Perth & Kinross Care Home - Post Fall Incident Report Form

Service User's Name	**DOB**
Room Number	
Date of fall	**Time of fall**

Fall Location	□ Outdoors □ Bedroom □ En-suite □ Bathroom □ Corridor □ Sitting room □ Dining room. Exact location……..
Surface Type	□ Carpet □ Linoleum □ Other (specify)……
Surface Condition	□ Wet □ Damaged □ Slippery □ Other ……
Bed position	□ High □ Low □ Tilted □ N/A
Call bell in reach	□ Yes □ No □ N/A
Light	□ On □ Off □ N/A
Mobility	□ Ambulant □ Non-ambulant □ Independent □ Assistance of 1 □ Assistance of 2
Aids	□ None □ Stick □ Zimmer □ Crutches □ Wheelchair
Was aid used at time of fall?	□ Used correctly □ Used incorrectly □ Not used □ Unknown Condition of aid……...
Type of fall	□ Slip □ Trip □ Collapse □ Legs gave way □ Loss of balance □ Unknown
Falls direction	□ Drop □ Forwards □ Backwards □ Sideways □ Unknown
Any warning prior to fall?	□ Dizziness □ Faintness □ Confusion □ Fit □ Loss of consciousness □ Palpitations □ Aggression □ Breathlessness □ Altered mental state □ None of above/Other (specify)……
Toileting	□ Resident attempting to go to toilet □ Incontinence □ Frequency □ Urgency
Footwear	□ Shoes □ Slippers □ Socks □ Bare feet. Condition……..
Glasses	□ None □ Reading □ Distance □ Bi-focals □ Vari-focals
Type worn at time of fall	□ None □ Reading □ Distance □ Bi-focals □ Vari-focals Condition of glasses……
History of falls	□ No □ Yes Number of falls in past 12 months ……
Medication/substance use - Potentially a contributory factor?	□ Yes □ No □ N/A □ Unknown Time taken …….. Medication/Substance identified ……

Description of Event

Was the service user aware the fall was going to happen? □ Yes □ No □ Unknown

Residents description of fall including activity immediately prior to falls

……

……

Brief description of fall. What was seen or heard. Witnesses description

……

……...

Witness name/status ……..…

Clinical Observation/Vital signs following fall

Vital Signs checked following fall □ Yes □ No □ N/A

Any noticeable changes in residents health □ Yes □ No

AMT/MMSE required □ Yes □ No □ N/A AMT/MMSE Score……

First Aid administered □ Yes □ No □ N/A Hospital attendance required □ Yes □ No □ N/A

Injuries sustained: Fracture □ Yes □ No Head Injury □ Yes □ No Laceration/bruising □ Yes □ No

Other (specify)

……..

Immediate Action Taken……

……..……...

……..……...

Doctor notified	□ Yes □ No Time notified ……..……
Seen by Doctor	□ Yes □ No Time seen ……**Doctors Name**……

Outcome……...……..

……..……

Action Taken to Prevent Reoccurrence –(please specify)

……...

……...

……...

……...

Falls risk assessment/Care plan updated □ Yes □ No □ N/A Environmental risk updated □ Yes □ No □ N/A

Relatives/NOK informed	□ Yes □ No Time notified ……..….

Assessed by ……..Grade…… Date……