Session 4
Post Fall Management: Getting to Types of Falls, Repeat Falls, and Determining Preventability

Pat Quigley,PhD,MPH,ARNP,CRRN,FAAN,FAANP
Nurse Consultant
Retired Associate Director, VISN 8 Patient Safety Center
Retired Associate Chief for Nursing Service/Research

E-Mail: pquigley1@tampabay.rr.com

Objectives

- Examine post fall practices as key intervention to reduce repeat falls
- Redesign patient/resident education to fully engage them as full partners in care
- Consider patient / resident autonomy as primary factor

Let's Share!

- How do you know your fall prevention program is working?
- Can you affirm that patients who fall more than once are not falling for the same reason?
- How is your post fall program working?
- How do you measure success?

Post Fall Practices

- Post Fall Huddle
- Post Fall Assessment
- Patient/Resident/Family Education
- Staff Education

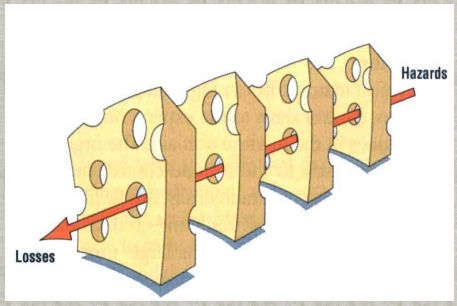
Huddles

How Many Huddles Are You Doing?

Safety Huddles

- **Pre-Shift Huddles**
- **Post Fall Huddles**
- Conducted with the patient/resident where the fall occurred within 15 minutes of the fall
- Post Fall Analysis
  - What was different this time?
  - When
  - How
  - Why
  - Prevention: Protective Action Steps to Redesign the Plan of Care

Accident Theory

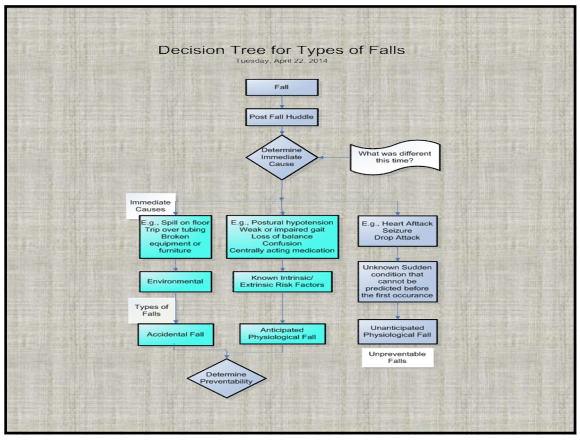


Post Fall Huddle (PFH): Essential Components

- A brief staff gathering, interdisciplinary when possible, that immediately follows a fall event.
- Convenes within 15 minutes of the fall event
- Clinician(s) responsible for patient/resident during fall event leads the PFH
- Involves the patient/resident whenever possible in the environment where the patient/resident fell
- Requires Group Think to discovery what happened.
- Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient/resident fell.
- Guiding question to ask: **What was different this time you were doing this activity, compared to all the other times you performed the same activity (and did not fall), but this time you fell?**

Steps to the Post Fall Huddle

1. TL makes announcement
2. Convene within 15 mins with the pt/resident in the environment where the patient/resident fell
3. Conduct Analysis; Determine type of Fall
4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.
5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall
7. Communicate updated plan of care in patient/resident hand-off reports.
8. Complete EMR Post Fall Note



Determine Preventability

Step 1: Conduct the Post Fall Huddle.

Step 2: Determine the Immediate Cause of the Fall.

Step 3: Determine the Type of Fall.

Step 4. If Accidental and Anticipated Physiological Falls, determine Preventability:

Could the care provider (direct care provider) have anticipated this event with the information available at the time?

