**Purpose**

1. To investigate the cause *of* all suspicious marks, discolorations, skin breaks and injuries that have not been witnessed
2. To identify any injuries after a resident sustains an accident or incident
3. To implement appropriate preventative measure immediately to prevent recurrence when indicated
4. To identify patterns and/or trends
5. To mitigate the seriousness of an incident or accident
6. To prevent repeat incidents or accidents

**Confidentiality**

Incident, accident occurrences reports are completed by nursing or other facility personnel. The contents of these reports are to be kept confidential and used for quality assurance purposes

**Definition**

Ohio Living Communities use the same definition for a fall that’s found in the “Long-Term Care Facility Resident Assessment Instrument User’s Manual.” A fall refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.”

1. All of the following are considered falls and should be reported using an incident report, recorded on the community’s incident tracking log, and on the MDS as indicated:
2. An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall
3. The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall
4. When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred
5. The distance to the next lower surface (in this case, the floor) is not a factor in determining whether a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall

**Definition**

1. When a resident fall, sustains an injury of unknown origin, and/or an unusual event occurs the direct-care staff nurse will do the following:
   1. Assess the resident, notify both the family and the doctor and complete an electronic [report in Risk Management,](file:///C:\Users\tgavin\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.IE5\Falls\OPRS%20INCIDENT%20REPORT.doc)
   2. Interview and obtain written and/or verbal statements from the resident and each witness with information related to the occurrence. Document these statements on paper or in Risk Watch.
   3. Open an Event, document a general description of the incident in the box marked “initial progress note,” conduct a physical assessment, implement immediate intervention(s) and clinical interventions where applicable and document notifications of family and physician
      1. All Fall Events are to be documented on every shift for 72 hours post fall. Each shift will attach a progress note and vital signs to the open Fall Event
   4. Initiate the investigation at the time of the occurrence (suspected abuse/neglect, fall, unusual incident, injury, etc.).
      1. In the case of abuse, neglect and/or misappropriation of property, the Abuse and Neglect policy will be set forth.
2. The Director of Nursing or appointed designee will perform all of the following where applicable:
   1. Audit the incident report for completion
      1. Complete the investigation that was started by the direct care nurse
         1. Interview any witnesses, staff on duty and any others that may be involved and/or have knowledge of the incident if their witness statements were not taken.
         2. Record a conclusion.
         3. Record any recommended interventions and follow up indicated.
   2. Audit the medical record
      1. Verify that immediate preventive actions taken were documented in the resident’s chart and on the Event.
      2. Verify that the immediate interventions is on the care plan
      3. Verify that the family and physician were notified
   3. Report and discuss incident at the daily clinical meeting and to the appropriate ad hoc committee (QA, falls, safety, Incident Review Team etc.).
3. Review the corporate Unusual Incident Reporting policy to determine if the incident must be reported to corporate personnel.
4. Analyze incidents monthly for trending and patterns.
5. Present statistics to the QA Committee.