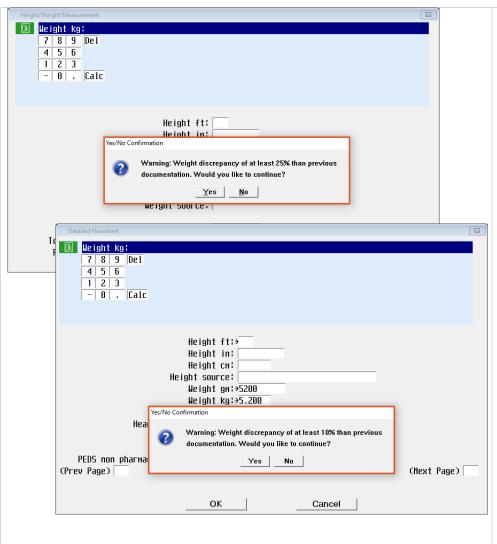
## **Height/Weight Measurement**

The **Height/Weight Measurement** screens have been updated to alert the clinicians if there is a discrepancy from the last documented weight within the same admission/visit.



The weight gm and weight kg fields alert as noted below:

- Increased or decreased by 10% or greater for Pediatric population, ages 17 and younger.
- Increased or decreased by 25% or greater for Adult population, ages 18 and older.
- If "No" is selected, the field is cleared and the clinician may enter a new weight.
- If "Yes" is selected, the clinician is forwarded to the next applicable field.

Note: This is only for the same admission. For example, if a patient is discharged and returns, the previous weight would not be compared against. The return visit is counted as a new encounter.



This change affects the following assessments and interventions:

| Nursing                   |
|---------------------------|
| Height/Weight Measurement |
| Vital Signs               |

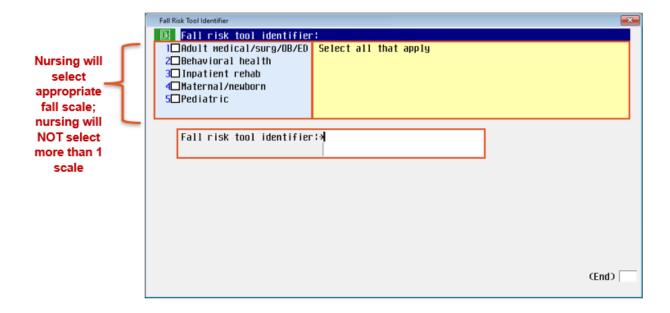
# **Fall Risk Assessment BH Nursing Education**

#### **Behavioral Health > Wilson Sims Fall Risk**

- For Adults at a dedicated BH Facility
- NOT appropriate for BH patients who are on an acute care medical unit
- **NOT** appropriate for adolescents or pediatrics

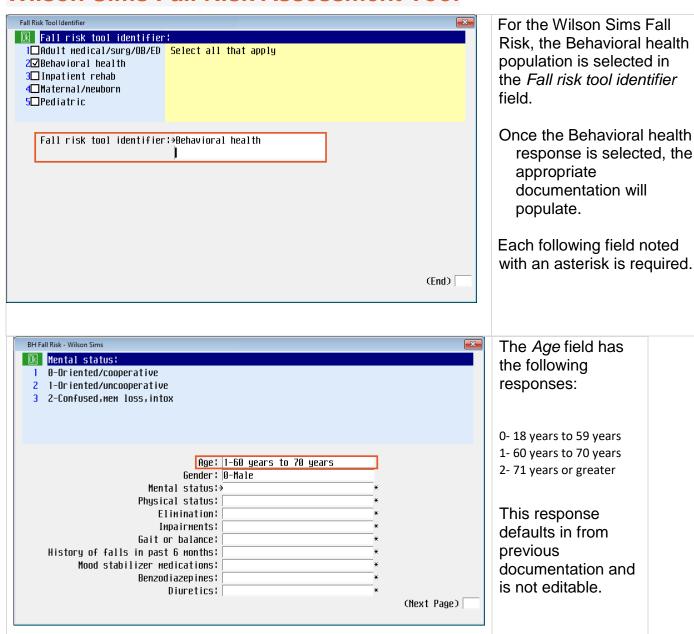
#### **Pediatric** → **CHAMPS Fall Risk**

