

FALL RISK ASSESSMENT

Adapted from the Ohio Falls Work Group, 1999

(This tool is only an example. Please adapt it to meet the needs of your facility and residents.)

Complete fall risk assessment upon admission, readmission and according to facility policy.
Check appropriate responses. Care Plan the appropriate areas.

Resident Name _____ Room _____

- Admission Readmission Other

Falls History

- None/no history of falls Fall(s) in last 90 days/# of fall(s) ____
 Fall(s) in last 30 days/# of fall(s) ____ Fall(s) in last 180 days/# of fall(s) ____
Circumstances surrounding fall(s) _____

Life Style Factors

What does the resident like to ...

Hear _____

Smell _____

Touch _____

Taste _____

See _____

What is the resident's favorite chair? _____

Night time sleep and behavior patterns _____

Resident can identify edge of bed Yes No

Behavioral patterns that make resident unsafe,
e.g. need to be independent, pacing, and other?

Where has the resident been sleeping?
If bed, include size _____

Elimination Patterns (Most descriptive of past seven days.)

- Independent and continent Requires assistance and incontinent
 Independent and incontinent Catheter or ostomy
 Requires assistance and continent

Internal Risk Factors

Cardiovascular

- None
 Orthostatic hypotension (systolic BP change > 20mm Hg drop lying and standing)
Lying _____ Sitting _____ Standing _____
 Cardiac dysrhythmia
 Pacemaker – last date checked _____
Diagnoses, e.g. PVD, other _____

Orthopedic

- Joint pain Hip fracture Other fracture Missing limb(s)
Diagnoses, e.g. osteoporosis, arthritis, other _____

Perceptual Deficits

- None Impaired hearing Impaired vision Dizziness/vertigo/syncope/BPPV

Neuromuscular Function

Body movement problems (gait and balance). Assess resident's gait and balance while:

- 1) standing with both feet on the floor for 30 seconds unsupported
- 2) walking forward
- 3) walking through a doorway and turning:
 - No difficulty with tasks
 - Partial or total loss of balance while standing
 - Partial or total loss of balance while walking
 - Jerking movements or instability
 - Gait pattern changes when walking
 - Use mobility devices when ambulating
 - Unsafe use of mobility devices
 - Poor muscular coordination
 - Unsteady gait
- Transfer difficulties
- Loss of arm/leg movement
- Diagnoses, e.g., CVA, Parkinson's seizure disorder, other _____
- Hemiplegia/hemiparesis

Mental Status

- Comatose
 - Oriented at all times
 - Confusion/disorientation at all times
 - Periods of confusion/disorientation
 - Lack of familiarity with surroundings
 - Inability to understand or follow directions
 - Impaired judgment/decision-making
 - Signs of depression/anxiety
 - Hallucinations/delusions
 - Decline in cognitive skills
- Diagnoses, e.g. delirium, manic depression/bi-polar disease, Alzheimer's or other dementia
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Medications (if any medications are checked, complete fall medication review)

- Antianxiety
- Hypnotic
- Antihypertensives
- Antidepressant
- Antiparkinson
- Antipsychotic
- Antivasculant
- Anticonvulsant
- Hypoglycemic
- Analgesic
- Laxatives
- Narcotics
- Antihistamine
- Anticoagulant*
- Non-steroidal
- Anti-inflammatory

* Not a medication that leads to falls, but increases risk for injury when fall occurs.

External Factors

- Restraints/devices/enablers (including side rails) _____
- Use of mobility devices when ambulating? What? _____
 - Using correctly
 - Using incorrectly Explain _____
- Appliances that contribute to falls potential _____
- Clothing/Footwear that contribute to falls potential _____
- Other environmental condition that contribute to falls potential _____

Summary

Indicate fall risk potential, identifying factors that can be managed, controlled or removed by staff intervention. If fall risk potential exists take to care planning. Include interventions that manage, control or remove the risk factors identified.

Nurse Completing Assessment _____ Date _____