Falls past 12 months
9-Osteoporosis
10-Hearing/visually impaired
11-70 years old or greater

Morse Fall Scale (introduced 2015)

This assessment looks at six variables and totals a score that can be used when evaluating a resident's risk for falling. These factors include:

1. History of falling within 3 months
2. Secondary diagnosis (more than one active medical diagnosis in the chart)
3. Ambulatory aids (crutches, cane, walker, furniture)
4. IV/Heparin lock

5. Gait/Transfer (weak or impaired)
6. Mental Status (does the resident understand his/her own limitations)
   For example ask the patient, "Are you able to go to the bathroom alone or do you need assistance?" Is the response consistent with orders or do they overestimate/forget their limits?

Scores are tabulated and the results are placed into three levels – low, moderate, and high risk. From here your facility can determine the type of intervention that is necessary for the individual from basic nursing standards to high risk prevention. How you define the scores and plan for care is left to your facility policy.

Suggestions for use – at admission, change of condition, transfer to a new unit, and after a fall. Some facilities may prefer to do this as part of their weekly or monthly documentation. Please refer to your facility policies.

How to enter data

Select your resident and then click the MORSE FALL SCALE button. You will be presented with the six variables and asked to select the most appropriate answer. Either use a touchscreen, keyboard, or mouse to select. When finished with the first three, then click NEXT PAGE (or the select the next tab at the top) to get to the final three. When you click NEXT PAGE, you will see the score.

If the score is blank, use the PREVIOUS button to check and make sure that you have answered all six of the variables. When you are finished, click SAVE INPUT.

What happens if I am interrupted? You may save what you have already entered and then go back to it later in the day. When you reopen the assessment, you will be told that there is already data and asked if you wish to continue. Complete the assessment and save. The incomplete data will be replaced with the completed assessment and score.

Reports

Reports – **Assessments** – **Morse Fall** (Current Score, Score Compare or Score History)

Current Score – Allows you to select a single person, a single unit, or a group of residents. You will see the number assigned to each of the variables and the total score for each resident that you choose. Scores in the high risk group will be highlighted yellow.

Resident	Room	Date	Entered by	History	Diagnosis	Aids	IV	Gait	Mental	Score
AAA, TRIPLE	01/119	05/08/15	CP3	0	15	15	0	0	0	30
ABOUT, SAM	01/402	05/15/15	CP5	25	15	15	0	10	0	65
ADMITTED, TRUELY MARYE	02/008	05/15/15	CP5	0	0	15	20	0	0	35

Score Compare – You also have the option of selecting a single person, a single unit, or a group of residents. You will see the total score from the four most recent assessments. Scores in the high risk group are highlighted yellow.

Resident	Room	Date	Score	Date	Score	Date	Score	Date	Score
AAA, TRIPLE	01/119	05/06/15	70	05/07/15	90	05/08/15	30		
ABOUT, SAM	01/402	05/07/15	15	05/08/15	30	05/15/15	65		
ADMITTED, TRUELY MARYE A.	02/008	05/07/15	15	05/08/15	50	05/15/15	35		

History – Again, select a single person, a single unit, or a group of residents. Enter a date range for the history. You will see the number for each variable and the total score for each assessment generated in that time period.

07/24/15

Morse Score History for : AAA, TRIPLE

Date	Entered by	History	Diagnosis	Aids	IV	Gait	Mental	Score
05/08/15	CP3	0	15	15	0	0	0	30
05/07/15	CP4	25	15	15	0	20	15	90
05/06/15	CEHAMLIN	25	15	15	0	0	15	70

Tinetti Balance Assessment (introduced 2015)

This assessment tool looks at balance (movement from a hard, armless chair) and gait (walking across a room). This tool can be used to evaluate the risks for fall. There are a group of variables for determining a balance subscore and another for determining a gait subscore. The two are added together for an assessment risk score.

Balance – sitting, standing, turning in various situations

Gait – initiation, step, trunk sway, stance, etc. Assessed at a low speed and then at a more rapid, but safe speed.

Scores are tabulated and the results are placed into three levels – low, moderate, and high risk. From here your facility can determine the type of intervention that is necessary for the individual from basic nursing standards to high risk prevention. As with the Morse Fall Scale, your facility policy will determine the appropriate use and level of care to administer.

Suggestions for use – at admission, change of condition, transfer to a new unit, and after a fall. Some facilities may prefer to do this as part of their weekly or monthly documentation. Please refer to your facility policies.

