

# FALL INCIDENT ASSESSMENT

(This tool is only an example. Please adapt it to meet the needs of your facility and residents.)

DATE \_\_\_\_\_

## DIRECTIONS

According to facility policy, the fall assessment shall be completed following any resident fall. This fall assessment shall not be made part of the resident's medical record. The assessment is completed as part of the facility's continuing quality assurance program. Information in this assessment should be used to revise the resident's plan of care. **Items noted below with a star\* should be appropriately documented in the resident's clinical record. All other items should be reviewed and acted upon solely at the discretion of the nursing facility.**

## IMMEDIATE ACTION

\*The following items should be documented in the resident's clinical record:

- Physician contacted  Family contacted
- Administration contacted, according to facility policy
- Resident first-aid and treatment
- Neuro-checks
- Vital signs: BP (sitting, then standing), temperature, pulse and respiration
- Signs/symptoms of injuries such as pain, bleeding, abrasions, contusions, bruises, swelling reddened areas, etc.
- Medical conditions such as:

Cardiac arrhythmia's	Hypotension
Syncope	Parkinson's
Hemiplegia	Seizure disorder
Arthritis	Pain
Osteoporosis	CHF
Bladder dysfunction (worsening or new onset)	
- Acute conditions or signs/symptoms of unknown origin.
- Urine tested by dipstick within 4 hours of fall
- The position of the resident upon discovery
- Resident and witness statements

## INVESTIGATION

\*What was the resident doing when incident occurred:

Standing  Sitting  Transferring ( Assistive Devices Used)  In Bed  Reaching  Other \_\_\_\_\_

\*Where was the resident when the incident occurred:

Own bedroom  Another bedroom  Own bathroom  Another bathroom  Hall  Dining Room  Lounge  Other –  
Specify \_\_\_\_\_

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Attending Physician

\_\_\_\_\_  
Room No. Res. #

**FALL INCIDENT ASSESSMENT (Continued)**

**\*What was the resident's state of mind when the incident occurred:**

Oriented/No Problem  Judgment Impaired  Non-communicative  Confused/Disoriented  Cooperative  
 Unable to understand others  Behavior Problems  Unknown  
Has there been a change in mental status in the last week before fall?  Yes  No

**\*What time was it when the incident occurred:**

Day of Week \_\_\_\_\_ Time of Day \_\_\_\_\_ am/pm Phase of moon \_\_\_\_\_ Last meal time \_\_\_\_\_  
Last toileting time \_\_\_\_\_ Last incontinence episode \_\_\_\_\_

**CURRENT MEDICATIONS**

Antianxiety  Antiparkinson  Hypoglycemic  Antihistamine  
 Hypnotic  Antipsychotic  Analgesic  Anticoagulant\*  
 Antihypertensives  Anticonvulsant  Laxatives  Non steroidal  
 Antidepressant  Diuretics  Narcotics  Anti-inflammatory

\*Not a medication that leads to falls, but increases risk for injury when fall occurs.

\*\*Within 24 hours of fall, notify pharmacy consultant by fax for medication review due to fall.

After faxing fax sheet to pharmacy consultant, attach fax sheet to this form.

**ENVIRONMENTAL FACTORS**

Has there been a recent change in the environment?  No  Yes, please list change \_\_\_\_\_  
\_\_\_\_\_

**Floor Surface**

Unknown  No problem  Loose rug, tiles  Clutter  
 Slippery/Glare  Threshold > 1/2"  Uneven surfaces  Other \_\_\_\_\_  
 Patterned carpet  Thick pile carpet

**Lighting**

Unknown  No problem  Inadequate  Glare  
 Too much  Other \_\_\_\_\_

**Handrail**

Unknown  No problem  Not accessible to resident  Difficult to grip  
 Loose  Other \_\_\_\_\_

**Bathroom**

Unknown  No problem  No grab bar  Grab bar loose  
 Floor slippery  Other \_\_\_\_\_

**Chair**

Unknown  No problem  No armrest  Unlocked wheels  
 Poor construction  Lack of 3 right angles when seated  Other \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Attending Physician Room No. Res. #

**FALL INCIDENT ASSESSMENT**(Continued)

**Bed**

Unknown       No problem       Too narrow       Overlay  
 Too low       Unlocked wheels       Side rails       Other \_\_\_\_\_

**Clothing and Shoes**

Unknown       No problem       Tripped person       Loose/ill-fitting shoes  
 Walking in stocking feet       Other \_\_\_\_\_

**Other factors contributing to incident**

None       Restraint       Lift       Staff  
 Other device, List \_\_\_\_\_

**RESIDENT SPECIFIC CARE PLAN IN PLACE, FOLLOWED AND DOCUMENTED**

Appropriate safety precautions and devices       Yes       No       NA  
Positioning devices       Yes       No       NA  
Toileting programs       Yes       No       NA  
Rehab/restorative program       Yes       No       NA  
Behavioral program       Yes       No       NA  
Other, list \_\_\_\_\_

**Did you educate resident about safety concerns?**       Yes       No – why not \_\_\_\_\_

**Did you educate resident on ways to fall?**       Yes       No – why not \_\_\_\_\_

Individual Completing Investigation \_\_\_\_\_ Date \_\_\_\_\_

**QA USE ONLY**

**ACTION PLAN**

Review incident report       Review nurse's notes  
 Review and revise care plan       Communicate changes to staff  
 Observation of implementation of care plan at least every shift

**CONCLUSION/SUMMARY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Last Name      First Name      Attending Physician      Room No.      Res. #