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[Home](#) | [Sitemap](#) | [Feedback](#) | [H](#)

[Webmail](#) | [Baycrest](#)

Search

[About Baycrest](#) | [Client Care](#) | [Employee Corner](#) | [Directories](#) | [Tools & Resources](#) | [News](#) | [Events](#) | [Workgroup](#)

Administrative

Introduction

Organization /

Administration
Client Care

Communications / Public

Affairs

Finance

General

Materials Management

Privacy

Quality Management

Research

Security

Human Resources

Nursing Administration

Ambulatory Clinic

Communication
Disorders

Dental

Infection Control

Nursing Clinical Practice
Procedures

Pharmacy Nursing

You are here > [BaycrestWork](#) > [Policies](#) > [Administrative](#) > [Client_Care](#) > [Incident Risk Management Form and Focused Audit for Fall Related Incident](#)

Incident Risk Management Form and Focused Audit for Fall Related Incident

Section: [Client Care / Services](#)

Index no.: VI-143

Issued by: Quality Management

Approved By: Senior Management
Committee

Effective: Jan-1996 | Revised: Jan-1999 | Reviewed: |

PURPOSE

The incident risk management form and focused audit is designed to assist the care team in identifying and evaluating interventions directed at reducing a client's risk for injury/loss/falling. Baycrest Centre for Geriatric Care is committed to providing quality care and service in a safe environment. Baycrest Centre undertakes to monitor, report, review and take appropriate action concerning the occurrence of any and all incidents which are not consistent with the routine operation of the Centre. Documenting identified real or potentially hazardous (risk) situations, and analysing incident trends facilitates measures to reduce or eliminate injury or loss.

POLICY

All incidents involving an individual or a non-person event, shall be attended to and reported as outlined in the policy on incident response and reporting (see Administration policy/procedure Manual, #VI-141).

The incident risk management form and focused audit should be completed for clients with serious* incidents, fall-related serious* incidents and repeat falls**.

Consent

A written consent is not required.

PROCEDURE

1. A focused audit for fall related incidents can be initiated by any member on the

care team and for any client.

2. The Nurse Manager or Cost Centre Manager will initiate the Incident Risk Management Follow-up Form for those clients with serious* injury/loss due to a fall or other types of incidents.

3. The Incident Risk Management form and Focused audit for repeat fallers can be initiated, completed and signed by the Nurse Manager and/or the Registered Nurse in consultation with the care team members.

4. The results of the Audit should be shared with the other members of the Care Team with the appropriate follow-up.

5. The incident report should be attached to the risk management form (i.e. for falls or other types of incidents) when the client has experienced a serious injury/loss.

6. The completed Incident Risk Management Form and Focused Audit is reviewed and signed by the Nurse Manager for all incidents.

7. The original Incident report, Incident Risk Management forms and Focused Audit forms are reviewed and signed by the Nursing Service Director.

8. The Nursing Service Director forwards the forms to Nursing Services Quality Management.

Recording and Reporting

1. Document in the progress notes that a Falls Focused audit was completed and any changes regarding the management of care directed at reducing the client's risk of falling.

2. Update the Client Care Plan.

3. Initiate a referral to the other team members as required and report the results of the Risk Management and Focused Audit.

Quality Indicators

* # serious incidents by location, type and outcome

* # of repeat falls

Note: *A "serious incident" is one where the outcome results in:

a) potential for severe physical and/or psychological discomfort, permanent impairment, major clinical intervention;

b) admission to acute care/CCU for treatment/monitoring (eg. head injury, fracture, surgery)

c) CPR

d) wandering client's exit is undetected (i.e. only those wandering incidents in which the client exits the Centre and is undetected due to a faulty bracelet or faulty door alarm system)

e) death

** A "repeat fall" occurs when a client falls three or more times within four weeks.

Baycrest Centre for Geriatric Care

INCIDENT RISK MANAGEMENT FORM & FOCUSED AUDIT

OTHER INCIDENTS

(eg. wandering, abusive behaviour, medication)

To be completed by manager(s) for serious*
injuries/incidents within 2 business days
following the incident. Addressograph

For FALLS incidents complete pages 2 & 3 only.

Note: RN/Manager to complete form for non-serious falls.

