FALL PREVENTION ASSESSMENT

How did the fall happen? Date of fall: _____

How can future falls be avoided? UCI #:_____

SANDIS Incident #:_____

Client Age: ☐ 0-18 ☐ 19-25 ☐ 26-40 ☐ 41-55 ☐ 55 and over

Where did the fall occur? (check all boxes that apply)

☐ Home ☐ Day Program ☐ Work ☐ Community setting
☐ Living room ☐ Bedroom ☐ Bathroom ☐ Kitchen ☐ Dinning room ☐ Family room
☐ Yard/Patio ☐ Park ☐ Restaurant ☐ Retail/Shopping ☐ Library ☐ Parking lot
☐ Sidewalk ☐ Location of the fall was new or unfamiliar to the client

Did medical issues contribute to the fall? (Check all that apply) ☐ Yes ☐ No

☐ Assistive walking device was in use when they fell; ☐ Walker ☐ Cane ☐ Wheelchair ☐ Gait belt
☐ Client was experiencing changes in; ☐ Vision ☐ Hearing ☐ Gait ☐ Health
☐ Recent medication changes ☐ Recent medical diagnosis ☐ Seizure disorder

Fall Prevention happens in steps:
Step 1: Identify and eliminate/reduce fall hazards
Step 2: Identify changes in client health status and alert ALL staff
Step 3: Create new plan for client
Step 4: Continuously reassess steps 1-3; adjust as needed

Step 1: Identify what could have contributed to the fall (Check all that apply)

☐ Carpeting/rugs not properly secured to the floor or laying flat
☐ Change in flooring/threshold
☐ Transferring from one position to another
☐ No handrails/grab bars available
☐ Rubber bath tub mats not in place
☐ Inefficient lighting, too dim and/or no nightlight present
☐ Missing, defective, or improperly used assistive device
☐ Failure of client/staff to follow protocols for assistance (transfers)
☐ Distracted caregiver/client
☐ Shoes, clothing, pets, children or other obstacles blocking the path
☐ Carrying objects, unable to hold onto railing/grab bars
☐ Physical walking distance of destination too great
☐ Wet, icy, uneven or rocky terrain, construction, crowds or other hazards
☐ Client in a rush/not paying attention
☐ Staff assisting distracted
☐ Inappropriate footwear (too big/small) ☐ Shoe laces untied

Step 2: Identify recent changes in health status (check all that apply)

☐ Client dizzy/disoriented due to new, changed or missed medication
☐ Client loss of leg strength or change in gait due to change in health/diagnosis
☐ Client experienced shortness of breath
☐ Client experienced confusion related to use of new mobility device(s)
☐ Client behaviors and or mental health may have contributed to the fall
☐ Client experienced seizure activity
☐ Client has experienced at least one fall in the past six months
☐ Client displayed any pain or discomfort prior to fall

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Step 3: Create a plan to avoid falls, make appropriate environmental changes, train staff on the work plan, and look for additional fall risks. If a Behavior Plan is needed, please attach a completed copy to this form. (Please address all checked boxes and attach extra pages as needed.)

Step 4: Continuously reassess current plan and make necessary changes. This plan is a living document and should be discussed with the Service Coordinator at every meeting. The plan is designed to reduce falls through an increased focus on strategies of fall prevention.

Is assistance requested from Far Northern Regional Center to complete fall plan?
Yes ☐ No ☐ If yes please describe: _____

Signature of Service Provider	Name of Facility	Date

Far Northern Regional Center Use Only **Date of Incident:**

Injury as a result of incident:

Approved or denied by community Service Committee Date:

Notes: