FALL INVESTIGATION TOOL

All information below reflects what happened at the time of the incident

Resident Name: _____ Date: _____ Time of Incident: _____

Location of fall: _____ Activity prior to fall: _____

Brief description of fall: _____

_____

What does the resident state happened? _____

_____

What do other witnesses state happened? _____

_____

ROM: ☐ WNL or ☐ Not WNL Pain ☐ Yes ☐ No Location/Description of injury _____

_____

Mild (pain expressed but does not interfere with activity) ☐ Moderate (pain interferes with normal activity) ☐ Severe (pain excruciating) Pain

T____ P____ R____ BP at ☐ sit or ☐ lay _____ BP at ☐ sit or ☐ stand _____

PERRLA (if applicable, explain concerns) _____

Environmental Concerns: (room order, glare, wet floor, equipment failure, etc) _____

_____

_____

Contributing Factors ☐ Positioning ☐ Behavior ☐ Cognition ☐ Acute Illness ☐ Gait Disturbance ☐ Unmet Need

☐ Vision Impairment ☐ Other Explain all checked: _____

_____

Was resident continent at time of fall? Bowel ☐ Yes ☐ No Bladder ☐ Yes ☐ No Time last toileted _____

☐ Use of Alarm ☐ Use of Restraint Explain alarm/restraint use _____

_____

Was the care plan being followed? ☐ Yes ☐ No Explain _____

_____

Immediate Interventions taken: _____

_____

Recommendations to IDT for fall prevention: _____

_____

_____

_____

Assigned NAR _____ Names of Others Involved _____

List Witnesses (including roommate) _____

Signature of person completing tool: _____

☐ **EVENT COMPLETED**

IDT Fall Review Tool

Resident	Date	Time	Safety Risk Reviewed	Reviewed Fall Tool & Event	Reviewed event history	Reviewed and updated careplan	Care plan change form completed	Reviewed medication	Referral/ recommendation	Issue Action	Internal Invegestigation	Determine MD Notifaction	Comments

ISSUE ACTION REPORT

ISSUE IDENTIFIED	RECOMMENDED SOLUTION	RESPONSIBLE PERSON	DATE TO BE COMPLETED	CORRECTIVE ACTION TAKEN (responsible person completes this section)

Re: Resident _____ To be turned in to _____

ISSUE ACTION REPORT

ISSUE IDENTIFIED	RECOMMENDED SOLUTION	RESPONSIBLE PERSON	DATE TO BE COMPLETED	CORRECTIVE ACTION TAKEN (responsible person completes this section)

Re: Resident _____ To be turned in to _____