McLaren Flint
Flint, MI

POST FALL HUDDLE FORM

Date of Fall: _____ Time of Fall: _____ Room#: _____

Witnessed: ☐Yes ☐No Hit Head: ☐Yes ☐No Activity before Fall (use Key): _____

Most recent Fall Assessment: ☐0-12 hrs ☐12-24 hrs ☐>24 hrs; Combined Fall Risk Score: _____

Unit Census at time of fall _____
Huddle Date:_____ Time:_____

Number of staff on Unit at time of Fall ___
RN's_____ NA's_____

Staff Attending Huddle:
DM/ANM:_____
Charge Nurse:_____
Patient's Nurse:_____ _____
RN/NA's:_____ _____
Other (Student, PT, UC, Sitter):_____

Time last hourly rounding completed:_____
Time since last toileting: Hrs./Min._____
Fall risk communicated in last handoff: ☐Yes ☐No
Does Patient have PT/OT ordered: ☐Yes ☐No

Background

Relevant patient history/symptoms (use Key): _____ Patient's cognition history (use Key): _____

Assessment

Asesssment: (use Key): _____ Glascow Coma Score: _____ Injury: _____

T: _____ P: _____ R: _____ BP: _____ O2 SAT: _____ Accu-check (for diabetic) _____

Recommendation

What could have been done to prevent this fall? _____

CT scan completed: Date: _____ Time: _____ Other treatment or testing provided: _____

Physician(s) notified: _____ Date; _____ Time: _____

Was patient transferred off of the unit following the fall? ☐Yes ☐No To room# _____

Signature of RN: _____ **Date:** _____ **Time:** _____

Document any changes in plan of care on the interdisciplinary care plan and 24-hour flow sheet.

Manager Follow up	Yes	No	Comment
Was the Post Fall Checklist completed properly?			
Was the Falls Bundle properly used?			
Is the fall documented in the chart?			
Were Neuro check and other assessments documented?			
Is follow up with other departments needed?			

Manager Signature_____Date/Time:_____
(Required)

THIS FORM IS NOT A PART OF THE PERMANENT MEDICAL RECORD

PT.
MR.#/P.M.
DR.

SBAR Key

Situation: (Activity before fall)
1. Assisted to floor
2. From bed
3. Walking to bathroom
4. In bathroom
5. Walking from bathroom
6. From bedside commode
7. Found on floor
8. Walking without assistance
9. Walking with assistance
10. From chair or wheelchair
11. From stretecher or table
12. Uses walker, cane, or crutches
13. In shower/tub
14. While standing
15. Reported by family
16. Other: must specify on front

Background: (Relevant patient history and symptoms prior to fall)
1. Gait disturbance
2. Weakness
3. Hypoglycemia
4. Seizure
5. In restraints
6. Fainted

Cognition History
7. Alert
8. Combative
9. Agitated
10. Impulsive
11. Sedated
12. Unconscious
13. Uncooperative
14. Other: must specify on front

Assessment: (Injury)
1. Abrasion
2. Bruise
3. Hematoma
4. Laceration
5. Redness
6. Skin tear
7. Range of Motion limitation
8. Pain
9. Swelling
10. Unknown
11. Change in level of consciousness
12. Change in mental status/confusion
13. Other: must specify of front