Providence HEALTH CARE

MEDICINE POST FALL SAFETY HUDDLE

Date of Fall: _____

Date of Huddle: _____

Present: (names) ☐ CNL _____ ☐ MRN _____ ☐ PT _____

☐ OT _____ ☐ Patient ☐ Other _____

Was Falls Risk Screen completed on admission?	☐ YES ☐ NO
Was risk for fall identified on admission?	☐ YES ☐ NO
Has this patient fallen previously during this stay?	☐ YES ☐ NO
Was this fall witnessed?	☐ YES ☐ NO
What was the patient doing when fall occurred? Be specific	
Describe any injuries sustained (degree of harm)	
Determine contributing factors of the fall	☐ Call bell not within reach ☐ Call bell not used ☐ Personal items not within reach ☐ Mobility aids not used/within reach ☐ Bed/wheelchair/commode too high / low ☐ Bed/chair alarm not working or not used ☐ Patient toileting self ☐ Patient not wearing Red Socks/non slip footwear ☐ Medications that increase risk of fall ☐ Medical condition of patient ☐ Other:
What did the team do well to prevent the fall?	
What were the actions after the event?	Physician notified ☐ YES ☐ NO Family notified ☐ YES ☐ NO ☐ PSLS report completed ☐ Completed Falls Risk Assessment and Care Plan ☐ Other:
What changes will be made to patient's plan of care to decrease the risk of future falls? OR What could have been done differently?	☐ Call bell & personal items within reach ☐ Mobility aids within reach ☐ Red Socks / non slip footwear ☐ Bed height appropriate, brakes functional ☐ Bed/chair alarm ☐ Medications reviewed (pharmacist/MD) ☐ PT / OT Consult ☐ Patient moved closer to nursing station ☐ Education ☐ Patient and family ☐ Staff ☐ Other:

DO NOT scan this form into the patient's permanent record. Shred after PSLS report completed and patient discharged.