# Fall Assessment QAPI

## RESIDENT

Resident: _____ ☐ Male ☐ Female Age: _____
Date of Fall: _____ Time of Fall: _____ Day of Week: _____ Shift: _____

## HUDDLE/QAPI MEETING INFORMATION

Date of Huddle: _____ Time of Huddle: _____
Location of Huddle: ☐ Nurse's Station ☐ Location of Fall ☐ Resident Room ☐ Other _____

Huddle Leader/Facilitator: _____ Number of Attendees: _____

| | | |
|---|---|---|
| ☐ Charge Nurse _____ | ☐ Medical Director _____ | ☐ Resident _____ |
| ☐ RN _____ | ☐ PT _____ | ☐ Family Member _____ |
| ☐ LPN _____ | ☐ OT _____ | ☐ Visitor _____ |
| ☐ Med Aide _____ | ☐ Housekeeping _____ | ☐ Social Services _____ |
| ☐ CNA _____ | ☐ Dietary _____ | ☐ Other (Name/Title) _____ |
| ☐ Administrator _____ | ☐ Maintenance _____ | _____ |
| ☐ DON _____ | ☐ Activities _____ | _____ |

## FALL INFORMATION

Location of Fall: ☐ Resident Room ☐ Resident Bathroom ☐ Hallway ☐ Dining Room ☐ Bathing Room
☐ Outside on Campus ☐ Outside off Campus ☐ Other

Type of Fall: ☐ Witnessed (observed the fall) _____
☐ Unwitnessed (found on floor/ground)
☐ Intercepted (would have fallen if not caught self or by another person)

Injury From Fall: ☐ No injury
☐ Injury, except major (skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains or any related injury causing the resident to complain of pain)
☐ Major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma)

Outside Medical Treatment Immediately After Fall? ☐ None ☐ Sent to Emergency Room ☐ Sent to Physician Clinic

## RESIDENT

What were you trying to do/What did you need? _____
Was something different this time (i.e., noisy, too many people)? _____
Assistive device being used? ☐ None ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other
Footwear? ☐ Barefoot ☐ Shoes ☐ Gripper socks ☐ Socks without grippers ☐ Slippers ☐ Other
Clothing? ☐ Fit well ☐ Loose ☐ Tight ☐ Other _____
Wears glasses? ☐ Yes ☐ No Wearing glasses when fell? ☐ Yes ☐ No
Wears hearing aids? ☐ Yes ☐ No Wearing hearing aids when fell? ☐ Yes ☐ No

## STAFF

Approximate time of last contact or visual of the resident before fall: _____ Who? _____
What was the resident doing/What did they need? _____
Was something different this time (i.e., new shoes)? _____
Who was in the area at the time of the fall? _____
Is anything about the resident different today than normal? _____
Was the call light on? _____ If yes, what was the response time? _____
Resident's baseline cognition: ☐ Intact ☐ Moderately impaired ☐ Severely impaired
What was the resident's cognition/confusion level at the time of the fall? _____
What was the lighting at the time of the fall: _____
Was PT consulted prior to the fall? ☐ Yes ☐ No If Yes, were all assistive devices/interventions in place? _____
Fall risk score: _____
Were all interventions/strategies in place from the care plan: ☐ Yes ☐ No If no, explain _____
_____

## ENVIRONMENT

Floor: ☐ Carpet ☐ Tile ☐ Rug ☐ Uneven ☐ Steps ☐ Shiny ☐ Wet: Suspected Liquid _____
☐ Other _____
Area where fall occurred: ☐ Light ☐ Dark ☐ Noisy ☐ Busy ☐ Cluttered ☐ Other _____
What items were near fallen resident? ☐ Bed ☐ Wheelchair ☐ Walker ☐ Chair/Recliner ☐ Toilet/Commode
☐ Other: _____
Equipment used at time of fall: ☐ Total Lift ☐ Sit-to-Stand Lift ☐ Bath Chair ☐ Other _____
Other environment factors: _____

## DRAW THE SCENE

Draw the scene of the fall. Be descriptive. Include the resident's position, equipment, and assistive devices:

## This Section to be Completed by the QAPI Team: FALL ROOT CAUSE ANALYSIS

Use the 5 Whys to identify the root cause of the fall. Ask "why" until the cause of the fall is reached. Then, verify the result is the root cause by asking, "if this reason was removed, would the fall have occurred?"

**Problem Statement**: One sentence description of the event

Why? _____
Why? _____
Why? _____
Why? _____
Why? _____

**Root Causes**

**1.** _____ **2.** _____ **3.** _____

*To validate root causes, ask the following: If you removed this root cause, would this event have been prevented?*

## This Section to be Completed by the QAPI Team: ACTION PLAN

What can be done to avoid future falls (intervention)? _____
_____

Care Plan Updated? ☐ Yes ☐ No
Signature of Leader/Facilitator: _____ Time Huddle Completed: _____
Fall Committee Review and Action: _____
Fall Committee Signature: _____ Date: _____
QAPI Committee Review and Action: _____
QAPI Committee Signature: _____ Date: _____
Administrator Signature: _____ Date: _____
Medical Director Signature: _____ Date: _____

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