HOSPITAL AUTHORITY
KCC / _____Hospital

PATIENT FALL INCIDENT REPORT

Name of Patient : _____
Sex / Age : _____
Hospital No. : _____
Dept / Ward / Bed : _____
Date of Admission :

Incident Reported to ☐ **HCE** ☐ **COS** ☐ **GM(N)** ☐ **DOM** ☐ **WM** ☐ **Others** _____

Please mark X in the appropriate boxes and brackets

Time and date of incident : at _____ hrs on _____ / _____ / _____
(Day / Month / Year)

Diagnosis before incident : _____

A. Patient Assessment

		Before Incident	After Incident
1.	Conscious Level	☐ Conscious	☐ Conscious
		☐ Semiconscious	☐ Semiconscious
		☐ Unconscious	☐ Unconscious
2.	GCS (If applicable)	_____ / 15	_____ / 15
3.	Mental State	☐ Orientated	☐ Orientated
		☐ Disorientated	☐ Disorientated
		☐ Restless	☐ Restless
		☐ Confused	☐ Confused
		☐ Others (Specify) _____	☐ Others (Specify) _____
4.	Ambulation	☐ Independent Ambulatory	☐ Independent Ambulatory
		☐ Ambulatory with assistance	☐ Ambulatory with assistance
		☐ Ambulatory with walking aid	☐ Ambulatory with walking aid
		☐ Confined to bed / chair	☐ Confined to bed / chair
		☐ Others (Specify) _____	☐ Others (Specify) _____
5.	Disability	☐ None	☐ None
		☐ Hearing	☐ Hearing
		☐ Visual	☐ Visual
		☐ Elimination	☐ Elimination
6.	Fall Risk	☐ Yes	☐ Yes
		☐ No	☐ No
7.	History of fall	☐ Yes	☐ Yes
		☐ No	☐ No
8.	Others Remarks	_____	_____
		_____	_____
		_____	_____

B. Medication before incident within 24 hrs

☐ Analgesics ☐ Anti-convulsants ☐ Anti-depressant
☐ Anti-hypertensives ☐ Anti-psychotics ☐ Cardiac drugs
☐ Diuretics ☐ Hypoglycaemics ☐ Laxatives
☐ Narcotics / Sedatives ☐ Others (Specify) _____

C. Specific preventive measures taken before incident

☐ Accompanied care ☐ Bedside rail ☐ Call bell
☐ Regular toileting ☐ Verbal advice ☐ Physical restraint device
☐ Not indicated ☐ Others (Specify) _____

D. Location of incident occurred

☐ Bathroom ☐ Bedside ☐ Chair - side
☐ Toilet ☐ Corridor ☐ Staircase
☐ Others (Specify) _____

E. Factors attributing to incident

☐ Physiological ( ) Unsteady gait ( ) Lost balance
( ) Visual impairment ( ) Bowel & bladder need
( ) Others (specify) _____

☐ Environment ( ) Lighting ( ) Floor
( ) Cluttered area ( ) Needed item out of reach
( ) Others (specify) _____

☐ Equipment & furniture ( ) Bed ( ) Wheelchair
( ) Others (specify) _____

☐ Others (specify) _____

F. Description of incident & event (add sheets if required)

_____

_____

_____

G. Physical injury sustained

☐ No apparent physical injury ☐ Pain ☐ Bruising
☐ Haematoma ☐ Abrasion ☐ Laceration
☐ Sprain / Strain ☐ Dislocation ☐ Fracture
☐ Others (Specify) _____

Description of injury (size and site) _____

_____

H. Dr. _____ was informed of incident at _____ hrs on _____
Dr. _____ attended patient at _____ hrs on _____

I. Action taken / Treatment given

☐ Monitoring increased ☐ Care plan revised & implemented
☐ X-ray taken ( ) No new finding ( ) New finding (specify) _____
☐ Others (Specify) _____

_____

J. Injury Index of the Fall incident

☐ 1 – patient did not sustain injury
☐ 2 – patient sustained minor injury (eg. bruise / abrasion that will heal within several days)
☐ 3 – patient sustained moderate injury (eg. Haematoma / laceration requiring suture / suspected fracture)
☐ 4 – patient sustained major injury (eg. fracture / head injury with change in vital signs)
☐ 5 – patient sustained permanent disability
☐ 6 – patient death

K. Relative was informed ☐ Yes, Relationship: _____ at _____ hrs on _____
☐ No, reason: _____

Reported by: _____ at _____ hrs on _____
(Block Letter)

Rank: _____ **Signature:** _____

Please complete as appropriate:

Follow-up action taken: _____

_____

_____

By: Name: _____
Rank: _____ Date: _____

Endorsed by Department I/C: Name: _____
Rank: Date:

QEH/Fall/June/2004