FALL PREVENTION AND MANAGEMENT TRAINING

for clients of:

TEAM TSI CORPORATION

www.teamtsi.com • 800.765.8998

Content developed and presented by:

POLARIS GROUP

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1. Which of the following areas are assessed upon admission?
   a. Side rail usage
   b. Fall risk
   c. Safety measures needed
   d. All of the above

2. Post fall which are acceptable practices?
   a. Wait and review at weekly Risk Team
   b. Immediate investigation is initiated
   c. Immediate IDT team review
   d. B and C

3. Which of the following is not a potential root cause for falls?
   a. Self directing care
   b. Need to void
   c. Gait issues
   d. None of the above

4. Which of the following could be care planned related to falls?
   a. Pain management
   b. Restorative needs
   c. Toileting
   d. All of the above

5. Which of the following are acceptable practices?
   a. PT referral after first fall
   b. Restraining after a fall for safety
   c. Bed against wall and full rails for confused residents who climb out of bed
   d. None of the above
POST TEST ANSWERS

1. Which of the following areas are assessed upon admission?
   a. Side rail usage
   b. Fall risk
   c. Safety measures needed
   d. All of the above
   Answer: D

2. Post fall which are acceptable practices?
   a. Wait and review at weekly Risk Team
   b. Immediate investigation is initiated
   c. Immediate IDT team review
   d. B and C
   Answer: D

3. Which of the following is not a potential root cause for falls?
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   b. Need to void
   c. Gait issues
   d. None of the above
   Answer: D

4. Which of the following could be care planned related to falls?
   a. Pain management
   b. Restorative needs
   c. Toileting
   d. All of the above
   Answer: D

5. Which of the following are acceptable practices?
   a. PT referral after first fall
   b. Restraining after a fall for safety
   c. Bed against wall and full rails for confused residents who climb out of bed
   d. None of the above
   Answer: A
Fall Prevention & Management

Fall Management Key Components

• QAA should ensure all Key Components are in place and effective
  1. Admission assessment/Baseline Care planning
  2. Communication with front-line staff
  3. Ongoing Monitoring / Quarterly Assessments
  4. Care Planning
     • Interventions
  5. Fall Investigation post fall, assessment, care plan updates
  6. Fall Tracking, Trending, Reporting to QAA
     • Risk Team - Individual Investigations & Environment
Risk Management Program Goals

• Prevent avoidable accidents by maintaining a culture of safety
• Provide quality care
• Provide for immediate reassessment and care plan revision
• Prevent citations
• Prevent legal actions
• Satisfied customers – residents & employees

Orientation & Training

• Education & Orientation
  – Multidisciplinary
  – Know ‘why’
  – Know how to identify and report problem areas – when to complete an incident report
  – Know the steps to complete a thorough investigation of fall
  – Team approach to problem solving
Admission – Risk

- **Complete a standardized Fall risk** tool at time of admission.
- Designed to identify Risk Factors and level of risk.
- Assists with baseline care planning interventions.

### Fall Risk Assessment

Upon admission, quarterly, and prior assess the resident status. Add up a total score. If the total score is 10 or greater, the resident is reconsidered at HIGH RISK for potential falls.

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SCORE</th>
<th>RESIDENT STATUS/CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Level of Consciousness / Mental Status</td>
<td></td>
<td>ALERT (oriented x 3)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>DISORIENTED X 1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>DISORIENTED X 2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>DISORIENTED X 3</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>WANDERS</td>
</tr>
<tr>
<td>B. History of Falls (past 3 months)</td>
<td></td>
<td>NO FALLS in past 3 months</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1-2 FALLS in past 3 months</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3 OR MORE FALLS in past 3 months</td>
</tr>
<tr>
<td>C. Ambulation Elimination Status</td>
<td>0</td>
<td>REGULARLY CONTINENT</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>REQUIRES REGULAR ASSIST WITH ELIMINATION</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>REGULARLY INCONTINENT</td>
</tr>
<tr>
<td>D. Vision Status</td>
<td></td>
<td>ADEQUATE (with or without glasses)</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>POOR (with or without glasses)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>LEGALLY BLIND</td>
</tr>
<tr>
<td>E. Gait/Balance</td>
<td></td>
<td>Gait/Balance Normal</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Balance problem while standing/walking</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Decreased muscular coordination/tearing movements</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Change in gait pattern when walking (i.e. shuffling)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Requires use of assistive devices (i.e. cane, w/c, walker, furniture)</td>
</tr>
<tr>
<td>F. Systolic Blood Pressure</td>
<td></td>
<td>NO NOTED DROP between lying and standing</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Drop LESS THAN 20 mm Hg between lying and standing</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Drop MORE THAN 20 mm Hg between lying and standing</td>
</tr>
</tbody>
</table>
### Admission – Risk

**Baseline Care Plan** – create inventory of intervention options to pick from based on risk factor and level of risk.

- Visual checks
- Low bed
- Safety strips
- PT screen
- Footwear
- Pharmacy Med Review
- Call Light education
- Side rail/enabler
- Lighting and environment
Admission – Risk

• Communicate fall risk to front-line staff
  — How is this communicated?
• Safety issues related to use of side rails
  — If still have half rails – these could be restrictive and increase risk of injury
  — Please consider removing
• If restrictive must have documentation:
  — Assessment - Consent - Orders - Coded on MDS

About Alarms

• Alarms: There is no evidence that alarms reduce falls. For some residents, a position change alarm may be restrictive, depending on the resident’s response to the alarm such as loss of dignity, decreased mobility, or confusion.
• Each resident should be assessed for benefits and risks, and monitored for adverse effects.
### SAFETY PLAN AND DEVICE AUTHORIZATION

#### RESIDENT FACTORS THAT IMPACT USE OF SIDE RAILS / OTHER - FALL RISK SCORE:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe independent transfer</td>
<td></td>
</tr>
<tr>
<td>Uses call light effectively</td>
<td></td>
</tr>
<tr>
<td>Waits for help</td>
<td></td>
</tr>
<tr>
<td>Alternation in safety awareness</td>
<td></td>
</tr>
<tr>
<td>Requires spatial awareness reminders</td>
<td></td>
</tr>
<tr>
<td>Comatose, semi, fluctuating</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk of seizure</td>
<td>Yes</td>
</tr>
<tr>
<td>Immobile in bed</td>
<td>Yes</td>
</tr>
<tr>
<td>Difficulty with trunk control</td>
<td>Yes</td>
</tr>
<tr>
<td>Able to use S/R for positioning</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### RATIONALE FOR USE - check all that apply

<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>No side rails needed</td>
</tr>
<tr>
<td>Resident does not desire side rails</td>
</tr>
<tr>
<td>Resident prefers one or both side rails up for feelings of safety</td>
</tr>
<tr>
<td>Enhance bed mobility with use of side rails</td>
</tr>
<tr>
<td>Side rail scoop mattress/pillows prevent rolling OOB would not try to rise unassisted</td>
</tr>
</tbody>
</table>

Describe: ____________________________

<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed against wall is resident preference and not restrictive</td>
</tr>
<tr>
<td>Bed against wall is resident preference and is restrictive because</td>
</tr>
<tr>
<td>Rise Alarm for (may be restrictive)</td>
</tr>
<tr>
<td>Side Rail scoop mattress/pillows provide reminder to not rise unassisted (restrictive)</td>
</tr>
</tbody>
</table>

Describe: ____________________________

### POTENTIAL RISKS:

1. Increased risk of injury from trying to climb over rails to get out of bed
2. Bruises from bumping into side rails
3. Decreased vision by creating a visual barrier
4. Strangulation
5. Entrapment (e.g. limbs or head caught in rails)
6. Death from entrapment
7. Minimal risk of injury from pillow or scoop mattress
8. Confusion/loss of dignity
9. Minimal risk of injury from bed against wall

### SAFETY PLAN:

- All down
  - One full rail up - R or L
  - One half rail up at head of bed - R or L
  - One bottom rail up - R or L
  - Mini rail up both sides only one side

Other (e.g. rise alarm, scooped mattress/pillow): ____________________________

I have been fully informed of the above risks and benefits related to the use of __________ in care planning and agree to the plan above:

Resident signature: ____________________________ Date: ________

Surrogate Decision Maker: ____________________________ Date: ________

Initial Review Signature: ____________________________ Date: ________

Review Dates and Signature: Date: ________ Signature: ____________________________

Date: ________ Signature: ____________________________

Date: ________ Signature: ____________________________

### RESIDENT’S NAME | PHYSICIAN | RM# | MR#

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

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Ongoing Monitoring

- Full RAI – Fall CAA
  - Admission
  - Annual
  - SCSA
- Quarterly Fall Risk Tool or at time of SCSA
- Quarterly review of side rail use

- Risk Team – reviews
  - 24-hour report
  - New meds – fall risk
  - Change in condition – Infection
  - Change in Cognition
  - Change in ADLs

#11 Fall(s)

<table>
<thead>
<tr>
<th>FALLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggering Conditions (any of the following):</td>
</tr>
<tr>
<td>1. Wandering occurs as indicated by a value of 1 through 3 as follows: E9900 := 1 AND E9900 := 3</td>
</tr>
<tr>
<td>2. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:</td>
</tr>
<tr>
<td>(G0380A = 1 OR G0380A = 2) OR (G0380B = 1 OR G0380B = 2) OR (G0380C = 1 OR G0380C = 2) OR (G0380D = 1 OR G0380D = 2) OR (G0380E = 1 OR G0380E = 2)</td>
</tr>
<tr>
<td>3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:</td>
</tr>
<tr>
<td>If A9368A = 01 AND A9760A = 1</td>
</tr>
<tr>
<td>4. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:</td>
</tr>
<tr>
<td>If A9368A = 01 AND A9760B = 1</td>
</tr>
<tr>
<td>5. Resident has fallen at least one time since admission or the prior assessment as indicated by: J9300 = 1</td>
</tr>
<tr>
<td>6. Resident received antipsychotic medication on one or more of the last 7 days or since admission/transfer as indicated by: N0410B := 1 OR N0410B := 7</td>
</tr>
<tr>
<td>7. Resident received antihypertensive medication on one or more of last 7 days or since admission/transfer as indicated by: N0410C := 1 OR N0410C := 7</td>
</tr>
<tr>
<td>8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows: P0800B = 1 OR P0800B = 2</td>
</tr>
<tr>
<td>9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows: P0900E = 1 OR P0900E = 2</td>
</tr>
</tbody>
</table>
**#11 Fall(s)**

**History of falling**
- Time of day, exact hour of the fall(s)
- Location of the fall(s), such as bedroom, bathroom, hallway, stairs, outside, etc.
- Related to specific medication
- Proximity to most recent meal
- Responding to bowel or bladder urgency
- Doing usual/unusual activity
- Standing still or walking
- Reaching up or down
- Identify the conclusions about the root cause(s), contributing factors related to previous falls

**#11 Fall(s), continued**

**Physical performance limitations**
- Difficulty maintaining sitting balance
- Need to rock body or push off on arms of chair when standing up from chair
- Difficulty maintaining standing position
- Impaired balance during transitions (G0300A-E)
- Gait problem such as unsteady gait, even with mobility aid or personal assistance; slow gait; takes small steps; takes rapid steps; lurching gait, etc.
- One leg appears shorter than the other
- Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg, etc.
#11 Fall(s), continued

Medications

- Antipsychotics (N0400A)
- Antianxiety agents (N0400B)
- Antidepressants (N0400C)
- Hypnotics (N0400D)
- Cardiovascular medications
- Diuretics (N0400G)
- Narcotic analgesics
- Neuroleptics
- Other medications that cause lethargy or confusion

Internal risk factors

- Circulatory/Heart
  - Anemia (I0200)
  - Cardiac dysrhythmias (I0300)
  - Angina, myocardial infarction (MI)
  - Atherosclerotic heart disease (ASHD) (I0400)
  - Congestive heart failure (CHF), pulmonary edema (I0600)
  - Cerebrovascular accident (CVA) (I4500)
  - Transient ischemic attack (TIA) (I4500)
  - Postural hypotension
#11 Fall(s), continued

**Internal risk factors**

- **Neuromuscular/functional**
  - Cerebral palsy (I4400)
  - Loss of arm or leg movement
  - Decline in functional status
  - Incontinence (H0300, H0400)
  - Hemiplegia/hemiparesis (I4900)
  - Parkinson's disease (I5300)
  - Seizure disorder (I5400)
  - Paraplegia (I5000)
  - Multiple sclerosis (I5200)

- **Neuromuscular/functional**
  - Traumatic brain injury (I5500)
  - Syncope
  - Chronic or acute condition resulting in instability
  - Peripheral neuropathy
  - Muscle weakness

- **Orthopedic**
  - Joint pain
  - Arthritis (I3700)
  - Osteoporosis (I3800)
  - Hip fracture (I3900)
  - Missing limb(s)

- **Perceptual**
  - Visual impairment (B1000)
  - Hearing impairment (B0200)
  - Dizziness/vertigo

- **Psychiatric or cognitive**
  - Impulsivity
  - Delirium (C1310)
  - Wandering (E0900)
  - Agitation (E0200)
  - Cognitive impairment (C0500,0700-C1000)
  - Alzheimer's disease (I4200)
  - Other dementia (I4800)
  - Anxiety disorder (I5700)
  - Depression (I5800)
  - Manic depression (I5900)
  - Schizophrenia (I6000)
#11 Fall(s), continued

### Internal risk factors
- Infection (I1700-I2500)
- Low levels of physical activity
- Pain (J0300)
- Headache
- Fatigue, weakness
- Vitamin D deficiency

### Environmental factors
- Poor lighting
- Glare
- Patterned carpet
- Poorly arranged furniture
- Uneven surfaces
- Slippery floors
- Obstructed walkway
- Poor fitting or slippery shoes
- Proximity to aggressive resident

### Laboratory tests
- Hypo - or Hyperglycemia
- Electrolyte imbalance
- Dehydration (J1550C)
- Hemoglobin and hematocrit

---

#11 Falls Summary

**Falls Focus:** Identify all contributors to falls or risk for falls.

- Identify medical conditions increasing fall risk.
- Identify medications increasing fall risk.
- Identify functional factors.
- Include Fall Risk Score
- Contributors:
  - Vision/hearing/communication loss/cognitive loss/behavior symptoms.
  - Summarize findings of prior falls that indicate patterns.
  - Why is resident rising?
  - Need to void - restraint - change in position needed - pain
Care Planning

• **Identify Risk factors for falls**
  - Physical limitations
  - Reasons for rising
  - Cognitive
  - Environment factors
  - Staff
  - Ability to learn
  - Self-directing care

• **Describe the type of fall clearly if known**
  - Rising out of bed
  - Rising out of chair
  - Rolling out of bed
  - Sliding out of chair
  - Falling forward out of chair
  - Self ambulating

• **Clarity of Goal or Outcome of Plan of Care**
  - Prevent further falls?
  - Prevent rolling out of bed?
  - Prevent injury from rising out of bed?
  - Prevent injury from fall?
  - Prevent injury from self – ambulating?
  - Demonstrate ability to ________ without falling? or without injury?
### Medical Interventions

- Medical Evaluation
- Positioning
- Managing pain
- Stopping or starting medication
- Changing the dose or time of a medication
- Assisting someone to bed when fatigued
- Medication review
- Referral to restorative
- Referral to rehab
- Referral to pharmacist
- Referral to mental health specialist

