ROSE VILLA

Falls Investigation

Resident Name: ________________________ **Name of Person Filling Out Form:** _____________________

Date: ______________ **Time:** ______________ **Shift:** ______________ **Location:** ______________

RESULT OF FALL

Vital Signs: BP________ **P**________ **R**________ **T** ________ **Start alert charting** ☐ **Done**

Was an injury sustained as a result of the fall? ☐ **Yes** ☐ **No**

If "Yes", explain: ____

____

Has abuse been ruled out? (flag to DNS) ☐ **Yes** ☐ **No**

Did the fall result in hospitalization or death? (flag to Administrator) ☐ **Yes** ☐ **No**

INVESTIGATE

1. Gather First Impressions

- List each staff members in the health center at the time of the incident, their location, and whether or not they have any knowledge of the incident. Knowledge would include witnessing the fall, being the first responder, being the last person to see the resident before the fall, the CNA who is working with the resident that day, etc.)

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

Name: ___________________ Location: _______________________ Knowledge: ☐ Yes ☐ No

- Ask people with either direct or indirect knowledge of the incident to describe their understanding of what happened and why, starting with the resident.
- Use open-ended questions, such as "Tell me a little more about…"
- Avoid accusatory language and try to get at the root cause.

Person #1: __Resident___________ What happened?: ____

____

Why do you think this happened?: ____

____

Person #2: _____________________ What happened?: ____

____

Why do you think this happened?: ____

____

Person #3: _____________________ What happened?: ____

____

Why do you think this happened?: ____

____

Person #4: _____________________ What happened?: ____

____

Why do you think this happened?: ____

____

2. Review Factors Related to Assessment and Care Planning

Had the resident been assessed as a fall risk (see care plan)? ☐ **Yes** ☐ **No**

If yes, were all care planned interventions being followed? ☐ Yes ☐ No

If no, explain:____

____

Does the resident require assistance with toileting? ☐ **Yes** ☐ **No**

If yes, when was the last time the resident was toileted? __________________

Are equipment needs documented on the care plan? ☐ **Yes** ☐ **No**

If yes, did equipment pose a safety risk in this instance? ☐ Yes ☐ No

Were all aspects of the care plan being followed? ☐ **Yes** ☐ **No**

If no, explain:____

____

Comments on Assessment & Care Planning: ____

____

____

3. Review Factors Related to Environment and Equipment

Make a diagram of scene at time of discovery. Show positions of furniture, doors/doorways, equipment, bathroom fixtures, etc. Draw a stick figure to indicate where the resident was found. Label as face-up or face-down.

Could the following potentially have been a factor in this fall? If yes, please explain:

Lighting ☐ **Yes** ☐ **No**
Flooring (wet, shiny, contrast, uneven) ☐ **Yes** ☐ **No**
Equipment placement ☐ **Yes** ☐ **No**
Furniture placement ☐ **Yes** ☐ **No**
Room to move freely in the space/turn radius ☐ **Yes** ☐ **No**
Others present (residents, staff, visitors, etc.) ☐ **Yes** ☐ **No**
Bed (height/position, brakes on/off, mattress-type) ☐ **Yes** ☐ **No**
Side rails (up/down, full/half/other, transfer cane, padding) ☐ **Yes** ☐ **No**
Fall Mat (thickness, placement on dominant side) ☐ **Yes** ☐ **No**
Call light (on dominant side, within reach, appropriate for resident) ☐ **Yes** ☐ **No**
Restraints & Supportive Devices (proper application) ☐ **Yes** ☐ **No**
Time applied: _____________ Time last checked: _____________

Explain Any "Yes's": ____
____
____
____
____

Is an alarm part of the resident care plan? ☐ **Yes** ☐ **No**
If yes, was the alarm being used in accordance with the care plan? ☐ Yes ☐ No
(turned on & working, properly placed)
If no, explain:____
____

Is an assistive device or transfer equipment part of the resident care plan? ☐ **Yes** ☐ **No**

If yes, type of device or equipment: ______________________________
(walker, cane, Sara lift, maxi-slide, maxi-lift, etc.)
Device present? ☐ Yes ☐ No
Device within reach of the resident? ☐ Yes ☐ No ☐ N/A
Device in good repair? ☐ Yes ☐ No
Brakes are ☐ On ☐ Off ☐ N/A
Footrests are ☐ Up ☐ Down ☐ N/A

Wheelchair cushion present?	☐ Yes	☐ No	☐ N/A
Nonskid material on wheelchair cushion?	☐ Yes	☐ No	☐ N/A
Resident positioned properly?	☐ Yes	☐ No	☐ N/A
Device is adjusted/fitted properly? (consider seat height/depth, foot placement)	☐ Yes	☐ No	

Explain any “No’s”: ____

____

____

4. Review Factors Related to the Resident

Could the following potentially have been a factor in this fall? If yes, please explain:

Cognition	☐ **Yes**	☐ **No**
Eyesight/visual field	☐ **Yes**	☐ **No**
Footwear/clothing	☐ **Yes**	☐ **No**
Mobility	☐ **Yes**	☐ **No**
Hearing	☐ **Yes**	☐ **No**

Prosthesis/splint	☐ **Yes**	☐ **No**
Dominant side	☐ **Yes**	☐ **No**

Consider placement of equipment, furniture, doors & doorways, bathroom fixtures

Explain Any “Yes’s: ____

____

____

Does the resident have any of the following medical conditions? Could it have been a factor?

