

Resident Fall Check List

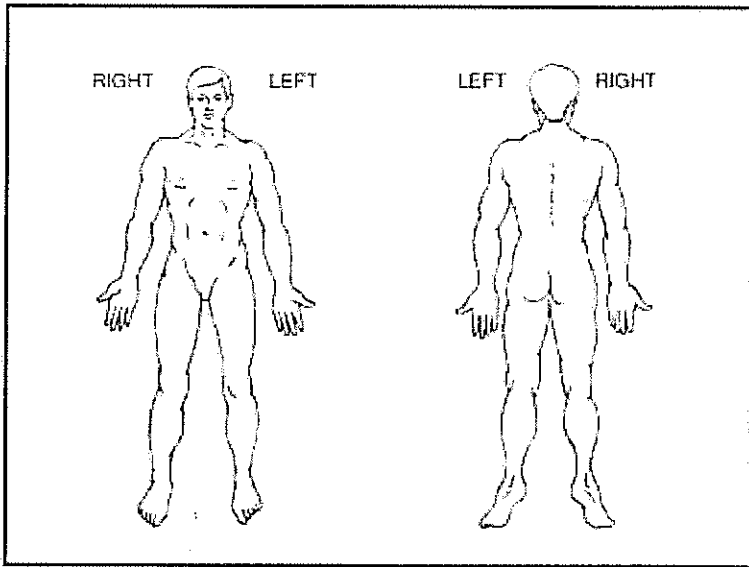
RESIDENT NAME: _____ MED REC #: _____

See Fall Report/Nurse Notes for full details. This is a working checklist to use to guide nurses through the fall process. Charge nurse that fills out Fall Report must fill this out also.

CHECKLIST	YES	NO	COMMENTS
Resident ill at the time of incident?			
Environmental hazards?			Describe:
Appropriate footwear?			Type:
Physical restraints Present?			
Did Resident hit their head?			Neuros started? Yes/ No
ANY BEHAVIOR PROBLEM AT THIS TIME?			
Temporary care plan filled out?			
Chart flagged?			
Full Body check done by whom?			
Toileted per Care Plan?			Time last toileted? _____
Last time resident checked prior to this incident?			
Vital Signs completed?			
Med changes in past 30 days?			
New wound/injury entered into wound book?			
MD Notified? Date _____ Time _____			On call MD or Primary MD
Family notified? Date _____ Time _____			Whom:
Care Plan followed?			
RN, DON or Social Services notified?			
Copy in Wall Pocket in main office?			

Follow up charting, in nurses notes completed q Shift x3 by charge nurse: Shift 1 _____ Shift 2 _____ Shift 3 _____

Signature of Charge Nurse filling out Fall Checklist _____



NO APPARENT INJURY (NAI) - NO INJURY NOTED
 INSIGNIFICANT - BRUISES, SKIN TEARS, AND SPRAINS
 SIGNIFICANT - FRACTURES OR HEAD TRAUMA

~~Note: Bruises, Lacerations and Level of Consciousness need to be followed for 24 hours. Any changes need to be recorded.~~

1ST Shift _____

2nd shift _____

24 hour after incident _____

QA Criteria for RN Case Manager or Supervisor

Care Plan/assess PT/OT notified if applicable Primary MD aware
 Medication review Labs reviewed Fall assessment record completed
 Administrator notified immediately or within 24 hours

RN Signature _____ Date _____

Vulnerable Adult /Abuse Prevention

Resident involved _____ Date _____

Was resident injured? _____ Did resident receive medical care? _____

Was Care Plan followed? _____ Education or counseling provided to staff involved. _____

Incident reported to MDH(OHFC) _____ Incident Report to CEP _____

DON Signature _____ Date: _____

Reviewed by:
