

# REPUBLIC COUNTY HOSPITAL - EVENT ASSESSMENT

Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Location: \_\_\_ Bathroom; \_\_\_ Room, # \_\_\_ ; \_\_\_ Hall; \_\_\_ Other: \_\_\_\_\_

Was staff with the patient? \_\_\_ Yes; \_\_\_ No      Eyeglasses on? \_\_\_ Yes; \_\_\_ No; \_\_\_ N/A

Prevention Equipment used at time of event: \_\_\_ TAB Monitor; \_\_\_ Bed Alarm; \_\_\_ Chair Alarm;  
\_\_\_ Lift (Sara/Maxi/Chorus); \_\_\_ Wedge Cushion; \_\_\_ Wander Guard Alarm;  
\_\_\_ Bean Bag; \_\_\_ Low Bed; \_\_\_ Gait Belt; \_\_\_ Other: \_\_\_\_\_

Medicated past 4 Hours: \_\_\_ No \_\_\_ Yes:

\_\_\_ psychoactive; \_\_\_ diuretic; \_\_\_ anti-hypertensive; \_\_\_ narcotic; \_\_\_ laxative

Was the call light within reach? \_\_\_ Yes; \_\_\_ No; \_\_\_ N/A      Was it used? \_\_\_ Yes; \_\_\_ No

Attempting to get to the bathroom? \_\_\_ Yes; \_\_\_ No      Is the person easily fatigued? \_\_\_ Yes; \_\_\_ No

Was the person wearing: \_\_\_ Long Bathrobe; \_\_\_ TED Hose Only; \_\_\_ Socks / Nylons; \_\_\_ Slippers;  
\_\_\_ Shoes; \_\_\_ Barefoot

Behavior at the time of fall: \_\_\_ Normal; \_\_\_ Memory Loss; \_\_\_ Agitation; \_\_\_ Disorientation;  
\_\_\_ Non-compliant; \_\_\_ Combative

Assistive Device used routinely: \_\_\_ None; \_\_\_ Walker; \_\_\_ Cane; \_\_\_ Wheelchair; \_\_\_ Other:

Assistive Device used at time of fall: \_\_\_ N/A; \_\_\_ Yes; \_\_\_ No

Environment: Floor Condition: \_\_\_ Dry \_\_\_ Wet  
Lighting: \_\_\_ Normal; \_\_\_ Dim; \_\_\_ Glare; \_\_\_ Dark  
Furniture: \_\_\_ New Placement; \_\_\_ Out of Usual Place;  
New environment for the person (first 24 hours): \_\_\_ Yes; \_\_\_ No

Vital Signs: \_\_\_ B/P; \_\_\_ Pulse; \_\_\_ Resp.; \_\_\_ Temp. Pain \_\_\_ No \_\_\_ Yes: site \_\_\_\_\_  
RATING (1-10) \_\_\_\_\_

Injuries: \_\_\_ None Noted; \_\_\_\_\_

Possible Head Injury: \_\_\_ No; \_\_\_ Yes: **Initiate Glasco Coma Scale**

To be done every 2 hours X 8 hours; then every 8 hours x 24 hours; then daily x 7 days. IF DETERIORATIVE CHANGES ARE NOTED contact physician immediately.

Family notified: (as appropriate)      Name \_\_\_\_\_ Time \_\_\_\_\_

Physician notified: (as appropriate)      Name \_\_\_\_\_ Time \_\_\_\_\_

Follow-up Diagnostic Exam / Treatment: \_\_\_\_\_

Follow-up Interventions Planned: \_\_\_ Toileting Schedule; \_\_\_ Activity / Position Chg.; \_\_\_ TAB Alarm;  
\_\_\_ Environmental Chg. / Diversional Activity; \_\_\_ Bed Check Alarm;  
\_\_\_ Chair Check Alarm; \_\_\_ Chair Wedges; \_\_\_ Assistive Devices;  
\_\_\_ Wander Guard Alarm; \_\_\_ Clip Call Light To Gown / Clothes;  
\_\_\_ Low Bed; \_\_\_ Bean Bag; \_\_\_ Gait Belt; \_\_\_ Lift (Sara/Maxi/Chorus)  
\_\_\_ Instruct Patient / resident to call for assist;  
\_\_\_ Other: \_\_\_\_\_

Education / Comments: \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_