	Have Condition?		If yes, could it have been a factor in the fall?	
Dementia	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Pain	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Neuromuscular	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Orthopedic	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Cardiovascular	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Recent condition change	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Dialysis	☐ **Yes**	☐ **No**	☐ Yes	☐ No
Neurological	☐ **Yes**	☐ **No**	☐ Yes	☐ No

Explain Any “Yes’s in the “factor” column: ____

____

____

5. Review Factors Related to Medications

New medications?	☐ **Yes**	☐ **No**	If “Yes”, time last dose given: ______________
Medication changed in dose, time, etc.?	☐ **Yes**	☐ **No**	If “Yes”, time last dose given: ______________
Med error in the last 24 hours?	☐ **Yes**	☐ **No**	

Did the resident exhibit or complain of (possible drug side effects):

Weakness	☐ **Yes**	☐ **No**	**Dehydration**	☐ **Yes**	☐ **No**
Acute delirium	☐ **Yes**	☐ **No**	**Impaired vision**	☐ **Yes**	☐ **No**
Dizziness	☐ **Yes**	☐ **No**	**Agitation**	☐ **Yes**	☐ **No**
Clammy skin	☐ **Yes**	☐ **No**	**Impulsiveness**	☐ **Yes**	☐ **No**
Gait disturbance	☐ **Yes**	☐ **No**			

CONCLUSION: THE 5 WHYS

Use the “5 Whys” to determine the root cause of this fall. Make sure to keep asking “why” until you get to the true root cause. The more you drill down, the more likely it will be that we will be able to prevent similar falls from happening in the future.

What do you believe to be the root cause of this fall? ____

____

____

NOTIFICATIONS

☐ **Physician, using SBAR** ☐ **HCPOA**

RESIDENT CARE MANAGER

1. **Review First Responder Investigation**

2. **Review MAR and indicate whether or not the following was potentially a factor in the fall:**

Drug to drug interaction	☐ Yes	☐ No	Drug to supplement interaction	☐ Yes	☐ No
Drug to food interaction	☐ Yes	☐ No	Drug to herb interaction	☐ Yes	☐ No

Explain Any “Yes’s: ____

____

Is the resident taking any of the following classes of medications? If yes, determine whether or not the issues associated with that class of medication was potentially a factor in the fall.

	Taking?		If yes, could it have been a factor in the fall?	
Diuretics	☐ Yes	☐ No	☐ Yes	☐ No
(Edema in lower extremity, lung status, change in urgency & void, change in fluid intake (72 hrs))				
Antibiotics	☐ Yes	☐ No		
If yes, diagnosis: ____________________________			☐ Yes	☐ No
Narcotics/Analgesics	☐ Yes	☐ No	☐ Yes	☐ No
Pain level at last dose ____________				
Hypo-/hyperglycemics	☐ Yes	☐ No	☐ Yes	☐ No

Last dose insulin/oral agent _________________ CBG results _______________

Last p.o. intake (time & quantity) ____

	Taking?		If yes, could it have been a factor in the fall?	
Laxatives	☐ Yes	☐ No	☐ Yes	☐ No
Antipsychotics	☐ Yes	☐ No	☐ Yes	☐ No
Anti-anxiety	☐ Yes	☐ No	☐ Yes	☐ No
Anti-depressant	☐ Yes	☐ No	☐ Yes	☐ No
Hypnotic	☐ Yes	☐ No	☐ Yes	☐ No
Anti-hypertensives	☐ Yes	☐ No	☐ Yes	☐ No

Explain Any "Yes's on the "factor" lines: ____

____

____

____

CONCLUSION & ACTION PLAN

1. **The 5 Whys**
   Use the "5 Whys" to determine the root cause of this fall. Make sure to keep asking "why" until you get to the true root cause. The more you drill down, the more likely it will be that we will be able to prevent similar falls from happening in the future. (If the same as the first responder conclusions, write "see first responder.")

   What do you believe to be the root cause of this fall? ____________________________________

   ____

   ____

2. **Develop an Action Plan**
   Review the care plan, including resident goals/preferences. Consider previous incidents and interventions for effectiveness. Consider how to keep the fall from happening again. Involve resident and responsible party in care plan changes.

   Intervention put in place to prevent fall from happening again: ____________________________

   ____

   ____

   Care plan revised ☐ **Done** ☐ **N/A**
   If N/A, document why the current care plan will not be changed: ___________________________

   ____

   ____

3. **Action Plan Implemented**
   Nursing staff notified ☐ **Done** ☐ **N/A**
   HCPOA notified ☐ **Done** ☐ **N/A**
   Resident notified ☐ **Done** ☐ **N/A**

DNS REVIEW

If abuse not ruled out, contact Adult Protective Services. ☐ **Done** ☐ **N/A**

Additional questions, comments or changes to above.

ADMINISTRATOR REVIEW

If hospitalization or death, report to Oregon Patient Safety Commission. ☐ **Done** ☐ **N/A**

Additional questions, comments or changes to above.