DUHS Post-Fall Huddle

Staffing

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<tr>
<th>Unit Census:</th>
<th>RN Ratio (pts:RN):</th>
<th>NA Ratio (pts:NA or MCA):</th>
<th>IP Sitter:</th>
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<td>Y / N / Requested</td>
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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

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

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- RN Ratio (pts:RN): ________
- NA Ratio (pts:NA or MCA): ________
- IP Sitter: Y / N / Requested

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- Enter results of testing/imaging related to suspected injury; correct injury level, if appropriate

Fall Date | Fall Time (Actual or discovered) | Assisted | Unit/Dept |
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Fall Precautions

- Was the patient identified as High Falls Risk prior to the fall? No Yes
- List falls precautions NOT in place at the time of the fall that should have been.

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

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

Inpatient Only

- Last BMAT score: ________
- Time: ________:

Date of Admission | Diagnosis | Previous fall this admission | No | Yes
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Fall from bed or chair? No Yes (continue)
- Alarm in use at time of fall: No Not applicable (per policy) No 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

Staff Checklist.

- Reference policy: “Falls: Management, Assessment, Intervention, Reporting”
- Notify OA
- Notify provider
- Document significant event in Maestro Care (flowsheet row and note type)
- Complete SRS
- Send copy of completed huddle form to Duke Moves facility coordinator
- Give original completed huddle form to unit leadership

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Visitor -or- MRN: __________
- Age _____

Patient Label -or- Patient Name: __________
- M / F

DRAH (direct contact preferred), fax: 954-3136
DRH (scan preferred), fax: 470-7438
DUH (scan preferred), fax: 613-2396
Revised 03/2019