Patient Name:_____ Date:_____

DAILY RISK ASSESSMENT TOOL FOR FALLS

DIRECTIONS: Place a check mark in front of elements that apply to your patient. Those items followed by an asterisk will automatically place the patient at risk for falls. Other items will be considered in making the judgement to place patient at risk for falls and initiating the Fall Prevention Protocol.

MISCELLANEOUS
- ❑ History of Falls*
- ❑ History of Seizures
- ❑ Orthotic Changes
- ❑ Recent Amputation*

PHYSICAL LIMITATIONS
- ❑ Weakness / Dizziness*
- ❑ Hemiparesis / Paralysis*
- ❑ Seizure disorder
- ❑ Impairment of vision
- ❑ Impairment of hearing
- ❑ Slow reaction time*

COMMUNICATIONS
- ❑ Inability or refusal to follow instructions*
- ❑ Inability or refusal to call for help*

AMBULATION
- ❑ Cane, Crutches, Walker
- ❑ Up with assistance

ELIMINATION
- ❑ Diuretics / Laxatives
- ❑ Urinary urgency / Frequency
- ❑ Diarrhea

MEDICATIONS
- ❑ Hypotensive or CNS depressants
- ❑ Tranquilizers / Sedatives
- ❑ Hypnotics*
- ❑ Analgesics

MENTAL STATUS
- ❑ Confusion / Disorientation*
- ❑ Impaired memory or judgement*

❑ **HIGH RISK FOR FALLS - Protocol Initiated** ❑ **LOW RISK AT THIS TIME**
❑ **Protocol remains in affect** ❑ **Protocol discontinued**

RESTRAINT / PROTECTIVE DEVICES (Staff to initial boxes)

TYPE:_____ ❑ Line / Tube Management Protocol ❑ Safety Protocol

TIME ⇨	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Patient Observation - at least hourly																								
Released Q 2 hr																								
Circulation Unimpaired																								
Skin Intact																								
ROM Completed																								
Food / Fluid Offered																								
Toileting and Hygiene offered																								
Assessed for Pain																								
ALTERNATIVES TRIED:																								
1:1 Conversation with Pt																								
Distractions/Activities/OT																								
Change of Environment																								
PRN meds for pain/anxiety																								
Bed Alarm																								
Removable Safety Device																								
Bladder/Bowel Training																								
Relaxation Techniques																								
Repositioning																								
Sitters/Family Supervision																								
Other:																								

Restraint Assessment Completed by RN:_____ Time:_____

Continued need for restraint? ❑ Yes ❑ No ❑ Physician Order Obtained

Supervision and Evaluation of Nursing Care Completed by:_____RN Date:_____ Time:_____

Care Plan: ❑ Reviewed ❑ Revised

INITIAL IDENTIFICATION

INIT	NAME	TITLE	INIT		TITLE