Fall Event Tool

Date: _____

FALL INVESTIGATION FINDINGS:

Pre-Fall Risk Assessment/Interventions/Documentation

1. Safety Needs Score on Admission ☐ Y ☐ N Score: _____

2. Safety Needs Education on Admission (pt/family) ☐ Y ☐ N

3. Safety Needs assessment completed daily with appropriate Interventions checked ☐ Y ☐ N

***Time** of last Hourly Rounds_____ Was patient: ___taken to BR ___pain med offered/given ___re-positioned

Assessment Factors

1. Was fall due to (actual/potential):
   a. Health Status (stroke / unsteady / syncope / etc.) ☐ Y ☐ N ☐ NA
   b. Mental Status (Alzheimer's / dementia / etc.) ☐ Y ☐ N ☐ NA
   c. Other reason (slick floor / tubing / etc.) ☐ Y ☐ N ☐ NA
   d. Response of: surgery / medications / anesthesia ☐ Y ☐ N ☐ NA

Post-Fall Assessment/Interventions/Documentation

1. Discussed documentation to be completed after fall to include:
   a. Nurse Statement regarding fall ☐ Y
   b. Patient Statement regarding fall ☐ Y
   c. Assessment / Interventions ☐ Y
   d. Fall prevention education / information given after fall (in progress notes or education flowsheet) ☐ Y
   e. Safety Needs Flowsheet – reassess and tally fall risk score ☐ Y
   f. Complete QRR incident report ☐ Y

***Was **staff assigned** to unit physically on the unit at the time of the fall? ☐ Y ☐ N

2. Patient Protective Device Utilized (if required / appropriate)	Pre-fall			Post-fall	
a. Bed Alarm	☐ Y	☐ N	☐ NA	☐ Y	☐ N
b. Chair Alarm	☐ Y	☐ N	☐ NA	☐ Y	☐ N
c. Restraint	☐ Y	☐ N	☐ NA	☐ Y	☐ N
d. 1:1	☐ Y	☐ N	☐ NA	☐ Y	☐ N

3. Notification:
   a. House Coordinator ☐ Y ☐ N ☐ NA
   b. Physician ☐ Y ☐ N ☐ NA
   c. Family ☐ Y ☐ N ☐ NA

CONCLUSION: _____

RECOMMENDATIONS: _____

_____

Return to Nurse Manager