- *If the Answer is **NO,** the fall is Not preventable.*
- *If the answer is **YES**, the provider must ask another question: Were appropriate precautions taken to prevent this event?*
- *Answer:*
  - *No, Clearly or likely Preventable;*
  - *Yes, Clearly or likely Unpreventable*

Levinson, D. R., (2010, Nov). Adverse events in hospitals: National incidence among Medicare beneficiaries. DHHS. OEI-06-09-00090

Let's Practice

- Case Studies

Case Study 1

: "Alert Patient walking with Nurse"

- On June 20, at 09:00am, Mr. Ambulatory, was ambulating down the hallway with the nurse for the first time, after undergoing a post-surgical procedure the day before, when he suddenly became weak in the knees and started to fall. The RN attempted to stop the fall by leaning Mr. Ambulatory against her chest and allowing him to slide down her legs in a gentle manner to the floor, breaking the fall. The RN immediately yelled for help and started to assess the patient. Mr Ambulatory was alert and oriented to person, place, time, and situation but stated he had started feeling dizzy, and did not want to fall, but could not seem to be able to communicate this to the RN.
- After another staff member arrived, and Mr. Ambulatory's vital signs were taken. The heart rate was 120, respiratory rate 16, temperature 98.6F, and his blood pressure 90/60 while lying on the floor. The staff asked Mr Ambulatory if he could stand long enough to conduct orthostatics, but he stated that he was still dizzy. He felt that he could get up into the wheelchair in order to go back his bed.
- The staff successfully moved the Veteran to the bed without incident and the provider was contacted to see him. The patient sustained no injury and was discharged two days later.

Case Study 2

"Alert Patient found at the Bedside"

- Mr. Patriot is a 65 year old Veteran, who was admitted on the day shift to a medical-surgical unit due to his increasing inability to care for himself and difficulty getting around. During the night shift, around 2:00am the nursing staff heard a loud noise in Mr. Patriot's room. When the CNA entered his room he found Mr. Patriot on the floor close to the bed, on the right side of the bed, and a foot tangled in the sheet, with the walker sideways next to him. Mr. Patriot said he was not hurt and that the walker had been placed too far away from the bed by the nurse and he was reaching for it, his foot got caught in the sheet, he lost his balance and fell on his side. His vital signs were within normal limits including his blood glucose. He denied any dizziness when he stood up. He wanted to be quickly helped up so he could get to the bathroom as he was not about to wet his pajamas.
- The RN quickly assessed that he was not injured, called for additional staff assistance, and together assisted the patient to a standing position – to the bathroom. The RN first tried to use a ceiling lift to pick him up and get him back to bed and then see about using the bathroom, but Mr. Patriots refused. Mr. Patriot strongly objected to "being handled like a side of beef" and said he would just get up on his own then. Still, the RN and CNA assisted the patient up, to the bathroom and the patient was able to toilet.
- After toileting Mr. Patriot and returning him to the bed, the RN called team members for a Post Fall Huddle. Mr. Patriot continued to insist that he would not call for help and would be fine as long as he had his walker where he could reach it.

Outcomes of Post Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient / Resident (family) involved in learning about the fall occurrence
- Prevent Repeat Fall
- Reduce Repeat Fall Rate

Post Fall Huddle Resources

VA: Falls Toolkit

Post Fall Huddles

www.patientsafety.va.gov

AHRQ Falls Toolkit 2013

Tools

- Post Fall Huddle Process
- Decision Tree
- Post Fall Huddle Form
- Determine Preventability
- Case Study Exercises

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Formative Measures

- Structures:
  - Who attends: Nursing and others – Count them
  - Changed Plan of Care: Add actions to your run-chart: Annotated run chart; Capture interventions
- Processes:
  - Timeliness of Post Fall Huddle (number of minutes)
  - Timeliness of changing plan of care
  - Time to implemented changed plan of care

Summative Outcome

- Prevent Repeat Fall: Same Root Cause and Same Type of Fall
- Reduce costs associated with falls and fall related injuries

Post Fall Assessment

Different than a Huddle!