- ALL patients <18 years old regardless of facility or location
- EDM identifies based on the patient's age and goes directly into the **CHAMPS Fall Risk**

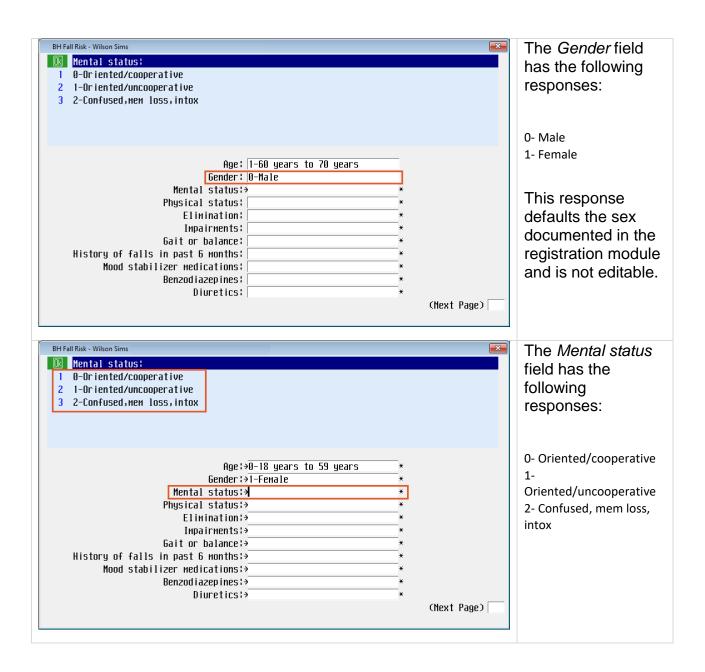




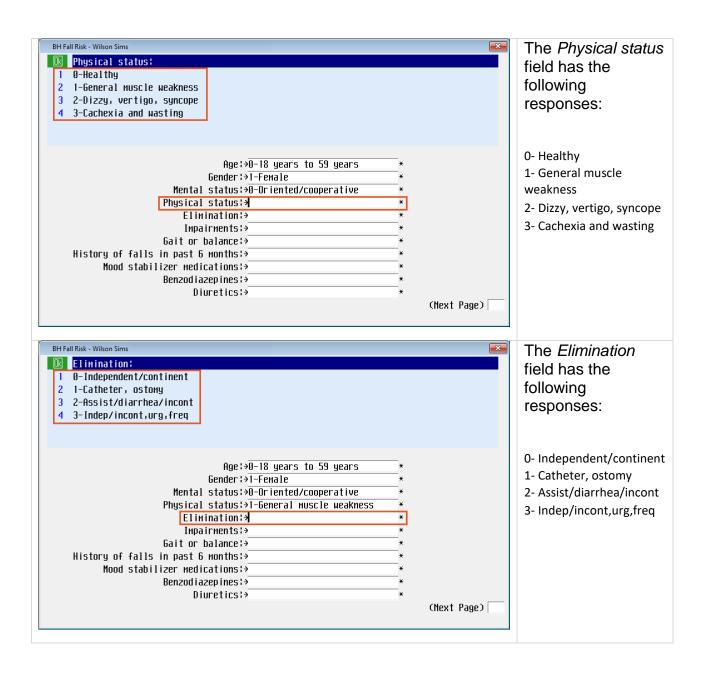
## Wilson Sims Fall Risk Assessment Tool



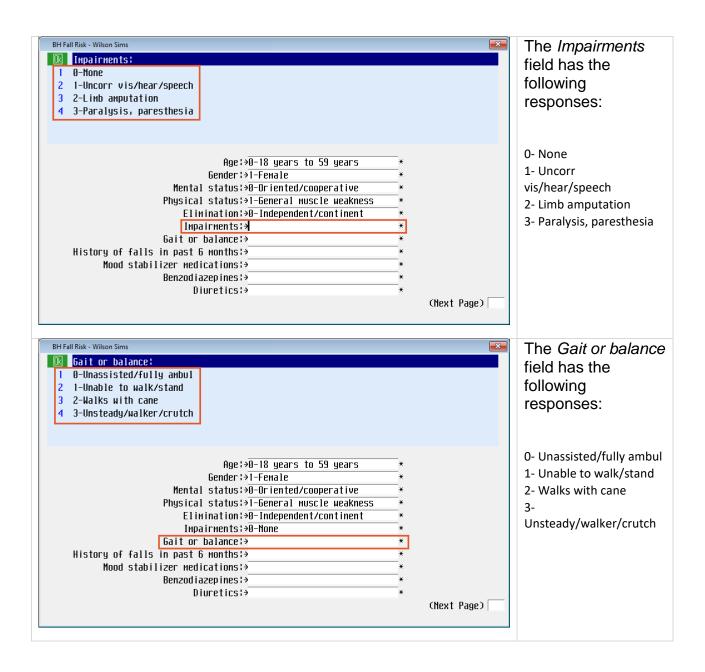




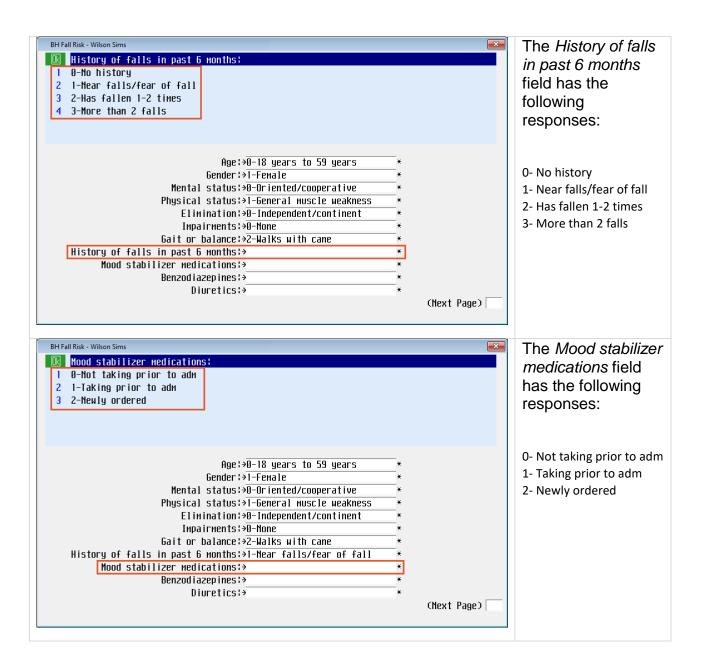




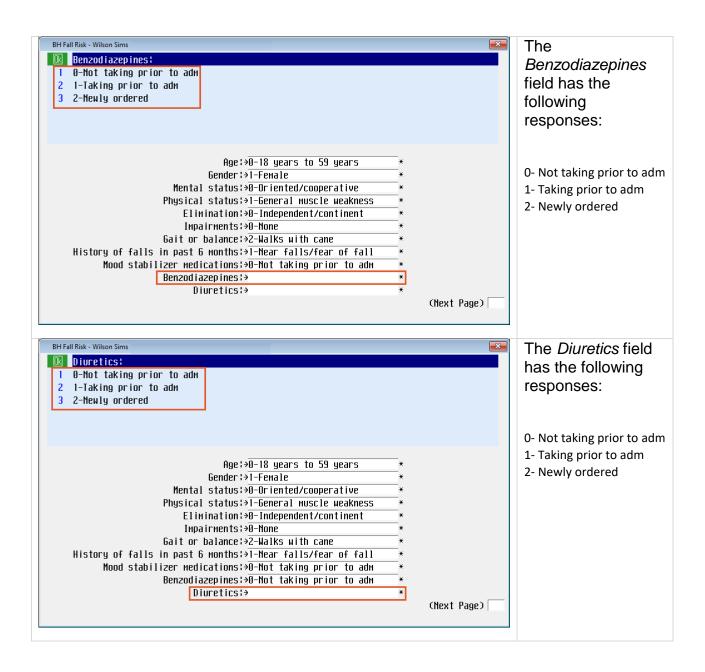




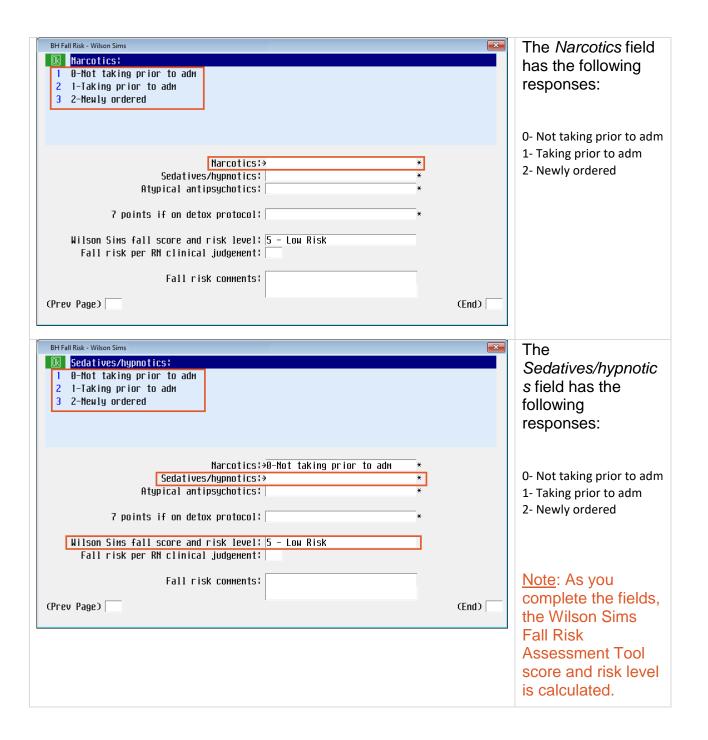




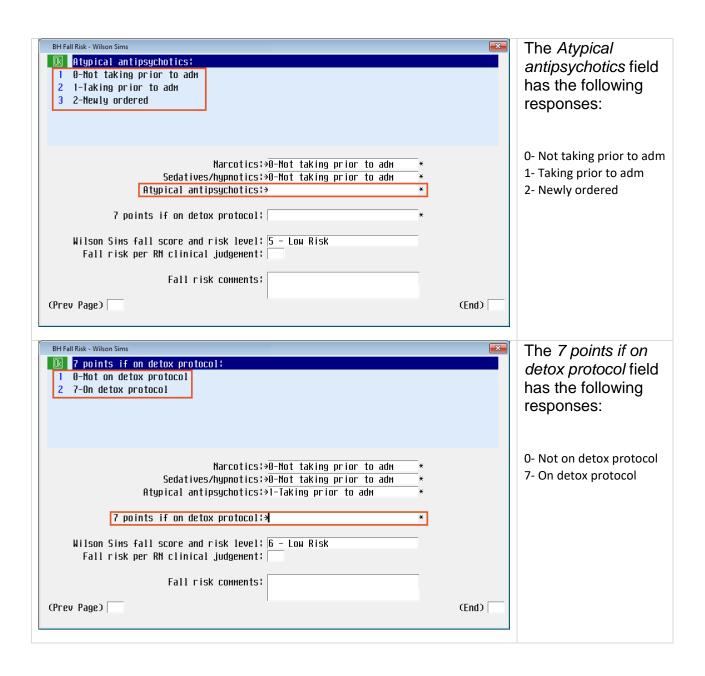




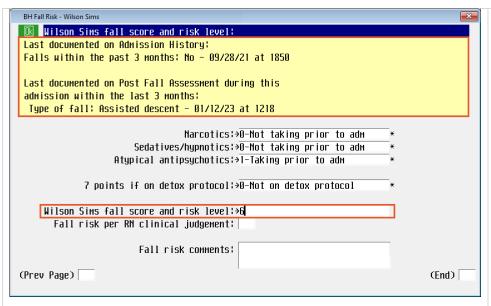












#### Risk Levels are as follows:

Low Risk: 0 to 6 High Risk: 7 to 39

The Wilson Sims Fall Risk Assessment Tool score and risk level field is calculated from the documentation above and is only editable by changing the prior responses.

