II. Resident Fall and Injury Assessment - Data Retrieval Worksheet

Date: _____ Nurse Completing Audit: _____

Unit: _____ Shift Completed: _____

Falls can be a symptom of other disease processes and should be seriously considered with any resident assessment. The definition of a fall according to the MDS 3.0 has not changed but has been reworded and clarified. The following definition can be found in section J 1400 of the 3.0 RAI manual: *"Fall - An unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g. onto a bed, chair or bedside mat). The fall may be witnessed, reported by a resident or an observer, or identified when the resident is found on the ground. Falls include any fall whether it occurred at home, out in the community, in an acute hospital, or in a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him or herself, or had not been intercepted by another person—this is still considered a fall."* Center for Medicare and Medicaid Services, January 2010, Resident Assessment Instrument Manual, 3.0.

In the event of a fall, an assessment should be completed that consists of the following components: Physical Assessment both immediate and ongoing, history of falls and risk factors (see fall risk and prediction data retrieval worksheet), circumstances surrounding falls, premonitory or associated symptoms, medication history, and environmental issues contributing to the fall. It is important to remember that a fall may be an atypical presentation or symptom of an acute or worsening chronic disease process.

Observation=O, Record Review=RR, Interview=I, Assessment=A (In most appropriate order)

Type of Data Retrieval	Monitoring Criteria	Yes/No	N/A	Incomplete	Comments
I. Immediate Post fall Assessment					
A, O, RR	1. Physical assessment: In the event of a resident fall a swift and thorough physical assessment is completed with special care taken to assess for injury and prevent further injury. The following is included: a. Vital signs, especially orthostatic BPs and pulse abnormalities, increased temp b. Potential injuries assessed 1. Fractures				

	2. Head injuries 3. Bruising 4. Skin tears 5. Abrasions 6. Evidence of joint deformity, rotation 7. Change in normal ROM, weight bearing, proprioception, etc c. Neurological status 1. Any change in cognition, level of consciousness, mental status, personality 2. Changes in visual acuity 3. Evidence of localized weakness, poor coordination, impaired balance, abnormal gait 4. Pain assessment, may need to use observable assessment if resident is not able to verbalize pain d. If diabetic, finger stick for glucose level e. Premonitory symptoms f. What resident remembers about fall g. Physician/family notified according to injury and facility policy				
II. Continued Post fall Assessment					
O, A, RR	1. Follow up of immediate post fall physical assessment includes: a. Vigilance for undetected injury or complications, i.e. subdural hematoma, fractures, cellulitis, new bruising, swelling, inflammation, etc b. Functional status changes, decreasing mobility, increasing/new pain, etc c. Neurological status checks done according to facility policy d. Neurological changes including drowsiness, lethargy, increasing confusion, change in safety awareness, increasing weakness d. Psychological factors				

	including increased nervousness, agitation, fear e. Medication recent additions/changes f. New /change in risk factors/level identified g. Associated environmental hazards identified and corrected h. Reasons for fall identified if possible				
RR, O	2. Underlying conditions that may contribute to falls are assessed and addressed (see CAA. 11 3.0 RAI Manual) Some examples are: a. Cardiovascular disease b. Dysrythmias c. Neurovascular disease d. CVA, TIA e. Depression f. Diabetes g. Arthritis h. Foot disorders i. Infections j. Involuntary movement disorders s/a Parkinson's k. Acute illness l. Orthostatic hypotension m. Osteoporosis n. History of fractures o. Dehydration p. General weakness q. Pain				
RR	3. Classes of medications that alone or in combination may contribute to falls or injury are assessed (See CAA 11. Some examples are: a. Antiarrythmics b. Antipsychotics c. Anti-hypertensives d. Antidepressants e. Opioid analgesics f. Anti-parkinsonian meds g. Anti-coagulants h. Diuretics i. Vasodilators j. Anticholinergics k. Benzodiazepines l. Antiepileptics				

A, O	4. Functional status is assessed a. Are there changes from previous physical functioning? b. Is resident able to perform get up & go test? c. Has gait or need for assistance changed?				
O	5. Contributing environmental factors are assessed. Some examples: a. Excessive bed height b. Inadequate/broken assistive devices c. Inadequate lighting or glare d. Poor seating or positioning while seated e. Use of restraints or side rails f. Clutter and unclear pathways g. Use of chair alarms h. Absent or poorly placed grab bars in bathroom i. Uneven flooring j. Ill fitting or improper footwear k. New/unfamiliar environment l. Wet/slippery floors m. Floor glare n. Loose flooring o. Poorly fit/incorrect/ dirty glasses p. Malfunctioning call systems q. Lack of meaningful activity for resident r. Staff disregarding resident physical or psychosocial needs				
III. Fall Investigation					
O, RR	1. Correct definition of a fall is used, and all falls, near falls, and interrupted falls are investigated 2. Resident history of falls, fall risk factors, investigation of falls are complete and up to date 3. Circumstances of each fall are investigated and documented (See CAA 11. 3.0 RAI manual) 4. Falls are tracked and trended by resident, neighborhood, shift,				

	and overall 5. All information reviewed by interdisciplinary team 6. Trended fall information is shared with direct care staff 7. Information is used to develop care plan for the individual 8. Any environmental factors contributing to the fall been corrected				
IV. Intervention/Care Planning					
RR, O, A	1. All documentation of falls, assessment and follow-up is present and complete according to facility policy 2. All assessment and related information is reviewed by interdisciplinary team and used for individualized care planning 3. All staff are informed of and have access to the resident's fall care plan and understand their interventional roles 4. Efficacy of fall plans are evaluated by all participating staff ongoing and changed according to resident response, progress and need				

American Medical Directors Association. 2003. *Falls and Fall Risk: Clinical Practice Guidelines*.

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