INTERDISCIPLINARY POST-FALL ASSESSMENT

Date of current fall: _____ Date of previous fall: _____

Number of falls in last: 30 days _____ 90 days _____ 180 days _____ 365 days _____

Description of fall: _____

_____

_____

_____

_____

_____

_____

Current fall: Time of day: _____

Activity at time of fall: ❑ Ambulation: ❍ Independent ❍ Staff assisted

❑ Transfer: ❑ W/C or gerichair ❑ Bed ❑ Toilet/Shower chair

❑ Other: _____

❍ Unwitnessed ❍ Witnessed _____

Location: ❑ Resident room ❑ Bathroom ❑ Shower/Tub room ❑ Hallway ❑ Dining room ❑ Lobby

❑ Outside facility ❑ Other: _____

Equipment involved: ❑ Walker ❑ Wheelchair ❑ Cane ❑ Other: _____

Restraint involved: ❍ No ❍ Yes, type: _____

Injury: ❑ No injury ❑ First aid provided ❑ Transfer to ER/acute care ❑ Death ❑ Other: _____

If injury, describe: _____

_____

_____

Orthostatic BP (if applicable): Lying _____ ❍ Rt. Arm ❍ Lt. Arm Sitting _____ ❍ Rt. Arm ❍ Lt. Arm Standing _____ ❍ Rt. Arm ❍ Lt. Arm

Diagnosis(es): _____

_____

Cardiovascular status: _____

New medical condition(s): ❍ No ❍ Yes, _____

Mental status: ❍ Alert and oriented ❍ Confused, specify: _____

Medications received in past 6 hours: _____

_____

_____

_____

Recent medication changes: ❍ No ❍ Yes, ❑ Added ❑ Discontinued ❑ Other: _____

Medication: _____ Dose: _____

Frequency: _____ Date of change: _____

Sensory deficits: ❍ No ❍ Yes, _____

Able to express needs: ❍ No, _____ ❍ Yes

Gait balance deficits: ❍ No ❍ Yes, _____

Bowel/Bladder status: ❍ Continent ❍ Incontinent ❑ Scheduled toileting plan ❑ Bladder retraining program

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

INTERDISCIPLINARY POST-FALL ASSESSMENT (Cont'd.)

6 MONTH REVIEW OF FALLS FOR THIS RESIDENT

Review the last 6 months of falls and/or incident reports for the resident. Are there any patterns or trends related to these falls? Did they all occur at or near the same time of day, shift, facility location, facility event such as meals, activities, trying to reach toilet, etc.?

❍ No ❍ Yes, describe patterns/trends:_____

_____

_____

_____

_____

Consider a probable cause for this fall based on review and investigation:_____

_____

_____

_____

QAPI REVIEW

Review the most recent MDS completed for this resident. Consider any responses in Section GG0130 and GG0170 – Functional Abilities and Goals (Self care and mobility) where resident requires 1 or 2 person physical assist to perform ADL's.

❍ No issues ❍ Yes, explain:_____

_____

_____

_____

Does the current plan of care for this resident clearly indicate the level of assistance the resident requires?

❍ No ❍ Yes, _____

_____

_____

Recommendations from review by IDT and primary/attending physician: _____

_____

_____

_____

_____

Care Plan revision: ❍ No ❍ Yes Date:_____

Physician notification: ❍ No ❍ Yes Date:_____ Time:_____

Family/Representative notification: ❍ No ❍ Yes Date:_____ Time:_____

REVIEWER SIGNATURES

Signature/Title	Date	Signature/Title	Date	Signature/Title	Date
Signature/Title	Date	Signature/Title	Date	Signature/Title	Date

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed