

FALL DOCUMENTATION GUIDE/TEMPORARY CARE PLAN

Complete and document all steps at time of fall:

- _____ 1. Assessment of resident – ROM, vs, BS if diabetic, neuro check per policy if hit head or unwitnessed, first aid as indicated
- _____ 2. Provide pain management – reposition for comfort unless contraindicated, PRN pain med, ice/heat, assess if needs routine med for 72 hours
- _____ 3. Notify Dr.
if injury – verbal notification immediately
if non-injury – verbal or written notification next day
- _____ 4. Notify family
if injury – verbal notification immediately
if non-injury – verbal or written notification next day
- _____ 5. Investigate cause of fall and complete occurrence report, route report to DON
- _____ 6. Update fall log and add **NEW** intervention, appropriate for cognitive level.
- _____ 6. Update fall assessment
- _____ 7. Update C.N.A. care plan (ADL book)
- _____ 8. Notify direct care staff of fall and changes in care plan
- _____ 9. Initiate follow up documentation – vitals x 72 hours, neurochecks (if unwitnessed or hit head) per neuro check sheet
- _____ 10. Complete this form and place in chart under Care Plan

Goal: _____

Resident Name _____ Room # _____
Med Rec # _____ Physician _____
Date _____ Nurse Signature _____

