Patient Safety Event Report - Hospital:

FALL

Use this form to report details of a fall. For purposes of patient safety, a fall is a sudden, unintended, uncontrolled, downward displacement of a patient's body to the ground or other object (e.g., onto a bed, chair, or bedside mat). This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person). This definition excludes near falls (loss of balance that does not result in a fall) and falls resulting from a purposeful action or violent blow (e.g., a patient pushes another patient). Narrative detail can be captured on the Healthcare Event Reporting Form (HERF). Highlighted fields are collected for local facility and PSO use. This information will not be forwarded to the Network of Patient Safety Databases (NPSD).

1. Was the fall unassisted or assisted? CHECK ONE:

a. ☐ Unassisted
b. ☐ Assisted
c. ☐ Unknown

2. Was the fall observed? CHECK ONE:

a. ☐ Yes
b. ☐ No
c. ☐ Unknown

3. Who observed the fall? CHECK FIRST APPLICABLE:

a. ☐ Staff
b. ☐ Visitor, family, or another patient, but not staff

4. Did the patient sustain a physical injury as a result of the fall? CHECK ONE:

a. ☐ Yes
b. ☐ No
c. ☐ Unknown

5. What type of injury was sustained? CHECK ONE; IF MORE THAN ONE, CHECK MOST SEVERE:

a. ☐ Dislocation
b. ☐ Fracture
c. ☐ Intracranial injury
d. ☐ Laceration requiring sutures
e. ☐ Skin tear, avulsion, hematoma or significant bruising
f. ☐ Other: **PLEASE SPECIFY**
____

6. Prior to the fall, what was the patient doing or trying to do? CHECK ONE:

a. ☐ Ambulating without assistance and without an assistive device or medical equipment
b. ☐ Ambulating with assistance and/or with an assistive device or medical equipment
c. ☐ Changing position (e.g., in bed, chair)
d. ☐ Dressing or undressing
e. ☐ Navigating bedrails
f. ☐ Reaching for an item
g. ☐ Showering or bathing
h. ☐ Toileting
i. ☐ Transferring to or from bed, chair, wheelchair, etc.
j. ☐ Undergoing a diagnostic or therapeutic procedure
k. ☐ Unknown
l. ☐ Other: **PLEASE SPECIFY** ____________________

7. Prior to the fall, was a fall risk assessment documented? CHECK ONE:

a. ☐ Yes →
b. ☐ No
c. ☐ Unknown

8. Was the patient determined to be at increased risk for a fall? CHECK ONE:

a. ☐ Yes
b. ☐ No
c. ☐ Unknown

9. At the time of the fall, were any of the following risk factors present? CHECK ALL THAT APPLY:

a. ☐ History of previous fall
b. ☐ Prosthesis or specialty/prescription shoe
c. ☐ Sensory impairment (vision, hearing, balance, etc.)
d. ☐ None
e. ☐ Unknown
f. ☐ Other: **PLEASE SPECIFY** ______________________

10. Which of the following were in place and being used to prevent falls for this patient? CHECK ALL THAT APPLY:

a. ☐ Assistive device (e.g., wheelchair, commode, cane, crutches, scooter, walker)
b. ☐ Bed or chair alarm
c. ☐ Bed in low position
d. ☐ Call light/personal items within reach
e. ☐ Change in medication (e.g., timing or dosing of current medication)
f. ☐ Non-slip floor mats
g. ☐ Hip and/or joint protectors
h. ☐ Non-slip footwear
i. ☐ Patient and family education
j. ☐ Patient sitting close to the nurses' station
k. ☐ Physical/occupational therapy, includes exercise or mobility program
l. ☐ Sitter
m. ☐ Supplemental environmental or area lighting (when usual facility lighting is considered insufficient)
n. ☐ Toileting regimen
o. ☐ Visible identification of patient as being at risk for fall (e.g., Falling Star)
p. ☐ None
q. ☐ Unknown
r. ☐ Other: **PLEASE SPECIFY** ______________________

11. At time of the fall, was the patient on medication known to increase the risk of fall? CHECK ONE:

a. ☐ Yes →
b. ☐ No
c. ☐ Unknown

12. Was the medication considered to have contributed to the fall? CHECK ONE:

a. ☐ Yes
b. ☐ No
c. ☐ Unknown

13. Did restraints, bedrails, or other physical device contribute to the fall (includes tripping over device electrical power cords)? CHECK ONE:

a. ☐ Yes
b. ☐ No
c. ☐ Unknown

Thank you for completing these questions.

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Public reporting burden for the collection of information is estimated to average 10 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer, Attention: PRA, Paperwork Reduction Project (0935-0143), AHRQ, 540 Gaither Road, Room #5036, Rockville, MD 20850.