TOOLKIT 3 · FALLS PREVENTION · TOOL 3 OF 5

Post-Fall Huddle

Fifteen minutes, at the bedside, within an hour, with whoever is there. Not blame — what happened, why, what changes now

Patient (name, no.) · ward · bed	
Date and time of fall · time of huddle	
Present at huddle	

1 · WHAT HAPPENED (TWO SENTENCES, THE PATIENT'S OWN ACCOUNT FIRST)

2 · CIRCUMSTANCES

Question	Answer
Where (bed, bathroom, corridor, chair)?	
Activity (getting up, toileting, walking, reaching)?	
Witnessed? Alone? Call bell used?	
Footwear? Mobility aid? Bed height and brakes? Rails?	
Last fall-risk score and date	
Medicines in the last 24 h (sedatives, opioids, BP, diuretics)?	
Toileted in the last 2 h? Last meal? Blood glucose / BP if measured	

3 · INJURY AND IMMEDIATE CARE

Injury	None ☐ Minor ☐ Moderate ☐ Major ☐ Death ☐
Doctor informed (time) · family informed (time)	
Head strike? Anticoagulated? → observation plan	

4 · WHAT CHANGES NOW (TICK AND SPECIFY)

	Change	Detail
☐	Re-screen and change risk band	
☐	Bed / bathroom / equipment change	
☐	Medicine review requested	
☐	Rounding frequency changed	
☐	Physiotherapy / mobility plan	
☐	Family briefed on plan	

5 · WHAT THE WARD LEARNS

One sentence for the monthly dashboard	

Rule. The huddle is about the system, not the person. Nobody is named as at fault on this sheet. A fall with major injury or death is also reported under the Sentinel Event Policy the same day.

ASF standards: Universal Floor — falls prevention; Sentinel Event Policy