PLACE LABEL HERE

Newark Beth Israel Medical Center
Staff Post Fall Huddle Form

REVIEW THE FALL

Directions for use: To be completed by the charge nurse during the post huddle with the staff involved in caring for the patient.

Date: _____ **Time:** _____ **Person completing form:** _____

Questions	Yes	No	Comments
1. Was the patient identified as a fall risk?			
2. If the patient was a fall risk, were interventions taken to prevent the fall?			
3. Was this the 1st fall for this patient?			
4. Was the patient alert and oriented?			
5. Was a restraint / bed or chair alarm in use? If so, specify which under comments.			
6. Was the fall related to the patient attempting to toilet?			
7. Did this fall occur after the use of sleeping medication, pain medication or sedatives?			
8. Is the patient receiving anticoagulants?			

After the fall, what precautions were taken to prevent another fall?

☐ **The MD was notified; Name of MD notified:** _____

☐ **Nursing Supervisor notified:** _____

☐ **Check this box if the patient has sustained an injury: Circle appropriate type:**

- Actual / Suspected head trauma
- Fracture
- Other _____

THIS FORM IS NOT A PART OF THE MEDICAL RECORD

Place completed form in the mailbox of the unit Patient Care Director.

Time since Fall Risk Assessment :

- ☐ >0 to 12 hours
- ☐ >12 to 24 hours
- ☐ >24 to 48 hours
- ☐ >48 to 72 hours
- ☐ >72 hours to 1 week
- ☐ >1 week

Score: _____

Patient at Fall Risk:

- ☐ **Yes** = if patient was at risk according to Fall Assessment
- ☐ **No** = not at risk
- ☐ **Not assessed**

Fall Prevention Protocol in place prior to fall:

- ☐ Yes
- ☐ No
- ☐ **Not applicable**=patient does not have identified risk factors

Physical Restraints at time of fall:

- ☐ **Yes**
- ☐ **No**
- ☐ **No documentation**

Prior Fall this month on this unit:

- ☐ **No**=this is the first time this patient fell this calendar month after admission to your unit
- ☐ **Yes**= this is a repeat fall since admission this calendar month on this unit

Form completed by: _____

Extension: _____