Post-Fall Assessment

Purpose: To identify factors that may have contributed to the fall and guide follow-up and fall prevention measures.

Instructions: The form is to be completed as soon as possible and before the end of your shift, with or by the person who witnessed or found the individual after the fall. Check all that apply. Notify supervisor or nurse. The Residential Supervisor or designee will forward the complete form to the Program Director or Nurse.

Name of Individual: _____ **Date and Time of Fall:** _____
DOB: _____ **Location of Fall:** _____
Name of Staff Person Completing Assessment: _____

1) Symptoms before the fall **If possible, ask individual "Why do you think you fell?"**	☐ Dizziness ☐ Trip/slip ☐ Loss of balance ☐ Leg weakness/ unsteadiness	☐ Disorientation/Confusion ☐ Unconsciousness/fainting ☐ Pushed/Shoved ☐ Experiencing urgency (moving quickly)	☐ Seizure ☐ Unknown ☐ Other (list):
2) Location of the fall	☐ Community ☐ Living Rm/Dining Rm ☐ Bedroom ☐ Bathroom ☐ Kitchen	☐ Outdoors ☐ Stairs ☐ Basement ☐ Vehicle ☐ Day Program	☐ Unknown ☐ Other (list):
3) Activity (at time of fall) **If possible, ask the individual "What were you doing when you fell?"**	☐ Transfer ☐ Walking with assistance ☐ Walking unassisted ☐ Reaching for something ☐ Walking with a cane, walker, or other assistive device ☐ Other:	☐ Person found on floor ☐ Person lowered self to floor ☐ Staff lowered person to floor ☐ Getting up or down ☐ Getting in/out of or riding in a car/van	☐ Behavioral Incident ☐ Bathing ☐ Toileting ☐ Unknown
4) Environmental factors contributing to the fall ***(check all that apply)***	☐ Clutter/obstacles ☐ Floor spills ☐ Rugs ☐ Uneven surface	☐ Unstable/broken furniture ☐ Improper footwear ☐ Outdoor conditions ☐ Poor lighting	☐ Wheelchair ☐ Unknown ☐ Other:
5) Was a fall prevention device in use at the time of fall? (Ex. Gait belt, alarm)	☐ Yes, describe:	☐ No	☐ Unknown
6) Head contact?	☐ No the person did not hit their head on any surface during the fall ☐ Yes, they hit their head on a surface		☐ Unknown
7) Medications prescribed at time of fall	☐ Antihistamine ☐ Antihypertensive ☐ Anti-seizure ☐ Unknown	☐ Laxatives ☐ Diuretics ☐ Hypoglycemic	☐ Narcotics ☐ Psychotropic ☐ Prostate Meds.

Ensure that the individual is SAFE and has received all necessary and appropriate care.

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After the Fall:

Is the person showing signs of pain after the fall? (check all that apply)	☐ Vocal complaints ☐ Facial grimacing and wincing ☐ Rubbing ☐ Restlessness ☐ Increased vocalization ☐ Crying ☐ Guarding or protecting body part ☐ Other (please define):
Vital Signs immediately after Fall	Temp: Pulse: Respiration: BP:
How responsive is the person after the fall?	☐ Normal/Alert ☐ Mildly Confused ☐ Very Confused ☐ Drowsy / Difficulty to Arouse (call 911) ☐ Unresponsive / Unconscious (call 911)
Does the person appear injured?	☐ None apparent or noted ☐ Yes, Required only first aid required ☐ Yes, Serious injury (required medical attention and/or hospitalization)

NOTIFY: Supervisor or Nursing staff or On Call about the fall and refer all above information.

Notified Name: Date/time:

How were they notified?

Follow-Up Actions and Recommendations

Name of Supervisor or Nursing staff completing Follow-up and Review:

Date of Review:

☐ Consider any recent changes in medications: ☐ No changes in the last 30 days
☐ Medications change in the last 30 days ☐ Medications not taken as prescribed

☐ Complete a review of the fall.

☐ Complete Fall Risk Screening Tool.

☐ Complete HCSIS report.

☐ Discuss findings during a team meeting, as appropriate.

☐ Clinical Consultation with ☐ PT ☐ OT ☐ PCP ☐ Other appropriate healthcare professionals

☐ Identify actions and recommendations to help prevent future falls.

☐ Document any recent medical illness or change in health status.

☐ Determine whether the individual has a history of falls.

- ☐ List dates of previous falls:
- ☐ Document any injuries related to previous falls:
- ☐ Document actions taken and follow up recommendations from previous falls:

☐ Other:

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