

Report Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

### Falls Event Reporting Form and Post-Fall Huddle Documentation

**Definition of fall:** For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).

1. Patient Medical Record Number: \_\_\_\_\_  
2. Patient Admission date: \_\_\_\_\_

2.a. Admission Type at time of fall:  Acute     Swing     Hospice     Observation     Outpatient

3. Patient Age: \_\_\_\_\_  
4. Patient Gender:  Male     Female

5. Patient's principal admitting diagnosis: \_\_\_\_\_

6. Date of Fall: \_\_\_\_\_  
7. Time of Fall: \_\_\_\_\_  
8. Prior to fall, when was the last time patient was visually assessed?

9. Where did the fall occur? *CHECK ONE*     < 1 hr     1-2 hrs     > 2 hrs

- Inpatient care area: Please specify (e.g. bedside, bathroom, etc.): \_\_\_\_\_
- Lab
- Labor and delivery area
- Emergency department
- Operating room or procedure area
- Therapy area (PT, OT, ST)
- Radiology/imaging area
- Outside area (i.e., grounds of this facility)
- Other: Please specify \_\_\_\_\_

10. Was the fall unassisted or assisted?  
 Assisted  
 Unassisted  
 Unknown

11. Was the fall observed?  
 Yes  
 No  
 Unknown



13. DESCRIBE THE FALL, how it occurred, where in detail it occurred, how it was discovered (a narrative may be attached):

14. Did the patient sustain a physical injury as a result of the fall?

<input type="checkbox"/> Yes	<ul style="list-style-type: none"> <li>• What type of injury was sustained? <i>CHECK ONE, IF MORE THAN ONE, CHECK MOST SEVERE</i></li> <li><input type="checkbox"/> Dislocation    <input type="checkbox"/> Skin tear, avulsion, hematoma</li> <li><input type="checkbox"/> Fracture    or significant bruising</li> <li><input type="checkbox"/> Intracranial injury    <input type="checkbox"/> Laceration requiring stitches</li> <li><input type="checkbox"/> Other: Please specify _____</li> </ul>
<input type="checkbox"/> No	
<input type="checkbox"/> Unknown	

16. After discovery of the fall, what was the extent of harm to the patient (i.e. extent to which the patient's functional ability is expected to be impaired subsequent to the incident and any attempts to minimize adverse consequences)? *CHECK FIRST OPTION THAT IS APPLICABLE*

- Death:** Dead at time of assessment
- Severe harm:** Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life.
- Moderate harm:** Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.
- Mild harm:** Minimal symptoms or loss of function, or injury limited to additional treatment, monitoring,

- and/or increased length of stay.
- No Harm:** Event reached patient, but no harm was evident.
- Unknown**

17. Approximately when after the fall was harm assessed? *CHECK ALL THAT APPLY*

- Within 24 hours
- Three days or later
- After 24 hours but before 3 days
- Unknown

18. Which of the following additional treatments or monitoring were performed as a result of the fall?

*CHECK ALL THAT APPLY*

- Transfer, including transfer to higher level care area within facility, transfer to another facility
- Monitoring, including observation, physiological examination, laboratory testing, phlebotomy, and/or imaging studies
- Additional medication therapy
- Surgical/procedural intervention
- Respiratory support (e.g., ventilation, tracheotomy)
- Unknown
- Other intervention: Please specify \_\_\_\_\_

19. Did, or will, the fall result in an increased length of stay? *CHECK ONE*

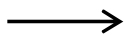
- Yes
- No
- Unknown

20. Did restraints, bedrails, or another physical device contribute to the fall (includes tripping over cords/tubing or other hazards)?

- Yes
- No
- Unknown

21. At the time of the fall, was the patient on medication known to increase the risk of fall?

- Yes
- No
- Unknown



22. Please indicate the number of each routine medication prescribed:

\_\_\_\_ Cardiovascular    \_\_\_\_ Diuretics    Psychotropics  
 \_\_\_\_ Hypnotics    Sedatives    Analgesics    \_\_\_\_  
                                  \_\_\_\_ Antihypertensives    \_\_\_\_ Laxatives

23. What factor(s) contributed to the event? *CHECK ALL THAT APPLY*

**Environment**

- Culture of safety, management of staff
- Physical surroundings cluttered
- Physical surroundings not customized to accommodate pt's mobility limitations

- Assistive device (walker, cane, etc.)
- Gait belt
- Wheelchair
- Call Light
- Bed Alarm
- Chair Alarm
- Other: Please specify \_\_\_\_\_



**Staff Qualifications**

- Lack of training (use of gait belt, transfers, lifts)

**Supervision/support**

- Lack of clinical supervision
- Poor teamwork

**Policies and procedures, includes clinical protocols**

- Poor clarity of policies
- Lack of compliance with policies

**Equipment/device**

How did the equipment device contribute to the fall?

