

**FALLS MANAGEMENT INVESTIGATION**

**Privileged and confidential Attorney-client communication. Not part of the Medical Record. Confidential document for Quality Improvement Analysis Only.**

**Facility Head Nurse to complete and copy to the CEO and Clinical Department Manager concurrently. Attach to the Unusual Occurrence Report.**

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_

DATE OF FALL \_\_\_\_/\_\_\_\_/\_\_\_\_. TIME OF FALL \_\_\_\_\_ a.m./ p.m.

LOCATION OF FALL (be as exact as possible) \_\_\_\_\_

WHO WITNESSED THE FALL \_\_\_\_\_

**THE FALL OCCURRENCE: (Check all that apply)**

- \_\_\_\_\_ pre admission to the unit
- \_\_\_\_\_ With staff escort (immediately next to patient)
- \_\_\_\_\_ post discharge from the unit after escort to the waiting room chair
- \_\_\_\_\_ Outside the building under the care of family or transportation
- \_\_\_\_\_ The patient was hypotensive sitting (< 100 systolic) post treatment
- \_\_\_\_\_ The patient had orthostatic hypotension post treatment, (100 systolic)
- \_\_\_\_\_ The patient uses assistive devices  
Wheelchair, cane, walker, other \_\_\_\_\_
- \_\_\_\_\_ The patient uses a wheelchair or stretcher, and there were protective or Safety Devices in use at the time of the fall.  
Which device? \_\_\_\_\_
- \_\_\_\_\_ The wheelchair foot rests were moved to the side to allow for transfer

**Investigate the surroundings where the incident occurred for any evidence of the following. The witness is to complete this section. Check yes or no.**

- Yes No Water spills or ice on the floor?
- Yes No Patient in a hurry? Explain \_\_\_\_\_
- Yes No Patient put personal belongings on the floor?
- Yes No Other clutter on the floor?
- Yes No Other furniture involved?
- Yes No Poor lighting?
- Yes No Was patient using usual cane or walker?
- Yes No If using a wheelchair, was it locked?
- Yes No If using a wheelchair, were the foot-rests in the way?

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Yes No Did the patient's clothing get in the way  
Yes No Was the patient reaching for items?  
Yes No Patient had on floppy shoes, slippery sole, or unsafe shoes?  
Other comments: \_\_\_\_\_

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**Has the patient's health status changed? Check Yes or No.**

Yes No New or recent adjustment in blood pressure medication?  
Yes No New or recent adjustment in psychotropic medications?  
Yes No New or recent adjustment in pain meds, antihistamines, or sedation?  
Yes No Recent return from the hospital?  
Yes No Recent dry weight loss? From \_\_\_\_kg. to \_\_\_\_\_, in \_\_\_\_\_ weeks.  
Yes No Changes in mental status?  
Yes No Recent changes in mobility status?  
Yes No Recent illness or surgery?  
Yes No Has the patient reported recent (past 6 months) falls at home or elsewhere?

**Investigation outcome:**

Was there a recent change in condition prior to fall \_\_\_\_\_

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Was the patient injured in the fall? Note location of sutures or fracture. \_\_\_\_\_

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Was the patient seen by a physician? \_\_\_\_\_

Was the patient hospitalized? \_\_\_\_\_

Was there a request made for additional assistive devices or restraint devices due to the fall? \_\_\_\_\_

Further education accomplished for the patient, family members, or transportation drivers? \_\_\_\_\_

