SAMPLE FORM A

Hospice and CommunityCare INSURANCE SERVICES
A Division of Glatfelter Insurance Group

FALL ASSESSMENT

Patient Name: ______________________________

Complete at admission and every 48 hours (in-patients), at the next visit (home patients), and after any of the following: change in functional ability, change in mental status, change in medical condition, after a fall incident. Maintain as part of permanent client record.

DATE

	POINTS					
History of a fall within the past 6 months • 1 or 2 falls • More than 2 falls	 **2** **3**					
Mental: • Intermittent confusion • Confused at all times	 **2** **4**					
Mobility: • Has a gait and/or balance problem • Confined to a bed or chair	 **2** **3**					
Uncooperative or unable to follow directions	**4**					
Sensory impairment (hearing or sight)	**1**					
Blood Pressure – drop in systolic blood pressure of 20 mm Hg or more between prone and standing positions	**2**					
Elimination: • Intermittent incontinence • Incontinent all or most of the time	 **2** **3**					
Medication: • Sedative/hypnotic • Diuretic • Narcotic • Psychotropic • Anti-Parkinson • Benzodiazepines	**1 point for each medication taken**					
Patient has a medical condition which could Impair his/her ability to ambulate: • Seizure disorder • Chronic debilitating illness • Weakness or paralysis of extremities • Parkinson's • Dementia	**1 point for each condition**					
	TOTAL POINTS					
	SIGNATURE					

POINT SUMMARY

2-6 points – AT RISK

~ Educate patient and family to request assistance for all transfers or ambulation.
~ Keep call bell and patient necessities (urinal, tissue, water, phone, etc.) within easy reach.
~ Keep top ½-rails up at all times*.
~ Keep bed in low position when care is not being provided.
~ Use mobility aids and make sure footwear fits well when ambulating.
~ Monitor every two hours and offer comfort measures if awake (toileting, water, etc.).
~ Keep a night light on in room and bathroom.

6-10 points – MODERATE RISK

~ Follow all AT RISK procedures.
~ Keep ALL bedrails up when the patient is in bed*.
~ Provide constant supervision when the patient is in the bathroom or on a bedside commode.
~ Use a seatbelt or other safety reminder when the patient is in a chair or wheelchair*.

10 or more points – HIGH RISK

~ Follow all AT RISK and MODERATE RISK measures.
~ Use bed and chair alarms.
~ Place the patient as close to the nurses' station as possible.
~ Monitor hourly or provide constant supervision with the use of a sitter or family member.

**Follow the facility's restraints policies.*

Maintain this form as part of permanent client record.
Document all fall prevention activities in the client record.

SAMPLE FORM B

Hospice and CommunityCare INSURANCE SERVICES A Division of Glatfelter Insurance Group

HOME SAFETY ASSESSMENT - FALL RISK

Each "no" answer indicates a need for intervention.
A copy of this form should be maintained in the client record and a copy provided to the client.

Patient: ____

Residence Location: ____

(Circle one)		ALL LIVING AREAS
YES	NO	Are light switches located at the entrance to each room?
YES	NO	Have electrical cords been placed away from walking areas or are they taped to help prevent tripping?
YES	NO	Have all area rugs, runners, and floor mats been removed or secured?
YES	NO	Are walkways, hall, and stairs free of clutter and obstacles?
YES	NO	Do stairs have handrails?
YES	NO	Are lighting levels adequate?
		BEDROOM
YES	NO	Is there a light within easy reach of the bed?
YES	NO	Are items such as glasses, telephone, tissue, water, etc., kept within easy reach of the bed or chair?
YES	NO	Is there a night light in the room?
YES	NO	Is a bell available to summon assistance?
		BATHROOM
YES	NO	Does the shower and/or tub have non-slip strips or a mat?
YES	NO	Does the tub and/or shower have grab bars?
YES	NO	Is the toilet equipped with grab bars?
YES	NO	Is an elevated toilet seat available?
YES	NO	Is there a night light in the room?
		PATIENT
YES	NO	Does footwear fit well and have non-slip soles?
YES	NO	If needed, are ambulatory aids (e.g., cane or walker) available?
YES	NO	Are ambulatory aids used?

Comments: Any deficiencies or problem areas noted above were addressed with the client and/or their support person. A copy of the form was left with the patient. Modifications that were made immediately included:

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Date: ________________ **Caregiver signature:** ______________________________

Date: ________________ **Client signature:** ________________________________