

### Post Fall Huddle Form

<b>SECTION A: FALL EVENT DETAILS--To be filled out by RN</b>	
Date of fall:	Time of fall (military):
Department/Nursing Unit where fall occurred:	
Patient's fall risk level prior to fall (in LW): <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Automatic High	
Did the patient have a falls risk wristband on when they fell? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When was the last time the patient was rounded on? _____ Which of the following were assessed during rounds? <input type="checkbox"/> Pain <input type="checkbox"/> Potty <input type="checkbox"/> Positioning <input type="checkbox"/> Placement of items	
Physical location of fall: <input type="checkbox"/> From bed <input type="checkbox"/> Between bed and bathroom <input type="checkbox"/> From chair <input type="checkbox"/> Between chair and bathroom <input type="checkbox"/> Other patient room location <input type="checkbox"/> From BSC <input type="checkbox"/> From toilet <input type="checkbox"/> From cart or gurney <input type="checkbox"/> Hallway <input type="checkbox"/> Shower/tub <input type="checkbox"/> Therapy/radiation/other treatment <input type="checkbox"/> Other:	
Was fall witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Was fall assisted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If fall was staff assisted, what transfer equipment was in use at the time of the fall? <input type="checkbox"/> None <input type="checkbox"/> Transfer belt <input type="checkbox"/> EZ stand <input type="checkbox"/> EZ lift <input type="checkbox"/> Walker <input type="checkbox"/> sliding board/slip sheet <input type="checkbox"/> N/A	
Was a staff member injured at the time of the fall? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please complete the Employee Accident or Injury Investigation Report.</i>	
If patient fell from bed, number of side rails in use at time of fall: _____ <input type="checkbox"/> N/A	
Medications administered within 8 hours prior to fall: <input type="checkbox"/> None <input type="checkbox"/> PCA <input type="checkbox"/> Opiates <input type="checkbox"/> Anticonvulsants <input type="checkbox"/> Antihypertensives <input type="checkbox"/> Antiarrhythmics <input type="checkbox"/> Diuretics <input type="checkbox"/> Hypnotics <input type="checkbox"/> Sedatives <input type="checkbox"/> Laxatives <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antipsychotics <input type="checkbox"/> Benzos <input type="checkbox"/> Antihistamines <input type="checkbox"/> Antiparkinsonians <input type="checkbox"/> Alzheimer drugs	
Is the patient on anticoagulants? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preventative measures in place prior to the fall: <input type="checkbox"/> Low Bed <input type="checkbox"/> Posey Sitter (chair pad) <input type="checkbox"/> Posey Sitter (bed pad) <input type="checkbox"/> Posey Vest <input type="checkbox"/> Wrist restraints <input type="checkbox"/> 4 side rails <input type="checkbox"/> 1:1 <input type="checkbox"/> Other:	
If the patient had a low bed or posey sitter in place, where the alarms properly set? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the alarms prompt the staff response to the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>SECTION B: POST FALL CHECKLIST—To be completed by RN</b>
<input type="checkbox"/> Page Flying Squad to respond to patient fall and facilitate second page of huddle form.
<input type="checkbox"/> MD notified—policy is to notify MD for <b>all</b> patient falls. <i>If the fall was unwitnessed or involved a potential head injury, complete a neuro exam every 15 minutes until the MD directs otherwise.</i>
<input type="checkbox"/> Nursing Supervisor epaged with FYI message of the fall event.
<input type="checkbox"/> Complete “High-falls” risk order set ( <i>Located in Lastword under COE order sets→Medicine or Nursing or search by “high falls.”</i> )
<input type="checkbox"/> Update the Care Plan
<input type="checkbox"/> <b>Complete a progress note, including the following information:</b> 1) Was the fall witnessed/unwitnessed and by whom. 2) Orientation status of pt. at time of fall: confused, drowsy, alert, etc. 3) Type of injury. 4) How was the patient lifted following the fall event—what equipment was used and how many staff members assisted?
<input type="checkbox"/> Update the falls nursing flowsheet, making the pt an automatic high falls risk.
<input type="checkbox"/> Pass on in report about fall and time to complete post-fall assessment (8 to 24 hours after the fall event).
Was next of kin notified? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, why not?)
<input type="checkbox"/> <b><u>Flying Squad to fax a copy of the completed POST FALL HUDDLE FORM and PROGRESS NOTE to Patient Safety, at 3-1334. Original huddle form goes to the Nurse Manager of the unit the fall occurred on.</u></b>

Label

**SECTION C: MINI ROOT CAUSE ANALYSIS—To be completed by Flying Squad**

	<b>First &amp; Last Name</b>	<b>Title</b>	<b>Home Unit</b>	<b>Manager</b>
Flying Squad RN				
Charge RN				
Primary RN				
Nurse Assistant				
Other (MD, students, etc)				


**What time did Flying Squad arrive for the mini root cause analysis?**

**What did the pt/family report was the reason for the fall?**

**Patient fell-WHY?**

 **WHY did that happen?**

 **WHY did that happen?**

 **WHY did that happen?**

 **WHY did that happen?**

**Root Cause(s) of fall determined:**

**Counter-measures taken that directly address the root cause(s) of the fall:**  
 Low bed placed    Posey sitter-chair pad placed    Pt/family education    Staff education    Care plan revised/updated    Equipment replaced/repared    PT/OT consult    1:1    Pt moved closer to the nurses station    Medications adjusted:  
 Other: