Report Date: ___________ Completed By: ________________

CAPTURE Falls Event Learning Form

Definition of fall: A fall is a sudden, unintended, descent of a patient's body to the ground or other object (e.g., onto a bed, chair, or bedside mat) that can be assisted (e.g., when a patient begins to fall and is assisted to a lower surface by another person) or unassisted.

1. Date of fall: _____________

2. Time of fall (military time): ____________

3. Admission type at time of fall: ☐ Acute ☐ Swing ☐ Observation ☐ Hospice ☐ Outpatient ☐ ED ☐ Ambulatory Care Clinic ☐ Visitor ☐ Other:___________

4. Patient medical record number: ______________________

5. Patient admission date: ___________

6. Patient age (if older than 90, simply indicate >90):__________

7. Patient Sex: ☐ Male ☐ Female

8. Reason for hospitalization: ____

9. Other conditions/co-morbidities: ____

____

10. Was the patient taking any of the following medications that are known to increase the risk for falls or fall-related injury? (Mark all that apply)

☐ Anticoagulants ☐ Antidiabetic agents ☐ Cardiovascular agents ☐ Corticosteroids
☐ Psychotropics ☐ Analgesics ☐ Anticonvulsants ☐ Anticholinergerics
☐ Other: _______________________ ☐ No, the patient was not taking any of these medications

11. Ambulatory status at time of fall (Mark all that apply): ☐ Not ambulatory ☐ With assist of 2 (hands-on) ☐ With assist of 1 (hands-on) ☐ With assistive device ☐ Stand by assist ☐ Independent ☐ Unknown

12. Where did the fall occur?
☐ Inpatient care area → 12a.
☐ Emergency department
☐ Therapy area (PT, OT, ST)
☐ Radiology/imaging area, including mobile
☐ Outside area
☐ Other: ______________________

12a. Where specifically in inpatient care?
☐ Bedside
☐ Chairside
☐ Bathroom
☐ Hallway
☐ Other: ________________

13. Did staff assist the patient (hands on) during the fall?
☐ Yes → 13a.
☐ No → 13b.

13a. Was a gait belt used?
☐ Yes
☐ No → 13a1.
☐ Unknown

13a1. If a gait belt was not used, was one available?
☐ Yes
☐ No
☐ Unknown

13b. Was the fall observed? ☐ Yes, by staff ☐ Yes, by family, visitor or other patient ☐ No

14. If unassisted and not observed, how did staff discover the fall?
☐ Patient found on floor ☐ Notified by family/friend/other patient
☐ Reported by patient ☐ Patient calling for help/using call light
☐ Alarm sounding ☐ Unknown
☐ Other: ___________________________

15. Describe the fall (Provide details on how and where the fall occurred, how it was discovered, etc.):

____
____
____
____

16. Was the patient injured as a result of the fall?

☐ Yes →
☐ No

16a. What was the type of injury? (Mark all that apply)

☐ Abrasion or Skin Tear (not requiring sutures or steri-strips)
☐ Laceration (requiring sutures or steri-strips)
☐ Fracture
☐ Intracranial injury
☐ Hematoma/Bruising
☐ Pain
☐ Dislocation
☐ Other:_______________

16b. What was the extent of harm to the patient as a result of the fall?

☐ Minor: Application of dressing, ice, cleaning of wound, limb elevation, topical medication, bruise or abrasion
☐ Moderate: Suturing, application of steri-strips/skin glue, splinting or muscle/joint strain
☐ Major: Surgery, casting, traction, consultation for or internal injury or need for blood products
☐ Death

17. Additional clinical treatments and/or monitoring that occurred as a result of the fall (Mark all that apply):

☐ No additional treatments and/or monitoring
☐ Transfer, including transfer to higher level care area within facility, or transfer to another facility
☐ Increased observation
☐ Lab tests
☐ Surgical/procedural intervention
☐ Increased length of stay
☐ Additional physiological exams
☐ Imaging studies
☐ Respiratory support
☐ Additional medication therapy, including change in pre-incident doses
☐ Other _______________________

18. Mark the action that most clearly describes what the patient was doing or trying to do when the fall occurred.

☐ Undergoing a procedure/test
☐ Ambulating w/assistance
☐ Ambulating w/o assistance
☐ Transferring w/assistance
☐ Transferring w/o assistance
☐ Dressing/undressing
☐ Dressing/undressing related to showering
☐ Showering
☐ Other: _____________________________
☐ Changing position (e.g. in bed, chair)
☐ Reaching for an item
☐ Toileting/on commode w/assistance
☐ Toileting/on commode w/o assistance (left alone)
☐ Ambulating to bathroom w/assistance
☐ Ambulating to bathroom w/o assistance
☐ Dressing/undressing related to toileting
☐ Performing personal hygiene in bathroom (unrelated to toileting)

19. If the fall was related to toileting, when was the last time, prior to the fall, the patient was toileted?

☐ Two hours or less ☐ More than two hours ☐ Unknown

20. Was the patient using an assistive device at the time of the fall (i.e. cane, walker, wheelchair, etc)?

☐ Yes →
☐ No
☐ Unknown

20a. What was the assistive device? ______________________________

20b. Did the assistive device contribute to the fall? If so, how? _______________

