FSI -- Fall Scene Investigation Report

**Facility Name:**

**Resident Name:** __________________________  **Med. Rec. #** _________  **Room #** _______

**Date of Fall** ________________  **Time of Fall:** __________ AM / PM  **Admit Date:** ______________

Staff / Witness present at / or finding resident after fall: ____________________________________________

### FALL DESCRIPTION DETAILS:

1. Factors observed at time of fall:
   - [ ] Resident lost their balance
   - [ ] Resident slipped (give details):
     - [ ] Lost strength/appeared to get weak
     - [ ] Wheelchair / bed brakes unlocked
     - [ ] Bed height not appropriate
     - [ ] Equipment malfunction (specify):
     - Environmental noise
     - Environmental factors (circle or write in): clutter, furniture, item out of reach, lighting, wet floor, other (specify)

2. Draw a picture of area and position in which resident was found. (e.g. face down, on back / R or L side, position of arms and legs, furniture / equipment / devices nearby)

*If fall within 5 feet of transfer surface do orthostatic BP

3. Fall Summary:
   - [ ] Found on the floor (unwitnessed)
   - [ ] Fall to the floor (witnessed)
   - [ ] Intercepted fall (resident lowered to floor)
   - [ ] Self-reported fall

4. Fall Location
   - [ ] Resident room
   - [ ] Activity Room
   - [ ] Hallway
   - [ ] Dining room/day room
   - [ ] Bathroom [CHECK TOILET CONTENTS]
     - [ ] Toilet contains urine /feces
   - [ ] Shower/tub room
   - [ ] Outside building on premises / off premises
   - [ ] Other (specify):

5. What was resident doing during or just prior to fall?
   - [ ] Ambulating
   - [ ] Attempting self-transfer
   - [ ] Transfer assisted by staff
   - [ ] Reaching for something
   - [ ] Slide out / fall from wheelchair
   - [ ] Rolling/sliding out of bed
   - [ ] Sitting on shower/toilet chair
   - [ ] Other (specify):

6. What type of assistance was resident receiving at time of fall?
   - [ ] Assisted per care plan:
   - [ ] Alone and unattended
   - [ ] Assisted with more help than care plan describes
7. What did the resident say they were trying to do just before they fell?

**CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:**

<table>
<thead>
<tr>
<th>8. Describe resident’s mental status prior to fall:</th>
<th>9. Describe resident’s psychological status prior to fall:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does this compare to the resident’s usual mental status?</td>
<td>How does this compare to the resident’s usual psychological status?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Footwear at time of fall:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Shoes</td>
</tr>
<tr>
<td>□ Bare feet</td>
</tr>
<tr>
<td>□ Gripper Socks</td>
</tr>
<tr>
<td>□ Slippers</td>
</tr>
<tr>
<td>□ Socks</td>
</tr>
<tr>
<td>□ Off load boots</td>
</tr>
<tr>
<td>□ Amputee</td>
</tr>
</tbody>
</table>

11. Gait Assist devices at time of fall:

- □ None
- □ Has device and was in use
- □ Has device but was not in use

12. Did vision or hearing contribute to fall?

- □ Yes
- □ No

Explain:

13. Alarm being used at the time of the fall?

- □ Yes
- □ No

If yes, was it working correctly?

14. Time last toileted or Catheter emptied:

- _________ AM / PM

Continence at above time:

- □ Wet
- □ Soiled
- □ Dry

15. Did fall occur?

- □ Next to transfer surface (assess postural hypotension)
- □ 10 ‘ from transfer surface (assess balance)
- □ > 15 ‘ from transfer surface (strength/ endurance)

16. Medications given in last 8 hours prior to fall (check all that apply):

- □ Anti-anxiety
- □ Anticoagulant
- □ Antidepressant
- □ Antipsychotic
- □ Cardiovascular
- □ Diuretic
- □ Laxative
- □ Narcotic
- □ Seizure
- □ New meds/changed dose within last 30 days
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<tr>
<td>Resident Name:</td>
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<td></td>
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</table>

### Vital Signs:

- **17.** Were temperature, pulse, respirations and/or O2 Sat out of normal range for this resident?
  - [ ] Yes
  - [ ] No

- **17.** Did orthostatic BPs suggest the BP change contributed to the fall?
  - [ ] Yes
  - [ ] No

- **17.** Lying
  - [ ] Yes
  - [ ] No

- **17.** Sitting
  - [ ] Yes
  - [ ] No

- **17.** Standing
  - [ ] Yes
  - [ ] No

### Blood Sugar

- **18.** (Blood Sugar check is required for diabetic resident) Was resident’s Blood Sugar significant?
  - [ ] Not applicable
  - [ ] Blood sugar within normal range for resident
  - [ ] Blood sugar out of normal range (describe):

### Recent Hgb

- **19.** Does recent Hgb show evidence of Anemia?
  - [ ] Yes
  - [ ] No

### Re-Creation of Last 3 Hours Before Fall

Below, the primary Nursing Assistant who observed and/or assisted the resident during the three hours prior to the fall will write a description to re-create the life of the resident before the fall:

### PRINT NAME:

**Re-enactment of fall** (to be done if Root Cause is NOT determined):

### Fall Huddle *(What was different THIS time?)*

### ROOT CAUSE OF THIS FALL:

Review of Contributing factors (Check all that apply):

- [ ] Alarm
- [ ] Amount of assistance in effect
- [ ] Assistive/protective device
- [ ] Environmental factors/items out of reach
- [ ] Environmental Noise
- [ ] Footwear
- [ ] Medication
- [ ] Medical status/Physical condition/Diagnoses
- [ ] Mood or mental status
- [ ] Toileting status
- [ ] Vision or hearing
- [ ] Vital signs abnormal or significant
- [ ] Last 3 hours “re-creation” issue/s
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Resident Name: ______________________________ Med. Rec. #: __________ Room #: ________

What appears to be the root cause of the fall?

<table>
<thead>
<tr>
<th>Describe initial interventions to prevent future falls:</th>
</tr>
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☐ Care Plan Updated ☐ Nurse Aide Assignment updated

NURSE COMPLETING FORM:

| Printed Name: ______________________________ | Date and Time: |
|--------------------------------------------------------|

<table>
<thead>
<tr>
<th>Signature:</th>
</tr>
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Falls Team Meeting Notes:

<table>
<thead>
<tr>
<th>Summary of meeting:</th>
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</table>

Conclusion:

Additional Care Plan / Nurse Aide Assignment Updates:

Signatures with Date and Time: