<table>
<thead>
<tr>
<th><strong>PATIENT FALL ANALYSIS TOOL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directions:</strong> Part A - To be completed by the HEAD NURSE/CHARGE NURSE in addition to INCIDENT REPORT for each fall. Part B - To be completed by SUPERVISOR. Forward to Nursing QA, by end of shift.</td>
</tr>
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### [PART A] Date | Time Of Fall | Witnessed Y N Dx: | REPEAT FALL Y N |
|------------------|--------------|--------------------|-----------------|

1. **LOCATION OF FALL**
   - [ ] Patient bedside
   - [ ] Bathroom
   - [ ] Shower [ ] Bath
   - [ ] Hallway
   - [ ] Other ____________

2. **FOOTWEAR AT TIME OF FALL**
   - [ ] Not applicable
   - [ ] Patient own footwear - non skid sole.
   - [ ] Patient own footwear - smooth soled.
   - [ ] heels
   - [ ] stockings/socks
   - [ ] Hospital provided slippers
   - [ ] Barefoot. ____________

3. **ACTIVITY AT TIME OF FALL**
   - [ ] In chair [ ] In bed
   - [ ] On toilet [ ] On bedside commode.
   - [ ] Ambulatory with assistance
   - [ ] Ambulatory without assistance.
   - [ ] Taking shower/bath
   - [ ] Other ____________

4. **MOST RECENT ACTIVITY ORDER**
   ____________________________
   Date Of Order ____________

5. **EQUIPMENT/ASSISTIVE DEVICES IN USE**
   - [ ] Walker [ ] W/C [ ] Stretcher
   - [ ] Cane [ ] Crutches
   - [ ] IV. Pole
   - [ ] Other ____________

6. **CONDITION OF EQUIPMENT/ASSISTIVE DEVICES(S) IN USE**

7. **IF FALL FROM BED:**
   - Number of Side Rails ____________
   - Position of Side Rails ____________
   - Condition of Side Rails ____________
   - Bed: [ ] High [ ] Low
   - Wheels: [ ] Locked [ ] Unlocked
   - Air Mattress Used? [ ] Yes [ ] No

8. **IF RESTRAINTS/ALTERNATIVES USED:**
   - Type: ____________
   - Current order for restraints per policy? [ ] Yes [ ] No
   - Safety interventions documented for restraints per policy?
   - [ ] Yes [ ] No

9. **CONDITION OF FLOOR**
   - [ ] N/A [ ] Wet [ ] Waxed
   - [ ] Dry [ ] Cluttered

10. **MENTAL STATUS BEFORE FALL**
    - [ ] Alert [ ] Confused
    - [ ] angry [ ] anxious
    - [ ] uncooperative
    - Other ____________

11. **PHYSIOLOGICAL STATUS BEFORE FALL**
    - [ ] hi. B/P [ ] low B/P
    - [ ] incontinent [ ] weak
    - [ ] Other ____________

12. **PATIENT STATUS POST FALL**
    - [ ] Alert [ ] Confused
    - [ ] hi. B/P [ ] low B/P
    - [ ] No change from baseline
    - [ ] Unresponsive
    - [ ] Other ____________

13. **PATIENT MEDICATIONS**
    - [ ] Diuretic [ ] Laxative
    - [ ] Narcotic [ ] Sedative
    - [ ] Tranquilizer
    - [ ] Anti-depressant
    - [ ] Hypoglycemic
    - [ ] B/P medication

14. **FALL/RISK ASSESSMENT**
    - Date of most recent fall assessment ____________
    - Fall/Risk Score ____________
    - Current safety plan?
    - [ ] Yes [ ] No
    - Safety plan appropriate for risks?
    - [ ] Yes [ ] No

Is documentation present that MD was informed of fall risk score 9 or above?
- [ ] Yes [ ] No