

ACCIDENT OR INCIDENT REPORT

(Report all accidents or incidents even if no apparent injury)

Last Name	First Name	Middle Name	Room No.	Bed No	Admission No,
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Date of accident or incident: _____ 20__ Time: _____ (am) (pm) Place: _____

Was it necessary to notify physician: yes ___ no ___ Time of notification : _____ (am) (pm)

Name of Physician: _____ Name of Supervising Nurse: _____

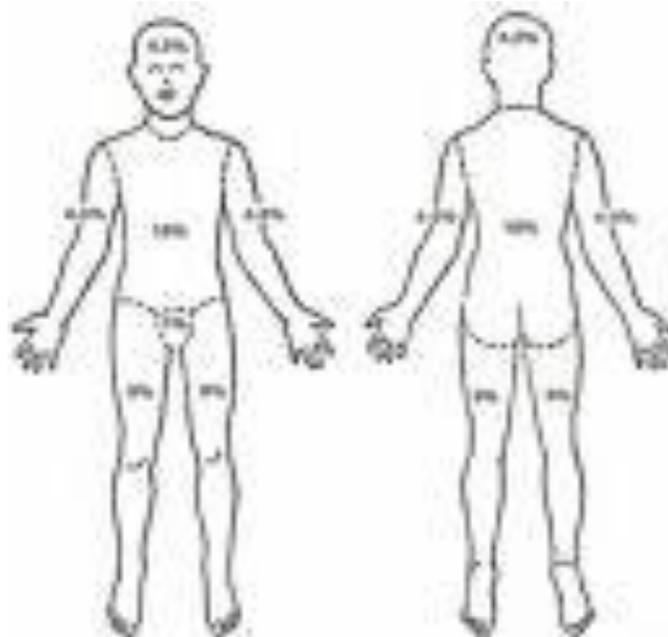
Describe nature of accident or incident and injuries received: _____

REPORTABLE? YES: ___ NO: ___

REPORTED? YES: ___ NO: ___

Illustrate on the diagram position or place of injury, if any.

T.P.R. _____ B.P. _____



Date Report Written: _____ 20__ Time: _____ (am) (pm) Signed _____

Physician or Nurse

Montana Mental Health Nursing Care Center

Fall Evaluation

(To be attached to Incident Report)

1. Has the resident had a previous fall in the last 30 days? Yes No
2. What type of foot wear was the resident wearing? Slippers Socks Shoes
3. If wheelchair was involved:
 a. Brakes were on Brakes were off Brakes were not functioning properly*
 (*If brakes were not functioning, please complete a maintenance request.)
- b. Does the resident have foot rests? Yes No
4. Light in the room? Yes No
5. Was the call light within reach? Yes No
6. Was equipment involved in the accident? Yes No
 If yes, explain:
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7. Was there urine on the floor? Yes No
 Was the resident on the way to the bathroom? Yes No
8. Was restraint being used? Yes No
 If yes, what device(s)?
-
9. Has the resident had a change in medical condition in last week to two weeks? Yes No
 If yes, explain:
-
10. Has the resident had a change in mental status in last two weeks? Yes No
11. Has the resident lost more than 5 pounds in the past month? Yes No
 If yes, alert dietary.
12. Has the resident recently had any medication changes? If so, what was the medication? Yes No
13. Was there water on the floor? Yes No
14. Has the resident's room been rearranged or had new furniture added in last 2 weeks? Yes No
15. Has the resident had a room change? Yes No
16. Did the resident have any of the following symptoms at time of fall?
 Dizziness Chest pain Black out Legs gave way Seizure
17. Does resident have Hearing aide or glasses? If yes, were they present? Yes No
18. Is "Risk for Falls" stated in the resident's Care Plan? Yes No
19. Time and date of last PRN given? _____

Action Plan:

- Discussed with Physician (i.e. medication changes) Discussed at Care Plans
- Completed change of condition MDS, Care Plan for Risk for Falls. Lab(s) ordered
- Isolated incident, oriented to call light, educated resident. No other follow-up.

Resident Name: _____ ID#: _____ Completed by: _____ Date: _____

POST FALL HUDDLE/AFTER ACTION REVIEW

NURSE REVIEWER: _____ **DATE:** _____

PATIENT NAME/ID: _____

INSTRUCTIONS:

1. Hold AAR as soon as possible after the patient fall occurred.
2. Keep the AAR meeting brief; 15 minutes.
3. Involve the patient if possible.
4. Forward completed review to Director of Nursing.

QUESTIONS	LESSONS LEARNED
Why did this patient fall? (Ask 3 times)	
Was patient at correct fall/injury risk level? Were the appropriate interventions in place?	
What accounted for the difference?	
How could the same outcome be avoided the next time?	
What is the follow-up plan?	
Patient's account (if able to share)	
Agreement with the patient for safety (Promise to use call bell; return demo of how to use call bell)	

Type of fall: _____

Nurse Manager Review: _____ Signature: _____ Date: _____