FALL PREVENTION AUDIT

Keep the floors clean and minimize slip, trip and fall injuries with this audit checklist.

Complete 4 times a year for every care unit. Deliver this document to the Quality Improvement Team before the end of August, November, February and May.

Audit the corridors and public areas of the unit, as well as 10 patient/resident rooms on the unit.

AUDIT INFORMATION	
DATE & TIME:	UNIT:
AUDIT DONE BY:	SIGNATURE:

CORRIDORS/PUBLIC AREAS	YES	NO	ACTION TAKEN
Are all corridors neat & tidy with no evidence of clutter? (One side of the hallway should always be clear for emergencies)			
Is signage appropriately used to identify hazards? (Example: Wet floor signs			
Is the lighting adequate?			
Are all cords and cables secured?			
Are walking surfaces free of holes, cracks and missing or loose tiles?			

PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
1- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			

PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
2- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	**YES**	**NO**	**ACTION TAKEN**
3- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	**YES**	**NO**	**ACTION TAKEN**
4- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	**YES**	**NO**	**ACTION TAKEN**
5- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			

PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
6- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
7- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
8- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			
PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
9- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			

PATIENT/RESIDENT ROOM	YES	NO	ACTION TAKEN
10- PATIENT NAME: _____ ROOM #: _____		**Patient in room? YES / NO**	
Does the room have a clean, orderly appearance with no evidence of clutter?			
Are all necessary items within reach of the patient? (Call bell, telephone, remote, water jug, assistive device)			
Are all cords/cables/electrical wires secured?			
Is the lighting adequate?			
Are the bed brakes on?			
If the patient is in bed, is the bed at the lowest level?			

TOTAL CONFORMITY IN PERCENTAGE

Total "Yes"		Total "No"	
Calculation: $\dfrac{\text{Total "Yes"}}{\text{Total Questions Answered}} \times 100 = \%$			_____%

FOLLOW-UP REQUIRED

ACTIONS	RESPONSIBLE INDIVIDUAL(S)	DEADLINE

ADDITIONAL COMMENTS