

**Home Oxygen Supplies and Ancillary Services, VACHS, San Juan, PR**

**Home Oxygen Use  
Fall Risk Assessment Form**

Respiratory Therapist / Tech. Signature:		Patient Signature:		Date: mm / dd / yy
Print Name:		Print Name: SS # _____		DOB: mm / dd / yy
<b>Fall Risks</b>	<b>Yes</b>	<b>No</b>	<b>Corrective Action Implemented (Prevention) / Comments / Goals and/or Outcomes</b>	
Has the patient fallen in the past year <b>OR</b> has had trouble getting out of a chair or felt unsteady when walking?	_____	_____		
Does the patient take four or more medications, including; Prescriptions; Non-prescriptions; Herbal?	_____	_____		
Does the patient feel dizzy when getting up from bed or chair?	_____	_____		
Does the patient have any vision problems?	_____	_____		
Does the patient have any problems with feet (Numbness, pain)?	_____	_____		
Does the patient have difficulty getting up from the floor without help?	_____	_____		
Patient and Caregiver(s) are encouraged to report concerns to patient safety issues (e.g. equipment malfunction, equipment supplies, etc.)	_____	_____		
Patient and Caregiver(s) were provided the opportunity to ask and respond to questions related to Fall Risk and prevention procedures.	_____	_____		
<b>Internal Factors</b>				
a. <b>Perceptual</b> (e.g. impaired vision, impaired hearing)	_____	_____		
b. <b>Neuromuscular/functional</b> (e.g. loss or decline in use of arm or leg movement, balance and gait disorder, CVA, chronic or acute conditions with instability, weakness, weight loss, decline in functional status, incontinence, Parkinson's, seizure disorder)	_____	_____		
c. <b>Cardiovascular</b> (e.g. cardiac dysrhythmia, hypotension, lightheadedness, vertigo, syncope)	_____	_____		
d. <b>Cognitive/Behavioral</b> (e.g. delirium, decline in cognition, confusion, depression, dementia, exacerbation in behavioral pattern, combativeness, refusal of intervention. Resident noncompliance, and of itself, an adequate explanation or justification for continued falling, because the underlying causes may occur in conjunction with	_____	_____		

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Patient knows how to remove cannula, shut off the oxygen supply and wait for oxygen to dissipate prior to smoking. (Wait time approx. 5 min). Patient can't smoke in the room must go outside.			
HOP Representative identifies risks associated with long-term oxygen therapy such as open flames, smoking material present and/or open flame near the vicinity of oxygen equipment.			
Patient and Caregiver(s) are encouraged to report concerns to patient safety issues (e.g. equipment malfunction, equipment supplies, etc.).			
Patient correctly verbalizes prescribed liter flow.			
Patient and Caregiver(s) were provided the opportunity to ask and respond to questions related to the <b>"NO SMOKING"</b> Policy.			
Alarm on concentrator sounds when machine is turned on.			
If patient is smoking: <ul style="list-style-type: none"> <li>No oxygen is running <b>AND</b></li> <li>Patient is a minimum 10' from equipment</li> </ul>	_____ _____ 	_____ _____ 	
If patient is smoking within 10' of running oxygen: <ul style="list-style-type: none"> <li>Immediately turn off oxygen</li> <li>Review hazards of smoking w/oxygen</li> <li>Document the event in patient record</li> <li>Notify the appropriate providers in accordance w/Directive 2006-021</li> </ul>	_____ _____ _____ _____ 	_____ _____ _____ _____ 	
Additional Notes and Comments:			
Other Providers Contacted as result of this visit: Yes ____ No ____			
<b>I certify that I have received orientation and educational material regarding the hazards of smoking. I fully understand the "NO SMOKING" assessment presented by the VA Caribbean Healthcare System Home Oxygen Program Representative.</b>			
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Print Name:		Print Patients' Name: SS # ____	DOB: mm / dd / yy

Reference:  
VHA Directive 2006-021  
2010 Home Care National Patient Safety Goals

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**Performance Improvement Monitor**