# DUHS Post-Fall Huddle

## Huddle Date

<table>
<thead>
<tr>
<th>Fall Date</th>
<th>Fall Time (Actual or discovered)</th>
<th>Assisted</th>
<th>Yes</th>
<th>Unit/Dept</th>
</tr>
</thead>
</table>

## Led by

<table>
<thead>
<tr>
<th>Led by</th>
</tr>
</thead>
</table>

## Attended by

<table>
<thead>
<tr>
<th>Staff caring for patient at time of fall (circle):</th>
<th>RN</th>
<th>NA</th>
<th>PT/OT</th>
<th>Sitter</th>
<th>Provider</th>
<th>Other:</th>
</tr>
</thead>
</table>

## Review & Consider:
- **Be sure to specify immediate actions in the SRS event report.**
  - Staff Account of Fall in Huddle (*enter relevant, objective info in SRS*)
  - Patient/Family Account of Fall (*enter relevant, objective info in SRS*)
  - Injury incurred from fall? □ None □ Yes (minor, moderate, major, death). *Describe injury & treatment/testing/imaging in SRS.*
  - Potential for complications (i.e., hit head; anticoagulation therapy) □ No □ Yes (ensure appropriate follow up)

## Fall Precautions

<table>
<thead>
<tr>
<th>Fall Precautions</th>
<th>Was the patient identified as High Falls Risk prior to the fall?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

- **List falls precautions NOT in place at the time of the fall that should have been.**
  - □ All appropriate precautions applied

## Contributing Factors (please indicate ALL that apply in the SRS event report)

- □ Patient-related:
  - □ Equipment/Supplies (bed/chair alarm, call bell malfunction)
  - □ Medications (new/changes, opioids, benzodiazepines, diuretics, sedatives, anti-hypertensive)
  - □ Physiological (vertigo/dizziness, orthostatic hypotension, blood sugar changes)
  - □ Other:

- □ Behavioral (agitated, impulsive)
- □ Cognitive impairment (dementia, TBI)
- □ Sensory impairment (vision, hearing, balance)
- □ Assessment (incomplete, inaccurate)
- □ Environmental (wet floor, poor lighting, trip hazards)

## Inpatient Only

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Diagnosis</th>
<th>Previous fall this admission</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

- **Last BMAT score:** _______  **Time:** _____

- **Fall from bed or chair?** □ No □ Yes (continue)

- **Alarm in use at time of fall:** □ Not applicable (per policy) □ Not at time of fall □ Chair □ Bed □ Other:
  - Bed alarm sensitivity at time of fall: □ In bed □ Edge of bed □ Out of bed
  - Issues with alarm? (Report faulty equipment, if appropriate.) □ No alert at nurses’ station □ No alert in room □ Other issues with alarm
  - Did patient refuse alarm at most recent rounding? □ No □ Yes, if yes, was this escalated? □ No □ Yes

- **Toileting-Related?** □ No □ Yes (continue)

- **Does patient have frequent urination/urgency?** □ No □ Yes
- **Was there a bedside commode?** □ No □ Yes

- **Time when patient last toileted prior to fall.** _____

- **Was privacy an issue/concern (by patient or staff)?** □ No □ Yes

## Action Plan (write on back of form, if needed)

1. What could have been done to prevent this fall?

2. What will be done to prevent patient from falling again?

3. How can we prevent this from happening to other patients?

## Staffing


## Manager/Champion Checklist

- Review SRS # _______
- Verify & correct the accuracy & completeness of event report (event location, immediate actions, contributing factors, expert review notes, manager/champion comments entered as appropriate)
- Enter results of testing/imaging related to suspected injury; correct injury level, if appropriate

## Revised 11/2018