### Environmental Interventions

- Decreasing noise level
- Adjusting lighting
- Assessing furnishings – placement, size, height
- Equipment change/location
- Use and/or type of restraint
Psychosocial & Activities Interventions

- Staff communication clear and concise
- Strategies and techniques for responding to emotional needs
- Contact family to talk with resident over phone or create a tape
- Spiritual/ Cultural and life preferences
- Referral to Social Services
- Referral to life long interests/groups

Activities

- Formal activities
- Informal small groups
- One-to-one activities
- Walk outside
- Visiting
- Staff access to materials/individually planned activities

Interventions to Address Sliding/Rising /Leaning Forward out of Chair

- Have wheelchair/seating assessment done by PT or OT
- Have wheelchair seat and back adjusted to create slight tilt back
- Self-releasing seat belt (may be restrictive)
- Consider risk/benefit of wedge (may be restrictive)
- Lap table (may be restrictive)
- Consider alternative chairs like a rocker wheelchair (may be restrictive)
- Try solid seat insert
- Adapt a recliner/wheelchair with extended, padded back rest
- Non-slip material in chair
- Auto-lock brakes on W/C
Interventions to Address Sliding/Rising /Leaning Forward out of Chair

- Try merry walker (may be restrictive)
- Place within view of staff
- Put to bed when fatigued
- Activity apron
- Anti-tips on wheelchairs
- Non-slip shoes
- Pummel cushion (may be restrictive)
- Pedals on wheelchair-on, off, one, or both.
- Reposition or ambulate a short distance and reseat: daily routine in and out of chair
- Pain management
- Weighted pillow
- Foam formed pads
- Lap buddy (may be restrictive)

Interventions to Address Unsafe Mobility

- Attach call light to gown
- Attach bells on blankets
- Positioning cushions for bed to create wedge
- Cushions under mattress to create wedge
- Place bed lower to floor to allow feet to touch the floor
- Check for appropriate shoes (a shuffling gait may require a sliding sole)
- Change height of drawers if rummaging
- Provide adequate lighting
- Commode at bedside
- Initiate voiding pattern
- Wandering guard bracelet
- Pad w/c arm rests
Interventions to Address Unsafe Mobility

• Monitor activity in room with nursery intercom walkie-talkie (Mattel, Fisher-Price)
• Develop formal, routine exercise programs geared to resident’s level of participation
• Mobility program: put to bed, toilet.

• Assess use of furniture with wheels or furniture that is unstable, remove if used for support
• Provide supportive assistive devices within reach which includes glasses and hearing aides

Interventions to Address Unsafe Mobility

• Bell on bathroom door
• Non-slip bath mat or rug if may urinate to decrease slipping
• Mattress/mat on floor to prevent injury from fall
• Walk-alert socks

• Anticipate needs; learn past patterns and coping styles, toileting schedule and habits
• Provide frequent accompanied walks – educate family.
• Use opportunities to ambulate to and from meals, bed, bath, etc.
Interventions to Address Standing Unsteady, but Lacking Ability to Walk

- See interventions for unsafe mobility
- Have seating and mobility assessment done by physical therapist or occupational therapist
- Offer adequate stimulation, small group gatherings
- Try activity apron
- Try age appropriate dolls or stuffed animals
- Place bed in low position so that center of gravity and bend of knees make it hard for the individual to come to a standing position
- Try merry walker (may be restrictive)
- Try rocking chairs
- Things to fiddle with and/or look at
- Anti-tip w/c

Interventions to Address Climbing out of Bed

- Place bed in low position so that center of gravity and bend of knees make it hard for individual to come to a standing position
- Place mattress on floor (know fire procedures and regulations)
- Remove wheels (know fire procedures) to lower bed if lower bed unavailable
- Low bed
- Place pillow or rolled blanket under mattress to create a lip at edge
Interventions to Address Climbing Out of Bed

- Concave mattress
- Body pillow
- Alarming floor mat
- Place furniture or chair against bed (make sure they are stable as resident may use to balance self and could be restrictive)
- Baby Monitor device
- Use inflatable, washable camping mattress to cushion fall
- Use position change and pressure change alarms
- Monitor activity with walkie-talkie
- Put bed against wall but have rail down on other side (make sure can rise on open side)

Interventions to Address Climbing Out of Bed

- Put end of bed against wall
- Sit with person to sooth until asleep
- Get out of bed, toilet, offer food, drink
- Try relaxation tapes
- Bring to lighted area
- Bed checks
- Night light
- Assess for pain
- Assess for need for a bowel movement
- Full mattresses by bed - one or two mattresses as needed for safety
## Interventions to Address Ambulatory Dementia Residents

- Physical therapy screening
- Wear protective devices
  - Hip protectors
  - Knee pads
  - Elbow pads
  - Wrist splinting
  - Thick foam helmet
- Schedule daily rest periods and routines
- Exercise program
- Sunlight exposure
- Toileting program
- Chronic pain management
- Colorful/contrasts for items such as waste basket and chairs to help with diminished vision

## Interventions to Address Ambulatory Dementia Residents

- Adaptive Seating (some may be considered restrictive/restraint)
  - Contrasting colored toilet seat
  - Wedge cushions
  - Slanted seats
  - Deep-seated, soft cushioned chair
  - Recliner
  - Bean bag chair
  - Tray table
- Footwear Adaptation
  - Slip resistant soles
  - Wearing non-slip tread socks to bed
  - Barefoot
  - Socks only
  - Moccasins
  - Footwear to improve gait
  - Thin hard soles shoes
Interventions to Address Ambulatory Dementia Residents

- Bed adaptations
  - Contrasting colored bedspread
  - Contrasting colored head/footboard
  - Body pillow
  - Rolled or curved mattress edges

- Lock, remove, or immobilize bed wheels
- Bed alarm
- Pressure sensitive carpet mat
- Transfer pole or handle
- Side rail as enabler
- Adjust bed height
- Relocate furniture away from bed

Interventions to Address Ambulatory Dementia Residents

- Evaluate Assistive device use (standard pick-up walker is the most dangerous choice)
  - Gliding walker
  - Rolling walker
  - Quad cane
  - Wheelchair or mobility chair to push
  - Wheelchair anti-rollback device
  - Chair alarm (limit use as alarm may cause resident distress)
At Time of Fall

Falls

• Unwitnessed, found on ground
• During Assisted Transfer
• During self transfer – bed
• During self transfer – toilet
• During self transfer – chair
• While self-ambulating
• During assisted ambulation

Initial Investigation – Step One

• Step One: Often performed by Charge Nurse
• Immediate protection of resident as indicated
• Perform physical assessment and first aid
• Begin data collection and investigation
  – Examine area and equipment
  – Interview resident
  – Identify witnesses
  – Conduct witness interviews
  – Determine if care plan was implemented as written
• Implement change to care plan as indicated
Investigation – Step One

- Document incident in progress notes
- Notify family and physician
- Determine if care plan was followed as written
- **Complete incident report**
- **Complete Investigation form**
- **Complete Witness Statement form**
  - Two options
    - Summarize interview and have staff sign
    - Staff document statement themselves
- **Report if suspected abuse/neglect**

<table>
<thead>
<tr>
<th>EVENT REPORT</th>
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</thead>
<tbody>
<tr>
<td>(Quality Assurance/Confidential)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completed By Charge Nurse On Duty</th>
<th>Nurse/Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident:</td>
<td>Date:</td>
</tr>
<tr>
<td>Day of Week</td>
<td>Time:</td>
</tr>
</tbody>
</table>

Resident Statement or describe Event Scene:

Describe environment, position of resident, equipment, floor surface, and site of injury:

Describe injury and resident status overall (size, depth, color, pain, bleeding, limitation in ROM results of head to toe assessment, VS & neuro checks):

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Guidelines for Documentation of Event

