THE SCARBOROUGH

Health and Well-being
Optimal Functioning
Preservation of Integrity, Autonomy & Dignity
Enabling Environment

VULNERABILITY ASSESSMENT SCREENING

Circle all points that apply	Points
1. Is the patient 80 years of age and over?	1
2. Does the patient have any sensory deficits: Vision, hearing?	1
3. Does the patient have difficulty in making their needs known?	1
4. Is the patient acutely confused or delirious?	2
5. Does the patient have cognitive impairment/dementia/memory deficits/forgetfulness?	2
6. Does the patient seem depressed or hopeless?	2
7. Is the patient currently physically or chemically restrained?	2
8. Is the patient aggressive/agitated/restless?	2
9. Is the patient currently taking any of the following medications? Anaesthetics in past 24 hours; Anticholinergics; Anticonvulsants; Antiemetics; Antihistamines; Antipyschotics; Cardiac drugs; Diuretics; Oral Antihyperglycemic agents; Narcotics; Sedatives	2
10. Does the patient have seven or more scheduled routine medications?	1
11. Is there a history of substance abuse? (Circle all that apply) Alcohol; Laxatives; Sleeping pills; Tobacco; Narcotics	1
12. Is the patient incontinent of urine?	1
13. Has the patient fallen at home or in hospital?	2
14. Is the patient dependent in transfers or ambulation?	2
15. Are the patient's vital signs unstable?	1
16. Does the patient have any of the following: O_2sat < 90; Arrhythmias; Delusions/hallucinations; Seizures; Hypotension; Unsteady gait/balance; Pain; Infection	2
17. Is the patient attempting to remove or pull out any of the following: Drains/hemovacs; Dressings; Endotracheal/trach tube; Foley catheter; Gastric-feeding tube; Nasal gastric tube; Oxygen via mask or nasal prongs; Vascular access lines (i.e. IV) Other: _____	2
18. Does the patient wander at home or has the patient wandered since admission?	2
TOTAL SCORE	
A SCORE OF 12 AND OVER INDICATES HIGH RISK	

Note: Algorithm on reverse side to identify specific risk

Date: _____

Time: _____

Signature: _____

Is this a reassessment? ☐ Yes ☐ No

Date on initial assessment: _____

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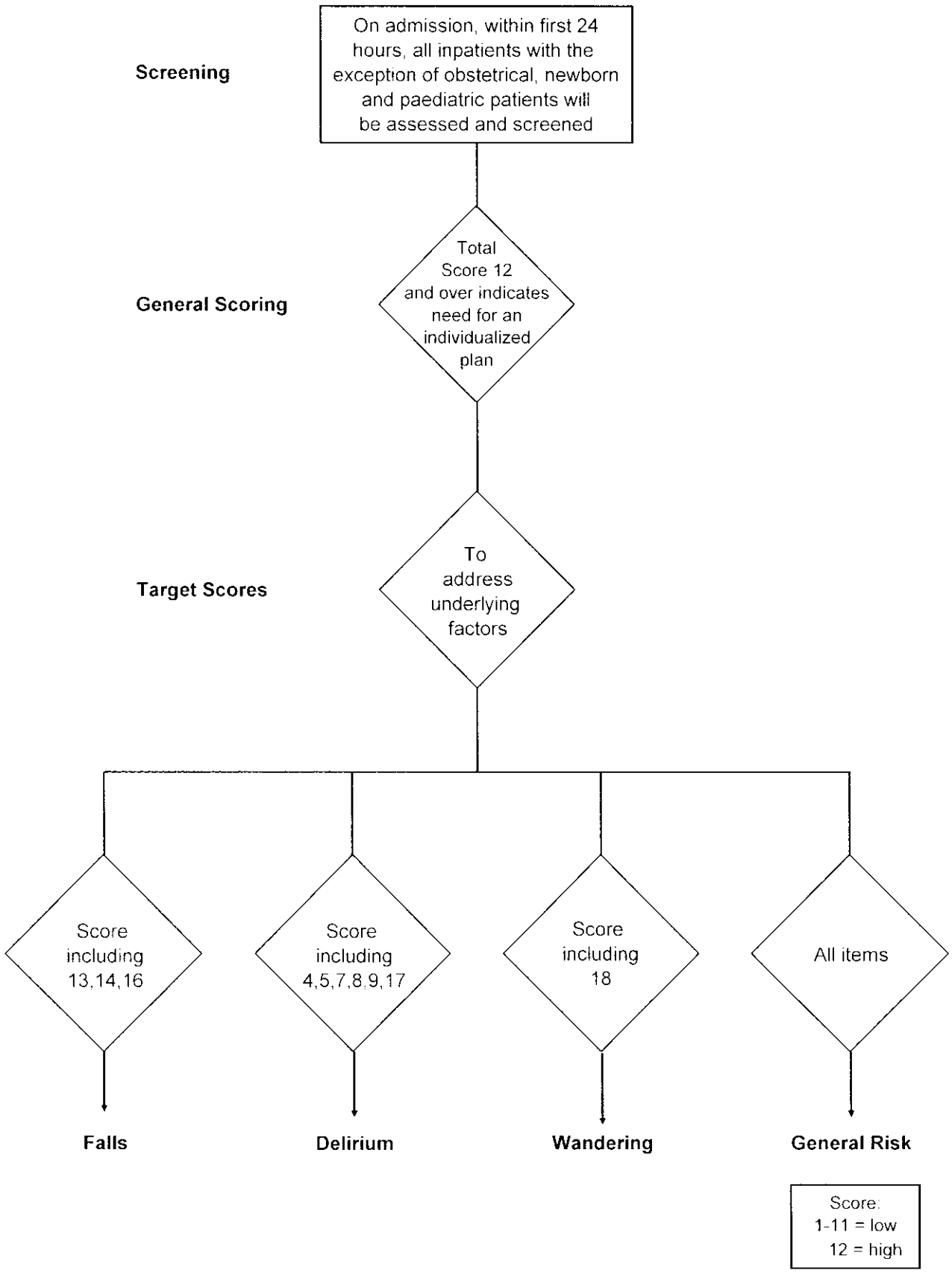
Algorithm for
Vulnerability Assessment Screening Form



PROCEDURE

1. On admission, within first 24 hours, all inpatients with the exception of obstetrical, newborn and paediatric patients will be assessed and screened to identify[1] global risk using the Vulnerability Assessment Screening Form.

