Hospital: _____ Report Date: _____ Completed By: _____

Appendix A: CAPTURE Falls Event Learning Form

Definition of fall: For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).

1. Patient Medical Record Number: _____ 2. Patient Admission date: _____

3. Admission Type at time of fall: ☐ Acute ☐ Swing ☐ Hospice ☐ Observation ☐ Outpatient ☐ Visitor

4. Patient Age (if older than 90 indicate >90): _____ 5. Patient Gender: ☐ Male ☐ Female

6. Patient's principal admitting diagnosis: _____

7. Date of Fall: _____ 7a. Time of Fall (military time): _____

8. Ambulatory Status Time of Fall: ☐ Not ambulatory ☐ With assist of 2 ☐ With assist of 1 ☐ Independent

9. Where did the fall occur?

☐ Inpatient care area
- ☐ Bedside
- ☐ Chairside
- ☐ Bathroom
- ☐ Hallway

☐ Emergency department
- ☐ Therapy area (PT, OT, ST)
- ☐ Radiology/imaging area, including mobile
- ☐ Outside area (i.e., grounds of this facility)
- ☐ Other: Please specify _____

10. Did staff assist the patient (hands on) during the fall?

☐ Yes → 10a. Was a gait belt used? ☐ Yes ☐ No ☐ Unknown

☐ No → 10b. Was the fall observed? ☐ Yes, by staff ☐ Yes, by family, visitor or another patient ☐ No

11. If unassisted and not observed, how did staff discover the fall?

- ☐ Patient found on floor
- ☐ Notified by non-clinical staff
- ☐ Reported by patient
- ☐ Alarm sounding
- ☐ Unknown
- ☐ Notified by family/friend/another patient
- ☐ Notified by ancillary care staff
- ☐ Patient calling for help
- ☐ Patient call light
- ☐ Other: Please specify _____

12. DESCRIBE THE FALL, how it occurred, where in detail it occurred, how it was discovered (a narrative may be attached):

_____

_____

_____

_____

13. What type of injury was sustained? *CHECK ONE, IF MORE THAN ONE, CHECK MOST SEVERE*

- ☐ No Injury, no signs or symptoms resulting from the fall (x-ray, CT scan or other post fall evaluation resulted in finding of no injury)
- ☐ Fracture ☐ Dislocation ☐ Intracranial injury
- ☐ Skin tear, abrasion, hematoma or significant bruising
- ☐ Laceration requiring sutures or steri-strips
- ☐ Other: Please specify _____

13a. What was the extent of harm to the patient as a result of the fall? *CHECK FIRST OPTION THAT IS APPLICABLE*

- ☐ **Death:** Patient died as a result of injuries sustained from the fall.
- ☐ **Major:** Fall resulted in surgery, casting, traction, consultation for neurological (e.g. skull fracture, subdural hematoma) or internal injury (e.g. rib fracture, liver laceration) or need for blood products.
- ☐ **Moderate:** Fall resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain.
- ☐ **Minor:** Fall resulted in application of dressing, ice, cleaning of wound, limb elevation, topical medication, bruise or abrasion.

14. Which of the following additional treatments or monitoring were performed as a result of the fall?
CHECK ALL THAT APPLY

☐ Transfer, including transfer to higher level care area within facility, transfer to another facility
☐ Monitoring, including observation, physiological examination, laboratory testing, phlebotomy, and/or imaging studies
☐ Medication therapy including change in pre-incident dose
☐ Surgical/procedural intervention
☐ Respiratory support (e.g., ventilation, tracheotomy)
☐ Unknown
☐ Other intervention: Please specify _____

15. Did, or will, the fall result in an increased length of stay? *CHECK ONE*

☐ Yes ☐ No ☐ Unknown

16. Prior to the fall, what was the patient doing or trying to do? *CHECK ONE*

☐ Toileting/on commode w/assistance
☐ Toileting/on commode w/o assistance (left alone)
☐ Ambulating w/assistance
☐ Ambulating w/o assistance
☐ Ambulating to bathroom w/assistance
☐ Ambulating to bathroom w/o assistance
☐ Dressing/undressing
☐ Showering
☐ Dressing/undressing related to toileting
☐ Dressing/undressing related to showering
☐ Transferring w/assistance
☐ Transferring w/o assistance
☐ Reaching for an item
☐ Loss of consciousness
☐ Rolled out / Slipped off of bed
☐ Chair/recliner related
☐ Geri chair related
☐ Wheelchair related
☐ Unknown
☐ Other: Please Specify _____