- Develop documentation guidelines for each type of Event
- Sample: Falls…
  - Time and describe scene
  - Residents behavior prior to event if known
  - Objective statements made by resident
  - Head to toe (list what you actually assessed)
  - ROM check
  - Describe resident injury if any
  - Absence or presence of pain
  - First aid given
  - Document VS and Ortho BP
Guidelines for Documentation of Event

• Document in nurses’ notes
  – Document neuro signs if head injury is suspected or fall was unwitnessed
  – Documentation physician notification/order
  – Document family notification
• Do NOT document
  – Fault
  – Failure to follow care plan
  – Staff discipline
  – Equipment failure
  – “Incident Report completed” statement

Investigation – Step Two

• Second step – often completed by the RN Care Manager e.g. ADON, DON, MDS Nurse.
  – Continue investigation outlined in Step One
  – Clinical assessment of possible causes
    • Medications
    • Medical
    • Cognitive or sensory
    • Environment
    • Psychosocial
    • Physical functioning
Investigation – Step Three

• Third step - Ongoing data gathering by RN Care Manager, or ADON, DON or Department Head
  – Incident trending based on prior incident information or log
    • Has this happened before?
    • Similarities/differences?
    • What was implemented in the past?
    • Initial identification of root cause
    • Staff assignments
    • Other more complex environmental issues

What to look for?
Falls

• Fall Investigation
  – What was resident doing?
    • Rising?
    • Sitting?
    • In bed or out of bed?
    • During assisted transfer?
    • To chair or from chair?
      – Indicate type of chair
      – Brakes on w/c/bed
      – Chair too low
      – Foot rests appropriate
    • Self ambulating?
What to **look** for?
Falls continued:

- What was resident doing?
  - Reaching
  - Assisted ambulation
  - Sliding/leaning forward out of chair
- Location & time of fall?
- Side rails?
  - Up, down, per care plan?
  - Malfunctioned
- Time since last voided/toileted?
- Call light within reach? Call light on?
- Time since last meal?

What to **look** for?
Falls continued:

- Environment/equipment a factor?
  - Failed or misused adaptive device?
  - Device out of reach?
  - Faulty equipment?
  - Furniture?
  - Clutter?
  - Lighting/glare?
  - Water on floor?
  - Uneven floor or if outside uneven pavement?
What to look for?
Falls continued:

- Mobility alarm on? Functioning? Removed by resident?
- Type of footwear?
  - Non-skid shoes
  - Slippers
  - Socks only
  - Shoes
  - Barefoot

What to look for?
Falls continued:

- Care Plan followed as written?
  - If not followed, if the resident has an injury, is there possible neglect?
- Assigned staff on break?
- Staff in orientation?
- Medical factors e.g. Parkinson’s
- Vital signs – BP lying and sitting
- Diabetic? Check blood sugar
What to look for?
Falls continued:

- Medications
  - Any new medications?
  - Meds in last two hours?
    - Psychoactive
    - Hypertension
    - Sedative/hypnotic
    - Narcotic

What to look for?
Falls continued:

- Physical functioning
  - Gait
  - Upper torso weakness
- Vision/sensory – glasses/hearing aide on?
  - Need for contrasting colors?
- Pain?
  - Sitting too long?
  - Seating Assessment done?
  - Tired?
Investigation – Step Four

• Fourth Step – IDT Team Review - Analyze and Summarize
  – What is the data telling you?
    • Report suspected abuse/neglect
  – How can this be prevented from happening again?
  – Utilize CAA guidelines to assist with assessment and investigation.
  – RN Designee processes incident report and gathers all pertinent data

• IDT team review of incident within 24 hours or next working AM.

• Investigation
Investigation – Step Four

- Summary on Investigation Form should:
  - Identify and list all risk factors and causal factors
  - Any fault of staff, equipment, etc.
  - If not predicable; then not avoidable
  - Action plan
  - Attach witness statements

- Summary note in medical Record
  - Indicate risk factors (like a CAA note)
  - List changes in care plan
  - If no changes, explain in summary note

- Update care plan to new interventions
## Tracking and Trending Root Cause

### Log events
- Document Follow-up, System issue, and Action taken

### System/root cause identification
- No system issues
- Failure of complete or accurate Assessment/Identification of risk factors prior to event
- Failure to Care Plan for Risk Factors prior to event
- Failure to implement Care Plan as written prior to event

### FALL TRACKING LOG

<table>
<thead>
<tr>
<th>RESIDENT NAME</th>
<th>SSN</th>
<th>WHEN</th>
<th>WITNESSED</th>
<th>REPEAT*</th>
<th>WITHIN* DAYS OF ADMISSION</th>
<th>WHAT TYPE</th>
<th>WHERE</th>
<th>RESULTS</th>
<th>CAUSE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>User medical record number</td>
<td>D just Time and Day of Week</td>
<td>Fall or Alleged Fall</td>
<td>It was a report fall or death or an event?</td>
<td>Any falls?</td>
<td>How?</td>
<td>Type of fall (bed to floor, chair to floor, standing transfer, or alleged Fall)</td>
<td>Where did the fall occur? (room, area, etc.)</td>
<td>Injury Type</td>
<td>Location</td>
<td>Environmental Risk</td>
</tr>
</tbody>
</table>

---

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Tracking and Trending Root Cause

System/Root Cause Identification

• Failure to provide Tx/Med as ordered
• Staff Ratio at time of event
• Supervision of residents by Staff
• Staff training and orientation
• Staff compliance with procedures
• Failed Preventive maintenance
• Environmental factors

Tracking and Trending Root Cause

System/Root Cause identification

• Inadequate Assessment post-event
• Inadequate adjustment in Care Plan post-event
• Change in Care Plan not implemented
• Other
Tracking and Trending Action Plans

- Action plans for root cause(s) trends
  - Staff education
  - Staff counseling
  - Resident education
  - Family education
  - Change in system e.g., orientation program
  - Environmental changes
  - QAA surveillance change
  - Process Improvement Team (PIT)

Tracking and Trending Reporting

- Weekly Risk Team review of falls
- Risk team reviews trends monthly
  - Monthly High Risk Event Report
    - Roll-up report for the month – Data reporting
    - Ideally should be computerized
    - QM Reports – Falls & Falls with Major Injury – Investigate if over the 75th percentile
    - Updates from PIT Team updates
### Tracking and Trending Reporting

#### FALLS

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Falls</td>
<td></td>
</tr>
<tr>
<td>Unwitnessed - found on ground</td>
<td></td>
</tr>
<tr>
<td>During assisted transfer</td>
<td></td>
</tr>
<tr>
<td>During self transfer-bed</td>
<td></td>
</tr>
<tr>
<td>During self transfer/toilet</td>
<td></td>
</tr>
<tr>
<td>During self transfer/chair</td>
<td></td>
</tr>
<tr>
<td>While self ambulating</td>
<td></td>
</tr>
<tr>
<td>During assisted ambulation</td>
<td></td>
</tr>
<tr>
<td>Total Falls</td>
<td></td>
</tr>
</tbody>
</table>

### FALLS TIME OF DAY

<table>
<thead>
<tr>
<th>Day of the Week</th>
<th>Time of Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>7a.m. – 9a.m.</td>
</tr>
<tr>
<td></td>
<td>9a.m. – 11a.m.</td>
</tr>
<tr>
<td>Monday</td>
<td>11a.m. – 1p.m.</td>
</tr>
<tr>
<td></td>
<td>1p.m. – 3p.m.</td>
</tr>
<tr>
<td>Tuesday</td>
<td>3p.m. – 5p.m.</td>
</tr>
<tr>
<td></td>
<td>5p.m. – 7p.m.</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7p.m. – 9p.m.</td>
</tr>
<tr>
<td>Thursday</td>
<td>9p.m. – 11p.m.</td>
</tr>
<tr>
<td>Friday</td>
<td>11p.m. – 1a.m.</td>
</tr>
<tr>
<td></td>
<td>1a.m. – 3a.m.</td>
</tr>
<tr>
<td>Saturday</td>
<td>3a.m. – 5a.m.</td>
</tr>
<tr>
<td></td>
<td>5a.m. – 7a.m.</td>
</tr>
</tbody>
</table>
### Tracking and Trending Reporting

- **Quarterly Meeting Reporting**
  - Data reporting Roll-up
  - Benchmarking
  - QM Report Trends
    - Incidence of Falls – long stay
      » CASPER report only
      » Does not impact 5 Star
    - Falls with Major Injury – long stay
      » CASPER and NHC
      » Impacts 5 Star
Tracking and Trending Reporting

• **Quarterly Meeting Reporting**
  – Data reporting Roll-up
  – Benchmarking
    • Incident of falls overall
      – May remove outliers like a resident rolling out of bed frequently
## Fall Risk Assessment

Upon admission, quarterly, and prn assess the resident status. Add up a total score. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls.

