

SAFETY COMMITTEE FALL INVESTIGATION

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

Resident Name _____

Date of Fall _____

- 1) Did the resident show signs of infection, cognitive or behavioral change or vital sign changes? Was/Is there a need for further medical evaluation and /or significant change assessment?
Comments: _____

- 2) Were environmental factors an issue? For example, equipment use, repair of assistive devices, physical environment. _____

- 3) Were medications a factor? Did the resident have a recent medication change? Review pharmacy response and comments: _____

- 4) If staff was assisting the resident at the time of the fall, is there a need to review the use of lifts, gait belt and transfer techniques with staff member/s? Comments: _____

- 5) Is there a need for therapy to follow up with the resident? Review therapy screen. Comments: _____

- 6) Was the need to toilet an issue? Was the resident attempting to go to the bathroom or incontinent? Is resident on toileting schedule? Comments: _____

- 7) Was failure to follow the care plan a factor? Comments: _____

- 8) Review immediate staff interventions and resident education taken after fall and update documentation/care plan as indicated. Comments: _____

- 9) Add information to Falls Tracking Log. _____
- 10) Update Falls Risk Assessment, if not previous fall risk. _____
- 11) Check that Plan of Care updated. _____
- 12) Further recommendations: _____

Completed by: _____ **Date:** _____