

MHCA Fall Prevention Mentorship Program: Post-Fall Evaluation

Fall: A fall is defined as “an unintentional change in position resulting in coming to rest on the ground or at a lower level” (Definition from HHQI Best Practice Intervention Package - Fall Prevention)

Patient: _____ Date of Birth: _____ Clinician: _____

Disciplines involved: SN PT OT ST MSS HHA Volunteer

Date of Fall: _____ Time: _____ Does patient live alone: No Yes

Fall was: Observed by staff Not observed, but reported by: _____

Did fall result in injury? No Yes, injury: _____

Did client experience previous fall in the last 3 months? No Yes

Did fall result in emergent care/hospitalization? No Yes

Does patient use any assistive device(s)? No Yes, type: _____

Was assistive device being used at time of fall? No Yes N/A

Was therapy involved prior to fall? No Yes, type: _____

Location of Fall:	Recent Changes in Pt's Health Status
<input type="checkbox"/> Bedroom	<input type="checkbox"/> Changes in blood pressure
<input type="checkbox"/> Bathroom	<input type="checkbox"/> Increased weakness
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Changes in mental status
<input type="checkbox"/> Living Room	<input type="checkbox"/> Changes in mobility status
<input type="checkbox"/> Stairway	Recent Changes to the following Medications:
<input type="checkbox"/> Other (list):	<input type="checkbox"/> Anti-depressant medication
Contributing Factors:	<input type="checkbox"/> Anti-anxiety medication
<input type="checkbox"/> Liquid spill	<input type="checkbox"/> Pain medication
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Hypoglycemic
<input type="checkbox"/> Patient in a hurry	<input type="checkbox"/> Anticonvulsive
<input type="checkbox"/> Incontinence may have played a role	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Tripped over item (ex: O2 tubing, phone cord, pet)	<input type="checkbox"/> Diuretic or Blood Pressure medication
<input type="checkbox"/> Pt not using assistive device as instructed	Notifications:
<input type="checkbox"/> Clothing got in the way	Physician notified: <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Reaching for item	Team members notified: <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Poor lighting	
<input type="checkbox"/> Improper bed height	
<input type="checkbox"/> Other (list):	Date/Time: _____

Narrative description of fall:

