QA: Post Fall Investigation Report

Resident name: _____ Room #: _____

Social Security #: _____ Date of incident: _____ Time of incident: _____

Staff completing report: _____ Date of Report: _____

1. Does the resident have a history of falls?

☐ Yes ☐ No

If yes, list falls for the past 12 months:

Date: _____ Time: _____ ☐ AM ☐ PM

Date: _____ Time: _____ ☐ AM ☐ PM

Date: _____ Time: _____ ☐ AM ☐ PM

Date: _____ Time: _____ ☐ AM ☐ PM

Date: _____ Time: _____ ☐ AM ☐ PM

Date: _____ Time: _____ ☐ AM ☐ PM

2. Was the resident identified on the care plan as high risk for a fall? ☐ Yes ☐ No

3. Do you see any patterns with falls? (Check all that apply.)

☐ Greater than 2 falls in the past 2 days ☐ Increased restlessness ☐ Going to the bathroom ☐ Time of day

☐ Specific activity ☐ Location ☐ Physical Factor (shoes, etc.) ☐ Other _____

4. Contributing factors: (Check all that apply.)

☐ Wet/slippery floor ☐ Call light off ☐ Non-compliant resident

☐ Need for bathroom ☐ Agitation ☐ Lighting off/low

☐ Pain ☐ Hunger ☐ Improper footwear

☐ Postural hypotension or dizzyness ☐ Other: _____

5. Location

☐ Resident room ☐ Bathroom ☐ Dining room

☐ Hallway ☐ Nurses' station ☐ Lobby

☐ Other: _____

6. Did anyone witness the fall? ☐ Yes ☐ No

7. Level of Injury:

☐ No injury ☐ Minor injury ☐ Major injury ☐ Death

8. Describe the incident: (Check all that apply.)

☐ Found on floor ☐ Found by bed ☐ Was walking unassisted

☐ Found by bathroom door ☐ Missed chair ☐ Slid out of chair

☐ Other:

A) Describe injury: _____

B) Describe accident: _____

_____

_____

_____

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9. Was the resident using bed rails? ☐ Yes ☐ No

10. What was the bed's position? ☐ High ☐ Low

11. Appliances/assistive devices used for ambulation (Check all that apply.)

☐ Walker or cane ☐ Restraint used

If physical restraints were used, list type: _____

12. Activity status:

☐ Bed rest ☐ Up in a chair ☐ Ambulatory

☐ Bathroom privileges

13. Medication factors:

☐ New medications ☐ Greater than 5 medications ☐ Medication changes

If medications were a factor, list medications: _____

14. Does the resident take any of the following? (Check all that apply.)

☐ Psychotropics ☐ Anti-anxiety ☐ Analgesics

☐ Antihypertensives ☐ Antidepressants ☐ Diuretics

☐ Sedatives ☐ Hypoglycemics

15. Had resident's health care status changed prior to this fall? ☐ Yes ☐ No

If yes, describe: _____

16. Safety measures and interventions

A. Were safety measures or fall prevention interventions in place prior to the current fall? ☐ Yes ☐ No

B. If yes, were the measures/intervention in the care plan? ☐ Yes ☐ No

C. Were the measures/interventions carried out as per the care plan? ☐ Yes ☐ No

If no, Explain:_____

_____

17. If the fall was unwitnessed, or if the head was impacted, were neuro checks done immediately and according to protocol? ☐ Yes ☐ No

18. Was increased monitoring documented for 72 hours post fall per standard of care?

☐ Yes ☐ No

19. Was the incident report completed in its entirety?

☐ Yes ☐ No

Findings: Summarize factors identified as contributing to and/or causing the fall(s). Then describe planned systemic interventions/changes:_____

_____

_____

_____

_____

_____

Document available at www.primaris.org

MO-08-42-REST August 2008 This material was prepared by Primaris, the Medicare Quality Improvement Organization for Missouri, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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