

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

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**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

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**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?

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### Post Fall Practices

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

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### Huddles

How Many Huddles Are You Doing?

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### 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

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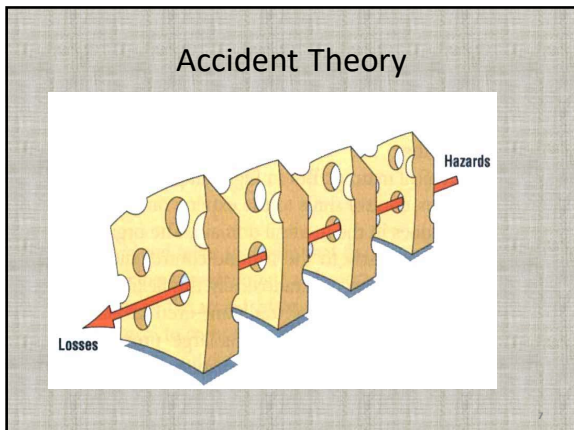
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### Post Fall Huddle (PFH): Essential Components

- 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 discover 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?**

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### Steps to the Post Fall Huddle

<ol style="list-style-type: none"><li>1. TL makes announcement</li><li>2. Convene within 15 mins with the pt/resident in the environment where the patient/resident fell</li><li>3. Conduct Analysis; Determine type of Fall</li><li>4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.</li></ol>	<ol style="list-style-type: none"><li>5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.</li><li>6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall</li><li>7. Communicate updated plan of care in patient/resident hand-off reports.</li><li>8. Complete EMR Post Fall Note</li></ol>
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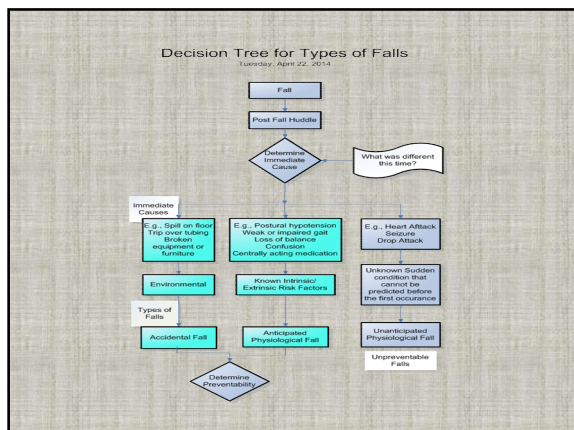
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## Determine Preventability

**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-06-09-0000

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## Let's Practice

- Case Studies

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**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.

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**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.

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**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

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### Post Fall Huddle Resources

VA: Falls Toolkit  
Post Fall Huddles  
[www.patientsafety.va.gov](http://www.patientsafety.va.gov)  
AHRQ Falls Toolkit 2013

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### Tools

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

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### 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

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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

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### Summative Outcome

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

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### Post Fall Assessment

Different than a Huddle!

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### Post Fall Assessment

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

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### 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

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### 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

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### Post Fall Note (EMR)

**GENERAL INFORMATION ON FALL**

Age: 109  
Gender: MALE  
Date/Time of Fall: \* [dropdown]  
Has patient already fallen today? \*  Yes  No  Unknown.

Location of Fall:

- Patient/Resident Room
- Patient/Resident Bathroom
- Shared Bathroom
- Hallway
- Patient/Resident Lounge
- A Non-Nursing Department - [dropdown]

Fall Witnessed:

- No
- Yes

*Annotations:*  
- Callout to "Location of Fall": "If non-nursing department, can type in location of fall"  
- Callout to "Fall Witnessed": "Fall Witnessed - Yes or No (i.e. no other choices or drop-downs)"

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### Gen Info

**GENERAL INFORMATION ON FALL**

Age: 109  
Gender: MALE  
Date/Time of Fall: \* [dropdown]  
Has patient already fallen today? \*  Yes  No  Unknown.

Location of Fall:

- Patient/Resident Room
- Patient/Resident Bathroom
- Shared Bathroom
- Hallway
- Patient/Resident Lounge
- A Non-Nursing Department - [dropdown]

Fall Witnessed:

- No
- Yes

Patient/Resident Assisted to Minimize Fall:

- No
- Yes

Category of Person Who Minimized Fall:

- RN
- LVN/LPN
- HA/OTA
- Other Professional Staff
- Student
- Another Patient
- Visitor
- Other:

*Annotation:*  
- Callout to "Category of Person Who Minimized Fall": "If pt/resident assisted to minimize fall - these are answer options for 'Yes' selection; added PT, OT"

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### Restrained at Time of Fall

**Patient/Resident Restrained at Time of Fall**

No  
 Yes *Comment:* [text box]

Options if 'Yes' selected for pt/resident restrained at time of fall:

