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

10a. 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
☐ Report by patient ☐ Patient calling for help
☐ Alarm sounding ☐ Patient call light
☐ Unknown ☐ Other: Please specify ______________________________

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

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

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

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.