Postfall Assessment for Root Cause Analysis

Background: A standardized approach to postfall evaluation is key to maintaining the patient’s safety and for organizational learning about how to prevent future falls.

Reference: This tool is adapted from a tool developed by Ronald I. Shorr, M.D., M.S. See Shorr RI, Mion LC, Chandler AM, et al. Improving the capture of fall events in hospitals: combining a service for evaluating inpatient falls with an incident report system. J Am Geriatr Soc 2008;56(4):701-4.)


How to use this tool: The information below can be customized for use within your hospital. Note that the tool was originally used as part of a dedicated fall evaluation service that was called to investigate each fall. For details, see the Shorr reference. This tool can be used by staff nurses and information systems staff.

The tool may be used for the purpose of root cause analysis to prevent future falls in this patient and in future patients. This assessment should be performed in conjunction with a medical provider’s or pharmacist's assessment of medications contributing to fall risk (see the Medication Fall Risk Scale and Evaluation Tool) and a medical provider's assessment of laboratory test results, if appropriate. The Orthostatic Vital Sign Measurement tool may be helpful in completing this tool.

The Postfall Clinical Assessment covers how to assess and follow injury risk immediately after a patient has fallen.

Postfall Assessment
1. PATIENT/WITNESS DESCRIPTION OF FALL

1.1. Can you remember anything about your fall?
  ___Yes ___No- The patient can't answer reliably

1.2. Did anyone witness the fall?
  ___Yes, by:
  ___No or don't know (if no good quality patient or witness description, go to part 2)

1.3. Where did you fall?
  ___Bathroom ___Hall ___Room ___Other, describe:

1.4. What were you doing at the time of the fall?
  ___Don't remember
  ___Rolled out of bed
  ___Trying to reach/pick-up something
  ___Trying to get in/out of bed to go to toilet/commode
  ___Trying to get in/out of bed for other reason
  ___Trying to get in/out of chair
  ___Trying to get on/off bedside commode/toilet
  ___Trying to use sink, shower, chair, or toilet/commode
  ___Trying to dress/undress
  ___Other, describe:
1.5. Why do you think you fell?
__ Don’t know, remember
__ I had a recent lower extremity amputation
__ Slipped, tripped
__ Got lightheaded, dizzy, or blacked out!
__ Arms or legs got weak
__ Tried to sit, but missed
__ I lost my balance
__ Got tangled up with IV, tubing, clothes, etc.
__ Bed or chair not locked
__ Other, describe:

2. BRIEF ASSESSMENT

2.1. Severity of injury (check the most severe)
__ None (skip to question 2.5)
__ Minor (complaint of pain; requires ice, dressing, cleaning of wound, elevating of limb, or medication)
__ Moderate (requires suturing, steri-strips, or splinting)
__ Major (requires surgery, casting, traction, neurologic consultation for change in level of consciousness)
__ Possible, at time of this evaluation major injury is suspected but not yet confirmed by tests
__ Definite, at time of this evaluation major injury has been confirmed
__ Death

2.2. Describe injuries; check all that apply

<table>
<thead>
<tr>
<th>Injury</th>
<th>Yes</th>
<th>No</th>
<th>Site of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasion/bruise/laceration/hematoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain/difficulty moving extremity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3. Orthostatic blood pressure

<table>
<thead>
<tr>
<th>Blood Pressure (mm Hg)</th>
<th>Heart Rate (beats per minute)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic blood pressure (supine)</td>
<td>Heart rate (supine)</td>
<td>Can’t obtain/Refused</td>
</tr>
<tr>
<td>Diastolic blood pressure (supine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure (standing)</td>
<td>Need for orthostatic</td>
<td>Heart rate (standing)</td>
</tr>
<tr>
<td>Diastolic blood pressure (standing)</td>
<td>Need for orthostatic</td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure (sitting)</td>
<td>Heart rate (sitting)</td>
<td>Can’t obtain/Refused</td>
</tr>
<tr>
<td>Diastolic blood pressure (sitting)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Sitting measurements are only necessary if standing cannot be obtained.

3. NURSE INTERVIEW (NURSE ASSIGNED TO PATIENT)

3.1. How did you find out that this patient fell?
__ I saw the patient fall
__ Alarm went off
__ Patient/witness called
__ Heard noise/found patient on floor
3.2. What was the patient doing at time of fall?
___ Don't know
___ Rolled out of bed
___ Trying to get in/out of chair
___ Trying to get in/out of bed to go to the bathroom/commode
___ Trying to reach/pick up something
___ Trying to get in/out of bed for another reason
___ Trying to get on/off toilet/bedside commode (BSC)
___ Trying to use the bedside sink, shower, toilet/BSC chair
___ Trying to dress/undress
___ Other, describe:

3.3. Why do you think the patient fell/lost their balance?
___ Don't know
___ Catastrophic event (e.g., stroke, arrhythmia NOT orthostatic hypotension)
___ Arms or legs got weak
___ Got lightheaded, dizzy, or blacked out
___ Tried to sit, but missed
___ Secondary gain (e.g., seeking attention)
___ Related to recent amputation
___ Got tangled up in equipment
___ Low blood sugar
___ Slipped or tripped
___ Lost balance
___ Medications
___ Bed, chair not locked
___ Other, describe:

3.4. Prior to the patient’s fall, what was his/her activity level (ask nurse this question)?
___ Up ad lib
___ Ambulate with assistance
___ Bedrest
___ Up in chair with assistance
___ Other, describe:

3.5. Prior to fall, identify the ancillary walking aids patient had available in room (check all that apply):
___ None
___ Cane
___ Walker
___ Wheelchair
___ Leg prosthesis
___ Other

3.6. Prior to fall, were fall prevention measures in place?

<table>
<thead>
<tr>
<th>Falls precautions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall alert identifier (door sticker)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed alarm: if yes, check those that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Alarm sounded properly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Alarm did not sound properly</td>
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<td></td>
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<tr>
<td>• Alarm was disconnected</td>
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<td></td>
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<tr>
<td>Call light/bell in reach</td>
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</tbody>
</table>
3.7. What CONNECTED IVs/tubes were present at the time of the fall?

| IV (central line, peripheral) | Yes | No |
| Bladder catheter | | |
| Gastrostomy or other feeding tube | | |
| Pneumatic compression stockings | | |
| Other: | | |

4. OTHER IMPORTANT INFORMATION NOT COVERED ON THIS FORM


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