**Resident Falls Process Auditing Chart Review**

**Confidential Data: Risk Management/QA Committee Work Document**

**Instructions:** Review medical record related to the resident’s fall risk and any falls. Interview staff as needed. Consider the items below and record findings.

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| **Resident Name:** | **Room Number:** |
| **Admission Date:** | **Review Date:** |
|  |
| **Fall Risk**  |
|  |
| **Consideration** | **Correct** | **Comments** |
| **Y** | **N** | **NA** |
| 1. | Is there documentation of diagnoses that may increase fall risk? |  |  |  |  |
| 2. | Is there documentation of medications that may increase fall risk? |  |  |  |  |
| 3. | Is there documentation of any falls prior to admission or since last MDS assessment? |  |  |  |  |
| 4. | Does the chart describe any behaviors, mobility issues, functional issues, assistive device use, restraints, etc., that could increase risk for falls? |  |  |  |  |
| 5. | Is a fall risk assessment done on admission, readmission, upon change of condition, or post fall? |  |  |  |  |
| 6. | Is a care plan developed and preventative interventions in place? |  |  |  |  |
| 7. | Is resident flagged as a fall risk or placed on a falls prevention program as per any facility protocol?  |  |  |  |  |
| 8. | Are staff made aware of the resident’s fall risk? |  |  |  |  |
|  |
| **Post Fall**  |
|  |
| **Consideration** | **Correct** | **Comments** |
| **Y** | **N** | **NA** |
| 1. | Was fall documented in medical record? Family/MD notified? |  |  |  |  |
| 2. | Was the resident assessed for injuries and injuries documented if so noted? |  |  |  |  |
| 3. | Did resident have to be sent out to the hospital post fall and was it documented, if so?  |  |  |  |  |
| 4. | Were neuro checks done, if unwitnessed or resident hit their head? |  |  |  |  |
| 5. | Was care plan updated and post fall interventions put into place? |  |  |  |  |
| 6. | Was follow up charting done as per facility policy? |  |  |  |  |
| 7. | Were environmental, physical, medical, etc., reasons for fall assessed? |  |  |  |  |
| 8. | Are there any patterns noted if there have been multiple falls (e.g., at shift change, before/after meals, at bedtime, etc.)? |  |  |  |  |
| 9. | Were preventative interventions in place and being utilized? |  |  |  |  |
| 10. | Is the fall(s) coded accurately on the relevant MDS in Section J? |  |  |  |  |

**Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Corrective Actions Needed (If Indicated): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Submitted to QA Committee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_