NAME _____

HEALTH HAZARD/RISK for FALLS

Date	Problem	Goal/Outcome	Interventions	Date	Evaluation	NOTES
	Related To: □ Risk for fall due to: □ Age (65<) □ Chronic medical conditions □ cognitive impairments □ Dizziness □ Visual difficulties □ Impaired physical Mobility □ History of falls □ Medications □ other (list) AEB: □Last fall _____ (date)	1. No falls x 1yr 2. No injury related to falls 3. Verbalize at least 2 safety measures to prevent falls	**NURSING** 1. Initial and ongoing nursing assessment/Review of Systems 2. Assess VS *(T/P/R/BP)* _____ (frequency) 3. Assess contributing factor(s) including review of all meds 4. Make changes to environment as needed 5. Complete fall assessment _____ (frequency) 6. Teach appropriate use of safety measures (state specifics) 7. Other (list) **DELEGATE** 1.Assist with meds as ordered 2. Take VS as ordered/directed 3. Assist with ambulation as needed		***(Address all items listed in "goal/outcome" column. If goal not met, revise plan)***	

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			4. Monitor for unsteadiness 5. Keep be in lowest position 6. Ensure appropriate room lighting especially at night 7. Encourage shoes with nonskid soles 8. Encourage use of handrails especially in bathroom Other (list)			
RN SIGNATURE:					**DATE:**	