Southampton Hospital **PATIENT LABEL**

Post-Fall "Huddle" Tool

This is NOT a permanent part of the patient's record.

This tool should be used to guide the immediate post-fall "huddle" and should take only 5 minutes of your time. Gather all available staff, including nurses, NA, and managers. Discuss at least the key points below to help modify the patient's care and prevent further falls. Then file an occurrence report immediately to capture all the data discussed in the huddle. Remember, the more information you include in the occurrence report, the better you can look at patterns and opportunities to prevent future falls.

☐ **Why does your patient think s/he fell?** ☐ **Morse fall scale was:**		

☐ **Why do YOU think the patient fell** (based on your nursing assessment of the following):
▪ Environmental Assessment
  ○ Bedrails up?
  ○ Bed/Chair alarm on?
  ○ Bed in low position?
  ○ Call light within reach?
▪ Fall history, fall circumstances, and fall risk factors assessment
▪ Health history and functional status
▪ Medications and alcohol consumption review
▪ Vital signs & Pain assessment
▪ Vision Screening
▪ Gait, Balance, or Musculoskeletal/Foot
▪ Continence Assessment
▪ Cardiovascular Assessment
▪ Neurological Assessment
▪ Depression Screening
▪ Walking Aids, Assistive Technologies, & Protective Devices Assessment
		Additional comments

☐ **What specifically can you change to prevent the patient from falling again?**		
☐ **File Fall Occurrence Report and include any "huddle" insight.**		
☐ **BE SURE to document patient fall in CPSI and report in Hand-Off Communication.**		

Please send this form to the nurse manager; the incident report and fall tracking tool goes to QM