

On-Time Falls Prevention: Overview Materials Packet

Samples of four types of reports are provided here:

- On-Time Falls High-Risk Report.
- Quarterly Summary of Falls Risk Factors by Unit or Facility.
- Monthly Contextual Factors Report.
- Postfall Assessment Summary Report.

On-Time Falls High-Risk Report

Sample Falls High-Risk Report

Unit: _____

Date: ___/___/___

Resident		Within 90 Days						Within 7 Days										ADL Decline and Other Clinical Information																
Name	Room	High-Risk Existing Conditions						High-Risk Change in Condition										New Contributing Risk Factors			ADL Decline and Other Clinical Information													
		Mental: Unsafe Behaviors	Mental: Cognitive Impairment	Gait and Balance Instability	Fall: 8-30 Days	Fall: 31-180 Days	Psychoactive Medications	Other High-Risk Medications	Acute Mental Status Change	Behavior: New Unsafe	New Gait/Balance or Device Order	New Fall	Med: New Med or Dose Change	Orthostatic Hypotension/Dehydration	Vertigo/Dizziness	Syncope/Fainting	Hypoglycemia	Possible Infection	New Seizure Activity	New Admission	Pain: New or Uncontrolled Chronic	Urinary Incont: New or Increased	Mobility: More Independent	Room Change	Bed Mobility	Transfer	Toileting	Depression Score Increase	Monthly BMI <18.5 kg/m ²	Significant Weight Change	Vitamin D Order	Osteoporosis	Diabetes	Visual Impairment
Resident A	122	X			X		X						X					X		X								25*			X			
Resident B	114				X	X								X				X				X											X	
Resident C	103	X	X						X			X									X						21							
Resident D	142			X															X											X				X
Resident E	112						X												X															
Resident F	133	X		X																			X						X					X
Total		3	1	2	2	1	1	1	1			1	1	1			2		3		1	1	1				2	1	2	1	1	1	2	2

ADL = Activities of Daily Living.

Quarterly Summary of Falls Risk Factors by Unit or Facility

Sample Quarterly Summary of Falls Risk Factors by Unit

On-Time Quarterly Summary of Falls Risk Factors by Unit

Nursing Unit: _____

Date: ___/___/___

	High-Risk Existing Conditions								High-Risk Change in Condition								New Contributing Risk Factor				Additional Info Within 30 Days								Injury		Totals							
	Mental: Unsafe Behaviors	Mental: Cognitive Impairment	Gait and Balance Instability	Fall: 8-30 Days	Fall: 31-180 Days	Psychoactive Medications	Other High-Risk Medications	Acute Mental Status Change	Behavior: New Unsafe	New Gait/Balance or Device Order	New Fall	Med: New Med or Dose Change	Orthostatic Hypotension/Dehydration	Vertigo/Dizziness	Syncope/Fainting	Hypoglycemia	Possible Infection	New Seizure Activity	New Admission	Pain: New or Uncontrolled chronic	Urinary Incontinence: New or Increase	Mobility: More Independent	Room Change	Bed Mobility	Transfer	Toileting	Depression Score	Monthly BMI <18.5 kg/m ²	Significant Wt Change	Vitamin D Order	Osteoporosis	Diabetes	Visual Impairment	Fall With Major Injury	Fall With Minor Injury	Total Residents Who Fell	Total Residents With >1 Fall	Total Falls
Apr-11																																						
# falls	7	9	8	4	6	7	4	1	0	0	4	2	8	2	2	0	1	0	3	1	3	2	6	0	2	3	2	3	2	1	1	6	8	3	13	11	3	16
% (of monthly total falls)	44	56	50	25	38	44	25	6	0	0	25	13	50	13	13	0	6	0	19	6	19	13	38	0	13	19	13	19	13	6	6	38	50	19	81			
May-11																																						
# falls	5	5	6	4	5	5	4	1	0	0	5	2	4	0	2	0	2	0	1	1	3	0	3	0	2	2	3	3	1	1	1	6	4	2	9	10	1	11
% (of monthly total falls)	45	45	55	36	45	45	36	9	0	0	45	18	36	0	18	0	18	0	9	9	27	0	27	0	18	18	27	27	9	9	9	55	36	18	82			
Jun-11																																						
# falls	5	7	7	2	0	6	6	1	0	0	3	0	5	2	2	0	1	0	1	1	1	2	3	0	2	4	2	0	0	2	1	6	4	1	13	9	3	14
% (of monthly total falls)	36	50	50	14	0	43	43	7	0	0	21	0	36	14	14	0	7	0	7	7	7	14	21	0	14	29	14	0	0	14	7	43	29	7	93			
Unit Quarterly TOTALS																																						
# falls	17	21	21	10	11	18	14	3	0	0	12	4	17	4	6	0	4	0	5	3	7	4	12	0	6	9	7	6	3	4	3	18	16	6	35	30	7	41
% (of quarterly total falls)	41	51	51	24	27	44	34	7	0	0	29	10	41	10	15	0	10	0	12	7	17	10	29	0	15	22	17	15	7	10	7	44	39	15	85			