- Limb Restraints
- Vest Restraints
- Side Fall Restraints
- Elastic Restraints
- Mittens
- Locked Leather Restraints
- Other Restraints: \*

**PATIENT/RESIDENT DESCRIPTION OF THE FALL**

Patient/Resident's Statement of What Occurred:

[text box]

**PATIENT/RESIDENT ASSESSMENT POST FALL**

Nursing Observations:  
(Please describe your observations of the patient and of the environment when arriving on the scene.)  
Patient/Resident:

[text box]

*Annotations:*  
- Callout to "Options if 'Yes' selected for pt/resident restrained at time of fall": "Options if 'Yes' selected for pt/resident restrained at time of fall"  
- Callout to "PATIENT/RESIDENT ASSESSMENT POST FALL": "Text boxes for pt/resident description of what occurred, as well as nursing description of pt/resident & environment at time of fall"

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PATIENT/RESIDENT ASSESSMENT POST FALL

Nursing Observations:  
 (Please describe your observations of the patient and of the environment when arriving on the scene.)

Patient/Resident:

Environment:

Vital Signs (Pulse/Blood Pressure)

Routine VS (If unable to take orthostatic VS)

Pulse:   
 Blood Pressure:   
 Respirations:

Enter routine Vital Signs (VS) if unable to take orthostatic VS

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Environment:

Vital Signs (Pulse/Blood Pressure)

Routine VS (If unable to take orthostatic VS)

Pulse:   
 Blood Pressure:

Orthostatic VS (If patient condition permits)

Take BP/P in two positions:  
 Lying --> Standing  
 OR  
 Lying --> Sitting (if patient is unable to stand or becomes symptomatic when sitting).

Initial: Lying (Have patient lie flat for two to five minutes before taking lying VS)

Pulse:   
 Blood Pressure:

Immediate Change in Position:  
 (Take BP/P upon immediate change in positions, lying to standing or lying to sitting)

Standing:  
 Pulse:   
 Blood Pressure:

Sitting: (If unable to stand)  
 Pulse:   
 Blood Pressure:

Unable to take due to fact that patient/resident can't tolerate upright position

Clicking on 'orthostatic VS' opens instructions and ability to document vitals

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Reminder Dialog Template: NURSING POST FALL ASSESSMENT (595-DT-336)

(Ref: Initial orthostatic hypotension is characterized by a BP decrease of more than 40 mm Hg immediately on standing. BP then spontaneously and rapidly returns to normal so that the period of hypotension and symptoms is short. Classic orthostatic hypotension is characterized by a decrease in SEP of 20 mm Hg or greater and in diastolic BP of 10 mm Hg or greater within 3 minutes of standing. (Cronin and Henny, 2010. Cardiac causes of falls. Clinics in Geriatric Medicine))

Repeat standing or sitting  
 (Take BP/P three minutes after immediate position change)

Standing:  
 Pulse:   
 Blood Pressure:

Sitting: (If unable to stand)  
 Pulse:   
 Blood Pressure:

Unable to take due to fact that patient/resident can't tolerate upright position

Orthostatic BP Reference/instructions

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Glucometer Reading

Is patient/resident diabetic?  
(If not diabetic but reading was taken, you may enter)

No

Yes

Glucometer Reading \*

Is Patient/Resident Hypoglycemic? (blood glucose level equal to or below 70 mg/dl)

No

Yes

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Visible Signs of Injury:

No

Yes (Select all that apply)

Swelling:

Location: (Select all that apply)

- Torso - Front
- Torso - Back
- Head
- Neck
- Shoulder - Right
- Shoulder - Left
- Arm - Right
- Arm - Left
- Elbow - Right
- Elbow - Left
- Wrist - Right
- Wrist - Left
- Hand - Right
- Hand - Left
- Hip - Right
- Hip - Left
- Knee - Right
- Knee - Left
- Leg - Right
- Leg - Left
- Foot - Right
- Foot - Left

If yes to visible signs of injury, type of injury can be selected (e.g. deformity); selection prompts nurse to select location on pt/resident body

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Visible Signs of Injury:

No

Yes (Select all that apply)

Swelling:

Laceration(s):

Abrasion(s):

Deformity(ies):

Other: \*

New Pain:

Unable to verbalize

No

Yes

Change in Range of Motion (ROM):

Unable to test due to pain

No

Yes

Physical assessment – New Pain or Change in Range of Motion – If selection is ‘Unable to Verbalize’ or ‘No’, can go on to next question (includes list of locations, including other as comment with pain rating)

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New Pain:

Unable to verbalize  
 No  
 Yes

Location: (Select all that apply)

<input type="checkbox"/>	Torso - Front	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Torso - Back	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Head	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Neck	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Shoulder - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Shoulder - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Arm - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Arm - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Elbow - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Elbow - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Hand - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Hand - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Hip - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Hip - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Knee - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Knee - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Foot - Right	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Foot - Left	Pain Rating: *	<input type="text"/>
<input type="checkbox"/>	Other: *	Pain Rating: *	<input type="text"/>

New Pain – if yes, can select location and pain rating for that location (1-10) scale

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Change in Range of Motion (ROM):

Unable to test due to pain  
 No  
 Yes

New decreased range of motion right upper extremity.  
 New decreased range of motion left upper extremity.  
 New decreased range of motion right lower extremity.  
 New decreased range of motion left lower extremity.  
 New decreased range of motion back.  
 New decreased range of motion neck.

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No  
 Yes

Change in ROM: if yes, select body area involved –

If no suspected or actual head impact, select 'no' and move on

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NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No  
 Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: \*   
Best Verbal Response: \*   
Best Motor Response: \*

Total Score (Select the correct Glasgow Coma Scale Score)

Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)  
 Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)  
 Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)

If Suspected or actual impact to head: 'Yes' selection opens Glasgow Coma scale and guidance

Adding up the Eye, Verbal, and Motor scores correlates with mild, mod, or severe brain injury

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NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: \*

Best Verbal Response: \* 1 = No eye opening

Best Motor Response: \* 2 = Eye opening to pain

3 = Eye opening to verbal command

4 = Eyes open spontaneously

Total Score (Select the correct score):

Glasgow Coma Scale Score 3-8 (Correlates with severe brain injury)

Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)

Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)

Scoring options for Best Eye Response

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NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: \*

Best Verbal Response: \* 1 = No verbal response

Best Motor Response: \* 2 = Incomprehensible sounds

3 = Inappropriate words

4 = Confused

5 = Oriented

6 = Intubated

Total Score (Select the correct score):

Glasgow Coma Scale Score 3-8 (Correlates with severe brain injury)

Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)

Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)

Scoring options for Best Verbal Response

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NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: \*

Best Verbal Response: \*

Best Motor Response: \* 1 = No motor response

2 = Extension to pain

3 = Flexion with pain

4 = Withdrawal from pain

5 = Localizing pain

6 = Obeys commands

Total Score (Select the correct score):

Glasgow Coma Scale Score 3-8 (Correlates with severe brain injury)

Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)

Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)

Best Motor Response

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Pupils

Size

- Equal
- Right greater than Left
- Left greater than Right.

Reactivity

- Right eye reactive to light
- Right eye not reactive to light
- Left eye reactive to light
- Left eye not reactive to light

Follow your facility policy for continuing neurological checks.

PREVIOUS MORSE FALL SCALE INFORMATION

Date	Instrument	Raw	Trans Scale
12/08/2011 14:10	MORSE FALL SCALE	0	Morse Score

Information on Morse Fall Scale (click to open)

Pupils as part of neurological assessment

Prior score pulled in from Mental Health Pkg for the last time pt/resident had a Morse Fall Scale done (or will say 'no data available')

Guidance for use of Morse Fall Scale

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### Other Interventions – Text Option

Patient/Resident forgets limitations (Mental Status Assessment) - (positive response to Morse Fall Scale Question #4) choose at least one

- Re-educate/reminders regarding safety
- Move closer to Nurses' Station
- Provide clock and calendar
- Use a wandering monitoring device
- Arrange for diversional activities
- Observe every one hour
- Other:

Other Fall Prevention Interventions (based on Clinical Judgment)

INJURY PREVENTION INTERVENTIONS

Injury Prevention Interventions:  
Select all that apply

Injury Prevention:

- Height adjustable bed (low position when resting in bed)
- Hip protectors
- Floor mat
- Helmet
- Patient Education about anticoagulation and fall occurrence
- Other:

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INJURY PREVENTION INTERVENTIONS

Injury Prevention Interventions:  
Select all that apply

Injury Prevention:

- Height adjustable bed (low position when resting in bed)
- Hip protectors
- Floor mat
- Helmet
- Patient Education about anticoagulation and fall occurrence
- Other:

NOTIFICATIONS

Physician Notified:  
Time of notification:   
Name of physician notified:

Nursing Administrator/Nursing Supervisor Notified:  
Time of notification:   
Name of administrator/supervisor notified:

Family Notified:  
 Family notified by nursing staff  
Time of notification:   
Name of family member/support person notified:

- MD responsible for notification
- No family member/support person listed
- Unable to reach family
- Other

Nursing Staff Notified (that the patient/resident has fallen and is at risk to fall again):  
Time of notification:

Other Corrective Actions Taken Post Fall:

Preventive intervention selections

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### 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?

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### Staff Education

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

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### You Can Always Reach Me!

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

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I Fall A lot! Why?



Oreo

Jethro and Mr. Goober



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