FALL ANALYSIS TOOL

Please provide as much detail as possible. Risk Management needs to gather as much information as possible regarding the circumstances of the fall. Thank you.

Primary diagnosis:_____
Additional diagnosis: _____

Initial risk assessment status: at risk_____ not at risk_____ Fall Risk Score: on arrival_____ Fall Risk Score: after fall_____

Patient / family education on safety documented: yes_____ no_____

Activity at the time of the fall. (What was the patient trying to do?) _____

Injuries associated with the fall: yes_____ no_____ please describe: _____

Was the fall attended? yes_____ no_____

Other factors: _____Used call light _____Did not use call light _____Did not wait for help

Comments: _____

Did fall occur during toileting or an attempt to get to the bathroom? yes_____ no_____

_____Patient toileted as scheduled; time of last toileting_____
_____Patient had hourly rounding; time of last rounding_____

Elimination Status
_____Incontinent
_____Urgency
_____Diarrhea

Comments: _____

Did the fall occur during a transfer? yes_____ no_____

_____Bed to wheelchair _____Wheelchair to bed _____To/from toilet

Did the fall occur during ambulation? yes_____ no_____

Was patient on anticoagulants? YES = Check Neurological Status: _____

Did medications contribute to patient fall? Yes _____ no _____ If YES What medication? _____

Safety precautions in place at time of fall. Check all that apply:

_____Bed in low position _____Bed alarm in use _____Bed rails up
_____Call light within reach _____Wheels locked (on bed or wheelchair)
_____Appropriate shoes/footwear _____Other (describe) _____

# of patients nurse was assigned to during shift of fall _____ Precepting New Employee/Student? # _____
# of admissions / discharges nurse had _____ Float Staff? _____
How many shifts (days/nights) in a row had nurse worked who was assigned to patient_____

RN Signature: _____ Date/Time: _____

Further Follow-up/Changes in Plan of Care: _____
_____
_____
_____

Additional Information / Other Comments:
_____
_____
_____

Nurse Manager: _____ Date: _____