Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Purposeful Post-Fall Huddle

RESIDENT

Resident:_____ ☐ Male ☐ Female Age:_____
Date of Fall: _____Time of Fall: _____Day of week:_____

HUDDLE INFORMATION

Date of Huddle: _____Time of Huddle: _____
Location of Huddle: ☐ Nurse's Station ☐ Location of Fall ☐ Resident Room ☐ Other _____

Huddle Leader/Facilitator: _____ Number of Attendees: _____

☐ Charge Nurse _____ ☐ Social Services_____ ☐ Resident_____
☐ RN _____ ☐ PT _____ ☐ Family Member_____
☐ LPN _____ ☐ OT _____ ☐ Visitor_____
☐ Med Aide _____ ☐ Housekeeping _____ ☐ Other (Name/Title)
☐ CNA _____ ☐ Dietary _____ _____
☐ Administrator _____ ☐ Maintenance_____ _____
☐ DON _____ ☐ Activities_____ _____

FALL INFORMATION

Location of Fall: ☐ Resident Room ☐ Resident Bathroom ☐ Hallway ☐ Dining Room ☐ Bathing Room
☐ Outside on Campus ☐ Outside off Campus ☐ Other

Type of Fall: ☐ Witnessed (observed to fall)_____
☐ Unwitnessed (found on floor/ground)
☐ Intercepted (would have fallen if not caught self or by another person)

Injury from Fall: ☐ No Injury
☐ Injury, except Major (skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains or any related injury causing the resident to complain of pain)
☐ Major Injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma)

Outside Medical Treatment Immediately after Fall? ☐ None ☐ Sent to Emergency Room ☐ Sent to Physician Clinic

RESIDENT

What were you trying to do? _____
Was something different this time?_____
Assistive device being used? ☐ None ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other _____
Footwear? ☐ Barefoot ☐ Shoes ☐ Gripper Socks ☐ Socks without Grippers ☐ Slippers ☐Other_____
Clothing? ☐ Fit well ☐ Loose ☐ Tight ☐ Other_____
Wears glasses? ☐ Yes ☐ No Wearing glasses when fell? ☐ Yes ☐ No
Wears hearing aides? ☐ Yes ☐ No Wearing hearing aides when fell? ☐ Yes ☐ No

STAFF

Approximate time of last contact or visual of resident before fall: _____Who? _____
What was the resident doing? _____
Who was in the area at the time of the fall?_____
Anything about the resident different today than normal?_____

ENVIRONMENT

Floor: ☐ Carpet ☐ Tile ☐ Rug ☐ Uneven ☐ Steps ☐ Shiny ☐ Wet: suspected liquid _____
☐ Other _____
Area where fall occurred: ☐ Light ☐ Dark ☐ Noisy ☐ Busy ☐ Cluttered ☐ Other_____
What items were near fallen resident? ☐ Bed ☐ Wheelchair ☐ Walker ☐ Chair/Recliner ☐ Toilet/Commode
☐ Other:_____
Equipment Used at Time of Fall: ☐ Total Lift ☐ Sit-to-Stand Lift ☐ Bath Chair ☐ Other_____
Other Environment Factors: _____

DRAW THE SCENE

Draw the scene of the fall.
Be descriptive.
Include the resident's position, equipment, assistive devices:

FALL ROOT CAUSE ANALYSIS

Use the 5 Whys to identify the root cause of the fall – Ask why until the cause of the fall is reached. Verify this result is the root cause by asking if this reason was removed, would the fall have occurred?

Problem Statement: One sentence description of the event

WHY

WHY

WHY

WHY

WHY

Root Causes

1.

2.

3.

To validate root causes, ask the following: If you removed this root cause, would this event have been prevented?

ACTION PLAN

What can be done to avoid future falls (intervention)? _____

_____

Care Plan Updated? ☐ Yes ☐ No
Signature of Leader/Facilitator: _____ Time Huddle Completed: _____
Fall Committee Review & Action: _____
Fall Committee Signature: _____ Date: _____
QAPI Committee Review & Action: _____
QAPI Committee Signature: _____ Date: _____

QAPI = Quality Assurance and Performance Improvement

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