POST FALLS DEBRIEF FORM

WITHIN 1 HOUR OF FALL, conduct multidisciplinary post-fall huddle with all staff available at the time of the fall (i.e. bedside nurse, HUC, PCC, patient/patient's family, Physical Therapist and others who may have witnessed or responded to fall)

Names of those participating in debrief: 

<table>
<thead>
<tr>
<th>Patient Name/Room #:</th>
<th>Date and Time of Fall:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4/26/12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fall Type</th>
<th>Date of most recent intentional rounds including tolling:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed to floor</td>
<td>4/26/12 3 pm</td>
</tr>
<tr>
<td>Stand to floor</td>
<td>4 pm 4 pm</td>
</tr>
<tr>
<td>Bed to bedside commode</td>
<td>4 pm 5 pm</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was there an Injury?</th>
<th>How many bed falls were up?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date/time of most recent intentional rounds including tolling:</th>
<th>Bed has alarm capacity?</th>
<th>Was bed alarm on?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/26/12 3 pm 4 pm 4 pm</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Patients perspective (what happened in the patient's or patient's family's words):

"Patient is confined to bed and Spanish speaking. Bed alarm not turned on." 

FALLS PRECAUTIONS IN PLACE AT TIME OF FALL

- Red socks
- Sign on door
- Call light within reach
- Continuous observer (after)
- Restraints

CONTRIBUTING FACTORS (CLINICAL)

- Incontinent
- New change in BP meds
- Patient with 24 hours post-op
- Faint/dizziness/weakness
- Change in mobility status
- Change in mental status/behavior
- Agitation
- New change in pain meds
- New change in psychotropic meds
- Change in BP
- Change in Labs (i.e. hot, hgp, glucose)
- Allergy to ADL ability

CONTRIBUTING FACTORS (ENVIRONMENT)

- Wet floor
- Clothing interfering/too long
- Wheelchair foam seat
- Improper use of assistive devices
- Call light/tray table out of reach
- Poor room lighting
- Grab bars unavailable
- Improper bed height
- Call light not working
- Reaching for personal items
- Clutter/cords on floor
- Wheelchair/bed unlocked
- Improper commode height
- Call light not answered
- Improper footwear

INTERVENTIONS TO PREVENT FUTURE FALLS

- Bed alarm
- Pharmacy review of meds list
- Falls re-education
- Upgrade to high risk
- Increase observation frequency
- Other:

What did we learn?

"Bed alarm and tray table must be re-education on importance of making sure bed alarm and tray table are within reach of patient."

"This form is not part of the Medical Record"

Please give completed form to Unit Manager who will fax it to Khaled Al-Rid at x3460 within 72 hours.

Version: 2/12/10

Staff was re-educated on importance of making sure bed alarm and tray table are within reach of patient.