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SCORE</th>
<th>RESIDENT STATUS/CONDITION</th>
<th>SCORE 1</th>
<th>SCORE 2</th>
<th>SCORE 3</th>
<th>SCORE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Level of Consciousness/Mental Status</strong></td>
<td></td>
<td>0 ALERT (oriented x 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 DISORIENTED X 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 DISORIENTED X 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 DISORIENTED X 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 WANDERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. History of Falls (past 3 months)</strong></td>
<td></td>
<td>0 NO FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 1-2 FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 3 OR MORE FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Ambulation Elimination Status</strong></td>
<td></td>
<td>0 REGULARLY CONTINENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 REQUIRES REGULAR ASSIST WITH ELIMINATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 REGULARLY INCONTINENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Vision Status</strong></td>
<td></td>
<td>0 ADEQUATE (with or without glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 POOR (with or without glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 LEGALLY BLIND</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E. Gait/Balance</strong></td>
<td></td>
<td>0 Gait/Balance Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Balance problem while standing/walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Decreased muscular coordination/jerking movements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Change in gait pattern when walking (i.e. shuffling)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Requires use of assistive devices (i.e. cane, w/c, walker, furniture)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 N/A – Not able to perform function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F. Systolic Blood Pressure</strong></td>
<td></td>
<td>0 NO NOTED DROP between lying and standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Drop LESS THAN 20 mm Hg between lying and standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Drop MORE THAN 20 mm Hg between lying and standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G. Medications</strong></td>
<td></td>
<td>Respond below based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics, Blood Thinners.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 NONE of these medications taken currently or within last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 TAKES 1-2 of these medication(s) currently and/or within last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 TAKES 3-4 of these medications currently and/or within last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 If resident has had a change in medications and/or change in dosage in the past 5 days = score 1 additional point</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>H. Predisposing Diseases</strong></td>
<td></td>
<td>Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson’s Disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures, Multiple Sclerosis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 NONE PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 1-2 PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 3 OR MORE PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

Total score above 10 represents HIGH RISK.

<table>
<thead>
<tr>
<th>ASSESS</th>
<th>SIGNATURE/TITLE/DATE</th>
<th>ASSESS</th>
<th>SIGNATURE/TITLE/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

NAME: Last                               First                                 Middle

Attending Physician

Record No.                         Room/Bed
# SAFETY PLAN AND DEVICE AUTHORIZATION

## RESIDENT FACTORS THAT IMPACT USE OF SIDE RAILS /OTHER– FALL RISK SCORE:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe independent transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses call light effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waits for help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alteration in safety awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires spatial awareness reminders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comatose, semi, fluctuating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of seizure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immobile in bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty with trunk control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to use S/R for positioning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## RATIONALE FOR USE - check all that apply

- No side rails needed
- Resident does not desire side rails
- Alert Resident prefers one or both side rails up for feelings of safety
- Enhance Bed mobility with use of side rails
- Side rail/scoop mattress/pillows prevent rolling OOB: would not try to rise unassisted.

Describe:

## POTENTIAL RISKS:

1. Increased risk of injury from trying to climb over rails to get out of bed
2. Bruises from bumping into side rails
3. Decreased vision by creating a visual barrier
4. Strangulation
5. Entrapment (e.g. limbs or head caught in rails)
6. Death from entrapment
7. Minimal risk of injury from pillow or scoop mattress
8. Confusions/loss of dignity
9. Minimal risk of injury from bed against wall

## POTENTIAL BENEFITS:

1. Enable/increase independence in bed mobility
2. Enable/increase independence in transfers
3. Enable better positioning and support in bed
4. Prevents rolling out of bed
5. Provides feelings of security/safety
6. Provides additional space in resident’s room for other activities
7. Resident preference
8. Provide safe, tactile boundaries for vision or cognitively impaired residents

## SAFETY PLAN:

<table>
<thead>
<tr>
<th>Configuration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All down</td>
<td>Full rails both sides up</td>
</tr>
<tr>
<td>One full rail up- R or L</td>
<td>Both half rails up at head of bed</td>
</tr>
<tr>
<td>One half rail up at head of bed - R or L</td>
<td>Both bottom rails up</td>
</tr>
<tr>
<td>One bottom rail up - R or L</td>
<td>All four rails up</td>
</tr>
<tr>
<td>Mini rails up both sides only one side</td>
<td>Side rail/mattress fit safety check performed</td>
</tr>
</tbody>
</table>

Other (e.g. rise alarm, scooped mattress/pillow): ______________________________________

I have been fully informed of the above risks and benefits related to the use of ___________ in care planning and agree to the plan above:

Resident signature: ___________________________   Date: ___________ or

Surrogate Decision Maker: ________________________   Date: ___________

Initial Review Signature: _________________________   Date: ___________

Review Dates and Signature:   Date: ______ Signature: ______________________________________
Date: ______ Signature: ______________________________________
Date: ______ Signature: ______________________________________

## RESIDENT’S NAME | PHYSICIAN | RM# | MR#

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**EVENT REPORT**  
(Quality Assurance/Confidential)

<table>
<thead>
<tr>
<th>Completed By Charge Nurse On Duty</th>
<th>Nurse/Staff:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident:</td>
<td>Date: _______ Time: _______</td>
</tr>
</tbody>
</table>

**Day of Week**

Resident Statement or describe Event Scene:

Describe environment, position of resident, equipment, floor surface, and site of injury:

Describe Injury and Resident Status overall (size, depth, color, pain, bleeding, limitation in ROM-results of head-to-toe assessment, VS & neuro checks:

**Location of occurrence:**

- [ ] Resident room
- [ ] Bathroom
- [ ] Hallway #
- [ ] Shower Room
- [ ] Nursing Station
- [ ] Dining Room
- [ ] Activity Room
- [ ] Therapy Room
- [ ] Lobby
- [ ] Grounds/Parking lot
- [ ] Front Exit
- [ ] Other Exit
- [ ] Off Premises
- [ ] Unknown
- [ ] Other (specify) _______________

**Incident:**

- [ ] FALL
  - [ ] Unwitnessed-found on ground
  - [ ] During Assisted Transfer
  - [ ] During self transfer – bed
  - [ ] During self transfer – toilet
  - [ ] During self transfer – chair
  - [ ] While self-ambulating
  - [ ] During Assisted Ambulation
- [ ] MISC
  - [ ] Found in Hazardous Situation
  - [ ] Other

**SKIN**

- [ ] Acquired Stage I
- [ ] Acquired Stage II
- [ ] Acquired Stage III
- [ ] Acquired Stage IV
- [ ] Skin Tear – unknown origin
- [ ] Skin Tear – known origin
- [ ] Bruise – unknown origin
- [ ] Bruise – known origin
- [ ] Burn/laceration/bite/other

