Nursing Home Fall Assessment

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Definition of fall: For the purposes of resident safety, a fall is a sudden, unintended and uncontrolled downward displacement of a person's body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a resident begins to fall and is assisted to the ground by another person).

According to the Centers for Medicare & Medicaid Services Minimum Data Set (MDS) Version 3.0 Resident Assessment Instrument (RAI) Manual, a fall is: the unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

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Fall Assessment

Name of Facility: _____

Resident: _____ Date: _____

Physician: _____ Nurse: _____

Date of admission: _____ Age: _____

Gender: ☐ Male ☐ Female

Diagnosis: _____

Date of fall: _____ Time of fall: _____

Prior to fall, when was the last time the resident was visually assessed? ☐ < 1 hr. ☐ 1-2 hrs. ☐ > 2 hrs.

Where did the fall occur? *Check one.*

☐ Resident's room, please specify (e.g., bedside, bathroom, etc.): _____

☐ Dining Room ☐ Common area/Lobby

☐ Hallway ☐ Therapy Department

☐ Activity Room ☐ Outside area

☐ Other, please specify: _____

Was the fall unassisted or assisted? ☐ Assisted ☐ Unassisted ☐ Unknown

Was the fall observed? ☐ Yes ☐ No ☐ Unknown

Who observed the fall? ☐ Staff ☐ Visitor, family or another patient, but not staff

Did the resident sustain a physical injury as a result of the fall? ☐ Yes ☐ No ☐ Unknown

What type of injury was sustained? *Check one. If there is more than one, check the most severe.*

☐ Dislocation ☐ Skin tear, avulsion, hematoma ☐ Fracture or significant bruising

☐ Intracranial injury ☐ Laceration requiring stitches

☐ Other, please specify: _____

Describe the fall

(e.g., How did it occur, where in detail did it occur and how it was discovered? A narrative may be attached.)

Fall Assessment

Which of the following additional treatments or monitoring were performed as a result of the fall? *Check all that apply.*

☐ Monitoring (e.g., observation, physiological examination and Neuro checks)
☐ Additional medication therapy
☐ Surgical/Procedural intervention
☐ Respiratory support (e.g., ventilation, tracheotomy)
☐ Unknown
☐ Other intervention, please specify: _____

After the discovery of the fall, who was notified? *Check all that apply.*

☐ Resident's family or guardian ☐ Physician ☐ Unknown

Prior to the fall, what was the resident doing or trying to do? *Check one.*

☐ Ambulating
☐ Changing position (e.g., in bed, chair)
☐ Dressing or undressing
☐ Navigating bed rails
☐ Reaching for an item
☐ Showering or bathing
☐ Toileting
☐ Transferring to/from bed, chair, wheelchair, etc.
☐ Undergoing a procedure
☐ Unknown

☐ Other, please specify: _____

Was the resident being supervised or assisted at the time of the fall? *Check one.*

☐ Yes, hands-on assist being provided
☐ Yes, in the same room, but not hands-on
☐ No
☐ Unknown

Was the resident using an assistive device or other type of equipment at the time of the fall? *Check one.*

☐ Yes ☐ No ☐ Unknown

What was the device or equipment? _____

Did the equipment or device contribute to the fall? ☐ Yes ☐ No.

If yes, please explain: _____

Prior to the fall, was a fall risk assessment documented? *Check one.*

☐ Yes ☐ No ☐ Unknown

Fall Assessment

Was the resident determined to be at risk for a fall?

☐ Yes ☐ No ☐ Unknown

What was the resident's score on the fall risk assessment? _____

Prior to this fall, has the resident fallen in the facility? ☐ Yes ☐ No

Which of the following were in place and being used to prevent falls for this resident? *Check all that apply.*

☐ Assistive devices (e.g., wheelchair, walker, commode)

☐ Physical/Occupational therapy includes, but is not limited to, gait training, balance, transfer training

☐ Bed and/or chair alarm

☐ Bed in low position

☐ Call light/Personal items within reach

☐ Change in medication (e.g., timing or dosing)

☐ Non-slip floor mats

☐ Hip and/or joint protectors fall

☐ Resident placed close to the nurses' station

☐ Purposeful rounding

☐ Sitter

☐ Supplemental environmental or area lighting

☐ Toileting regimen

☐ Visible identification of resident as being at risk

☐ Non-slip footwear

☐ Resident and family education

☐ Gait belt

☐ None

☐ Other, please specify: _____

Did restraints, bedrails or other physical devices contribute to the fall (i.e., tripping over cords or other hazards)?