Post Fall Assessment

- In-depth Data Gathering
- Circumstances of the Fall
- Patient/Resident Presentation
- Assessment of Patient/Resident Condition

Comprehensive Post-Fall Assessment

Includes:

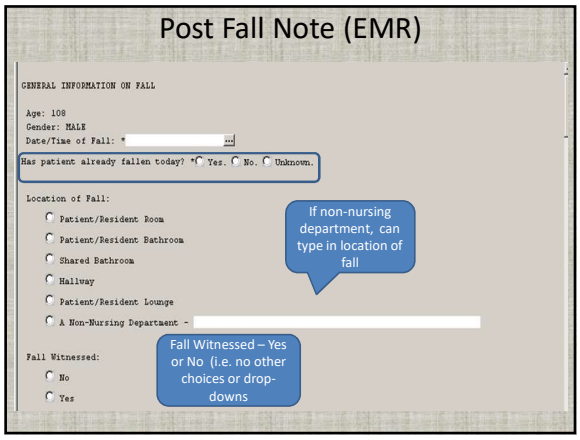
- General information about the fall
- Subjective & objective falls documentation
- Patient/Resident Assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based on Fall Risk Scale/ Morse falls scale
- Facility personnel and family notification

Post-Fall Assessment: History: Review of Systems

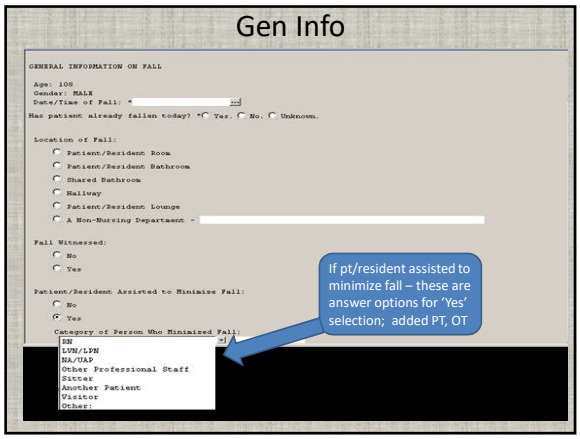
- Patient Symptoms to Elicit on History Linked to Risk Factors

Symptom	Fall Risk Factor
Visual disturbance (double vision, blurry vision, loss of vision)	Visual impairment?
Dizziness/lightheadedness	Orthostatic hypotension? Abnormal vital signs?
Leg weakness	Gait or balance instability?
Urinary urgency or frequency	Urinary incontinence?
Syncope/loss of consciousness	One or more chronic diseases

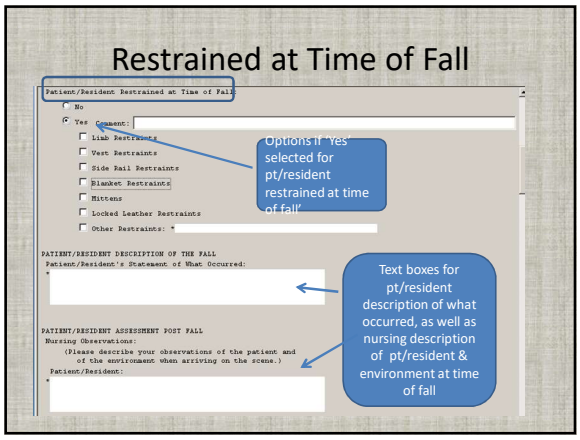
Post Fall Note (EMR)

