Post Fall Checklist –

Have the client give account of fall and reason for falling in their own words.

When did fall occur? Date/day and time/Day or night.

Where did the fall occur?

Activity prior to fall or what were they doing/attempting to do?

Were appropriate fall interventions (fall precautions, using adaptive devices, etc.) in place?

Was the fall observed? If yes, by whom and obtain their account of the fall.

Was the fall assisted? If yes, by whom and obtain their account of the fall.

Was agency staff scheduled to be present?

Injury sustained? Nature of injury and to what body part. Did they go to urgent care, ER, or do they need treatment or further evaluation?

Additional falls/fall history reviewed.

Any recent changes with client? (Med changes, change in living situation, following usual medication regimen, symptoms of illness, hospitalization, etc.)

RN identified cause of fall.

New intervention implemented to avoid additional falls. Discuss intervention with client and HHA.

Add intervention to service plan and POC Goal.

RN Comprehensive Asessment completed at follow up.

Medication reconciled.

Home Observation Form completed, if follow up was in the home.

Contact MD.

Fill out Incident Report and place information on appropriate QAPI logs

Ensure documentation is in medical record.

This list is created to assist in choosing fall interventions. It is by no means an all-inclusive list and interventions should be applied based on an individual's needs and capabilities.

Complete fall root cause analysis to identify cause. *Include the client, the caregiver, the family in your investigation!

1. Complete pain assessment
2. Obtain eye exam. Glasses appropriate for walking (multifocal glasses contribute to falls)
3. Proper seating if in wheelchair – feet flat on the floor, lowering the back of the seat, etc.
4. Ensure proper footwear
5. Helmets if applicable
6. Exercise program – improve balance, plus tires them (satisfies need to walk), gait training
7. Assess staffing – increase hours? Adjust schedule to evenings, etc.
8. Environment friendly – no clutter, keep objects in same place, remove throw rugs, add grab bars, etc. Non-skid floor mats/strips, Skid resistant strips in showers/tubs. Skid resistant strips on steps, handrails for steps
9. Assess medications for side effects and interactions
10. Assess for postural hypotension, Assess for syncope
11. Evaluation of BP, blood sugar
12. Assess for foot problems and proper footwear
13. Educate client and family regarding risks for falls
14. Staff education regarding falls and interventions applied. Educate client when applying intervention. <u>*Add to your client's service plan and goal intervention</u>
15. Toileting program: scheduled, cueing
16. Use of pictures to provide cues to where something is (bathroom – pic of toilet, etc.)
17. Keep most used items within reach
18. Raised toilet seat
19. Lower bed height
20. Instruct client to change positions slowly. Count to 10 after standing but before walking
21. Night light in bedroom, kitchen, bathroom, hallway
22. Keep furniture and other items in same position
23. Ensure assistive device is used appropriately
24. Assess continence. Do not take diuretics after lunch if possible
25. Proper clothing to prevent tripping and ease of toileting
26. Keep bed, wheelchair, walker, rollator, etc. locked
27. Assess for change in behavior, illness (symptoms of infection)
28. Maintain daily routine
29. Use bath seat
30. Non-skid material on all steps
31. MD to assess
32. Use of telephone to signal 911 or family.
33. PERS button. Obtain if needed or educate to keep on themselves always
34. Bedtime snack
35. PT/OT evaluation or skilled agency referral