CVH-575 **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____

New 5/18 **POST-FALL ASSESSMENT**

[ ] Addiction Services Division MPI #: _____ *Print or Addressograph Imprint*

[ ] General Psychiatry Division

Unit: _____

Date of Assessment: _____ **Date of Fall**: _____ **Time of Fall:** _____ AM/PM

RN's Section:

Date(s) of fall(s) within the past 30 days: _____

Type of Fall: ☐ Witnessed Fall ☐ Un-witnessed Fall

Cause of Fall: _____ ☐ actual ☐ suspected ☐ unknown

Location of Fall: ☐ bedroom ☐ day hall ☐ bathroom ☐ out of doors ☐ other: _____

Activity at time of fall: ☐ resting/sleeping in room ☐ ambulating ☐ using bathroom ☐ engaged in activity: _____

If assistive devices needed, were they in use? ☐ N/A ☐ No ☐ Yes: ☐ walker ☐ cane ☐ wheel chair ☐ other: _____

If safety devices ordered, were they in use? ☐ N/A ☐ No ☐ Yes: ☐ bed alarm ☐ chair alarm ☐ door alarm ☐ hi/lo bed

Environmental Factors: ☐ wet floor ☐ crowded area ☐ visual blockage ☐ poor footwear ☐ lighting ☐ other: _____

Injury: ☐ No ☐ Yes: Nature of Injury: ☐ bruise/contusion ☐ abrasion ☐ Other Location: _____

Post-Fall Vital Signs: Temp: _____ HR: _____ RR: _____ BP: _____ O2 Saturation: _____ Accucheck (*if indicated*): _____

Neuro Checks (*if head injury suspected*): Pupils: ☐ reactive ☐ non-reactive ☐ equal ☐ unequal Hand Grasp: ☐ equal ☐ unequal Foot Strength: ☐ equal ☐ unequal

Notified: ☐ Attending Psychiatrist ☐ Ambulatory Care Services Clinician ☐ On-Call Physician Date/Time: _____

RN Signature: _____ Print: _____ Date: _____

ACS Clinician/Attending Psychiatrist/On-Call Physician Section:

Was there a significant change in the patient's psychiatric status in the week preceding the fall?

☐ No ☐ Yes: Describe: _____

Was there a significant change in medical or neurological condition in the week preceding the fall?

☐ No ☐ Yes - If yes, please specify (*Check all that apply*):

☐ Infection ☐ New Medical Diagnosis ☐ Lethargy ☐ Unsteadiness

☐ Visual Changes ☐ Auditory/Vestibular Changes ☐ Seizures ☐ Dialysis issues

☐ Admission from Acute Care Hospital (*within 3 days*)

☐ Other: _____

Were there changes in prescribed medications preceding the fall?

☐ No ☐ Yes: ☐ Refusal ☐ ↑ PRN Use ☐ Cardiac ☐ Psychotropic ☐ Other: _____

Describe: _____

ASSESSMENT: _____

_____

PLAN: ☐ **Physical Therapy Post Fall Assessment ordered and faxed to ext. 7012** (***Required after all falls***)

☐ Ambulatory Care Services Referral ☐ Psychiatry Referral ☐ Occupational Therapy Referral

☐ Pharmacy Consultation ☐ Medication Adjustment ☐ Review of Patient with Treatment Team

☐ Level of Observation: _____ ☐ Other: _____

Complete Focused Treatment Plan Review? ☐ No – Not warranted at this time ☐ Yes – Complete Focused TPR (CVH-546)

Clinician Completing Assessment: ☐ Attending Psychiatrist ☐ Ambulatory Care Services Clinician ☐ On-Call Physician

Signature: _____ Print Name: _____ Date: _____ Time: _____AM/PM

Consultation of the Medical Director is required for Frequent Falls –more than 2 falls within 30 days or Serious Fall - with injuries requiring medical intervention beyond first aid.

Medical Director Signature: _____ Print: _____ Date: _____ Time: _____AM/PM

File Chronological with Progress Notes