

QA: Post Fall Investigation Report

Resident name: _____ Room #: _____

Social Security #: _____ Date of incident: _____ Time of incident: _____

Staff completing report: _____ Date of Report: _____

1. Does the resident have a history of falls?

Yes

No

If yes, list falls for the past 12 months:

Date: _____

Time: _____

AM

PM

Date: _____

Time: _____

AM

PM

Date: _____

Time: _____

AM

PM

Date: _____

Time: _____

AM

PM

Date: _____

Time: _____

AM

PM

Date: _____

Time: _____

AM

PM

2. Was the resident identified on the care plan as high risk for a fall? Yes No

3. Do you see any patterns with falls? (Check all that apply.)

Greater than 2 falls in the past 2 days Increased restlessness Going to the bathroom Time of day

Specific activity Location Physical Factor (shoes, etc.) Other _____

4. Contributing factors: (Check all that apply.)

Wet/slippy floor

Call light off

Non-compliant resident

Need for bathroom

Agitation

Lighting off/low

Pain

Hunger

Improper footwear

Postural hypotension or dizziness

Other: _____

5. Location

Resident room

Bathroom

Dining room

Hallway

Nurses' station

Lobby

Other: _____

6. Did anyone witness the fall? Yes No

7. Level of Injury:

No injury

Minor injury

Major injury

Death

8. Describe the incident: (Check all that apply.)

Found on floor

Found by bed

Was walking unassisted

Found by bathroom door

Missed chair

Slid out of chair

Other:

A) Describe injury: _____

B) Describe accident: _____
