Attachment C

ValleyCare Olive View- UCLA Medical Center
Department of Nursing

PERFORMANCE IMPROVEMENT FALL EVALUATION TOOL

1. Unit/ Bed # :	2. Date:	3. Time of fall:
4.Day of week: (circle) M Tu W Th F Sa Su		
5.Census at time of fall:	6. Last Morse Score & Date/Time:	
7. Medical diagnosis:		
8.Nurse/ patient ratio: (circle) Licensed: 1:1 1:2 1: 3 1: 4 1:5 1:6 Other: Non Licensed: 1:1 1:2 1: 3 1: 4 1:5 1:6 Other:		
9.Was patient with a sitter? □ No □ 1:1 □ 1:2		

	RNs	LVNs	NAs		Registry Nurses	Travel Nurses
			Total # of NAs	Of the total, # of sitter		
10. # Of staff on duty:						
11. # Of staff floated:						
12. # Staff present on the unit at time of fall:						

13.Fall precaution: □ Yes □ No	14.ETOH protocol: □ Yes □ No
15.Isolation precaution: □ Yes □ No	16.Was call light within easy reach? □ Yes □ No Was call light on? □ Yes □ No If yes, was call light promptly answered? □ Yes □ No
17.Patient's activity order: □ Bed Rest □ BRP □ Up Ad Lib □ Assisted ambulation	
18.Medications within 12 hours of fall: □ Pain med/Barbiturates □ Laxatives □ Hypnotic/Tranquilizers □ Diuretics	
19.Place of Fall: □ From bed: □ High □Low Side Rails: □ Up □ Down □ From chair □ In bathroom □ From commode □ Others	
20.Need for assistance with elimination? □ Yes □ No	21.Disorientation □ Yes □ No
22.Restraints: □ Yes □ No □ Soft restraints □ Posey □ Hard Restraints	23.Failure of patient to follow instructions in the past? □ Yes □ No If yes, documented in the medical records? □ Yes □ No
24. What did the patient say he/she was trying to do?	
25. Patient Injuries? □ Yes □ No	Comments:
26. Did provider examine patient? □ Yes □ No	
27. X-Ray? □ Yes □ No	28. CT? □ Yes □ No
29. Name of provider called?	
30. Nurse Signature	

PATIENT DATA-IMPRINT OR PRINT LEGIBLY
Name

MRUN No.
Date of birth □ I
Ward or Clinic □ O

Revised 07/2/2008