Post Fall Huddle Guidelines

Date: __________ Time of Fall: _______ Time of Huddle: _______ Room #: _______ SHIFT*(circle one):* D/PM/NOC

Diagnosis: ____ Pertinent Medical Hx: ____

LOCATION of FALL:

☐ Bed/ Bedside Commode ☐ Chair ☐ Gurney ☐ Hallway ☐ Room ☐ Restroom

☐ Other: ____

BACKGROUND: Fall risk factors / risk for injury *(check all that apply):*

☐ Altered Mental Status
☐ Dizziness/Lightheadedness
☐ Change in Vital Signs
☐ Medications *(Benzodiazipines, Pain meds, B/P meds, hypnotics)*
☐ SOB
☐ Anti -coagulation
☐ s/p OD or intoxication
☐ Pain or Discomfort: Location
☐ Diagnosis r/t *(Hypoglycemia/ Seizure/ Hypotension/Parkinson /Dementia)*
☐ Bones *(Osteoporosis)*
☐ Surgery *(recent/Fracture/amputee)*
☐ Physical condition *(poor balance, weakness)*
☐ Sensory or Neural Deficit
☐ ETOH use
☐ Age (>85)
☐ Prior Fall History
☐ Impaired Communication
☐ New infection or Illness
☐ Environmental Factors *(equipment)*
☐ Other: ____________________

Information Related to Fall Event	FINDINGS
1. Was patient on Fall precaution?	______ YES ______ NO
2. Most recent Fall Risk Assessment score ?	
3. Was patient alone at the time of fall?	______ YES ______ NO
4. Describe in patient's own words what they were doing prior to fall.	
5. Elimination problems : *(____ urgency; ____ diarrhea, ____ incontinence)*	______ YES ______ NO
TYPE of FALL	**DESCRIPTION**
A. ____ Accidental Fall	______ Slip _____ Trip
B. ____ Anticipated Physiological Fall Related to: ____ loss of balance ____ impaired gait or mobility ____ impaired cognition/confusion ____ impaired vision ____ functional deficits ____ disease process ____ unrealistic assessment of their ability	
C. ____ Unanticipated Physiological Fall *(created by condition that cannot be predicted, e.g. unexpected orthostasis, extreme hypoglycemia, stroke or heart attack.)*	
D. ____ Intentional Fall: *(Patient who voluntarily alters body position to lower level).*	
NURSING OBSERVATION/ASSESSMENT	**FINDINGS**
Neuro checks: Glascow Coma Scale: ______	___ Changes in MS *(Mental Status)* ___ Headache ___ Vomiting ___ Bleeding
Did Patient hit his/her head?	______ YES ______ NO
Fall witnessed?	______ YES ______ NO
What were the provider's findings and orders?	__ Injury __ Pain __ Functional change __ Other:

ACTION/RECOMMENDATION/PREVENTATIVE MEASURES

___ Assistive device *(e.g. walker, cane)*
___ Bed Alarm
___ Close Observation
___ Behavioral Management Plan
___ Hip protectors
___ Non-skid socks
___ Moved patient *(higher visibility)*
_____Pain Management Assessment
___ PT/OT evaluation
___ Removed Clutter / equipment
___ Toileting plan

____

Follow – up Plan: *(Free text new interventions or family to prevent further falls).*

Print and Signature (RN/LVN): ____