56 Lakeview Hospital
Patient Post Fall Huddle

Date of Fall ____________ Time of Fall ____________

Ask the patient:

“Do you remember falling?”

Yes ____
No ____

“What were you doing when you fell?”

“Had you put on your call light?”

“Were you injured?”

Yes ____ If so, how and where? ____________________________
No ____

Additional comments from patient, family, staff? ____________________________

Patient Status:

Was patient on Falls Protocol?

Yes ____
No ____

Falls interventions in place:

Bed Alarm____
Bed in low position____
TABS____
Sitter____

Were hourly rounds done?

Yes ____
No ____

What time was the patient last seen/observed/assisted? ____________

Call Light Status:

Was the call light on?

Yes ____
No ____

Number of minutes call light was on? ______
Contributing Factors:

Medication________________ (please specify name of medication)
Equipment____
Footwear____
Mental status____
Urgency of toileting needs____
Environmental issues____

Unit Census______

Number of Staff assigned to the unit at the time of fall:

RN______ (including floor charge nurse)       RN assigned to patient______
CNA______       CNA assigned to patient______
HUC______
Other______

Is this fall a repeat during this stay?______
Was the fall assisted by staff?______

Suggestions for interventions to be implemented post fall:________________________

Not a permanent chart copy       Please return to the Manager