Sample Quarterly Summary of Falls Risk Factors by Facility

On-Time Facility-Level Quarterly Summary of Falls Risk Factors

Date: ___/___/___

	High-Risk Existing Conditions							High-Risk Change in Condition									New Contributing Risk Factor				Additional Info Within 30 Days							Injury		Totals								
	Mental: Unsafe Behaviors	Mental: Cognitive Impairment	Gait and Balance Instability	Fall: 8-30 Days	Fall: 31-180 Days	Psychoactive Medications	Other High-Risk Medications	Acute Mental Status Change	Behavior: New Unsafe	New Gait/Balance or Device Order	New Fall	Med: New Med or Dose Change	Orthostatic Hypotension/Dehydration	Vertigo/Dizziness	Syncope/Fainting	Hypoglycemia	Possible Infection	New Seizure Activity	New Admission	Pain: New or Uncontrolled Chronic	Urinary Incontinence: New or Increase	Mobility: More Independent	Room Change	Bed Mobility	Transfer	Toileting	Depression Score (0-27)	Monthly BMI <18.5 kg/m2	Significant Wt Change	Vitamin D Order	Osteoporosis	Diabetes	Visual Impairment	Fall With Major Injury	Fall With Minor Injury	Total Residents Who Fell	Total Residents With >1 Fall	Total Falls
Unit A																																						
# falls	17	21	21	10	11	18	14	3	0	0	15	4	17	4	6	0	4	0	5	3	7	4	12	0	3	0	7	10	1	4	3	18	16	6	35	30	7	41
% (of Q total falls)	41	51	51	24	27	44	34	7	0	0	37	10	41	10	15	0	10	0	12	7	17	10	29	0	7	0	17	24	2	10	7	39	39	15	85			
Unit B																																						
# falls	9	9	6	3	12	12	5	1	4	6	20	2	11	0	2	9	2	1	1	1	3	0	3	0	7	7	3	3	1	3	1	13	4	2	35	31	4	37
% (of Q total falls)	24	24	16	8	32	32	14	3	11	16	54	5	30	0	5	24	5	3	3	3	8	0	8	0	19	19	8	8	3	8	3	35	11	5	95			
Unit C																																						
# falls	5	7	7	2	0	6	6	1	0	0	14	0	14	2	2	9	1	0	1	1	1	2	3	0	2	4	2	0	0	11	1	6	4	1	26	22	3	27
% (of Q total falls)	19	26	26	7	0	22	22	4	0	0	52	0	52	7	7	33	4	0	4	4	4	7	11	0	7	15	7	0	0	41	4	22	15	4	96			
# falls	31	37	34	15	23	36	25	5	4	6	49	6	42	6	10	18	7	1	7	5	11	6	18	0	12	11	12	13	2	18	5	37	24	9	96	83	14	105
% (of Q total falls)	30	35	32	14	22	34	24	5	4	6	47	6	40	6	10	17	7	1	7	5	10	6	17	0	11	10	11	12	2	17	5	35	23	9	91			

Monthly Contextual Factors Report

Sample Monthly Contextual Factors Report by Facility

Monthly Contextual Factors Report

Date: ___/___/___

	Day of Week							Shift			Time of Day								Location								Other	Fall totals								
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Days	Evenings	Nights	7 a.m. - 9:59 a.m.	10 a.m. - 11:59 a.m.	12p.m. to 1:29 p.m.	1:30 p.m. to 2:59 p.m.	3p.m. - 4:59 p.m.	5p.m. - 7:59 p.m.	8p.m.-10:59 p.m.	11p.m.- 12:59p.m.	1 a.m.- 4:59 a.m.	5 a.m. - 6:59 a.m.	In room	Bathroom	Hallway	Dining Room	Activities	Therapy	Beauty/Barber	Shower/Tub	Nursing Station	Out of Facility	Other	Room Change Within 30 Days of Fall Date	Total Residents Who Fell	Total Residents With >1 Fall	Total Falls	
Unit A																																				
# falls	0	0	2	0	0	1	1	1	2	1	0	0	0	1	1	1	0	0	1	0	1	1	0	0	0	0	0	0	2	0	0	0	3	3	1	4
% (of total falls)	0	0	50	0	0	25	25	25	50	25	0	0	0	25	25	25	0	0	25	0	25	25	0	0	0	0	0	50	0	0	0	75				
Unit B																																				
# falls	1	2	1	1	2	1	0	2	3	3	2	0	0	0	1	1	1	1	1	1	3	2	1	0	0	0	0	2	0	0	0	5	6	2	8	
% (of total falls)	13	25	13	13	25	13	0	25	38	38	25	0	0	0	13	13	13	13	13	13	38	25	13	0	0	0	0	25	0	0	0	63				
Unit C																																				
# falls	0	0	1	1	1	0	0	1	2	0	0	0	3	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	3	0	3	
% (of total falls)	0	0	33	33	33	0	0	33	67	0	0	0	100	0	0	0	0	0	0	0	0	0	0	33	33	33	0	0	0	0	0	0				
FACILITY TOTALS																																				
# falls	1	2	4	2	3	2	1	4	5	5	2	0	3	1	2	2	1	1	2	0	4	3	1	1	1	1	0	4	0	0	0	8	12	3	15	
% (of total falls)	7	13	27	13	20	13	7	27	33	33	13	13	20	7	13	13	7	7	13	0	27	20	7	7	7	7	0	27	0	0	0	53				

Note: Percentages may not add to 100 due to rounding.

