Fall Prevalence Audit Form

Institution/ Ward: _____
Date: _____

**Please indicate the reason if No or NA is selected*

		Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
SCM Audit	Fall Risk Assessment done upon admission	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Morse Score:										
	Fall Intervention documented in SCM	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
Environmental Observations	Presence of Green Risk Band* *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Call Bell in sight and within reach* *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Bed in low position* *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐

		Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
Environmental Observations	Table and personal items within reach* *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Any trip hazards around patient? * *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Is patient's mobility status updated on the mobility status board timely and accurately?* *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Is Geri chair seatbelt applied firmly with the lapboard in place? (applicable only to patients with high fall risk and/or dementia) * *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐

		Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
Patient Education	Does patient know how to use call bell? * *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Is NOK aware of the fall prevention measures? * *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
	Does patient/ NOK know the consequences of fall? * *Remarks*	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐
Remarks											

Name and signature of Auditor: _____