FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

Date of Fall _____ Time of Fall: _____ AM / PM Admit Date: _____

Staff / Witness present at / or finding resident after fall: _____

FALL DESCRIPTION DETAILS:

1. Factors observed at time of fall:
   - ☐ Resident lost their balance
   - ☐ Resident slipped (give details):
   - ☐ Lost strength/appeared to get weak
   - ☐ Wheelchair / bed brakes unlocked
   - ☐ Bed height not appropriate
   - ☐ Equipment malfunction (specify):
   - ☐ Environmental noise
   - ☐ Environmental factors (circle or write in): clutter, furniture, item out of reach, lighting, wet floor, other (specify)

2. Draw a picture of area and position in which resident was found. (e.g. face down, on back / R or L side, position of arms and legs, furniture /equipment /devices nearby)

***If fall within 5 feet of transfer surface do orthostatic BP**

3. Fall Summary:
   - ☐ Found on the floor (unwitnessed)
   - ☐ Fall to the floor (witnessed)
   - ☐ Intercepted fall (resident lowered to floor)
   - ☐ Self-reported fall

4. Fall Location
   - ☐ Resident room
   - ☐ Activity Room
   - ☐ Hallway
   - ☐ Dining room/day room
   - ☐ Bathroom [CHECK TOILET CONTENTS]
     - ☐ Toilet contains urine /feces
   - ☐ Shower/tub room
   - ☐ Outside building on premises / off premises
   - ☐ Other (specify) :

5. What was resident doing during or just prior to fall?
   - ☐ Ambulating
   - ☐ Attempting self-transfer
   - ☐ Transfer assisted by staff
   - ☐ Reaching for something
   - ☐ Slide out / fall from wheelchair
   - ☐ Rolling/sliding out of bed
   - ☐ Sitting on shower/toilet chair
   - ☐ Other (specify):

6. What type of assistance was resident receiving at time of fall?
   - ☐ Assisted per care plan:
   - ☐ Alone and unattended
   - ☐ Assisted with more help than care plan describes

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7. What did the resident say they were trying to do just before they fell?

CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:

8. Describe resident's mental status prior to fall:

How does this compare to the resident's usual mental status?

9. Describe resident's psychological status prior to fall:

How does this compare to the resident's usual psychological status?

10. Footwear at time of fall:
- ☐ Shoes
- ☐ Bare feet
- ☐ Gripper Socks
- ☐ Slippers
- ☐ Socks
- ☐ Off load boots
- ☐ Amputee

11. Gait Assist devices at time of fall:
- ☐ None
- ☐ Has device and was in use
- ☐ Has device but was not in use

12. Did vision or hearing contribute to fall?
- ☐ Yes
- ☐ No

Explain:

13. Alarm being used at the time of the fall?
- ☐ Yes
- ☐ No

If yes, was it working correctly?

14. Time last toileted or Catheter emptied:
_____ AM /PM

Continence at above time:
- ☐ Wet ☐ Soiled
- ☐ Dry

15. Did fall occur?
- ☐ Next to transfer surface (assess postural hypotension)
- ☐ 10 ' from transfer surface (assess balance)
- ☐ > 15 ' from transfer surface (strength /endurance)

16. Medications given in last 8 hours prior to fall (check all that apply):
- ☐ Anti-anxiety
- ☐ Anticoagulant
- ☐ Antidepressant
- ☐ Antipsychotic
- ☐ Cardiovascular
- ☐ Diuretic
- ☐ Laxative
- ☐ Narcotic
- ☐ Seizure
- ☐ New meds/changed dose within last 30 days

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17. Vital Signs:
    - ☐ Were temperature, pulse, respirations and/or O2 Sat out of normal range for this resident?
        - ☐ Yes
        - ☐ No
    - ☐ Did orthostatic BPs suggest the BP change contributed to the fall?
        - ☐ Yes
        - ☐ No

    Lying _____
    Sitting _____
    Standing _____

18. (Blood Sugar check is required for diabetic resident) Was resident's Blood Sugar significant?
    - ☐ Not applicable
    - ☐ Blood sugar within normal range for resident
    - ☐ Blood sugar out of normal range (describe):

19. Does recent Hgb show evidence of Anemia?
    - ☐ Yes
    - ☐ No

Re-Creation of Last 3 Hours Before Fall

Below, the primary Nursing Assistant who observed and /or assisted the resident during the three hours prior to the fall will write a description to re-create the life of the resident before the fall:

PRINT NAME:

Re-enactment of fall (to be done if Root Cause is NOT determined):

Fall Huddle *(What was different THIS time?)*

ROOT CAUSE OF THIS FALL:

Review of Contributing factors (Check all that apply):

- ☐ Alarm
- ☐ Amount of assistance in effect
- ☐ Assistive/protective device
- ☐ Environmental factors/items out of reach
- ☐ Environmental Noise
- ☐ Footwear
- ☐ Medication
- ☐ Medical status/Physical condition/Diagnoses
- ☐ Mood or mental status
- ☐ Toileting status
- ☐ Vision or hearing
- ☐ Vital signs abnormal or significant
- ☐ Last 3 hours "re-creation" issue/s

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What appears to be the root cause of the fall?	
Describe initial interventions to prevent future falls:	
☐ Care Plan Updated ☐ Nurse Aide Assignment updated	
NURSE COMPLETING FORM:	
Printed Name: _____ Signature:	Date and Time:
Falls Team Meeting Notes:	
Summary of meeting:	
Conclusion:	
Additional Care Plan / Nurse Aide Assignment Updates:	
Signatures with Date and Time:	