Glatfelter Healthcare Practice℠
A Division of Glatfelter Insurance Group

SAMPLE FORM A

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.

	POINTS	DATE				
History of a fall within the past 6 months						
• 1 or 2 falls	**2**					
• More than 2 falls	**3**					
Mental:						
• Intermittent confusion	**2**					
• Confused at all times	**4**					
Mobility:						
• Has a gait and/or balance problem	**2**					
• Confined to a bed or chair	**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	**2**					
• Incontinent all or most of the time	**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.

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SAMPLE FORM B

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:

_____
_____
_____
_____

Date: _____ **Caregiver signature:** _____
Date: _____ **Client signature:** _____