The Yellow Information Box guides the clinician on previous documented falls:

Last documented on Admission History:

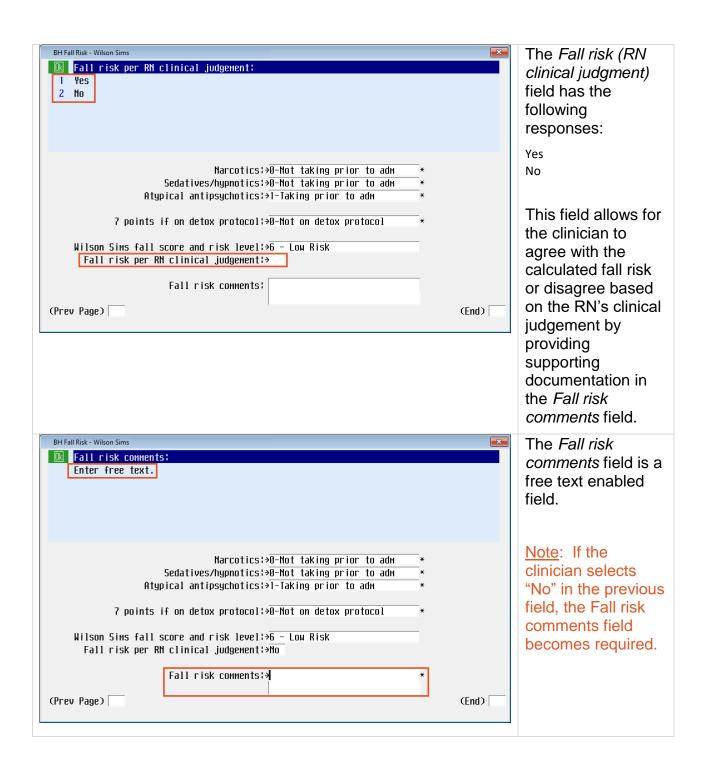
Falls within the past 3 months: No – MM/DD/YY at HHMM

Last documented on Post Fall Assessment during this admission within the last 3 months:

Type of fall:

Note: Upon entry into this field, the actual risk level will disappear. Once the clinician enters into the next field, the risk level will appear.







### **Pediatric** $\rightarrow$ **CHAMPS** Fall Risk Assessment

- ALL patients <18 years old regardless of facility or location
- EDM identifies patient based on the patient's age and goes directly into the **CHAMPS Fall Risk**

The CHAMPS Pediatric Fall Risk Assessment should be completed for <u>all</u> pediatric ages, less than 18 years of age, in the Pediatric areas. This **also includes Pediatric** patients in a Behavioral Health Unit or Facility.

For the CHAMPS Fall risk tool identifier: Pediatric Fall Risk, the Adult medical/surg/OB/ED | Select all that apply Pediatric population is Rehavioral health Inpatient rehab selected in the Fall risk Maternal/newborn tool identifier field. Pediatric Once the Pediatric Fall risk tool identifier:>Pediatric response is selected. the appropriate documentation will populate. Each following field noted with an asterisk is (End) required. ediatric Fall Risk - CHAMPS The Change in mental 🔣 Change in mental status: status field has the 1 1-Yes Episodes of disorientation, dizziness, or confusion following responses: 2 0-No related to post-op status, medication (high dose of narcotics, rapid weaning of sedation), or illness. Newborn/infant indicators may include irritability, 1- Yes agitation, inconsolability, or nonresponsiveness to 0- No auditory, visual or tactile stimuli. The Yellow Information Change in mental status:→ History of falls: Box guides the clinician Age less than 36 months: in correctly selecting Mobility impairment: the response: CHAMPS fall score and risk level: Episodes of disorientation, Parental involvement: Safety interventions: dizziness, or confusion related to post-op status, medication (End) (high dose of narcotics, rapid weaning of sedation), or illness. Newborn/infant indicators may include: irritability, agitation, inconsolability, or nonresponsiveness to auditory, visual or tactile stimuli.