Manager to complete form for serious fall related incidents.

INCIDENT REPORT IS ATTACHED TO THIS FORM Yes _____

Outcome and current status of client:
Preventative measures in place prior to incident:
Immediate actions taken to prevent recurrence and observed outcome:
Details of treatment (include physician interventions):
Quality Improvement recommendations for long term correction of situation:
*Serious Injury: Potential for severe discomfort, permanent impairment, major clinical intervention,
transfer to acute care / CCU (i.e. fracture, surgery, CPR, death).

PLEASE SIGN BACK OF FORM

Send Original to: Nursing Service Director (if client-related)

Appropriate Director (if not client-related)

FALLS INCIDENTS ONLY:

A combination of chart audit, observation of the client/environment and consultation with the care team are required to answer all of the following questions completely for clients with serious fall-related injuries and repeat falls*.

Please Indicate () : Serious Injury (Incident report attached) Repeat Falls

Outcome and current status of client:
Client condition at time of fall: (check off all that apply and add comments where applicable)
History of fracture: Medications changed in the last 2 weeks:
History of Osteoporosis or Musculoskeletal Disorder: Experienced an acute illness or change in medical
Admitted or moved within the past 2 weeks: condition:
Other: _____
Preventative measures in place prior to incident: (check off all that apply and add comments where applicable)
Fall risk score: _____ * Fall prevention strategies in place:
Safe Mobility care plan initiated: Falls magnet on door: Falls sticker used: Specify where _____ Pharmacy review client's medications: Family / Client Information provided: Other _____
* Refer to Fall Risk Assessment Form and Intervention Tool total score.
ACTIONS TO BE TAKEN TO PREVENT RECURRENCE AND TO OBSERVE OUTCOME: (check off all that apply and add comments where applicable)
Altered mental status (cognition, behaviour) Followed by Psychiatry / Behavioural Neurology
Attempts to get out of bed / chair unsafely Use of side rails: one side rail two side rails Reason for use documented Sensory monitor device used: Bed Chair Low bed obtained · OT consulted for seating modifications Mattress on floor used for clients who are unable · Bed height appropriate to rise from the floor independently
* Repeat Fall: Three or more falls within a four week period.
* Serious Injury: Potential for severe discomfort, permanent impairment, major clinical intervention, transfer to acute care / CCU (i.e. fracture, surgery, CPR, death).
FALLS INCIDENTS ONLY
Physiologic Response: related to patient's condition and not the environment Evidence that medical status has been reviewed by the: Attending Physician ; Geriatrician Cardiologist ; other: _____ Evidence of documented assessment & screening for signs and symptoms of contributing medical conditions

List: _____ Orthostatic vital signs checked N/A Other: _____
Impaired Mobility: (balance, gait) Referred to PT for gait and balance assessment On planned walking program - Appropriate gait aid in use Appropriate gait aid in good repair Orthotic footwear requested Received Usually worn OT consulted Special chairs requested for specific needs Received Protective gear used Describe _____ Other: _____
Alterations in Urinary Elimination: (frequency, urgency, nocturia) Use of a bedside commode Toileting schedule Elimination device accessible and visible (i.e. night light, WR near bed) Other: _____
Medications within 24 hours: Medication adjustment made in response to fall episode(s) Orthostatic vital signs checked before medication(s) and one hour after medication N/A Other: _____
Environmental factors: Environmental audit initiated N/A Changes to the environment initiated (specify): _____
Use of restraint: Restraint ordered Type: _____ Informed Consent obtained N/A Documented evidence that alternative methods have been tried prior to the use of a restraint Documented evidence that the need to use a restraint has been re-evaluated Other contributing factors: Care Team conference conducted To be conducted Safe Mobility Care Plan updated Quality Improvement recommendations for long term correction of situation: _____

The incident was reviewed with the staff member(s) who discovered/witnessed the incident. It is understood that the manager directly responsible for the unit(s) will assume responsibility for required follow-up.

Date of Review: _____ Time of Review: _____
 Send Original to: Nursing Service
 Director (if client-related)
 Managers Signature Registered Nurse Signature Appropriate Director (if not client-treated)
 rmf0699.doc,word, lb cc, Nursing Quality Management



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