____

21. Did any equipment or furniture contribute to the fall (i.e. alarm, bed rail, call light, IV pole, chair, etc)?

☐ Yes →
☐ No
☐ Unknown

21a. What was the equipment or furniture? __________________________

21b. How did the equipment or furniture contribute to the fall? _______________

____

22. Was a fall risk assessment documented for this patient?

☐ Yes → 22a
☐ No → 22b
☐ Unknown

22a. What was the patient's score on the fall risk assessment? __________ →

22a1. Was the patient determined to be at risk for a fall?
☐ Yes
☐ No
☐ Unknown

22b. Why was no fall risk assessment documented?____________________

____

23. Prior to this fall, has the patient fallen while hospitalized?

- ☐ Yes, during this admission
- ☐ Yes, during a previous admission
- ☐ No
- ☐ Unknown

24. Which of the following interventions were in place and being used to prevent falls or fall injury for this patient? (Mark all that apply)

- ☐ Assistive device
- ☐ Bed alarm
- ☐ Chair alarm
- ☐ Bed in low position
- ☐ Call light/personal items within reach
- ☐ Gait Belt
- ☐ Hip and/or joint protectors
- ☐ Medication change
- ☐ Non-slip floor mats
- ☐ Non-slip footwear
- ☐ Commode
- ☐ Not to be left alone while toileting
- ☐ Orthostatic vital signs monitoring
- ☐ Patient and family education
- ☐ Patient placed close to nurses' station
- ☐ Physical/occupational therapy, includes exercise or mobility program
- ☐ Purposeful rounding
- ☐ Sitter
- ☐ Supplemental or area lighting
- ☐ Toileting regimen
- ☐ Video monitoring
- ☐ Visible identification of patient as being at risk for fall (e.g., falling star)
- ☐ Other: ______________________________

25. Which organizational factors may have contributed to the event? (Mark all that apply)

- ☐ Communication, other than at the time of handoff
- ☐ Handoff
- ☐ Data issues (e.g. availability, accuracy)
- ☐ Environment (e.g. culture of safety, physical surroundings
- ☐ Human factors (e.g. fatigue, stress, inattention, cognitive factors)
- ☐ Policies and procedures, including clinical protocols (e.g. absence, adequacy, clarity)
- ☐ Staff qualifications (e.g. competence, training)
- ☐ Staff supervision/support (e.g. clinical, managerial)
- ☐ Health information technology (e.g. electronic health record)

26. Which patient factors may have contributed to the event? (Mark all that apply)

- ☐ Dizziness/vertigo
- ☐ Hypotension
- ☐ Cognitive impairment
- ☐ Overestimated ability
- ☐ Impulsive behavior
- ☐ Neurological comorbidities (e.g. previous CVA, MS, Parkinson's Disease
- ☐ Weakness
- ☐ Incontinence/urgency
- ☐ Procedure within last 24 hours
- ☐ Sensory Impairment (vision, hearing, balance, etc.)
- ☐ Other: ______________________

CAPTURE Falls Collaborative Members: Please use the Know Falls System at https://unmcredcap.unmc.edu to complete this form electronically. Contact the UNMC CAPTURE Falls Team at capture.falls@unmc.edu for assistance.

Medical Record Number ______________ Date of Fall________ Time of Fall_______

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

During the huddle look for specific answers and continue asking "*why?*" until the root cause is identified.

1. **Establish facts:**
   - **a. Did we know this patient was at risk? YES NO**
   - **b. Has this patient fallen previously during this stay? YES NO**
   - **c. Is this patient at high risk of injury from a fall? Age 85+ Brittle Bones Coagulation Surgical Post-Op Patient**

2. Establish what patient and staff were doing and why.	HAND WRITTEN NOTES
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). **Ask why multiple times.**	
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	

3. Determine underlying root causes of the fall.	HAND WRITTEN NOTES
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	

4. Make changes to decrease the risk that this patient will fall or be injured again.	HAND WRITTEN NOTES
ASK: How could we have prevented this fall? ☐ **Need to consult with physical/occupational therapy about mobility/positioning/seating** ☐ **Need to consult with pharmacy about medications** ☐ **Need to consult with other health care professional(s):______________________**	
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	
ASK: What patient or system problems need to be communicated to other departments, units or disciplines?	

Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 should be completed by the organizational fall risk reduction team.

1. Date of Huddle ______________ **Time of Huddle** ____________ **Huddle Facilitator Initials** ___________

2. Who was included in the huddle? CHECK ALL THAT APPLY

☐ Patient	☐ Primary Nurse	☐ COTA	☐ Physical Therapist
☐ Family/Caregiver	☐ CNA	☐ Pharmacist	☐ Physical Therapy Assistant
☐ Charge Nurse	☐ Occupational Therapist	☐ Pharmacy Tech	☐ Quality Improvement Coordinator

☐ Other: ________________________

3. Cause of fall – Patient Level: Identify the fall type and preventability by checking the appropriate box below and describe actions taken to prevent a reoccurrence for this patient.

FALL CAUSE	FALL TYPE PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
☐ **Environmental (Extrinsic) Risk Factors** Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	**Accidental** → **Possibly could have been prevented**	
☐ **Known Patient-Related (Intrinsic) Risk Factors** Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	**Anticipated Physiological** → **Possibly could have been prevented**	
☐ **Unknown, Unpredictable Sudden Condition** Examples: Heart Attack, Seizure, Drop attack	**Unanticipated Physiological** **Unpreventable**	

☐ **Unsure** – Please describe fall cause and your assessment of preventability: ______________________________________

____

____

Could this fall have been considered **intentional**? If yes, explain why: ______________________________________

____

____

4. Cause of Fall – System Level: Discuss the fall with your fall risk reduction team.

Describe/discuss what your team learned about your fall risk reduction system as a result of this fall:	
How will your team communicate the knowledge gained from this fall to the rest of your organization?	

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