**Fall Debriefing Form: Confidential and Privileged. For Quality Improvement Only.**

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| **Instructions:** Use this form and complete a debrief as soon as possible after a fall occurs. When complete, save and send a copy to the Administrator, the Director of Nursing and Quality Consultant. |
| Patient Age:\_\_\_\_\_\_ HRN:\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date/Time of fall: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Area which fall occurred: Waiting area \_\_\_\_ SPA\_\_\_ OR \_\_\_ P ACU \_\_\_ Phase II \_\_\_ Endo \_\_\_ |
| Local only \_\_\_\_ Conscious Sedation \_\_\_\_ MAC \_\_\_\_ General \_\_\_\_Fall witnessed □ Yes □ No Patient injured □ Yes, minor □ Yes, moderate □ Yes, major □ No  |
| **Contributing factors to the fall:** (Check all that apply) |
| □ Curtains drawn at bedside □ Cluttered environment □ Inadequate lighting  |
| □ Endoscopic prep performed □ SCDs on □ First time up from bed |
| □ Bed in high position □ Lack of assistive device (glasses, walker, etc.)  |
| □ Left unassisted while toileting □ Left unassisted while changing clothes |
| □ Other (describe): |
| **Did any human factors/red flags contribute to the fall?** (Check all that apply to staff/environment) |
| □ Distractions □ Ambiguity □ Trying something new under pressure |
| □ Fatigue □ Rushing □ Deviating from routine |
| □ Interruptions □ Poor communication  |
| **Staffing considerations:** |
| □ Traveler □ Short by one staff member □ Short by two or more staff members |
| □ Primary nurse on break □ New employee / Orientation to Unit |
| **Fall risk factors:** |
| Age > 85 years □ Yes □ No Orthopedic (lower limb) pt. □ Yes □ No |
| Bone disorders □ Yes □ No Coagulation disorders □ Yes □ No |
| (e.g., osteoporosis/metastasis/prolonged steroid use) (e.g., bleeding, anticoagulant use) |
| Delirium □ Yes □ No Received pain injection □ Yes □ No |
| □ Last dose of pain medication: □ Last dose of sedation/anesthetic medication:  |
| **Interventions that were in place prior to the fall: (Check all that apply)** |
| □ Staff assistance □ Call light given to patient □ Non-skid foot covers on |
| □ Gait belt while walking □ Other: |
| Describe event, include patient contributing factors: |
| What actions will be taken to prevent fall recurrence? |
| Manager’s signature: |