ALR COMMUNITY – FALL RISK ASSESSMENT

Individual's Name: _____ Date: _____

Physical Therapy (PT)/Occupational Therapy (OT) Assessment:

Obtain any PT or OT assessments and review for fall-related information. Enter information as appropriate below.

Assistive Devices:

Type of Device	Does individual have this device?	How reliant is individual on device?	Does individual use device when needed?	Does individual use device correctly?
Cane	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Scooter	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Walker	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Wheelchair	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Other: *please specify*	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Vision:

Does individual have any visual impairment that puts them at risk for falls?

Does individual wear glasses? _____

Does individual wear the appropriate glasses to meet their need? _____

Medication:

Does the individual take medications that put them at increased risk for falls?

Flat Surfaces:

Does the individual transition well between surfaces (e.g., carpet to tile, carpet to rug, etc.)?

_____

Does the individual navigate objects safely (e.g., furniture, boxes, etc.)?

Stairs (if applicable):

Does individual hold onto hand rails? _____

Does individual place foot fully on stairs? _____

Does individual miss stairs? _____

Individual Name: _____ Date of Assessment: _____

Other:

Does individual use furniture or other objects to maintain balance when walking?

Does individual wear well-fitting shoes? _____

Does individual have any balance issues? _____

Does individual have history or current issues with dizziness? _____

Is there any particular time of day that falls occur? _____

Does individual have any foot issues that may contribute to falls (e.g., numbness)?

History of falls in the past three months:

None: ☐

Number in the last three months: _____

Location of falls and time of day:

Any other information relevant to fall risk:

Interventions:

Were any interventions in the past successful in minimizing fall risk?

Conclusion:

Can ALR Community develop and implement a care plan that includes specific interventions to minimize falls and keep the resident safe?

Use of this document does not constitute nor imply compliance with Federal or State rules and regulations. All facilities must follow their own internal guidelines and policies for admission. All facilities are responsible for gathering the appropriate information required to ensure the facility is able to meet the needs of each individual admitted.

Signature of person completing Assessment: _____

Individual's signature: _____ Date: _____

INSTRUCTIONS

Fall Risk Assessment

Use the Fall Risk Assessment to determine the individual's fall risk and your ALR community's ability to provide services based upon that risk.

- Enter the individual's full name.
- Enter the date of the Fall Risk Assessment.
- Enter the name of the individual and date of assessment in the document's header, starting on page 2.

Physical Therapy (PT) or Occupational Therapy (OT) Assessment

If there are any current/relevant PT or OT assessments, obtain them and review for fall-related information. Enter that information as appropriate in the Fall Risk Assessment.

**When performing assessments, it is good practice to: ask the individual questions, speak with family members, and obtain information from their physician (as appropriate). Additionally, whenever appropriate and possible, it is ideal to observe the individual performing any tasks related to the assessment questions.

Assistive Devices

- Note if the individual uses any assistive devices (i.e., cane, scooter, walker, wheelchair, etc.).
- Comment on the individual's reliance on the device (e.g., must use at all times, uses only outside the home, uses only in bad weather, etc.).
- Note if the individual does or does not use the device when needed.
- Note if the individual does or does not use the device correctly (i.e., do they use the equipment as designed?).

Vision

- Note if the individual has any vision impairment that puts them at risk for falls (e.g., blindness, glaucoma, cataracts, macular degeneration, etc.).
- Note if the individual wears glasses.
- Note if the individual's glasses meet their current vision needs.

Medication

- Note if the individual takes medications that put them at increased risk for falls.

Flat Surfaces

- Comment on the individual's ability to transition between surfaces (e.g. carpet to tile, carpet to rug, etc.)
- Note if the individual does or does not navigate objects like furniture or boxes safety.

Stairs (if applicable)

- Note if the individual does or does not hold onto hand rails when using stairs.
- Note if the individual does or does not place their foot fully onto each stair when using stairs.
- Note if the individual has a tendency to miss stair steps when using stairs.

Other

- Note if the individual uses furniture or other objects to maintain balance when walking.
- Note if the individual does or does not wear well-fitting shoes.
- Note of the individual does or does report having any balance issues.
- Note if the individual does or does not report having a history of or current issues with dizziness.
- Note if the individual reports any particular time of day that falls occur.
- Note if the individual does or does not have any foot issues that may contribute to falls, like numbness.

History of falls in the past three months

- Note if the individual reports having had zero falls in the last three months, or
- If needed, enter the number of falls the individual reports in the last three months.
- Note the location and time of day for any falls in the last three months.

Any other information relevant to fall risk

- Document any other information relevant to the individual's fall risk.

Interventions

- Document any interventions used in the past that were successful in minimizing the individual's fall risk.

Conclusion

ALRs can only admit residents whose needs can be met by the ALR. The ALR must have sufficient number of trained staff to meet needs and keep people safe. Document if the ALR can develop and implement a care plan that includes specific interventions to minimize falls and keep the individual safe.

Signatures

The individual who performed the Fall Risk Assessment signs the document.

Request that the individual sign the document.

Date the document.