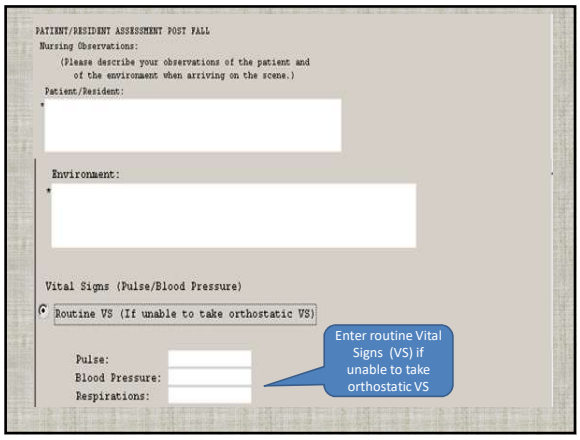


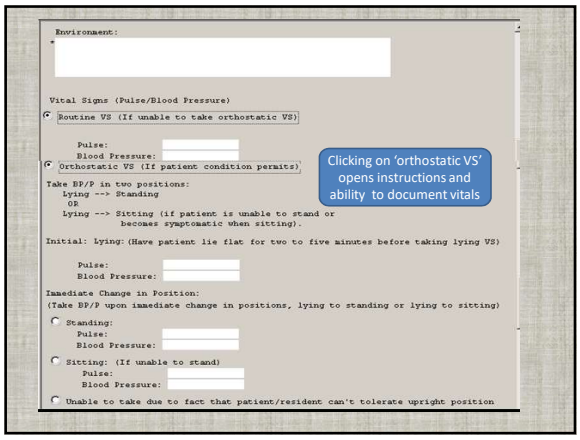
Gen Info

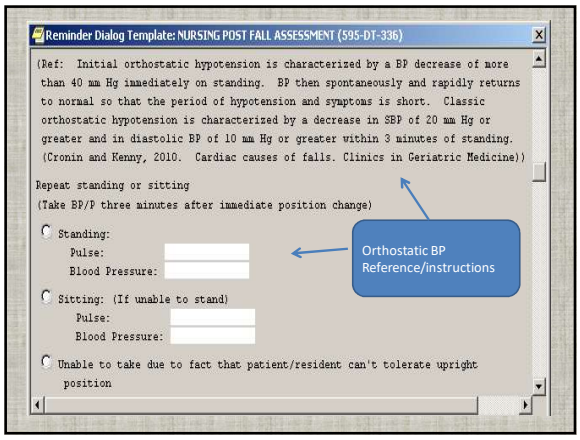


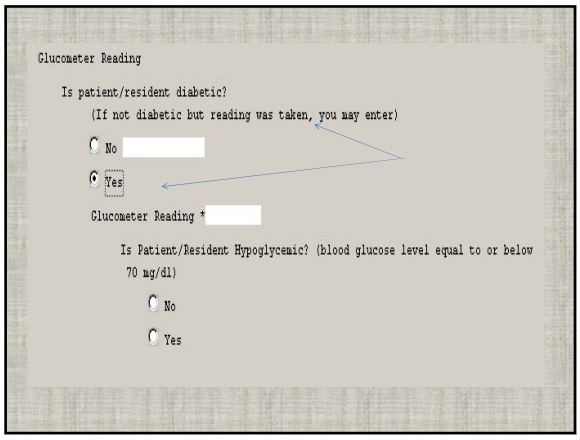
Restrained at Time of Fall

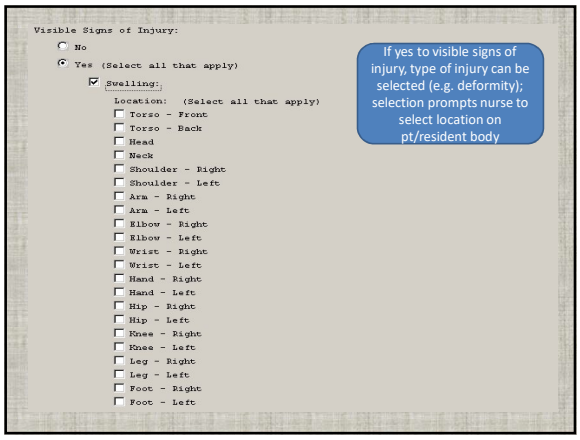


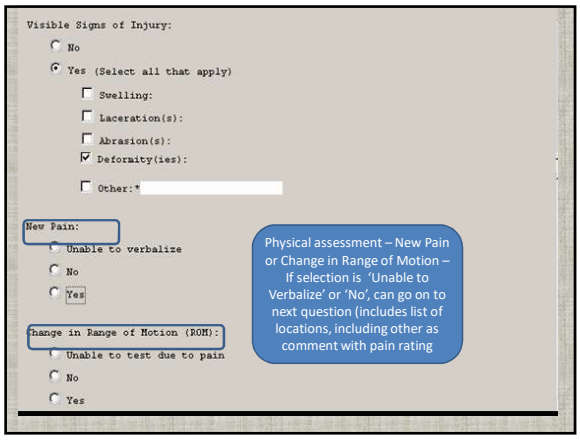


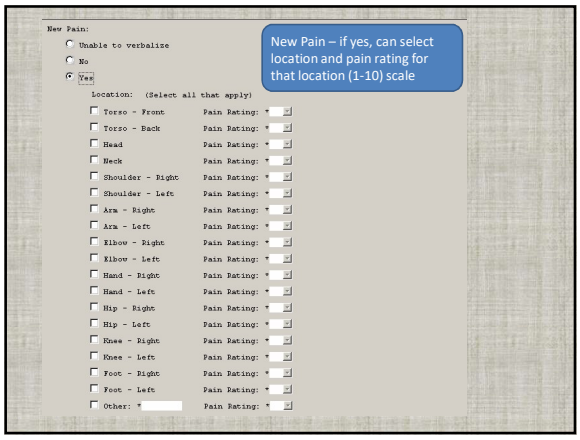


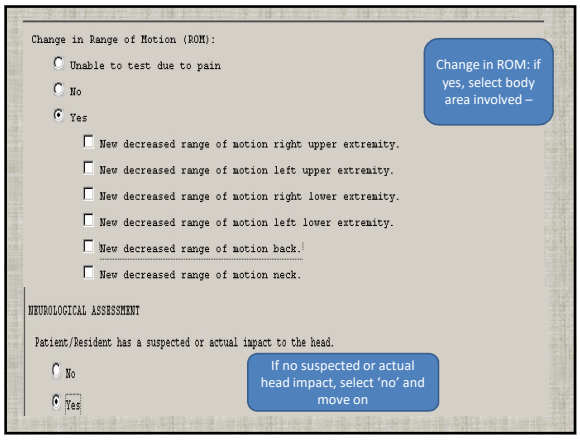


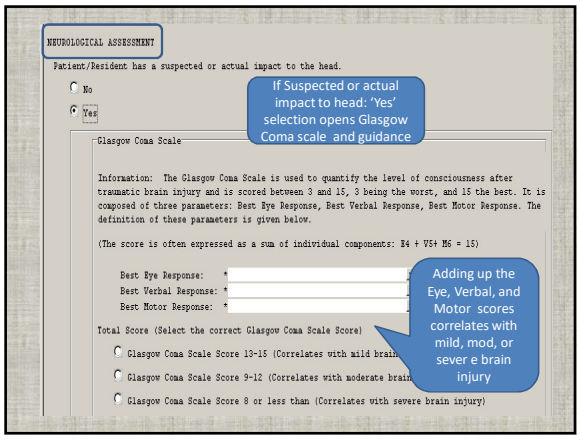


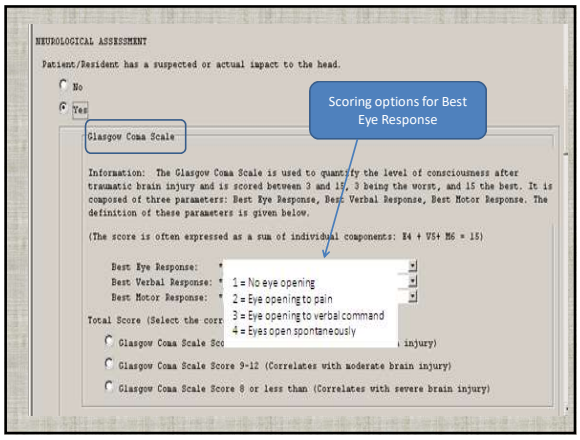


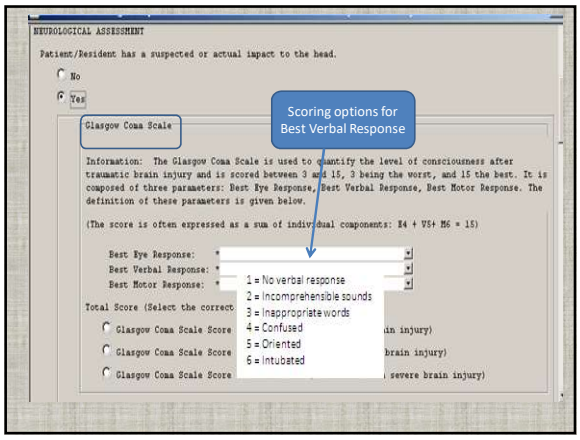


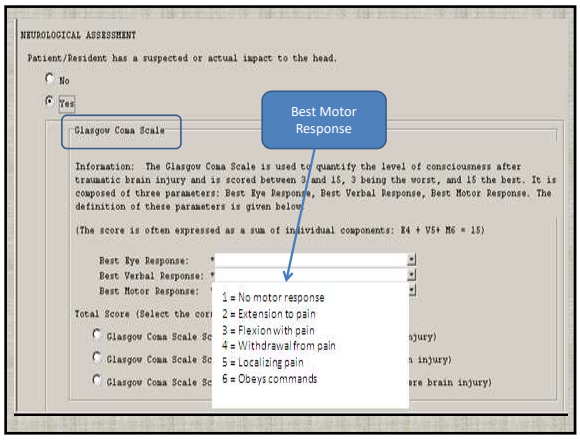


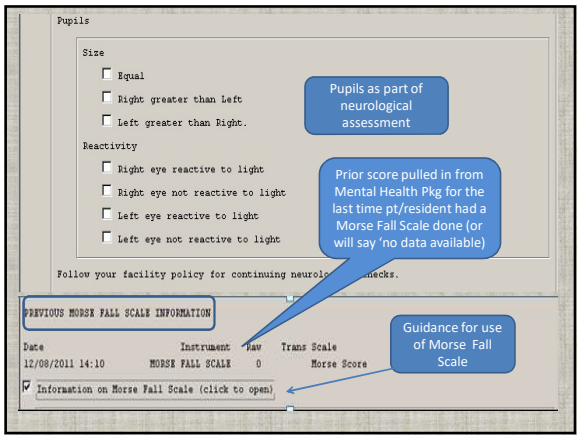




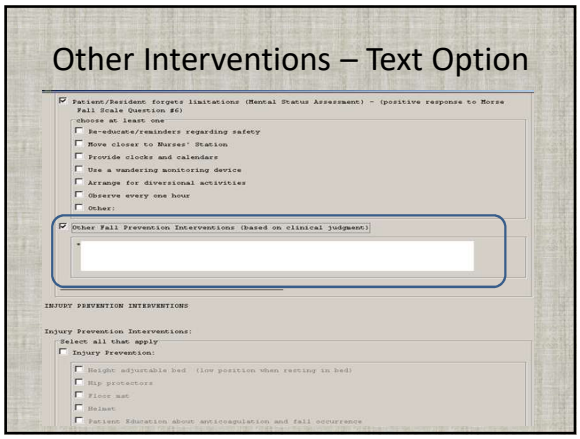


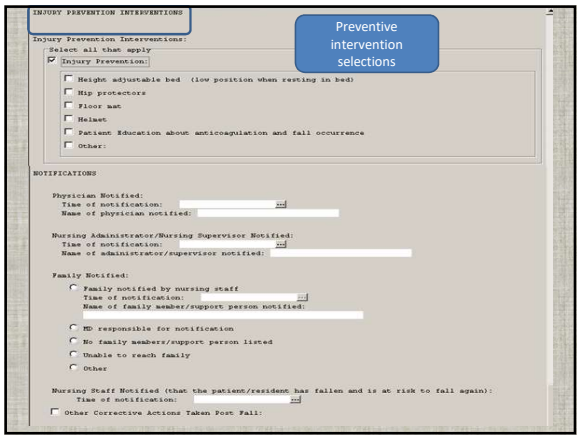






Other Interventions – Text Option





Teaching: After a Fall

- Reframe patient/resident education curricula to include "what happens after a fall".
- What can we learn from this event?
- How can we work together to prevent this again?

Staff Education

- Universal Fall Prevention
- Individualized Fall Prevention
- Injury Reduction Strategies
- Root Cause Trends of Falls
- Interventions for Improvement
- Impact of Changes in Practices

You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com

I Fall A lot! Why?

Oreo

Jethro and Mr. Goober