

Report Date: _____

Completed By: _____

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 Emergency department
 Bedside Therapy area (PT, OT, ST)
 Chairside Radiology/imaging area, including mobile
 Bathroom Outside area (i.e., grounds of this facility)
 Hallway 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 family/friend/another patient
 Notified by non-clinical staff Notified by ancillary care staff
 Reported by patient Patient calling for help
 Alarm sounding Patient call light
 Unknown 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
- No
- Unknown

17a. What was the device or equipment? _____

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

- Yes
- No
- Unknown

18a. Was the patient determined to be at risk for a fall?

- Yes
- 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
- Orthostatic vital signs monitoring
- 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 _____