How to enter data

Select your resident and then click the TINETTI BALANCE ASSESSMENT button. You will notice tabs across the top of the window showing the variable numbers and whether they are balance tasks or gait tasks. You may use the tabs to move from section to section or the NEXT PAGE button at the bottom of the page.

Each variable shows a list of answers and the associated score. Using either a touchscreen, keyboard, or mouse, click the appropriate answer. After you answer the question at the bottom of the last page, select the next tab or click the NEXT PAGE button.

The SCORE tab will show you the balance and gait subscores as well as the final combined score. If no score is shown, use the PREVIOUS PAGE button to check for any missed responses. When you are finished, press SAVE INPUT.

What happens if I am interrupted? You may save what you have already entered and then go back to it later in the day. When you reopen the assessment, you will be told that there is already data and asked if you wish to continue. Complete the assessment and save. The incomplete data will be replaced with the completed assessment and score.

Reports

Reports – **Assessments** – **Tinetti Assessment** (Current Score, Score Compare, or Score History)

Current Score – Allows you to select a single person, a single unit, or a group of residents. You will see the number assigned to each of the variables, a subtotal for balance and another for gait, and the total score for each resident that you chose. Scores in the high risk group will be highlighted yellow.

				Balance Section											Gait Section											
Resident	Room	Date	Entered by	1	2	3	4	5	6	7	8	9	10	Tot	1	2	3	4	5	6	7	8	9	10	Tot	Score
AAA, TRIPLE	01/119	05/15/15	CP5	1	1	1	2	2	2	1	1	1	2	14	1	1	1	1	1	1	1	2	2	1	12	26
ABOUT, SAM	01/402	05/20/15	CEHAMLIN	1	1	1	1	1	1	1	1	1	1	10	1	1	1	1	1	1	1	1	1	1	10	20
ADMITTED, TRUELY MARYE	02/008	05/15/15	CP5	0	0	0	1	0	0	0	0	0	0	1	1	1	1	0	1	0	0	1	0	1	6	7

Score Compare – You also have the option of selecting a single person, a single unit, or a group of residents. You will see the total score only from the four most recent assessments. Scores in the high risk group are highlighted yellow.

Resident	Room	Date	Score	Date	Score	Date	Score	Date	Score
AAA, TRIPLE	01/119	05/13/15	20	05/14/15	26	05/14/15	18	05/15/15	26
ABOUT, SAM	01/402	05/13/15	0	05/14/15	20	05/15/15	24	05/20/15	20
ADMITTED, TRUELY MARYE A.	02/008	05/13/15	28	05/14/15	28	05/15/15	7		

History – Again, select a single person, a single unit, or a group of residents. Enter a date range for the history. You will see the number for each variable, the subscores, and the total score for each assessment generated in that time period.

07/24/15

Tinetti Score History for: AAA, TRIPLE

		Balance Section											Gait Section										
Date	Entered by	1	2	3	4	5	6	7	8	9	10	Tot	1	2	3	4	5	6	7	8	9	10	Tot	Score
05/15/15	CP5	1	1	1	2	2	2	1	1	1	2	14	1	1	1	1	1	1	1	2	2	1	12	26
05/14/15	CEHAMLIN	0	0	0	1	1	1	1	1	1	2	8	1	1	1	1	1	0	0	2	2	1	10	18
05/14/15	CP5	1	1	1	2	2	2	1	1	1	2	14	1	1	1	1	1	1	1	2	2	1	12	26
05/13/15	CEHAMLIN	1	1	1	1	1	1	1	1	1	1	10	1	1	1	1	1	1	1	1	1	1	10	20

Please note, the variables are numbered 1-10 for both balance and gait. At the bottom of the report is a legend that explains what they are. We do not expect you to memorize them.

Page 1 At Risk

Risk: High (<=18) Moderate (19 - 23) Low (>= 24)

Balance: 1-Sitting; 2-Rises from chair; 3-Attempts to rise; 4-Imm. Standing Bal; 5-Standing Balance; 6-Nudged; 7-Eyes closed; 8-Turning continuous; 9-Turning steady; 10-Sitting down

Gait: 1-Initiation of gait; 2-Step length right; 3-Step length left; 4-Foot clearance right; 5-Foot clearance left; 6-Step symmetry; 7-Step continuity; 8-Path; 9-Trunk; 10-Walk stance