# **POST FALL “HUDDLE” SBAR**

Within 15-30 minutes of a fall, gather all pertinent members of the team (including patient/resident, and housekeeper) to complete the following questions and attach to occurrence report.

|  |
| --- |
| Situation |

##### When and where

Date and time of fall: \_\_\_\_\_\_\_\_\_ Location (Department/unit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staffing:

* Staffed according to standard
* Shift not staffed by standard. Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Some staff unavailable due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., breaks, emergency on unit, shift change)

 Where did the fall occur?

|  |  |
| --- | --- |
| * Patient Room
 | * Patient bathroom
 |
| * Hallway
 | * Other:
 |

What do we think this person was doing at the time of the fall?

* Getting up on own
* Trying to get to the bathroom
* Trying to get (where)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Reaching for something
* Leaning on something
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the patient last seen? \_\_\_\_\_\_\_\_\_\_\_\_ What was the patient doing when last seen?

**Ask the patient: “What happened this time *that was different* from all the other times you have done this activity before?**

Date/Time of most recent fall risk assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of fall risk scale? \_\_\_\_Morse \_\_\_\_ Humpty-Dumpty™ \_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fall Risk Assessment score: \_\_\_\_\_\_\_\_\_\_ Risk Level: \_\_\_\_Low \_\_\_\_\_Medium \_\_\_\_\_\_High

Had the appropriate fall risk precautions been implemented based on the fall risk score? \_\_\_\_Y \_\_\_\_N (explain):

*Environment Assessment (check any item that could played a role in the fall—check all that apply):*

* Item(s) out of patient’s reach. If checked, which item was out of reach:

|  |  |
| --- | --- |
| * Call light
 | * Phone
 |
| * Kleenex box
 | * Food tray
 |
| * Waste basket
 | * Assistive device (cane, walker, glasses, hearing aid)
 |
| Other: |

* Trip hazards? If checked, what was the trip hazard:

|  |  |
| --- | --- |
| * Clothing/gown
 | * Hazardous footware (ill-fitting, slick, untied laces)
 |
| * Tubing/cord
 | * Obstructed path to bathroom
 |
| * Slippery floor
 | * Bed linens tangled around patient’s legs
 |
| Other: |

* Equipment/Lighting. If checked, what was the hazard:

|  |  |
| --- | --- |
| * Dim lighting
 | * Bed not in lowest position
 |
| * Bed/chair alarm malfunction
 | * Other:
 |
| * Equipment malfunction or furniture in need of repair:
 |
| * Restraints in place.

 Why? |

|  |
| --- |
| Background |

B. *Patient Fall risk factors (check all that apply):*

* Impaired mobility
* Impaired mentation
* Impaired / altered elimination patterns (nocturia, urgency, frequency, diarrhea, incontinence, laxative, bowel prep)
* Impaired communication / sensory (vision, hearing, neuropathy)
* Impaired vital signs (fever, slow or fast heart rate, low blood pressure)
* Prior fall history (at home, previous facility, or during this stay)
* Medication NOTE: If pertinent, attach copy of MAR for previous 12-hours

|  |  |
| --- | --- |
| * Anticonvulsant
 | * Anti-anxiety agent
 |
| * Psychotropic
 | * Hypnotic/Sleep aid
 |
| * Pain Medication
 | * Diruetic
 |
| * Notable medication change within the past 2 days
 |
| Other: |

* Diagnosis-related

|  |  |
| --- | --- |
| * Hypotension
 | * Hypoglycemia
 |
| * TIA/Syncope
 | * Parkinson’s
 |
| * History of CVA or paralysis
 |
| * Orthopedic condition
 |
| Other: |
|  |

|  |
| --- |
| Assessment |

Vital Signs: T\_\_\_\_\_\_\_ P\_\_\_\_\_\_ R \_\_\_\_\_\_\_ B/P\_\_\_\_\_\_ Oxygen Sat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurochecks if evidence/suspicion of head injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If diabetic, do glucometer. Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Level: \_\_\_\_\_\_\_\_\_ Describe any NEW onset pain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injury (describe findings):

* None
* Minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Major:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Recommendation |

What can we do to prevent this from happening again? Care plan recommendations:

|  |  |  |
| --- | --- | --- |
| * High-Fall Risk Precautions
 | * Clear path to BR
 | * Move to room closer to nurses’ station
 |
| * Hourly rounding
 | * Remove clutter
 | * Identify items pt wants near them
 |
| * Toileting plan
 | * Non-slip footwear
 | * Oxygen/IV tubing mgmt
 |
| * Alarm
 | * Hip protectors
 | * Patient/family education
 |
| * PT Eval
 | * Improved positioning
 | * Request family or sitters to stay with patient
 |
| * Pharmacy review of meds
 | * Other:
 |
| * Other:

  |

**Names of individuals participating in the post-fall assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Post-fall checklist

* **Notify physician**
* **Notify house supervisor**
* **Notify family per disclosure policy**
* **Assess patient for injury and document assessment findings in the**

 **medical record**

* **Revise plan of care to include prevention strategies**

 **based on HUDDLE findings**

* **Fill out occurrence report and attach this form (SBAR Huddle) to the**

 **report & forward to the risk manager**