

# 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**



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 \_\_\_\_\_