### 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).

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#### CAPTURE Falls Event Learning Form

1. Patient Medical Record Number:  
2. Patient Admission date:  
3. Admission Type at time of fall:  
   - [ ] Acute  
   - [ ] Swing  
   - [ ] Hospice  
   - [ ] Observation  
   - [ ] Outpatient  
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  
   - [ ] 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  
   - [ ] No  
10a. Was a gait belt used?  
   - [ ] Yes  
   - [ ] 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  
   - [ ] 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
- Ambulating w/assistance
- Ambulating to bathroom w/assistance
- Dressing/undressing
- Dressing/undressing related to toileting
- Transferring w/assistance
- Reaching for an item
- Rolled out / Slipped off of bed
- Geri chair related
- 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 patient's 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

<table>
<thead>
<tr>
<th>Environment</th>
<th>Information About Fall Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Culture of safety, management of staff</td>
<td>□ Not Available</td>
</tr>
<tr>
<td>□ Physical surroundings cluttered</td>
<td>□ Not Accurate</td>
</tr>
<tr>
<td>□ Physical surroundings not customized to</td>
<td>□ Not Legible</td>
</tr>
<tr>
<td>accommodate pt’s mobility limitations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Qualifications</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Lack of competence (qualifications, experience)</td>
<td>□ Supervisor to staff</td>
</tr>
<tr>
<td>□ Lack of training (use of gait belt, transfers,</td>
<td>□ Among staff or team members</td>
</tr>
<tr>
<td>lifts)</td>
<td>□ Staff to patient (or family)</td>
</tr>
<tr>
<td></td>
<td>□ Fall associated with a handoff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision/support</th>
<th>Human factors (Staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Lack of clinical supervision</td>
<td>□ Fatigue</td>
</tr>
<tr>
<td>□ Lack of managerial supervision</td>
<td>□ Stress</td>
</tr>
<tr>
<td>□ Poor teamwork</td>
<td>□ Inattention</td>
</tr>
<tr>
<td></td>
<td>□ Cognitive factors</td>
</tr>
<tr>
<td></td>
<td>□ Health issues</td>
</tr>
</tbody>
</table>

| Policies and procedures, includes clinical       | External factors                        |
| protocols                                        |                                        |
| □ Absence of policies                            | □ Family/Visitor involvement            |
| □ Poor clarity of policies                       |                                        |
| □ Lack of compliance with policies              |                                        |

24. Which patient factors contributed to the event? CHECK ALL THAT APPLY

<table>
<thead>
<tr>
<th>Patient factors</th>
<th>Environment, management of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Dizziness/Vertigo</td>
<td>□ Culture of safety, management of staff</td>
</tr>
<tr>
<td>□ Hypotension</td>
<td>□ Physical surroundings cluttered</td>
</tr>
<tr>
<td>□ Procedure within last 24 hours</td>
<td>□ Physical surroundings not customized</td>
</tr>
<tr>
<td>□ Constipation</td>
<td>to accommodate pt’s mobility limitations</td>
</tr>
<tr>
<td>□ Cognitive impairment</td>
<td></td>
</tr>
<tr>
<td>□ Impulsive behavior</td>
<td></td>
</tr>
<tr>
<td>□ Overestimated ability</td>
<td></td>
</tr>
<tr>
<td>□ Neurological Comorbidities (e.g. previous</td>
<td></td>
</tr>
<tr>
<td>CVA, MS, Parkinson’s Disease)</td>
<td></td>
</tr>
<tr>
<td>□ Weakness</td>
<td>□ Anticoagulant / bleeding disorder</td>
</tr>
<tr>
<td>□ Anticoagulant / bleeding disorder</td>
<td>□ Bowel Prep in Progress</td>
</tr>
<tr>
<td>□ Bowel Prep in Progress</td>
<td>□ Incontinence/urgency</td>
</tr>
<tr>
<td>□ Incontinence/urgency</td>
<td>□ Symptomatic depression</td>
</tr>
<tr>
<td>□ Morbid obesity</td>
<td>□ Sensory Impairment (vision, hearing,</td>
</tr>
<tr>
<td></td>
<td>balance, etc.)</td>
</tr>
<tr>
<td>□ Other: PLEASE SPECIFY ________________________</td>
<td>□ Other: ____________________________</td>
</tr>
</tbody>
</table>

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.