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Short Form for Reporting Patient Falls

Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Event No.\_\_\_\_\_\_\_\_\_\_\_\_

Note: All falls resulting in a Level 1 injury (death or serious disability lasting seven days or present on discharge) must be reported in accordance with the requirements of 10.07.06. This form may be used in lieu of a root cause analysis. This form does not replace the initial report of an adverse event form. Email RCA documents to [hospital.selfreport@maryland.gov](mailto:hospital.selfreport@maryland.gov)

**CONFIDENTIAL: THIS REPORT IS MADE PURSUANT TO THE EVALUATION AND IMPROVEMENT OF QUALITY HEALTH CARE FUNCTIONS SET FORTH IN SECTION 14-501 (c) OF THE HEALTH OCCUPATIONS ARTICLE OF THE ANNOTATED CODE OF MARYLAND AND IS INTENDED AS A RECORD OF A MEDICAL REVIEW COMMITTEE AS DEFINED IN THAT STATUTE.**

Please report the following:

1. Patient date of birth:
2. Patient sex:
3. Patient admit date:
4. Patient admitting diagnoses:
5. Event day, date, time:
6. Was event witnessed?
7. Was family notified? Was physician notified?
8. Number of routine medications:
9. Functional and cognitive contributory or causal factors:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Y | N | Root cause | Contributing factor |
| a. | Pt. assessed as fall risk |  |  |  |  |
| b. | Appropriate interventions in place |  |  |  |  |
| c. | Recent change in meds |  |  |  |  |
| d. | Incontinent or foley |  |  |  |  |
| e. | Dependent for ADLs |  |  |  |  |
| f. | Gait or balance limitations |  |  |  |  |
| g. | Need for assistive devices |  |  |  |  |
| h. | Confusion or memory deficits |  |  |  |  |
| i. | Sedated or on pain meds |  |  |  |  |
| j. | Related medical conditions |  |  |  |  |
| k. | Did care plan address these issues? |  |  |  |  |

1. Did communication breakdown contribute to fall?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Y | N | Root cause | Contributing factor |
| a. | Staff to staff |  |  |  |  |
| b. | Staff to/from patient |  |  |  |  |
| c. | Staff to/from family/other |  |  |  |  |
| d. | Physician to/from patient/staff |  |  |  |  |
| e. | Patient/family education |  |  |  |  |

1. Environmental factors:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Y | N | Root cause | Contributing factor |
| a. | Restraints in use |  |  |  |  |
| b. | Protective devices in use |  |  |  |  |
| c. | Adequate footwear |  |  |  |  |
| d. | Bed side rails, Number\_\_\_\_\_\_\_\_ |  |  |  |  |
| e. | Floor dry? |  |  |  |  |
| f. | Physical obstacles |  |  |  |  |
| g. | Adequate personnel |  |  |  |  |
| h. | Adequate lighting |  |  |  |  |
| i. | Bed/wheelchair locked |  |  |  |  |
| j. | Equipment failure |  |  |  |  |
| k. | Bed alarm in use |  |  |  |  |
| l. | Fall during transfer |  |  |  |  |
| m. | Other |  |  |  |  |

1. What happened (with description of injury)?
2. Patient-specific care plan changes:
3. Facility post-fall actions