Nursing will

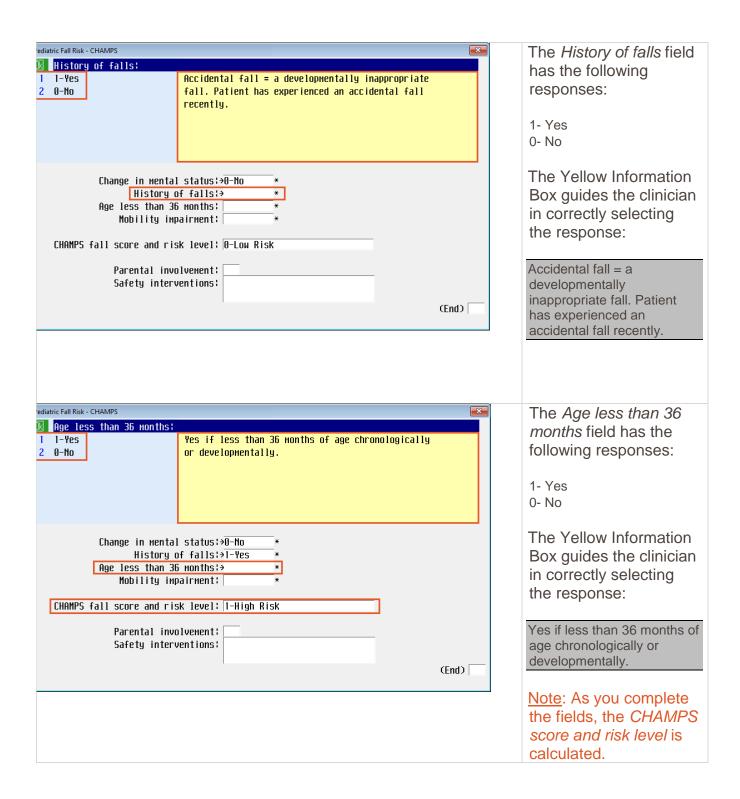
select

appropriate

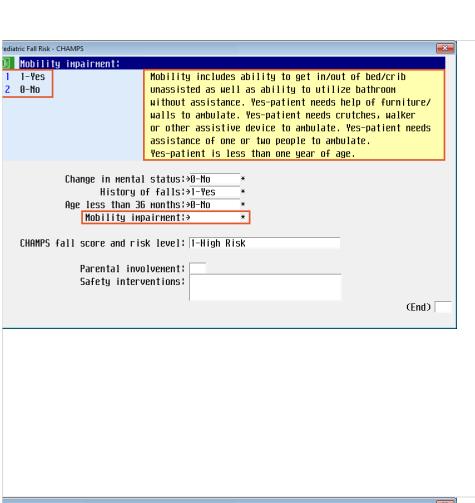
fall scale;

nursing will NOT select more than 1

scale







The *Mobility impairment* field has the following responses:

1- Yes

0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

Mobility includes ability to get in/out of bed/crib unassisted as well as ability to utilize bathroom without assistance. Yes-patient needs help of furniture/walls to ambulate. Yes-patient needs crutches, walker or other assistive device to ambulate. Yes-patient needs assistance of one or two people to ambulate. Yes-patient is less than one year of age.

CHAMPS fall score and risk level:

\_ast documented on Admission History:
-alls within the past 3 months: No - 09/28/21 at 1850

\_ast documented on Post Fall Assessment during this
admission within the last 3 months:
Type of fall: No results found

Change in mental status:>0-No \*
 History of falls:>1-Yes \*
 Age less than 36 months:>0-No \*
 Mobility impairment:>0-No \*

CHAMPS fall score and risk level:>1

Parental involvement:
Safety interventions:

(End)

The CHAMPS score and risk level field is calculated from the documentation above and is only editable by changing the prior responses.

The Yellow Information Box guides the clinician on previous documented falls:

Last documented on Admission History:

Falls within the past 3 months: No – MM/DD/YY at HHMM

Last documented on Post Fall Assessment during this admission within the last 3 months:

/pe of fall: No results found