**BEHAVIORS**

- [ ] Elopement
- [ ] Resident/Visitor
- [ ] Resident/Staff
- [ ] Unaccompanied Exit
- [ ] Self inflicted injury
- [ ] Repeat Administration
- [ ] Wrong medication/wrong resident given
- [ ] Wrong dose/route given
- [ ] Omission
- [ ] IV Error
- [ ] Transcription error only, not administered

**Immediate Intervention initiated to protect resident: (check all that apply):**

- [ ] Care plan updated to new interventions
- [ ] First Aid
- [ ] Physician orders/Tx
- [ ] ER visit/Hospital admission
- [ ] Med error-Req. Medical care
- [ ] Med error – no intervention
- [ ] Press. Reduction: Bed / chair
- [ ]Environmental Adjustment
- [ ] Provide immediate protection
- [ ] Initiate Rise Alarm w/c / bed
- [ ] Initiate frequent checks____
- [ ] Lower bed
- [ ] Mat/mattress by bed
- [ ] Provide food/diversion
- [ ] Placed in supervised area
- [ ] Oriented to call light
- [ ] Protective clothing-skin
- [ ] Toileted
- [ ] Put to bed
- [ ] Wanderguard initiated
- [ ] Add Enabler bar/trapeze
- [ ] Review meds
- [ ] PRN Med
- [ ] Removed S/R or restraint
- [ ] Added non-slip device: w/c chair Geri
- [ ] Initiated body pillow

**Notification of Physician:**

- [ ] Physician notified Name:___________________ Date:_________ Time:_______

**Notification of Responsible Party:**

- [ ] Responsible Party notified Name:___________________ Date:_________ Time:_______

**Non Staff Witnesses to event Yes/No**

- [ ] Yes
- [ ] No

Name:___________________ Phone:__________ Address:__________________

**Staff Witness Yes/No**

- [ ] Yes
- [ ] No

Name:___________________ Phone:__________ Address:__________________
### INVESTIGATION

(Quality Assurance/Confidential)

**Resident:** ___________________________

**Date:** __________  **Time:** _____  **Event:** ____________________________

**Initial Investigative Data:**

**COMPLETED BY CHARGE NURSE** Or **UNIT MANAGER**

<table>
<thead>
<tr>
<th>Medication factors-all events</th>
<th>Fall or Behaviors as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New medication in last 14 days</td>
<td>Side rails used at time of event</td>
</tr>
<tr>
<td>Taking psychoactive drugs?</td>
<td>One side: ½, ¾, full, split</td>
</tr>
<tr>
<td>Name: _________________________</td>
<td>No side rails used at time of event</td>
</tr>
<tr>
<td>Meds that could cause bruising/bleed</td>
<td>Two side: ½, ¾, full, split</td>
</tr>
<tr>
<td>Name: _________________________</td>
<td>Physical Restraint in use?</td>
</tr>
<tr>
<td>Taking narc/analgesic</td>
<td>Type: _________________________</td>
</tr>
<tr>
<td>Name: _________________________</td>
<td>Applied correctly</td>
</tr>
<tr>
<td>Meds Cause constipation:</td>
<td>Floor wet</td>
</tr>
<tr>
<td>Meds given for bowel Regime</td>
<td>Urine/Feces on floor</td>
</tr>
<tr>
<td><strong>Medication contributed to event</strong></td>
<td>Position of bed /recent room change</td>
</tr>
<tr>
<td>Exit Front Door</td>
<td>Walker not within reach</td>
</tr>
<tr>
<td>Other door _______</td>
<td>Clutter in room</td>
</tr>
<tr>
<td>Time last seen:</td>
<td>Glare/Floor/cement</td>
</tr>
<tr>
<td>Unaccompanied Exit: Yes ____ No ____</td>
<td>Vision loss/sensory impairment</td>
</tr>
<tr>
<td>Actual Elopement: Yes ____ No ____</td>
<td>Cognitive decline</td>
</tr>
<tr>
<td>Location Found:</td>
<td>Behaviors</td>
</tr>
<tr>
<td>Time: _______</td>
<td>Noise/staff approach</td>
</tr>
<tr>
<td><strong>Factors that contributed to Event:</strong></td>
<td>Mobility Alarm</td>
</tr>
<tr>
<td></td>
<td>Yes / No type: _________________________</td>
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<tr>
<td></td>
<td>Alarm attached</td>
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<tr>
<td></td>
<td>Alarm turned on</td>
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<td></td>
<td>Alarm Functioning</td>
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<tr>
<td></td>
<td>Alarm removed by resident</td>
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<tr>
<td></td>
<td><strong>Factors that contributed to Event:</strong></td>
</tr>
<tr>
<td></td>
<td>Shuffling/altered gait</td>
</tr>
<tr>
<td></td>
<td>Refuses to use adaptive device</td>
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<tr>
<td></td>
<td>Refuses to ask for help</td>
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<tr>
<td></td>
<td>Hypotension</td>
</tr>
<tr>
<td></td>
<td>Need to void</td>
</tr>
<tr>
<td></td>
<td><strong>MEDICATION ERROR CAUSE</strong></td>
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<tr>
<td></td>
<td>Transcription issue</td>
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<td></td>
<td>No order written</td>
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<tr>
<td></td>
<td>Mislabeled/outdated medication</td>
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<tr>
<td></td>
<td>Allergy not documented</td>
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<tr>
<td></td>
<td>Verified incorrectly</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Bruises/skin tears/other skin/pressure ulcer:**

Residents skin condition and risk factors are:

<table>
<thead>
<tr>
<th>Good texture</th>
<th>Fragile</th>
<th>Prosthetic/leg rests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeds easily</td>
<td>Protruding IV</td>
<td>Prone to bruising</td>
</tr>
<tr>
<td>Self-inflicting e.g. hit hand on wall</td>
<td>Prone to ecchymosis</td>
<td>Pressure ulcer risk factors</td>
</tr>
</tbody>
</table>

**Care Planning and Assess.**

<table>
<thead>
<tr>
<th>Risk assessment NOT doc. Prior to e.g. falls, skin tear, elopement, pressure ulcer, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan was followed as written</td>
</tr>
</tbody>
</table>

**COMPLETED BY UNIT MANAGER OR DON SUMMARY OF FINDINGS:**

Investigation Summary and final Action Plan Completed by DON or assigned staff. Attach witness statement form as indicated.

---

**Use codes on Incident Log.**

**CONCLUSION: SYSTEMS FINDINGS: #_____**  **ACTION TAKEN: #______**

- IDT Review
- Post-Event Assessment in chart
- Care Plan revised

**Reported to local agency:**

**Agency Name:** ____________________________

By whom: ____________________________  **Log only**  **Extended Investigation Initiated**

- DON Signature ____________________________  **Date:** __________
- Adm. Signature ____________________________  **Date:** __________
- Medical Director Signature ____________________________  **Date:** __________
POST FALL REVIEW

Date/Time/Location of Fall: ____________________________________________________________

1. Immediate Interventions and Recommendations for Follow-up:

☐ Check Positioning/Seating    ☐ Rx Change    ☐ Screen for UTI    ☐ R/O Delirium
☐ Drug Screens    ☐ B&B program    ☐ More frequent toileting    ☐ R/O Constipation
☐ Referred to therapy    ☐ Offer food    ☐ R/O Medical issues/concerns    ☐ Lab work
☐ Assist to bed    ☐ Environmental Modifications    ☐ R/O Constipation
☐ Other: ________________________________________________________________

What was the resident attempting to do just prior to the fall? ________________________________________________________________

2. History of Previous Falls:

☐ Yes    ☐ No _________________________ Pattern? ☐ Yes    ☐ No

Last Fall Risk Assessment Total Score _______ Does a new risk assessment need to be completed? ☐ Yes    ☐ No

Comments: ______________________________________________________________________________________________