17. Was the patient using an assistive device or other type of equipment at the time of the fall?

☐ Yes → 17a. What was the device or equipment? _____
☐ No
☐ Unknown

18. Prior to the fall, was a fall risk assessment documented? *CHECK ONE*

☐ Yes → 18a. Was the patient determined to be at risk for a fall?
☐ Yes
☐ No
☐ Unknown
☐ No
☐ Unknown

→ 18b. What was the patients score on the fall risk assessment? _____

19. Prior to this fall, has the patient fallen while hospitalized? CHECK ALL THAT APPLY

☐ Yes, during this admission
☐ No
☐ Yes, during a previous admission
☐ Unknown

20. Which of the following were in place and being used to prevent falls for this patient?
CHECK ALL THAT APPLY

☐ Alarm - Bed
☐ Alarm - Chair
☐ Assistive devices (e.g., wheelchair, walker, commode)
☐ Bed in low position
☐ Call light/personal items within reach
☐ Change in medication (e.g., timing or dosing)
☐ Gait Belt
☐ Hip and/or joint protectors
☐ Non-slip footwear
☐ Non-slip floor mats
☐ NOT to be left alone while toileting
☐ Patient and family education
☐ Patient placed close to nurses' station
☐ Physical/Occupational therapy includes strengthening; gait, balance, transfer training
☐ Purposeful rounding
☐ Sitter
☐ Supplemental environmental or area lighting
☐ Toileting regimen
☐ Video monitoring
☐ Visible identification of patient as being at risk for fall (e.g., falling star)
☐ Other: Specify_____
☐ NONE

21. Which equipment/devices/furniture contributed to the fall?

- ☐ None
- ☐ Alarm, bed
- ☐ Alarm, chair
- ☐ Assistive device (walker, cane, etc)
- ☐ Bed rails
- ☐ Call Light
- ☐ Gait belt
- ☐ Restraints
- ☐ Wheelchair
- ☐ Other: Please specify_____

21a. How did the equipment device contribute to the fall?

_____

_____

22. At the time of the fall, was the patient on medication known to increase the risk of fall?

- ☐ Yes
- ☐ No
- ☐ Unknown

31. Please indicate the number of each routine medication prescribed:

____ Cardiovascular	____ Diuretics	____ Psychotropics
____ Hypnotics	____ Sedatives	____ Analgesics
	____ Antihypertensives	____ Laxatives

23. Which **organizational factors** contributed to the event? CHECK ALL THAT APPLY

Environment
- ☐ Culture of safety, management of staff
- ☐ Physical surroundings cluttered
- ☐ Physical surroundings not customized to accommodate pt's mobility limitations

Staff Qualifications
- ☐ Lack of competence (qualifications, experience)
- ☐ Lack of training (use of gait belt, transfers, lifts)

Supervision/support
- ☐ Lack of clinical supervision
- ☐ Lack of managerial supervision
- ☐ Poor teamwork

Policies and procedures, includes clinical protocols
- ☐ Absence of policies
- ☐ Poor clarity of policies
- ☐ Lack of compliance with policies

Information About Fall Risk Status
- ☐ Not Available
- ☐ Not Accurate
- ☐ Not Legible

Communication
- ☐ Supervisor to staff
- ☐ Among staff or team members
- ☐ Staff to patient (or family)
- ☐ Fall associated with a handoff

Human factors (Staff)
- ☐ Fatigue
- ☐ Stress
- ☐ Inattention
- ☐ Cognitive factors
- ☐ Health issues

