

FALL VARIANCE REPORT

Definition of Fall: An unintentional event that resulted in a person coming to rest on the ground or other lower level.

Date: _____ Weekday _____ Time _____ Location (specify) _____ LOS _____

V/S: Prior: B/P _____ Pulse _____ Resp _____ After: B/P _____ Pulse _____ Resp _____ Not Recorded

Was this unintended? Yes No

Is there a history of Falls? Yes No

Patient identified as fall risk prior to Fall? Yes No

Observation status at time of Fall : Q30 Q15 min Direct Observation 1:1 Other (specify) _____

Was patient medicated (Routine or PRN) within 4^o? No Yes (if yes, specify name of medication) _____

Fall Witnessed? Yes No

Age: 4-12 13-17 18-35 36-50 51-64 65-80 >80

Mental Status: Oriented x3 Disoriented Sedated Other _____

Incident: Fall: From Bed From Chair While walking Other _____

Potential Cause: Sudden change in position Medication (specify) _____
 Wet floor Unsteady gait Recreational activity (specify) _____
 Confusion Visual impairment Blind Assisted device (specify) _____
 Dizziness Incontinence Orthostatic Hypotension Sedation Hypertension
 Environmental Obstacle _____ Other _____
(Sample: Bedding/Blankets) (specify) (specify)

Injury: None Ecchymosis Abrasions Lacerations Fractures
 Loss of consciousness Other (specify) _____

Area of Injury: Arm Leg Buttocks Hip Chin Eye Head Other (specify) _____

Severity: No effect (injury did not require treatment)
 Minor injury (required administration of minor first aid (e.g. band-aid, ice packs, creams, Tylenol))
 Major injury (requiring medical intervention provided by outside facility, i.e. emergency room)
 Severe injury (requiring in-patient medical intervention at a general acute care hospital)
 Death

Additional Comments: _____

Immediate Action: No action required Fall precautions 1:1 MTP update First Aid
 Revised Vital Sign Monitoring Toiletry Plan
 Transfer to medical facility (specify) _____
 Patient/Family education Staffing adjusted X-Ray ordered
 Environmental changes (e.g. patient moved near nurse's desk, chair removed from room, placed in hospital bed) (specify) _____
 Assistive Device (e.g., wheelchair, walker) (specify) _____

_____ Person Completing Form	_____ Date/Time	_____ Nurse Manager Signature	_____ Date/Time
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