3. Medication(s) that fall could be attributed to:

☐ Barbiturates    ☐ Anti Depressants    ☐ Analgesics    ☐ Vasodilators    ☐ Hypnotics/sedatives
☐ Antipsychotics    ☐ Anticonvulsants    ☐ Glycosides    ☐ Alcohol    ☐ Antiparkisonian
☐ Diuretics    ☐ Antiarrhythmics    ☐ Tranquilizers    ☐ Hypotensives
☐ Other: ________________________________________________________________

4. Indicate Potential Contributing Factors:

☐ Need to void    ☐ Call light not within reach    ☐ Pain/Need to change position    ☐ Rises unassisted
☐ Forgets to use call light    ☐ Resident self directing care    ☐ Dismantled Rise Alarm    ☐ Misuse/lack of adaptive device
☐ Call light on    ☐ Vision loss    ☐ Unsteady gait    ☐ History of hypotension
☐ Increased agitation    ☐ Wet floor or glare    ☐ Behavior symptoms    ☐ Cognitive decline
☐ Hungry    ☐ Environmental factor: ____________________________    ☐ Type of footwear
☐ Other contributing medical factors (please list): ________________________________________________________________

☐ Mental/Physical factors (please list): ________________________________________________________________

☐ Other ______________________________________________________________________________________________

Notes: ____________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

5. Summary of Care Plan Revisions: ________________________________________________________________

__________________________________________________________________________________________________________

Assessment Completed By: Signature: ____________________________ Date: ____________________________

Resident: ____________________________ RM#: ________ MD: ____________________________ MR#: ________
## 11. FALL(S)

### Review of Indicators of Fall Risk

<table>
<thead>
<tr>
<th>✓</th>
<th>History of falling (J1700, J1800, J1900)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Time of day, exact hour of the fall(s)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Location of the fall(s), such as bedroom, bathroom, hallway, stairs, outside, etc.</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Related to specific medication</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Proximity to most recent meal</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Responding to bowel or bladder urgency</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Doing usual/unusual activity</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Standing still or walking</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Reaching up or reaching down</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Identify the conclusions about the root cause(s), contributing factors related to previous falls</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Physical performance limitations: balance, gait, strength, muscle endurance (G0300A-G0300E)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Difficulty maintaining sitting balance</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Need to rock body or push off on arms of chair when standing up from chair</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Difficulty maintaining standing position</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Impaired balance during transitions (G0300A-G0300E)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• One leg appears shorter than the other</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg</td>
<td></td>
</tr>
</tbody>
</table>
## Medications

- Antipsychotics (N0410A)
- Antianxiety agents (N0410B)
- Antidepressants (N0410C)
- Hypnotics (N0410D)
- Cardiovascular medications (from medication administration record)
- Diuretics (N0410G) (from medication administration record)
- Narcotic analgesics (from medication administration record)
- Neuroleptics (from medication administration record)
- Other medications that cause lethargy or confusion (from medication administration record)

## Internal risk factors (from diagnosis list and clinical indicators)

- Circulatory/Heart
  - Anemia (I0200)
  - Cardiac Dysrhythmias (I0300)
  - Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400)
  - Congestive Heart Failure (CHF) pulmonary edema (I0600)
  - Cerebrovascular Accident (CVA) (I4500)
  - Transient Ischemic Attack (TIA) (I4500)
  - Postural/Orthostatic hypotension (I0800)
<table>
<thead>
<tr>
<th>✓</th>
<th><strong>Internal risk factors</strong> (from diagnosis list and clinical indicators) (continued)</th>
<th><strong>Supporting Documentation</strong> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
</table>
|  | • Neuromuscular/functional  
  — Cerebral palsy (I4400)  
  — Loss of arm or leg movement (G0400)  
  — Decline in functional status (G0110)  
  — Incontinence (H0300, H0400)  
  — Hemiplegia/Hemiparesis (I4900)  
  — Parkinson’s disease (I5300)  
  — Seizure disorder (I5400)  
  — Paraplegia (I5000)  
  — Multiple sclerosis (I5200)  
  — Traumatic brain injury (I5500)  
  — Syncope  
  — Chronic or acute condition resulting in instability  
  — Peripheral neuropathy  
  — Muscle weakness | |
|  | • Orthopedic  
  — Joint pain  
  — Arthritis (I3700)  
  — Osteoporosis (I3800)  
  — Hip fracture (I3900)  
  — Missing limb(s) (G0600D) | |
|  | • Perceptual  
  — Visual impairment (B1000)  
  — Hearing impairment (B0200)  
  — Dizziness/vertigo | |
|  | • Psychiatric or cognitive  
  — Impulsivity or poor safety awareness  
  — Delirium (C1310)  
  — Wandering (E0900)  
  — Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.  
  — Cognitive impairment (C0500, C0700-C1000)  
  — Alzheimer’s disease (I4200)  
  — Other dementia (I4800)  
  — Anxiety disorder (I5700)  
  — Depression (I5800)  
  — Manic depression (I5900)  
  — Schizophrenia (I6000) | (continued)
<table>
<thead>
<tr>
<th>✓</th>
<th>Internal risk factors (from diagnosis list and clinical indicators) (continued)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>• Infection (I1700 – I2500)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Low levels of physical activity</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Pain (J0300)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Headache</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Fatigue, weakness</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Vitamin D deficiency</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Laboratory tests</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>☐</td>
<td>• Hypo- or hyperglycemia</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Electrolyte imbalance</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Dehydration (J1550C)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Hemoglobin and hematocrit</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Environmental factors (from review of facility environment)</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>☐</td>
<td>• Poor lighting</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Glare</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Patterned carpet</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Poorly arranged furniture</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Uneven surfaces</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Slippery floors</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Obstructed walkway</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Poor fitting or slippery shoes</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Proximity to aggressive resident</td>
<td></td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  - Description of the problem;  
  - Causes and contributing factors; and  
  - Risk factors related to the care area. | Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): __________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes  ☐ No

Signature/Title: __________________________ Date: __________________________
# FALL TRACKING LOG

**MONTH:**  

<table>
<thead>
<tr>
<th>RESIDENT NAME</th>
<th>RM #</th>
<th>WHEN</th>
<th>WITNESS ED?</th>
<th>REPEAT?</th>
<th>WITHIN 7 DAYS OF ADMISSION</th>
<th>WHAT/TYPE</th>
<th>WHERE</th>
<th>RESULTS</th>
<th>CAUSE</th>
<th>Care Plan Interventions updated</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use medical record number</td>
<td>Date/Time and Day of Week</td>
<td>Fall or Alleged Fall</td>
<td>Is this a repeat fall in the last month? 3 months? 6 months?</td>
<td>Type of fall (bed to floor, chair to floor, during transfer) and Alleged Fall?</td>
<td>Where did the fall occur? (common area or room)</td>
<td>Injury/Tx/location</td>
<td>Environment/risk factors/staff behavior</td>
<td></td>
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</tr>
</tbody>
</table>

Quarterly Evaluation of Fall Data:

Signature ___________________________________ Date___________________

DEVELOPED BY POLARIS GROUP Page 1 of 1
### Example One

**Resident’s Name:** Jane Doe  
**Date Now:**  
**Assessor:** Nurse Nancy

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SCORE</th>
<th>RESIDENT STATUS/CONDITION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Level of Consciousness/Mental Status</strong></td>
<td></td>
<td>0 ALERT (oriented x 3) OR COMATOSE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>DISORIENTED X 3 at all times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>INTERMITTENT CONFUSION</td>
<td>X</td>
</tr>
<tr>
<td><strong>B. History of Falls (past 3 months)</strong></td>
<td></td>
<td>0 NO FALLS in past 3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1-2 FALLS in past 3 months</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3 OR MORE FALLS in past 3 months</td>
<td></td>
</tr>
<tr>
<td><strong>C. Ambulation/Elimination Status</strong></td>
<td></td>
<td>0 AMBULATORY/CONTINENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>CHAIR BOUND-Requires restraints and assist with elimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>AMBULATORY/INCONTINENT</td>
<td>X</td>
</tr>
<tr>
<td><strong>D. Vision Status</strong></td>
<td></td>
<td>0 ADEQUATE (with or without glasses)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>POOR (with or without glasses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>LEGALLY BLIND</td>
<td></td>
</tr>
<tr>
<td><strong>E. Gait/Balance</strong></td>
<td></td>
<td>To assess the resident’s Gait/Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Gait/Balance Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Balance problem while standing</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Balance problem while walking</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Decreased muscular coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Change in gait pattern when walking through doorway</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Jerking or unstable when making turns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Requires use of assistive devices (i.e. cane, w/c, walker, furniture)</td>
<td>X</td>
</tr>
<tr>
<td><strong>F. Systolic Blood Pressure</strong></td>
<td></td>
<td>0 NO NOTED DROP between lying and standing</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Drop LESS THAN 29 mm Hg between lying and standing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Drop MORE THAN 20 mm Hg between lying and standing</td>
<td></td>
</tr>
<tr>
<td><strong>G. Medications</strong></td>
<td></td>
<td>Respond below based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>NONE of these medication taken currently or within last 7 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>TAKES 1-2 of these medications currently and/or within last 7 days</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>TAKES 3-4 of these medications currently and/or within last 7 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>If resident has had a change in medications and/or change in dosage in the past 5 days = score 1 additional point</td>
<td></td>
</tr>
<tr>
<td><strong>H. Predisposing Diseases</strong></td>
<td></td>
<td>Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson’s disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>NONE PRESENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1-2 PRESENT</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3 OR MORE PRESENT</td>
<td></td>
</tr>
</tbody>
</table>

**Total score of 10 or above represents HIGH RISK**  
**TOTAL SCORE:** 17
### DATE SUMMARY NOTES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 20XX</td>
<td>Risk score of 17. History of falls in apartment prior to admission; loses balance when rising or walking.</td>
</tr>
<tr>
<td></td>
<td>Should use walker but refuses or forgets. Diagnosis include Parkinson’s, dementia, and</td>
</tr>
<tr>
<td></td>
<td>Post-pneumonia so has increased weakness. Resident is on Benadryl for sleeping but</td>
</tr>
<tr>
<td></td>
<td>she does not try to rise at night. Need to void is a factor as she rises without using Walker or call light.</td>
</tr>
</tbody>
</table>

### CARE PLAN EXAMPLE:

<table>
<thead>
<tr>
<th>DATE</th>
<th>PROBLEM</th>
<th>GOAL</th>
<th>DATE</th>
<th>INTERVENTIONS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.1 20XX</td>
<td>At risk for falls contributing factors:</td>
<td>Will not experience a fall</td>
<td>April 1, 20XX</td>
<td>• Toilet at scheduled times: early am, prior to meals, mid-morning, prior to afternoon nap, after dinner, and meal time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hx of falls</td>
<td></td>
<td></td>
<td>• Remind to use call light.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Need to void</td>
<td></td>
<td></td>
<td>• Put walker next to bed.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Forgets to use walker</td>
<td></td>
<td></td>
<td>• Refer to therapy</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Forgets to use call light</td>
<td></td>
<td></td>
<td>• Commode by bedside at night.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Overall unsteady gait</td>
<td></td>
<td></td>
<td>• Ambulate with walker to bathroom and dining room.</td>
<td>1/3/XX</td>
</tr>
<tr>
<td></td>
<td>• Parkinson’s</td>
<td></td>
<td></td>
<td>• Rise alarm in chair. Will monitor for resident’s response</td>
<td>1/5/XX</td>
</tr>
<tr>
<td></td>
<td>• Dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Example Two

Resident’s Name: Jane Smith  
Date: Now  
Assessor: Nurse Nancy

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SCORE</th>
<th>RESIDENT STATUS/CONDITION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Level of Consciousness/Mental Status</strong></td>
<td>0</td>
<td>ALERT (oriented x 3) OR COMATOSE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>DISORIENTED X 3 at all times</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>INTERMITTENT CONFUSION</td>
<td></td>
</tr>
<tr>
<td><strong>B. History of Falls</strong> (past 3 months)</td>
<td>0</td>
<td>NO FALLS in past 3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1-2 FALLS in past 3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3 OR MORE FALLS in past 3 months</td>
<td>X</td>
</tr>
<tr>
<td><strong>C. Ambulation/Elimination Status</strong></td>
<td>0</td>
<td>AMBULATORY/CONTINENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>CHAIR BOUND-Requires restraints and assist with elimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>AMBULATORY/INCONTINENT</td>
<td>X</td>
</tr>
<tr>
<td><strong>D. Vision Status</strong></td>
<td>0</td>
<td>ADEQUATE (with or without glasses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>POOR (with or without glasses)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>LEGALLY BLIND</td>
<td></td>
</tr>
<tr>
<td><strong>E. Gait/Balance</strong></td>
<td>0</td>
<td>Gait/Balance Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Balance problem while standing</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Balance problem while walking</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Decreased muscular coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Change in gait pattern when walking through doorway</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Jerking or unstable when making turns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Requires use of assistive devices (i.e. cane, w/c, walker, furniture)</td>
<td>X</td>
</tr>
<tr>
<td><strong>F. Systolic Blood Pressure</strong></td>
<td>0</td>
<td>NO NOTED DROP between lying and standing</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Drop LESS THAN 29 mm Hg between lying and standing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Drop MORE THAN 20 mm Hg between lying and standing</td>
<td></td>
</tr>
<tr>
<td><strong>G. Medications</strong></td>
<td>0</td>
<td>NONE of these medication taken currently or within last 7 days</td>
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<tr>
<td></td>
<td>2</td>
<td>TAKES 1-2 of these medications currently and/or within last 7 days</td>
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<tr>
<td><strong>H. Predisposing Diseases</strong></td>
<td>0</td>
<td>NONE PRESENT</td>
<td>X</td>
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<tr>
<td></td>
<td>2</td>
<td>1-2 PRESENT</td>
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</tbody>
</table>

**Total score of 10 or above represents HIGH RISK**

**TOTAL SCORE** 15

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FH34 - Developed by Polaris Group  
[www.polaris-group.com](http://www.polaris-group.com)
Risk Score 15. Resident has Alzheimer’s so paces frequently and can get very tired. Falls occur in later afternoon as resident is more tired or agitated. When agitated the resident speeds up and walks too fast. Resident has a shuffle. Resident has fallen sitting on the toilet. Therapy has seen resident in the past with no recommendations. Resident will continue to self ambulate so risk continues. Goal is for continued independent ambulation.

<table>
<thead>
<tr>
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<th>PROBLEM</th>
<th>GOAL</th>
<th>DATE</th>
<th>INTERVENTIONS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1, 20XX</td>
<td>At risk for repeat injury falls contributing factors:</td>
<td>Will not experience an injury fall.</td>
<td>April 1, 20XX</td>
<td>• Prompted voiding, remind to void every two hours</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Repeat falls</td>
<td></td>
<td></td>
<td>• Raised toilet seat</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Vision</td>
<td></td>
<td></td>
<td>• Contrasted toilet seat cover.</td>
<td>2/3/XX</td>
</tr>
<tr>
<td></td>
<td>• Need to void</td>
<td></td>
<td></td>
<td>• Encourage to lay down when tired in afternoon.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td>• Tiredness</td>
<td></td>
<td></td>
<td>• Wear her thin hard sole shoes during day.</td>
<td>2/8/XX</td>
</tr>
<tr>
<td></td>
<td>• Ambulates independently</td>
<td></td>
<td></td>
<td>• When agitated, walk with resident if resident allows until slows down or sits down.</td>
<td>1/9/XX</td>
</tr>
<tr>
<td></td>
<td>• Paces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Agitated, walks too fast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>