External factors
- ☐ Family/Visitor involvement

24. Which **patient** factors contributed to the event? CHECK ALL THAT APPLY
- ☐ Dizziness/Vertigo
- ☐ Hypotension
- ☐ Procedure within last 24 hours
- ☐ Constipation
- ☐ Cognitive impairment
- ☐ Impulsive behavior
- ☐ Overestimated ability
- ☐ Neurological Comorbidities (e.g. previous CVA, MS, Parkinson's Disease)
- ☐ Weakness
- ☐ Anticoagulant / bleeding disorder
- ☐ Bowel Prep in Progress
- ☐ Incontinence/urgency
- ☐ Symptomatic depression
- ☐ Sensory Impairment (vision, hearing, balance, etc.)
- ☐ Morbid obesity
- ☐ Other: PLEASE SPECIFY _____

Thank you for contributing to patient safety and quality of care.

Reporter: Please return this completed form to your quality improvement coordinator.

Quality Improvement Coordinator: Please scan and email via encryption to askinner@unmc.edu.

Medical Record Number _____ Date of Fall_____ Time of Fall_____

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

Remember: Patients fall because their center of mass is outside their base of support.

During the huddle look for specific answers and continue asking "*why?*" until the root cause is identified.

1. Establish facts:

1.a. Did we know this patient was at risk? **___ YES** **___ NO**

1.b. Has this patient fallen previously during this stay? **___ YES** **___ NO**

1.c. Is this patient at high risk of injury from a fall? (ABCS)

___ Age 85+ **___ Brittle Bones** **___ Coagulation** **___ Surgical Post-Op Patient**

2. Establish what patient and staff were doing and why.	**HAND WRITTEN NOTES**
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). **Ask why multiple times.**	
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	
3. Determine underlying root causes of the fall.	**HAND WRITTEN NOTES**
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	
4. Make changes to decrease the risk that this patient will fall or be injured again.	**HAND WRITTEN NOTES**
ASK: How could we have prevented this fall? ☐ **Need to consult with physical/occupational therapy about mobility/positioning/seating** ☐ **Need to consult with pharmacy about medications**	
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	
Ask: What patient or system problems need to be communicated to other departments, units or disciplines?	

Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 should be completed by the fall risk reduction team.

1. Date of Huddle _____ Time of Huddle _____ Huddle Facilitator Initials _____

2. Who was included in the huddle? CHECK ALL THAT APPLY

☐ Patient ☐ Primary Nurse ☐ COTA ☐ Physical Therapist
☐ Family/Caregiver ☐ CNA ☐ Pharmacist ☐ Physical Therapy Assistant
☐ Charge Nurse ☐ Occupational Therapist ☐ Pharmacy Tech ☐ Quality Improvement Coordinator
☐ Other: _____

3. Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this patient..

FALL CAUSE	FALL TYPE / PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
❑ **Environmental (Extrinsic) Risk Factors** Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	**Accidental** → **Possibly could have been prevented**	
❑ **Known Patient-Related (Intrinsic) Risk Factors** Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	**Anticipated Physiological** → **Possibly could have been prevented**	
❑ **Unknown, Unpredictable Sudden Condition** Examples: Heart Attack, Seizure, Drop attack	**Unanticipated Physiological** **Unpreventable**	
❑ Unsure – Please describe fall cause and your assessment of preventability, :_____		

4. If preventable, determine error type and describe actions taken to decrease risk of reoccurrence at the system level.

ERROR TYPE	ACTIONS TAKEN TO DECREASE RISK OF REOCURRENCE AT THE SYSTEM LEVEL
❑ **Task** An individual did NOT ensure planned interventions were in place as intended (e.g. bed alarm not activated)	
❑ **Judgement** An individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)	
❑ **Care Coordination** Communication among multiple staff members was Incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)	
❑ **System** Communication and multiple elements (tasks, knowledge, equipment) combine to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)	

Thank you for contributing to patient safety and quality of care.

Facilitator: Please return this completed form to your quality improvement coordinator.

***Quality Improvement Coordinator**, please scan and email via encryption to askinner@unmc.edu.*

Quality Improvement: Not part of the medical record. Not discoverable by Nebraska Rev. Stat. Section 71-7904 to 71-7913.