OSBORNE COUNTY MEMORIAL HOSPITAL

POST FALL HUDDLE

PATIENT NAME: _________________________________ Date __________________

TIME OF FALL: __________ Location of fall ________________________________

Was fall Witnessed __________ Unwitnessed ___________ When was the patient last seen? ________

__________ What was the patient doing when last seen? _______________ Behavior at time of fall:

Normal __________ Memory Loss ______ Agitation ________ Disorientation ________ Combative ______

Was this a staff assisted fall: Yes ________ No ________ Was staff injured in this fall? ______

ENVIRONMENT ASSESSMENT: Did any of these things play a role in the fall? (check all that apply)

Call light ______ Kleenex Box ______ Waste Basket ________ Phone ________ Food Tray ________

Assistive Device (cane, walker, glasses, hearing aid) __________ Dim Lighting ________ Bed/Chair
alarm malfunction ________ Bed not in lowest position ________ Toilet/Bed side Commode

__________ Using urinal __________ If using the restroom, was staff within arm reach? YES _____ No

_____ Ambulating in hall way ________ Reaching for item ________ Balance impairments ________

Weakness ________ falls at home ________ Activity order __________________

MEDICATIONS ADMINISTERED IN LAST 8 HOURS: (check all that apply) Anti-hypertensives ______

Anti-arrhythmics _________ Diuretics ___________ Sedatives __________ Laxatives __________

Hypnotics __________ Antidepressants ________ Antipsychotic __________ Antihistamines’

__________ Alzheimer’s Drugs ________ Antiparkinsonians ________ Antiemetic ______

Is the patient on an anti-coagulant YES ________ NO ________ Has there been any medication
change in the last 2 days? Yes ______ No ______

TRIP HAZARDS: (check all that apply): Clothing ____________ slick shoes or no shoes __________

Tubing or cords on the floor (oxygen, TV cords etc) ________ Furniture ________ Equipment

__________ Foley Catheter in place ________ IV ________ Bed linens ________ Clothing/gown

_____ Slippery floor __________

FACILITY FACTORS: What is the current census on the floor? ________ Anything unusual happening
during the time of the fall? Code ________ Change of shift/report ________ Multiple
admits/discharges ________ Staff meeting ________ Meal time ________ Extended ER times ______

FALL PREVENTION: Check all that apply Call light within reach ________ Keep close to nurse’s station

______ Sitter ________ Night light ________ Toilet schedule ________ Personal safety alarm ______

Bed alarm ________ Gripper socks/shoes ________ Falling star on door ________ Toilet

schedule ________ Clear path to Bathroom ________ Room change in last 2 days ______

WHO ATTENDED THE POST FALL HUDDLE? (check all that apply) Patient ________ CNA ________

Nurse ________ QA/QI ________ PT ________ Risk Management ________ Family

______ Other ________

THIS DOES NOT REPLACE THE INCIDENT REPORT!