Postfall Assessment Summary Report

Sample Postfall Assessment Summary Report

Resident Name: _____

		Date of Fall					
Fall Date	Date	10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
Fall Day	Day of week	Saturday	Thursday	Tuesday	Thursday	Thursday	Thursday
Fall Time	Time or "not known"	6:35 a.m.	5:35 a.m.	7:15 a.m.	6:50 a.m.	6:10 a.m.	5:15 a.m.
Shift	Shift	N	N	D	E	N	N
Fall Witnessed?	Yes/no	N	N	Y	Y	N	N
If yes, who witnessed?	Staff, family, visitor, volunteer, other	Staff	Staff	Family	Staff	Staff	Family
	Name of person who witnessed the fall	text	text	text	text	text	text
If no, who found the resident?	Staff, family, visitor, volunteer, other	Staff	Staff	Family	Staff	Staff	Family
	Name of person who found the resident	text	text	text	text	text	text
Fall Location	Fall location: room; bathroom; hallway; dining room; activities; therapy; beauty parlor; shower/tub; nursing stations; out of facility; other	Bathroom	Bathroom	Room	Room	Bathroom	Bathroom
Resident Position When Found	Position when found; supine, lying left, lying right, sitting, other	Supine	Sitting	Lying right	Supine	Sitting	Sitting
Resident Activity at Time of Fall	Activity prior to fall: walking; transferring; toileting; in bed; in chair; other	Toileting	Toileting	Walking	Walking	Toileting	Toileting
Potential Causes of Fall	Unknown						
	Behavior – agitation/other						
	Loss of balance (reaching, turning, sudden movement, other)						
	Gait/balance instability			X	X		
	Bowel/bladder: trying to get to bathroom on own	X	X	X	X	X	X
	Personal device or equipment or attached appliance (cane, walker, crutch, O ₂) – improper use			X	X		
	Equipment failure, bed, chair, floor mat alarms						
	Potential medication issue: new med/dose change/suspected reaction						
	Resident chooses not to follow recommendations: alert and oriented						
	Resident unable to follow recommendations: cognitively impaired						
	Other, please describe						
Fall Comments	Free text						

Fall Injury?	Yes/no	N	N	Y	Y	Y	N
If yes, what type of injury?							
Injury Type: Major	Fracture: hip				X		
	Fracture: other						
	Joint dislocation						
	Closed head injury with altered consciousness						
	Subdural hematoma						
Injury Type: Minor	Skin tear	X					
	Abrasion			X			
	Laceration					X	
	Superficial bruises, hematomas			X		X	
	Sprain						
	Other injury that causes pain						
Injury Site	Head	LE	LE	LE	LE	LE	UE
	Upper extremity (UE)						
	Lower extremity (LE)						
Injury Assessment	ROM upper: full/decreased	Full	Full	Full	Full	Full	Decr
	ROM lower: full/decreased	Decr	Decr	Decr	Decr	Decr	Full
	Loss of consciousness: yes or no	No	No	No	No	No	Yes
	Neuro status: usual or not usual (changes noted)	Usual	Usual	Usual	Usual	Usual	Not usual
	Bleeding: none, minor, significant	None	None	None	None	None	None
	Other						
	Free text						
Where Resident Was Treated	Facility, ER, hospital admit	Facility	Facility	ER	ER	Facility	Facility
PCP Notified?	Yes/no	Y	Y	Y	Y	Y	Y
MD Notified	Physician name	Brewer	Brewer	Cannon	Jackson	Brewer	Brewer
PCP Notification Date	Date	10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
PCP Notification Time	Time	7:00 a.m.	7:00 a.m.	8:00 a.m.	7:00 a.m.	7:00 a.m.	6:30 a.m.
Family Notified?	Yes/no	Y	Y	Y	Y	Y	Y
Family Notified	Family name/relationship	Daughter	Daughter	Son	Son	Son	Son
Family Notification Date	Date	10/4/13	1/16/14	2/11/14	2/27/14	3/6/14	4/17/14
Family Notification Time	Time	8:00 a.m.	8:00 a.m.	8:30 a.m.	7:30 a.m.	8:00 a.m.	8:00 a.m.
PCP Exam Performed?	Yes/no	Y	Y	Y	N	Y	Y
PCP Exam Date	Date	10/6/14	1/17/14	2/12/14		3/6/14	4/17/14
PCP Exam Time	Time	8:00 a.m.	8:00 a.m.	8:30 a.m.		8:00 a.m.	8:00 a.m.
PT Notified?	Yes/no	Y	Y	Y	N	Y	Y
PT Consult	Date	10/4/13	1/16/14	2/11/14		3/6/14	4/17/14