Methodist Hospital

Label

Post Fall Huddle Form

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

SECTION B: POST FALL CHECKLIST—To be completed by RN	
□	Page Flying Squad to respond to patient fall and facilitate second page of huddle form.
□	MD notified—policy is to notify MD for **all** patient falls. *If the fall was unwitnessed or involved a potential head injury, complete a neuro exam every 15 minutes until the MD directs otherwise.*
□	Nursing Supervisor epaged with FYI message of the fall event.
□	Complete "High-falls" risk order set (*Located in Lastword under COE order sets→Medicine or Nursing or search by "high falls."*)
□	Update the Care Plan
□	**Complete a progress note, including the following information:** 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?
□	Update the falls nursing flowsheet, making the pt an automatic high falls risk.
□	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? □Yes □No (If no, why not?)	
□	**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.**

Label

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

	First & Last Name	Title	Home Unit	Manager
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/repaired □PT/OT consult □1:1 □Pt moved closer to the nurses station □Medications adjusted:

□Other: