

Patient Name:

Medical Record:

Date of Birth:

POST FALL HUDDLE

SECTION A: FALL EVENT DETAILS

Date of Fall: _____ Time of Fall: _____

Location of Fall: Unit: _____ Room: _____

Fall Risk Score Prior to Fall: _____

Fall Precautions in Place:

- Yellow Arm Band Falling Star at Door
 Fall Sign at HOB Documentation of fall POC

When was the last time the patient was rounded on? _____

Which of the following were assessed during the last round?

- Pain Personal needs Position Placement of items Prevention of falls

Location of Fall: Between bed and bathroom From bed From chair

From BSC From toilet From cart or gurney Hallway Shower/tub

Therapy/radiation/other treatment Other: _____

Was fall witnessed? Yes No Was fall assisted? Yes No

If fall was assisted, what transfer equipment was in use at time of fall?

- None Transfer belt Walker Cane Cardiac Chair slidingboard/chux/sheet None
 Other: _____

If patient fell from bed, number of side rails up at time of fall: _____ N/A

Medications received within 8 hours prior to fall: None PCA/PCEA Opiates

Anticonvulsants Antihypertensives Antiarrhythmics Sedatives Hypnotics

Diuretics Laxatives Antidepressants Antipsychotics Benzodiazepines

Antihistamines Antiparkinsonians Alzheimer drugs

Is patient on anticoagulant therapy? Yes No

If Yes:

- Heparin IV Coumadin Lovenox Heparin SQ Warfarin Other: _____

Preventative measures already in place at time of fall: Bed/low position

Bed alarm Posey vest Wrist restraints 4 side rails 1:1 supervision

Other: _____

Was a staff member injured at the time of the fall? Yes No

SECTION B: POST FALL HUDDLE -- MINI ROOT CAUSE ANALYSIS

Post Fall Huddle Team members:

	First & Last Name	Title	Home Unit	Manager/CNS
Lead Nurse				
Primary Nurse				
CCP				
Other				

Contributory Factors:

Activity/Mobility: Attempting OOB to toilet Up in room ad lib Best rest

Chair/Wheelchair Up ambulating in hallways, etc.

Transferring or with assistance from: _____ Other: _____

Return to Unit Director/CNS/Educator – NOT for Medical Record

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POST FALL HUDDLE

SECTION B: - POST FALL HUDDLE - Continued

Contributing Factors continued

Cognitive & Functional factors (check all that apply):

- Incontinent-circle appropriate choice(s): bowel or bladder
- Confused/memory impaired
- Dementia
- Delirium
- Altered gait/balance/dizzy
- Altered ADL
- Orthostatic B/P issues

Environmental/Equipment (check all that apply):

- Needed item out of reach
- Improper footwear: _____
- Clothing issues
- Cluttered area
- Wet floor
- Poor lighting
- Faulty/broken equipment (chairs, assistive devices, etc.): _____

Interventions (check all that apply):

- No falls assessment
- Call light not available/within reach
- Bed not in lowest position
- High falls risk pt left alone/unattended while toileting
- Bed alarm/low bed malfunction
- Incomplete follow-through with falls risk levels/interventions
- Bed alarm not plugged in or turned on

What did the patient/family report was the reason for the fall?

Why do the huddle members think this patient fell?

Corrective/Preventative measures taken to reduce the risk of another fall (check all that apply):

- Patient/family education on falls
- Staff education
- Care plan revised/updated
- Equipment replaced/repaired
- PT/OT consulted
- Pt moved closer to nursing station
- Medications reviewed/adjusted
- Other: _____
- Bed alarm placed Yes No Reason _____
- Low Bed placed Yes No Reason _____
- 1:1 Yes No Reason _____

SECTION C: - POST FALL CHECKLIST

MD Notified – hospital policy is to notify MD for **all** patient falls. *If the fall was unwitnessed or involved a potential head injury, complete assessments per the Falls Guideline, including vital signs and neuro checks*

Notify unit management team: UD/CNS with FYI message of the fall event.

Update Care plan

Complete a “Documentation of Fall” note or a “Post Fall/Post Fall Head Injury” note found in Essentris in the Notes section.

- Update the falls nursing flow sheet on the assessment tab and the POC making the patient an automatic High falls risk. Complete the post falls POC
- Complete an event report

Pass on, in report, information regarding fall and time to complete post-fall assessment (8- 24 hours after the fall event) Note if the patient was on any anticoagulant therapy.

Was the next of kin notified? Yes No (If no, why not?) _____

Return to Unit Director/CNS/Educator – NOT for Medical Record