2. To Complete the Vulnerability Assessment Screening Form:
   Circle the points that apply to your patient in the points column. Complete the information based on your best professional judgement at the time and the information that is available. Where feasible, attempt to get the information from the patient or family. Total the points to calculate the overall risk.

3. To Interpret the Score:
   A Score of 12 and over is considered high risk. Use the algorithm to plan an individualized approach for falls, delirium and wandering. A combination of points scoring 12 and over indicates general risk. Use the evidence-based interventions to guide your care for underlying problems.

4. To Identify Patient's at Risk:
   Place a **"V"** sticker in the following places: Spine of chart, on patient's name tag above bed and on lower left hand corner of Kardex. In the Emergency Department, place the **"V"** sticker on the admission sheet.

5. Ongoing assessment and screening for vulnerability is to be completed as the patient's condition warrants or as directed in the Nursing Care Plan.

6. Document all interventions used and their effectiveness in the interdisciplinary plan of care.

[1] Global areas of risk include: falls, acute confusion (delirium), wandering, agitation/aggression, pain and frailty.

Interventions must be individualized to each patient and are based on patient's needs.
Evidence-based interventions are listed below. The interventions listed are not all inclusive.

Interventions for Falls-Physical Deficits or Weaknesses

- PT/OT referral
- Incorporate walking into patient's daily routine
- Walking schedule
- Therapeutic recreation
- Recliner chair
- Wedge cushion (foam)
- Sensory deficit support (hearing device, glasses)
- Mobility aids
- Assess for orthostatic hypotension

Orthostatic Hypotension

- Elevate head of bed prior to getting out of bed
- Ankle pumps/hand clenches
- Lay-sit-stand slowly
- Antiembolic stockings
- Adequate fluid intake
- Supervision with transfers/ambulation

Delirium

Environmental Modifications

- Orientation aids (calendar, clock), familiar objects
- Noise reduction
- Safe & familiar environment

Psychological Support

- Cognitive stimulation (Therapeutic recreation for activities)
- Encouragement of "touch" and contact with family members
- Use of radios/TVs for stimulation

Physiological Stability

- Early recognition of dehydration and volume repletion
- Encourage oral fluid intake
- Maximize oxygenation
- Provide nutritional support
- Support of Sensory Function
- Visual aids: glasses or magnifying lenses
- Hearing devices: amplification devices, earwax disimpaction, use of sensory aids

Physical Activity

- Early mobilization
- PT/OT referral

Pharmacotherapy

- Pain management strategies
- Use of low doses of medications
- Initiate slowly

Wandering

- Assess for hunger, pain, heat, cold
- Buddy system among staff/consistency
- Label environment (bathroom door)
- Increase social interactions/diversional activities
- Redirect with simple commands
- Assess past coping strategies
- Involve family in planning care
- Tape (stop) line on floor
- Alarm devices-bed/chair/door
- Clutter free rooms
- Night light
- Room close to nursing station
- Glasses, hearing aids, walking aids easily available

General Strategies

- Toileting routine
- Bedside commode
- Bed/chair alarm
- Medication management/review
- Pain relief/comfort measures
- Ensure patient is wearing eye glasses, hearing aids
- Assess for hunger, heat cold
- Increase social interaction
- Involve family in planning care
- Diversional activities (e.g., music, pets, puzzles, crafts, folding paper bags)
- Mattress on the floor
- Hip guards
- Acceptance of risk
- Schedule daily naps
- Gentle touch

Increase Surveillance Strategies

- Move patient closer to the nursing station
- Move patient within full view of nursing station during evening and night shift
- Observation checks q 15-30 minutes
- Ask family if they can stay to provide support to the patient
- Sitters

Environmental Factors

- Low gloss, non-slippery floors
- Non-slip strips on floor beside bed
- Nightlights in bathroom
- Appropriate walking shoes
- Clutter free rooms
- Keep telephone lines, O_2 tubing etc. out of walking path
- Appropriate height of chairs, beds
- Appropriate rails in bathrooms, rooms and hallways
- Raised toilet seats
- Brakes on bedside commodes, beds, wheelchairs
- Keep things within reach (tissues, telephone, meals, call bell)
- Label environment (signs on bathroom doors)

Pulling Out Invasive Tubes

- Reassessment of tube for necessity
- Discontinue tube when possible
  IV's: If for rehydration consider hypodermoclysis
- Rotate site
- Cover IV site with kling, stockinette. A small slit for the thumb hole to keep the stockinette anchored
  N/G: Change to a smaller tube
- Gardening gloves worn by patients
- Small nerf ball inside the palm of the glove if still managing to pull the tube
- Foley Catheters: Boxer shorts for men, leg bands
- G-tubes: apply abdominal binder
- Diversionary tool (cloth dolls to keep hands occupied)