**Information About Fall Risk Status**

- Not Available
- Not Accurate
- Not Legible

**Communication**

- Among staff or team members
- Staff to patient (or family)

**Human factors (Staff)**

- Fatigue
- Stress
- Inattention
- Cognitive factors
- Health issues

**External factors**

- Family/Visitor involvement

28. Prior to the fall, what was the patient doing or trying to do? *CHECK ONE*

- Ambulating
- Changing position (e.g. in bed, chair)
- Dressing or undressing
- Navigating bed rails
- Reaching for an item
- Showering or bathing
- Toileting
- Transferring to/from bed, chair, w/c, etc.
- Undergoing a procedure
- Unknown
- Other: Please Specify \_\_\_\_\_

29. Prior to the fall, was a fall risk assessment documented? *CHECK ONE*

- Yes
- No
- Unknown

30. Was the patient determined to be at risk for a fall?

- Yes
- No
- Unknown

31. What was the patients score on the fall risk assessment? \_\_\_\_\_

32. Prior to this fall, has the patient fallen while hospitalized? *CHECK ALL THAT APPLY*

- Yes, during this admission
- No
- Yes, during a previous admission
- Unknown

33. Which of the following were in place and being used to prevent falls for this patient?

*CHECK ALL THAT APPLY*

- Assistive devices (e.g., wheelchair, walker, commode)
- Physical/Occupational therapy, includes strengthening, gait training, balance, transfer training
- Bed or chair alarm
- Sitter
- Bed in low position
- Supplemental environmental or area lighting
- Call light/personal items within reach
- Toileting regimen
- Change in medication (e.g., timing or dosing)

24. After the discovery of the fall, who was notified?

*CHECK ALL THAT APPLY*

- Patient's family, or guardian \_\_\_\_\_
- Physician: \_\_\_\_\_
- Unknown

25. Was the patient being supervised or assisted by a health care professional at the time of the fall?

*CHECK ONE*

- Yes, hands on assist being provided
- Yes, in the same room, but not hands on
- No
- Unknown

26. Was the patient using an assistive device or other type of equipment at the time of the fall?

*CHECK ONE*

- Yes
- No
- Unknown

- Non-slip floor mats
- Hip and/or joint protectors
- Non-slip footwear
- Patient and family education
- Gait Belt

- Visible identification of patient as being at risk for fall (e.g., falling star)
- Patient placed close to the nurses' station
- Purposeful rounding
- Other: Please Specify: \_\_\_\_\_

**Other Contributing Factors (Patient)**

- Dizziness/Vertigo
- Hypotension
- Procedure within last 24 hours
- Constipation
- Cognitive impairment
- Impulsive behavior
- Other: PLEASE SPECIFY

- Weakness
- Anticoagulant / bleeding disorder
- Bowel Prep in Progress
- Incontinence/urgency
- Symptomatic depression
- Sensory Impairment (vision, hearing, balance, etc.)
- Overestimated ability

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## Post Fall Huddle Documentation

A Post Fall Huddle is one suggested best practice for reducing falls. Post fall huddles provide a mechanism to learn from falls by immediately assessing the situation and reviewing the event with the people involved, including the patient and family members, as well as determining what can be done at the bedside to prevent another fall from occurring.

**Directions:** To be completed after ALL patient falls as soon as possible after patient care is provided but prior to leaving the shift.

1. Has this patient fallen previously during this admission?

- Yes
- No
- Unknown

2. If Yes, what interventions were in place to minimize the risk of a fall?

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3. How preventable was the fall? CHECK ONE

- Almost certainly could have been prevented
- Likely could have been prevented
- Likely could not have been prevented
- Almost certainly could not have been prevented
- Unknown

4. How could the fall have been prevented?

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5. Who was included in the huddle? CHECK ALL THAT APPLY

- Patient
- Primary Nurse
- Physical Therapist
- Family/Caregiver
- CNA
- Pharmacist
- Physical Therapy Assistant
- Charge Nurse
- Occupational Therapist
- Pharmacy Tech
- Quality Improvement Coordinator
- Other: \_\_\_\_\_

6. What factors were discussed in the huddle?

Were there task errors?(e.g. planned interventions were not in place as intended)

Please describe: \_\_\_\_\_

Were there judgment errors?(e.g. strategy used to assist with transfers/gait was inappropriate)

Please describe: \_\_\_\_\_

Were there care coordination errors?(e.g. fall risk status not communicated to all parties)

Please describe: \_\_\_\_\_

Need to consult with Physical Therapy about balance/transfers/mobility?

Please describe: \_\_\_\_\_

Need to consult with Pharmacy about medications?

Please describe: \_\_\_\_\_

7. Additional comments regarding the huddle. \_\_\_\_\_  
\_\_\_\_\_

8. What actions will be taken to prevent another fall from occurring?

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**Thank you for contributing to patient safety and quality of care.**

Reporter: Please return this completed form to the med/surg nurse manager.

Quality Improvement: Not part of the medical record.