### 3O: 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.](http://www.ncbi.nlm.nih.gov/pubmed/18205761) J Am Geriatr Soc 2008;56(4):701-4.) The Confusion Assessment Method within this tool is adapted from a tool by Sharon K. Inouye, M.D., M.P.H. (See Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion. Ann Intern Med 1990;113(12):941-8.)

**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 Tool 3I, “Medication Fall Risk Scale and Evaluation Tools”) and a medical provider’s assessment of laboratory test results, if appropriate. The Orthostatic Vital Sign Measurement tool (Tool 3F) and the Delirium Evaluation Bundle (Tool 3J) may be helpful in completing this tool. A separate tool (Tool 3N, ‘Postfall Assessment, Clinical Review) 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 MENTAL AND PHYSICAL ASSESSMENT**

**2.1. Short Portable Mental Status Questionnaire**

| Question | Response | Error? |
| --- | --- | --- |
| What are the date, month, and year?\* | Date | Month | Year |  |
| What is the day of the week? |  |  |
| What is the name of this place? |  |  |
| What is your phone number? |  |  |
| How old are you? |  |  |
| When were you born? |  |  |
| Who is the current president? |  |  |
| Who was the president before him? |  |  |
| What was your mother’s maiden name? |  |  |
| Can you count backward from 20 by 3s? |  |  |

\* A mistake on ANY part of this question should be scored as an error.

Total Errors: \_\_\_\_\_\_\_

##### SCORING\*:

0-2 errors: normal mental functioning

3-4 errors: mild cognitive impairment

5-7 errors: moderate cognitive impairment

8 or more errors: severe cognitive impairment

\* One more error is allowed in the scoring if a patient has had a grade school education or less. One less error is allowed if the patient has had education beyond the high school level.

Section 2.1 adapted with permission from Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr. Soc 1975;23(10):433-41. © E. Pfeiffer, 1994.

##### 2.2. Confusion Assessment Method

|  |  |  |
| --- | --- | --- |
| In the 24 hours prior to the fall did this patient: | Yes | No |
| CAM 1a. Have an acute change of mental status from baseline? |  |  |
| CAM 1b. Exhibit behavioral fluctuations (come and go)? |  |  |
| CAM 2. Have difficulty focusing attention or appear easily distractible (for example, have difficulty keeping track of what was said)? |  |  |
| CAM 3. Exhibit disorganized or incoherent thinking such as irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? |  |  |
| CAM 4. Are any of the following abnormal levels of consciousness observed (or reported) in the 24 hours prior to the fall?* Vigilant (hyperalert)
* Lethargic (drowsy, easily aroused)
* Stupor (difficult to arouse)
* Coma (unarousable)
 |  |  |
| If yes to CAM 1a and 1b and CAM 2 AND either CAM 3 or CAM 4, then delirium is likely to be present in this patient.  |

Section 2.2 adapted from Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion. Ann Intern Med 1990;113(12):941-8. Used with permission, Sharon K. Inouye, M.D., M.P.H. ©2000, Hospital Elder Life Program. All rights reserved.

##### 2.3. 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

##### 2.4. Describe injuries; check all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Injury | Yes | No | Site of Injury |
| Abrasion/bruise/laceration/hematoma |  |  |  |
| Bleeding |  |  |  |
| Pain/difficulty moving extremity |  |  |  |
| Other:  |  |  |  |

##### 2.5. Orthostatic blood pressure

|  |  |
| --- | --- |
| Blood Pressure (mm Hg) | Heart Rate (beats per minute) |
| Systolic blood pressure (supine) |  | Heart rate (supine) | Can’t obtain Refused |
| Diastolic blood pressure (supine) |  |
| Systolic blood pressure (standing) | Need for orthostatic | Heart rate (standing) | Can’t obtain Refused |
| Diastolic blood pressure (standing) | Need for orthostatic |
| Systolic blood pressure (sitting)\* |  | Heart rate (sitting)\* | Can’t obtain Refused |
| Diastolic blood pressure (sitting)\* |  |

\* 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?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Falls precautions  |  |  |
| Fall alert identifier (door sticker) |  |  |
| Bed alarm: if yes, check those that apply:Alarm sounded properlyAlarm did not sound properlyAlarm was disconnected |  |  |
| Call light/bell in reach |  | no n/a |
| Other: |  |  |

##### 3.7. What CONNECTED IVs/tubes were present at the time of the fall?

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

**4. OTHER IMPORTANT INFORMATION NOT COVERED ON THIS FORM**

Please record orthostatic blood pressure readings in the patient’s chart and return this form to the designated place in the staffing office.