# Falls Risk Assessment for Ambulatory Care/Dialysis/Same Day Surgery/CancerCare

| Date | | Age | |
|---|---|---|---|
| **Risk Factors** | **Response:**<br>If more than one response applies, Select ONE response with the HIGHEST score | Score<br>(circle) | Comments: |
| 1. Mobility | ▪ Ambulates with no gait disturbance<br>▪ Ambulates or transfers with assistive device or assist<br>▪ Ambulates with unsteady gait and no assistance<br>▪ Unable to ambulate or transfer | 0<br>1<br>1<br>0 | |
| 2. Cognition | ▪ Alert, orientated x 3<br>▪ Periodic confusion<br>▪ Confusion at all times | 0<br>1<br>1 | |
| 3. Elimination | ▪ Independent in elimination<br>▪ Independent with frequency or diarrhea<br>▪ Needs assistance with toileting<br>▪ Incontinence | 0<br>1<br>1<br>1 | |
| 4. Prior Fall History | ▪ Yes- Before admission (home/previous in-patient care)<br>▪ Yes - During stay in ACC/SDS<br>▪ No<br>▪ Unknown | 1<br>2<br>0<br>1 | |
| 5. Current Medications | ▪ Any Meds for: sleep, mood control, antiarrhythmics, anti-hypertensives, diuretics, diabetes, seizures, narcotics<br>▪ None of the above medications | 1<br>0 | |
| 6. Falls History | Have you fallen within the past 6 months? ☐ Yes ☐ No | 1<br>0 | |
| | **Total Score** | | |

■ **All patients: apply Universal Precautions** **Implemented** ☐ YES

☐ **Score of 3 or greater,** implement Falls Prevention Management Protocol including Universal Precautions and High-Risk Precautions.

**Universal Precautions**

■ Orientate the patient to their environment
■ Provide signage for patients with mild cognitive impairment
■ Maintain adequate hydration and nutrition
■ Prior to any transfer, complete a "Transfer and Mobility Assessment"
■ Assist with transfers as required
■ Place and maintain an up-to-date patient transfer and handling requirement on the communication whiteboard at the bedside.
■ Assist with toileting as required
■ Administer analgesic(s) as ordered and required
■ Keep patient items within easy reach
■ Place nurse call bell within reach
■ Remind patient to ask for assistance
■ Ensure the patient has properly fitting clothes and footwear
■ Ensure proper use and function of eyewear and hearing aids
■ Keep the bed/stretcher/chair in the lowest position with brakes on
■ Keep bottom bed rails down unless otherwise indicated
■ Ensure the room is kept obstacle free
■ Ensure the patient is using a proper mobility aid as applicable
■ Purposeful rounding by conducting hourly checks (at minimum)
■ Ensure proper lighting and flooring

**High Risk Precautions (check all that apply):**

■ Communicate the patient's risk for falls and safety plan with all care transitions
■ Interprofessional care planning for patients who are cognitively impaired or have complex care needs.

☐ Apply a yellow armband to patients identified as high risk for falls
☐ Have the patient dangle and perform ankle pump while sitting before standing, and then to stand up slowly
☐ Encourage Patient Mobility and assist with same as required.
☐ Establish a toileting routine
☐ Place a commode and/or urinal at the bedside
☐ Use incontinent products, as appropriate
☐ Use bed and/or chair alarm
☐ Use a fall mat by the bed or stretcher
☐ Engage family or volunteers to interact /monitor the patient
☐ Review all medications
☐ Consult, as applicable, interdisciplinary team members that may be available and/or appropriate
☐ Physiotherapy ☐ Occupational Therapy ☐ Social Worker
☐ Mental Health Liaison Nurse ☐ Dietitian
☐ Pharmacy - Medication review/ Vitamin D and calcium

**If admitted,** risk for falls is communicated to receiving unit ☐ Yes ☐ No
**If discharged,** review Falls Prevention with patient, family and/or designate ☐ Yes ☐ No ☐ NA

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| **Additional Recommended Measures** |
|---|
| ☐ Information given to Consult Physiotherapy in the community<br>☐ Information given to Consult Occupational Therapy in the community<br>☐ Educational materials - Falls and You… Most falls Are Preventable<br>☐ Other Educational materials: _____ |
| **Nurse Completing Falls Risk Assessment:**<br><br>Date: _____Time: _____ Signature: _____ |
| ☐ **Same Day Surgery:** Repeat assessment post-operative procedure, following a fall or when condition changes<br>**Reassessment:**<br>Date & time _____ Reassessment Reason & Score: _____<br><br>Signature of Nurse: _____<br><br>Date & time _____ Reassessment Reason & Score: _____<br><br>Signature of Nurse: _____ |