☐ Yes ☐ No

☐ Unknown, please describe: _____

_____

At the time of the fall, was the resident on medication known to increase the risk of fall?

☐ Yes ☐ No ☐ Unknown

Please indicate the number of each routine medication prescribed:

_____ Cardiovascular

_____ Hypnotics

_____ Antihypertensives

_____ Diuretics

_____ Sedatives

_____ Laxatives

_____ Psychotropics

_____ Analgesics

Fall Assessment

What factor(s) contributed to the event? *Check all that apply.*

Other Contributing Factors (Patient)

☐ Dizziness/Vertigo
☐ Hypotension
☐ Procedure within last 24 hours
☐ Constipation
☐ Cognitive impairment
☐ Impulsive behavior
☐ Overestimated ability
☐ Weakness
☐ Anticoagulant/Bleeding disorder
☐ Bowel prep in progress
☐ Incontinence/Urgency
☐ Symptomatic depression
☐ Sensory impairment (e.g., vision, hearing, balance, etc.)

☐ Other, please specify:_____

☐ Need to consult with pharmacy about medications? Please describe:

What are other factors that could have attributed to the fall? *Check all that apply.*

Environment

☐ Culture of safety, management of staff
☐ Physical surroundings cluttered
☐ Physical surroundings not customized to accommodate resident's mobility limitations

Staff Qualifications

☐ Lack of competence (e.g., qualifications, experience)
☐ Lack of training (e.g., use of gait belt, transfers, lifts)

Supervision/Support

☐ Lack of clinical supervision
☐ Lack of managerial supervision
☐ Poor teamwork

Policies and procedures, includes clinical protocols

☐ Absence of policies
☐ Poor clarity of policies
☐ Lack of compliance with policies

Fall Assessment

Equipment/Device

☐ Assistive device (e.g., walker, cane,etc.)
☐ Gait belt
☐ Wheelchair
☐ Call light
☐ Bed alarm
☐ Chair alarm
☐ Other, please specify:_____

Information About Fall Risk Status

☐ Not Available
☐ Not Accurate
☐ Not Legible

Communication

☐ Supervisor to staff
☐ Among staff or team members
☐ Staff to resident (or family)

Human Factors (Staff)

☐ Fatigue
☐ Stress
☐ Inattention
☐ Cognitive factors
☐ Health issues

External Factors

☐ Family/Visitor involvement

Fall Assessment

Post Fall Huddle Documentation

A Post Fall Huddle is one suggested best practice for reducing falls. Post Fall Huddles provide a mechanism to learn from falls by immediately assessing the situation and reviewing the event with the people involved, including the resident and family members, as well as determining what can be done to prevent another fall from occurring.

Directions: To be completed after ALL resident falls as soon as possible after resident care is provided, but prior to leaving the shift.

Has this patient fallen previously during this admission?

☐ Yes ☐ No ☐ Unknown

If yes, what interventions were in place to minimize the risk of a fall?

How preventable was the fall? *Check one.*

☐ Almost certainly could have been prevented

☐ Likely could have been prevented

☐ Likely could not have been prevented

☐ Almost certainly could not have been prevented

☐ Unknown

How could the fall have been prevented?

Who was included in the huddle? Check all that apply.

☐ Resident

☐ Family/Caregiver

☐ Charge Nurse

☐ Restorative Aide

☐ Director of Nurses

☐ CNA

☐ Occupational Therapist

☐ COTA

☐ Physical Therapist

☐ Pharmacist

☐ Physical Therapy Assistant

☐ Pharmacy Tech

☐ Other: _____

Fall Assessment

What factors were discussed in the huddle?

☐ Were there task errors? (e.g., planned interventions were not in place as intended)

Please describe:

☐ Were there judgment errors? (e.g., strategy used to assist with transfers/gait was inappropriate)

Please describe:

☐ Were there care coordination errors? (e.g., fall risk status not communicated to all parties)

Please describe:

Need to consult with Physical Therapy about balance/transfers/mobility? ☐ Yes ☐ No

Please provide more information as needed:

Please provide any additional comments regarding the huddle.

What actions will be taken to prevent another fall from occurring?

Thank you for contributing to patient safety and quality of care.