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 ASSESMENT: 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) Antihypertensives _____
Antiarrhythmics _____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!