FALLS MANAGEMENT – POST FALL ASSESSMENT TOOL

Resident		Age	Room #
Admit Date	Admit Dx	Current Dx	
Date of Fall	Day of Week	Time	AM PM
Assigned caregiver(s) (Name and title)			

1. Was this fall observed? ❒ Yes ❒ No *If yes*, by whom: _____
(name and title)

2. Was the resident identified as "high risk" prior to the fall? ❒ Yes ❒ No

3. Resident vital signs

Usual vital signs *before* the fall:	BP Lying:	Pulse:
	BP Sitting:	Pulse:
	BP Standing:	Pulse:
Vital signs *just after* the fall:	BP Lying:	Pulse:
	BP Sitting:	Pulse:
	BP Standing:	Pulse:

4. Does the resident have a history of falling? ❒ Yes ❒ No *If yes*, list dates of all previous falls for the past 12 months:

DATE/TIME OF FALL	DATE/TIME OF FALL

5. List any life safety measures in place prior to this current fall:

6. Ask the following question of the resident "immediately" after the fall: WHY DO YOU THINK YOU FELL?

7. Ask the following questions of the resident immediately after the fall:

	Yes	No		Yes	No
Were you hungry?			Did you need to use the bathroom?		
Were you in pain?			Other:		
Were you bored?					

8. What footwear did the resident have on?

❒ Barefoot ❒ Shoes ❒ Slippers ❒ Other:

9. What was the resident doing at the time of the current fall?

	Yes	No		Other:
Getting out of bed?				
Going to the bathroom?				
Looking for something?				
Getting up from a chair?				
Going to the dining room?				

10. Location of this current fall (check all that apply):

Activity room		Day room		Shower		Other:
Bathroom		Dining room		Toilet		
Bed room		Hall		Transferring		
Commode		Outside		Wheelchair		

11. Was a restraint used during this fall?

None		Waist restraint		Other:
Geri Chair		Vest restraint		
Side rails		Mittens		
Wrist restraint		Lap board		

12. If a restraint was present during the fall, was it properly applied prior to the fall? ❒ Yes ❒ No
If no, please describe:

13. Mechanical/Assistive Devices:

What *mechanical devices* were in use?	✓		**Yes**	**No**
Chair alarm		Was chair alarm working at time of fall?		
Bed alarm		Was bed alarm working at time of fall?		
Mobility monitor		Was monitor working at time of fall?		
What *assistive devices* were in use?	✓		**Yes**	**No**
Cane ❒ straight ❒ hemi ❒ quad		Was cane in good repair?		
Crutches		Were crutches in good repair?		
Walker		Was walker in good repair?		
Wheelchair		Was wheelchair in good repair?		
Geri-chair		Was Geri-chair in good repair?		
Lap board		Was lap board in good repair?		

14. Mental status of resident (check all that apply):

Mental status *prior to* the fall:	**YES**	**NO**	**Mental status *after* the fall:**	**YES**	**NO**
Alert			Alert		
Oriented			Oriented		
Disoriented/confused			Disoriented/confused		
Unable to follow directions			Unable to follow directions		
Other:			Other:		

15. Physical status of resident prior to the fall (check all that apply):

Physical Status *prior to* fall	**Yes**	**No**	**NA**	**Physical status *prior to* fall**	**Yes**	**No**	**NA**
Unsteady gait				Impaired mobility/transfer			
Visual impairment				Glasses on			
Hearing impairment				Hearing aid in/working			
Weakness/fatigue				Recent acute illness			
Hearing impairment				Recent change in lab values (Hgb/Hct, blood sugar, O_2, etc.)			
Dizziness				Other:			
Pain							

16. Environmental status at the time of the fall (check all that apply):

Environmental status *at time* of fall	**Yes**	**No**	**NA**	**Environmental status *at time* of fall**	**Yes**	**No**	**NA**
Call bell within reach				Call bell on at time of fall			
Bed locked				Room light on			
Wheelchair locked				Floor wet			
Night light on				Patterned carpet/throw rugs			
Uneven floor surfaces				Power/phone/TV cords out			
Glare on floor				Other:			

17. Medication Status

	Yes	**No**	**NA**		**Yes**	**No**	**NA**
Diuretic				Cardiac			
Antihypertensive				Antibiotic			
Psychotropic				Other:			
Laxative							

18. List all new medications prescribed/administered to resident in the past 7 days:

19. Describe the general health of the resident in the hours, days, and weeks before the fall:

20. Is there a need to re-educate the resident, family, staff: ❒ Yes ❒ No

21. Has the resident's care/service plan been updated? ❒ Yes ❒ No

Additional notes:

Signature/title of person completing form

Date