Tool 17b: Post fall/incident report form

Resident's name:

Date of birth:

Room number:

Date of fall/ incident:

Time of fall:

Fall location

Outdoors ☐ Bedroom ☐ En-suite ☐ Bathroom ☐

Corridor ☐ Sitting room ☐ Dining room ☐ Exact location

Surface type

Carpet ☐ Linoleum ☐ Other (specify)

Surface condition

Wet ☐ Damaged ☐ Slippery ☐ Other ☐

Bed position

High ☐ Low ☐ Tilted ☐ N/A ☐

Call bell in reach

Yes ☐ No ☐ N/A ☐

Light

On ☐ Off ☐ N/A ☐

Mobility

Ambulant ☐ Non-ambulant ☐ Independent ☐ Assistance of 1 ☐

Assistance of 2 ☐

Aids

None ☐ Stick ☐ Walking Frame ☐ Crutches ☐ Wheelchair ☐

Was aid used at the time of fall?

Used correctly ☐ Used incorrectly ☐ Not used ☐

Unknown ☐ Condition of aid ☐

Type of fall

Slip ☐ Trip ☐ Collapse ☐ Legs gave way ☐ Loss of balance ☐

Unknown ☐

Falls direction

Drop ☐ Forwards ☐ Backwards ☐ Sideways ☐ Unknown ☐

Any warning prior to fall

Dizziness ☐ Faintness ☐ Confusion ☐ Fit ☐

Loss of consciousness ☐ Palpitations ☐ Aggression ☐ Breathlessness ☐

Altered mental state ☐ None of above/other (specify) ☐

Toileting

Resident attempting to go to toilet ☐ Incontinence ☐ Frequency ☐ Urgency ☐

Footwear

Shoes ☐ Slippers ☐ Socks ☐ Bare feet ☐ Condition ☐

Glasses

None ☐ Reading ☐ Distance ☐ Bi-focals ☐ Vari-focals ☐

Type worn at the time of fall

None ☐ Reading ☐ Distance ☐ Bi-focals ☐ Vari-focals ☐

Condition of glasses ☐

History of falls

No ☐ Yes ☐ Number of falls in past 12 months ☐

Medication/substance use - potentially a contributory factor?

Yes ☐ No ☐ N/A ☐ Unknown ☐

Time taken ☐

Medication/substance identified ☐

Description of event

Was the resident aware the fall was going to happen? Yes ☐ No ☐ Unknown ☐

Residents description of fall including activity immediately prior to falls

_____

_____

_____

Brief description of fall. What was seen or heard. Witnesses description (note any incontinence or abnormal movements).

_____

_____

_____

Witness name/status: _____

Clinical observation/vital signs following fall

Vital signs checked following fall (BP, pulse, respiration) Yes ☐ No ☐ N/A ☐

Any noticeable changes in residents health (note any pallor or cyanosis) Yes ☐ _____ No ☐

AMT required Yes ☐ No ☐ N/A ☐ AMT Score: _____

First aid administered Yes ☐ No ☐ N/A ☐

Hospital attendance required Yes ☐ No ☐ N/A ☐

Injuries sustained: Fracture: Yes ☐ No ☐

Head injury Yes ☐ No ☐

Laceration/bruising Yes ☐ No ☐

Other (specify): _____

Immediate action taken _____

_____

Doctor notified Yes ☐ No ☐ Time notified: _____

Seen by doctor Yes ☐ No ☐ Time seen: _____ Doctors name: _____

Outcome (note if RIDDOR reportable)

Action taken to prevent re-occurence (please specify)

MFRS/falls care plan updated? Yes ☐ No ☐ N/A ☐

Environmental risk updated? Yes ☐ No ☐ N/A ☐

Assessed by

Date