

Section 1 | Resident details.

Name	<input type="text"/>	Last Known Wellness Check mm/dd/yy	<input type="text"/>
Room #	<input type="text"/>	Last Contenance Check mm/dd/yy hh:mm	<input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM
Date/Time of Fall mm/dd/yy hh:mm	<input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	First Responder Name	<input type="text"/>

Section 2 | Fall scene. Scene Details (filled out by first responder):

Was the resident last seen in bed?	Yes	No	N/A
<i>If yes, consider the following:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a wheelchair or walker placed at the bedside?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are extra mobility aids visible to the resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If there is a floor mat, is it secured to the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is a transfer enabler in place (bed rail, cane or halo)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the bed in a low position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is bedding out of place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the resident last seen in a chair?	Yes	No	N/A
<i>If yes, consider the following:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a mobility aid positioned near the chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the resident transfer in/out of this chair on their own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the chair a recliner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, is the footrest up?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the resident transfer in/out of the recliner independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the resident ambulate in their room?	Yes	No	N/A
<i>If yes, analyze the scene for activity clues.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the resident... <input type="checkbox"/> Trying to change clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retrieving or moving belongings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heading for the bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching for something?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other items to consider	Yes	No	N/A
Do clothes and shoes fit properly and comfortably?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are socks non-skid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the resident seem weaker than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 3 | Room details.

	Yes	No	N/A
Could the flooring be a contributing factor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Could it be too dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the television on?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the bathroom light on?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the bedroom door open?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the closet door open?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the room cluttered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there multiple mobility aids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were other people present? (i.e. visiting family or staff attending)	<input type="checkbox"/>	<input type="checkbox"/>	
Does the resident seem weaker than usual?	<input type="checkbox"/>	<input type="checkbox"/>	

Section 4 | Action plan.

Immediate Interventions

Additional comments regarding the fall scene

→ Take a de-identified photo of the fall scene for review during the team huddle. (Refer to community policy on the use of photos.)

Post Fall Action (complete during team fall huddle)

Contributing Factor	Action Item	Due Date mm/dd/yy	Responsible Party