COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

POST-FALL ASSESSMENT FORM (NUR-023F)

Directions: This form should be completed for ALL falls and forwarded to the Quality Manager. This analysis should be done ASAP after the fall, but less than 24 hours. This review should include all staff involved in the patient/visitor fall, the staff who found the patient/visitor and facilitated by the House Supervisor/Charge Nurse or Department Manager at the time of fall. This report is not intended to place blame or serve for disciplinary action.

SECTION A: FALL DETAILS – To be filled out by RN
Date of fall: **Time of fall:**
Department/Nursing Unit where fall occurred:
Staff Involved:
Patient's fall risk level prior to fall: ☐ Low ☐ Moderate ☐ High ☐ N/A
When was the last time the patient was rounded on: ___________________________________ **Which was of the following were assessed during rounds:** ☐ Pain ☐ Toileting ☐ Positioning ☐ Placement of Items ☐ N/A
Physical location of fall: ☐ from bed ☐ between bed and bathroom ☐ from chair ☐ between chair and bathroom ☐ from BSC ☐ from toilet ☐ from cart/gurney ☐ hallway ☐ shower/tub ☐ therapy/other treatment ☐Other:
Was fall witnessed: ☐ Yes ☐ No **Was fall assisted?** ☐ Yes ☐ No
Pre-fall Activity Status: ☐ Independent ambulation ☐ Independent ambulation w/assistive device (i.e. cane, walker, crutches, etc.) ☐ Ambulation w/staff assistance ☐ Transfer w/staff assistance ☐ Bedbound
If fall was staff assisted, what transfer equipment was in use at the time of the fall? ☐ None ☐ Transfer belt ☐ Walker ☐ Sliding board/transfer sheet ☐ Other: ___________________________ ☐ N/A
If patient fell from bed, number of side rails in use at time of fall: ☐ N/A
Medications administered within 8 hours prior to fall: ☐None ☐PCA ☐Opiates ☐Anticonvulsants ☐Antihypertensives ☐Antiarrhythmics ☐Diuretics ☐Hypnotics ☐Sedatives ☐Laxatives ☐Antidepressants ☐Antipsychotics ☐Benzos ☐Antihistamines ☐Antiparkinsonians ☐Alzheimer drugs **Is the patient on anticoagulants?** ☐ Yes ☐ No ☐ N/A
Preventative measures in place prior to the fall: ☐Low Bed ☐Chair alarm on ☐Bed alarm on ☐Bed in low position/locked ☐Non-skid socks on ☐Hourly rounding done/toileting offered ☐Wheelchair locked ☐Room free of obstructions ☐Call light within reach ☐Patient/family education done ☐Room close to nursing station ☐ N/A
If the patient had a bed or chair alarm in place, were the alarms properly set? ☐ Yes ☐ No **If yes, did the alarms prompt the staff response to the fall?** ☐ Yes ☐ No
Describe Event: Include patient/visitor activity and symptoms at time of fall and just prior to fall.

How was the patient/visitor evaluated for injury?	**Describe the actual/suspected patient/visitor injury(s):** ☐ No apparent injury ☐ Minor (bruises, abrasions) ☐ Moderate (fracture, laceration that requires repair) ☐ Major (requires surgery, transfer to higher level of care) ☐ Death

Contributing Factors (please indicate ALL that apply in the Incident Event Report):

Patient-Related:	Environmental:
☐ Behavioral (agitated, impulsive)	☐Equipment/Supplies (bed/chair alarm, call light malfunction)
☐Cognitive impairment (dementia, TBI)	☐Wet floor
☐Physical impairment (weakness, amputee, etc)	☐Poor lighting
☐Sensory impairment (vision, hearing, balance)	☐Trip hazards
☐Assessment (incomplete, inaccurate)	☐Personal items within reach
☐Medications (new/changed, opioids, benzos,etc)	
☐Physiological (dizziness, blood sugar changes, etc)	
☐Other:	

What was the Fall Risk Assessment for the patient prior to the fall?	
What was the patient's fall risk score and level of risk prior to this fall? ☐ N/A	Score: ☐ Low Risk ☐ Moderate Risk ☐ High Risk
What was the date/time of the patient's last fall risk assessment?	Date:_________________ Time: _______________ ☐ N/A
Was fall risk assessment documented on: Admission to unit?	☐ Yes ☐ No ☐ N/A
Every ___ since admission?	☐ Yes ☐ No ☐ N/A
Each change in level of care?	☐ Yes ☐ No ☐ N/A
Has the patient/visitor had a fall in the past 3 months?	☐ Yes ☐ No ☐ N/A

SECTION B: POST FALL CHECKLIST – To be completed by RN

☐Perform full nursing assessment and obtain set of vital signs.

☐MD notified – policy is to notify MD for ALL patient falls. If the fall was unwitnessed or involved a potential head injury, complete a neuro every 15 minutes x ___, then every hour x 4 hours, then every 4 hours x 24 hours.

☐Notify Chief Nursing Office and Director of Quality of fall event by **[insert hospital preference for notification]**

☐Perform Post-Fall Risk Assessment, making patient an automatic "High Risk" for falls

☐Update patient's Care Plan

☐Complete a program note, including the following information: 1) Was the fall witness/unwitnessed and by whom. 2) Orientation status of patient at time of the fall: confused, drowsy, alert, etc. 3) Type of injury. 4) How was the patient lifted following the event – what equipment was used and how many staff members assisted?

☐Was family notified? ☐ Yes ☐ No

☐Was modification to patient's fall precautions implemented: ☐ Yes ☐ No
If yes, what precautions were implemented:

SECTION C: ACTION PLAN
What could have been done to prevent this fall?
What will be done to prevent patient from falling again?
How can we prevent this from happening to other patients?

Staff Signature:__________________________________ Staff Signature: ______________________________________

Staff Signature: __________________________________ Staff Signature: ______________________________________

Staff Signature: __________________________________ Staff Signature: ______________________________________