Post Fall Assessment

Fall Occurs

Immediately Ensure Resident is Safe, Assess and Treat for Injury

- Complete the physical assessment
- Put any preliminary preventative steps into place
- Complete the Scott Fall Risk **Screening Tool** (within 24 hours)
- Complete the Post-Fall Huddle Tool
- Update the Care Plan in collaboration with the resident, family, and interprofessional team

All tools can be accessed via **Risk Management**





Contributing Factors

Environmental Factors

- Clutter
- Carpet
- Poor lighting
- Equipment
- Crowding
- Wet floor
- Noise
- Furniture

Physiological Factors

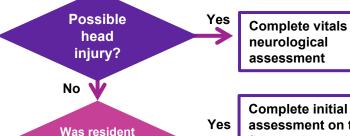
- Confused
- Incontinent
- Sedated
- Change in condition
- UTI
- Hypotension
- Gait imbalance
- Impaired memory
- Change in medication
- Weakness

Situational Factors

- Alcohol use
- Admitted within 72 hrs
- Transfer
- Ambulating without assisting
- Exit seeking
- Recent room change
- Footwear
- Restrained
- Resistive to care
- Side rails up
- Mobility device
- Previous falls

Registered Staff





Complete vitals and neurological assessment

assessment on the floor and complete assessment after the resident has been lifted and returned to chair or bed

Complete Post-Fall Clinical Assessment

No 🐧

found on the

floor?

- Head
- Scalp
- PERRLA (pupils, equal, round, react to light, accommodate)
- Chest (Breath Sounds, Symmetry)
- **Abdominal Auscultation** (Inspection, Auscultation, LUQ, RUQ, LLQ, RLQ)
- ROM (Upper R, Upper L, Lower R, Lower L)
- Strength (Upper R, Upper L, Lower R, Lower L)
- Skin (Tears, Abrasions, Bruises)
- Vital Signs
- Complete Pain Assessment

Monitoring of Residents

- · Were comfort care rounds completed?
- Is there a toileting routine and is it followed
- Was the call bell in reach?
- Was the resident wearing their glasses and were the clean?
- Was the resident wearing their hearing aid and do the batteries work?
- What was the last Scott Fall Risk Screen Score?
- Were the appropriate interventions in place.

Why did the resident fall?

Hosting a Huddle

Contributing Factors



Gather any **members of** the team (PT, OT, PSW, Rec, Housekeeping, MD) who are available including resident (when appropriate) and families

- Identify contributing factors
- Were falls prevention interventions in place?
- Was the Care Plan appropriate and followed?

Complete the 5 Whys what contributed to the fall?

Ask "what can we do to keep similar events from happening?" Implement new interventions.

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Example – The 5 Ways

A question asking method used to uncover the underlying cause of an event.

Uncovering the root cause leads to more successful actions.

Resident Fell in Room

Why? ψ

She tripped over a chair

Why? ψ

She didn't see the chair

Why? ψ

The room was dark (no nightlight

Why?



Nightlight was not part of the care plan

Why?

Resident was not a high risk for falls

Action:

Remove or move the chair

Action:

Put nightlights in rooms

Action:

Review the new risk and interventions