

GENERAL HISTORY

Name	<input type="text"/>	Date of Assessment <i>mm/dd/yy</i>	<input type="text"/>
Date of Birth <i>mm/dd/yy</i>	<input type="text"/>	Time of Assessment <i>hh:mm</i>	<input type="text"/> AM <input type="text"/> PM
		Assessor Name	<input type="text"/>

CLINICAL ASSESSMENT

To assess fall risk more accurately with memory care residents, use a multifactorial approach. The questions below cover a range of issues and take many factors into account, helping you better determine if a resident has an elevated fall risk. A “Yes” response to 6 or more of these questions indicates someone who may be at higher risk for altered mobility or falls.

General/Medical History Issues	YES	NO	NOTES
Is the resident a new admission or have they changed living units?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the resident moved in within the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
Was the resident recently hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
Has there been a recent decline in status, either physical or mental?	<input type="checkbox"/>	<input type="checkbox"/>	
Gait and Balance Issues			
Does the resident have a history of falls?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident have ambulation/gait issues, i.e. shuffling, scissoring, difficulty making turns or walking in a straight line, difficulty with balance, difficulty transferring from positions (sit to stand, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident use a mobility aid?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes to above, is it used appropriately and consistently?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident require assistance or cueing to use the mobility aid appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	
Physical/Medication Issues			
Does the resident have injuries from past falls?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the resident incontinent?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident have an acute illness?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the resident in pain? (verbal or non-verbal expression)	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident have impaired sensory awareness (limited vision, limited hearing, tactile impairment)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident take 5 or more medications?	<input type="checkbox"/>	<input type="checkbox"/>	

Cognitive/Behavioral/Psychological

For new move-in, consult with family or caregiver. For change in living units consult resident's chart or nurse.

	YES	NO	NOTES
Does the resident have a diagnosis of depression or take medication for depression?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident demonstrate impaired safety awareness?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident wander during the day or night?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident have sleep disturbances? (difficulty sleeping through the night, day/night confusion)	<input type="checkbox"/>	<input type="checkbox"/>	
Environmental			
Does the resident have fall hazards in their room? (throw rugs, a gliding/rocking chair, obstructed pathways to the bathroom and exit or around the bed)	<input type="checkbox"/>	<input type="checkbox"/>	
Is the resident's room cluttered?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident's room lack space for staff to assist with transfers?	<input type="checkbox"/>	<input type="checkbox"/>	
Are desired/required items for hygiene and dressing difficult to reach/access?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident have inadequate light at night to access bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	

Additional fall risks?

Describe

ED/WD Signature _____

FOLLOW-UP

Any “YES” in fall risk categories consider implementing these recommendations:

General/Medical History Issues

1. Monitor closely for first few days after new move-in
2. Communicate with resident’s physician
3. Engage resident in activities
4. Provide comfort, structure, and routine for new move-ins

Gait and Balance Issues

1. Consider therapy referral
2. Care planning and staff training around mobility aid placement and use
3. Staff training for cueing and assisting of resident with/without mobility device

Physical/Medication Issues

1. Consult resident’s physician
2. Monitor and assess for pain
3. Evaluate environment to accommodate for sensory impairments (vision, hearing, touch)
4. Consider toileting schedule and incontinence briefs for comfort

Cognitive/Behavioral/Psychological

1. Assess for patterns around wandering and establish activity and engagement plan
2. Evaluate environment for safety hazards
3. Consult with resident’s physician for sleep disturbances
4. Engage resident in daytime activities to decrease daytime sleep
5. Evaluate resident’s preferences around sleep schedule and accommodate as appropriate

Environmental

1. Conduct an environmental review for furniture or other safety hazards
2. Remove any unstable or unnecessary furniture
3. Rearrange furniture to optimize pathway around bed and to bathroom/exit
4. Consider installing motion sensor lights
5. Place most frequently used hygiene and dressing items within easy reach