

Incident Resulting in a Fracture Checklist

Instructions:

Proactive Risk Management: If a person receiving services/supports has this identified risk factor, this checklist can be utilized when developing and/or reviewing/revising a risk plan.

Educational Tool: Training curriculum, both general and individual-specific, can incorporate the information on this checklist.

Addressing Specific Incidents: As an incident occurs, the team can work through the variables that could have been contributing factors and ensure appropriate actions are taken to reduce the likelihood of a future incident of a similar manner.

Issue	#	GENERAL QUESTIONS
		WAS THERE A FALL?
<input type="checkbox"/>	1	Was there a prior fall (with or without injury) in the past six months?
<input type="checkbox"/>	2	Does the person have a known "fear of falling"?
<input type="checkbox"/>	3	What was the activity at the time of the fall?
<input type="checkbox"/>	4	What was the location of the fall (e.g., kitchen, bathroom, sidewalk, etc.)?
<input type="checkbox"/>	5	What type of surface did the person land on?
<input type="checkbox"/>	6	If from a height, how far did the person fall?
<input type="checkbox"/>	7	If the fall occurred outside, what was the temperature and weather conditions at the time?
<input type="checkbox"/>	8	Was there a use of restraint at the time of the fall? If so, what kind?
<input type="checkbox"/>	9	Was there a challenging behavior exhibited at the time of the fall?
<input type="checkbox"/>	10	If #9 is yes, what was the staff's response to reduce the behavior prior to the fall?
<input type="checkbox"/>	11	If #9 is yes, was there a behavior support plan?
<input type="checkbox"/>	12	Were there any signs of illness/unsteadiness prior to the fall?
<input type="checkbox"/>	13	Was the fall associated with a new onset of a medical problem?
<input type="checkbox"/>	14	Does the person have a known medical problem which contributes to falls?
<input type="checkbox"/>	15	Does the person use assistive devices for ambulation?
<input type="checkbox"/>	16	Were there any recent medication changes (e.g., new medications, change in dosage of old medications, new over-the-counter medications, etc.)?
<input type="checkbox"/>	17	Did the environment contribute to the fall (e.g., poor lighting, loose rugs, cords on the floor, worn footwear, shoelaces, glare, slippery floors, etc.)?
<input type="checkbox"/>	18	How has the team addressed preventing another fall?
<input type="checkbox"/>	19	Was an updated fall risk assessment completed after the fall?
<input type="checkbox"/>	20	Is there use of preventive health programs (e.g., exercise program, strengthening, PT, OT, home evaluation by OT, personal emergency response system (PERS), etc.)?
<input type="checkbox"/>	21	Was there a recommendation for an assistive device?
<input type="checkbox"/>	22	Have any other changes been implemented (e.g., footwear, environmental improvements, etc.)?
<input type="checkbox"/>	22.1	Was a fall prevention plan in place prior to the incident? If so, was the plan being followed at the time of the incident?

	23	IF THE PERSON DID NOT FALL, WHAT CAUSED THE FRACTURE?
<input type="checkbox"/>	a.	Altercation with a peer?
<input type="checkbox"/>	b.	Altercation with a nonpeer?
<input type="checkbox"/>	c.	Bumping into something/Crushing injury?
<input type="checkbox"/>	d.	Motor vehicle accident/bicycle/pedestrian accident?
<input type="checkbox"/>	e.	Sports activity or other leisure activity?
<input type="checkbox"/>	f.	Pathological cause (e.g., osteoporosis, bone cyst, etc.) as determined by physician?
<input type="checkbox"/>	g.	Undetermined, but probable fall
<input type="checkbox"/>	h.	Undetermined, but probably not due to a fall

AFTER THE INCIDENT		
<input type="checkbox"/>	24	Were there other injuries at the time of the fracture?
<input type="checkbox"/>	25	Was the person seen in the ER or hospitalized? If hospitalized, how many days of hospitalization?
<input type="checkbox"/>	26	What changes have been made to the risk plan to prevent further fractures?
<input type="checkbox"/>	27	What type of fracture occurred (e.g., displaced/nondisplaced, simple/compound, stress, other, etc.)?
<input type="checkbox"/>	28	What treatment was provided?

STAFFING ISSUES/STAFF TRAINING ISSUES		
<small>Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform)</small>		
<input type="checkbox"/>	29	Were staff following the required level of supervision/monitoring (including required proximity to the person) during the incident?
<input type="checkbox"/>	30	How long had the staff on duty been working with the person (e.g., years, months, weeks, days, etc.)?
<input type="checkbox"/>	31	Are all staff in all settings trained to competency on specific details of the fall/fracture prevention plan?

MONITORING BY MANAGEMENT		
<input type="checkbox"/>	32	How does the team ensure that the fall/fracture prevention plan is implemented consistently?

PERTINENT DOCUMENTATION		
<input type="checkbox"/>	33	Copy of person's previous fall/fracture prevention plan
<input type="checkbox"/>	34	Copy of person's updated fall/fracture prevention plan
<input type="checkbox"/>	35	Copy of a fall assessment completed by the team
<input type="checkbox"/>	36	Copy of a fracture risk assessment completed by the team
<input type="checkbox"/>	37	Staff training records regarding the fall/fracture prevention plan (ALL settings - home and day programs)
<small>Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform)</small>		

Name	
Date	