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Rural Health

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

September 15, 2021, 12:00 PM – 1:00 PM

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The Nurse who won’t give up on falls!

As a Clinical Nurse Specialist and a Nurse Practitioner in Rehabilitation, Dr. Quigley is passionate about fall prevention and her contributions to patient safety, nursing and rehabilitation are evident at a national level – with emphasis on clinical practice innovations designed to promote elders’ independence and safety.

The falls program research agenda continues to drive research efforts across health services and rehabilitation researchers.

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Objectives

- Examine post fall practices as key intervention to reduce repeat falls
- Differentiate:
  - Post Fall Huddles
  - Post Fall Management
  - Post Fall Documentation
  - Incident Report

My Hope

- *Change your post fall management practices to differentiate Post Fall Huddle as an essential and core intervention*
- Increase precision in your application of your post fall huddle to mitigate and eliminate causes of falls and injury

Burden

- Falls affect between 700,000 - 1,000,000 patients each year (AHRQ, Patient Safety Network [PSNet], Patient Safety Primer: Falls. Updated Sept. 2019)
- Fall Rates: 3-5/1000 patient days (AHRQ, PSNet, Sept 2019)
- More than 1/3 of in-hospital falls result in injury (AHRQ, PSNet, 2019)
- Ranked among the most reported incidents in hospitals and other facilities (AHRQ, PSNet, Sept 2019)
- Falls can lead to severe injuries, hip fractures, and head trauma

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?

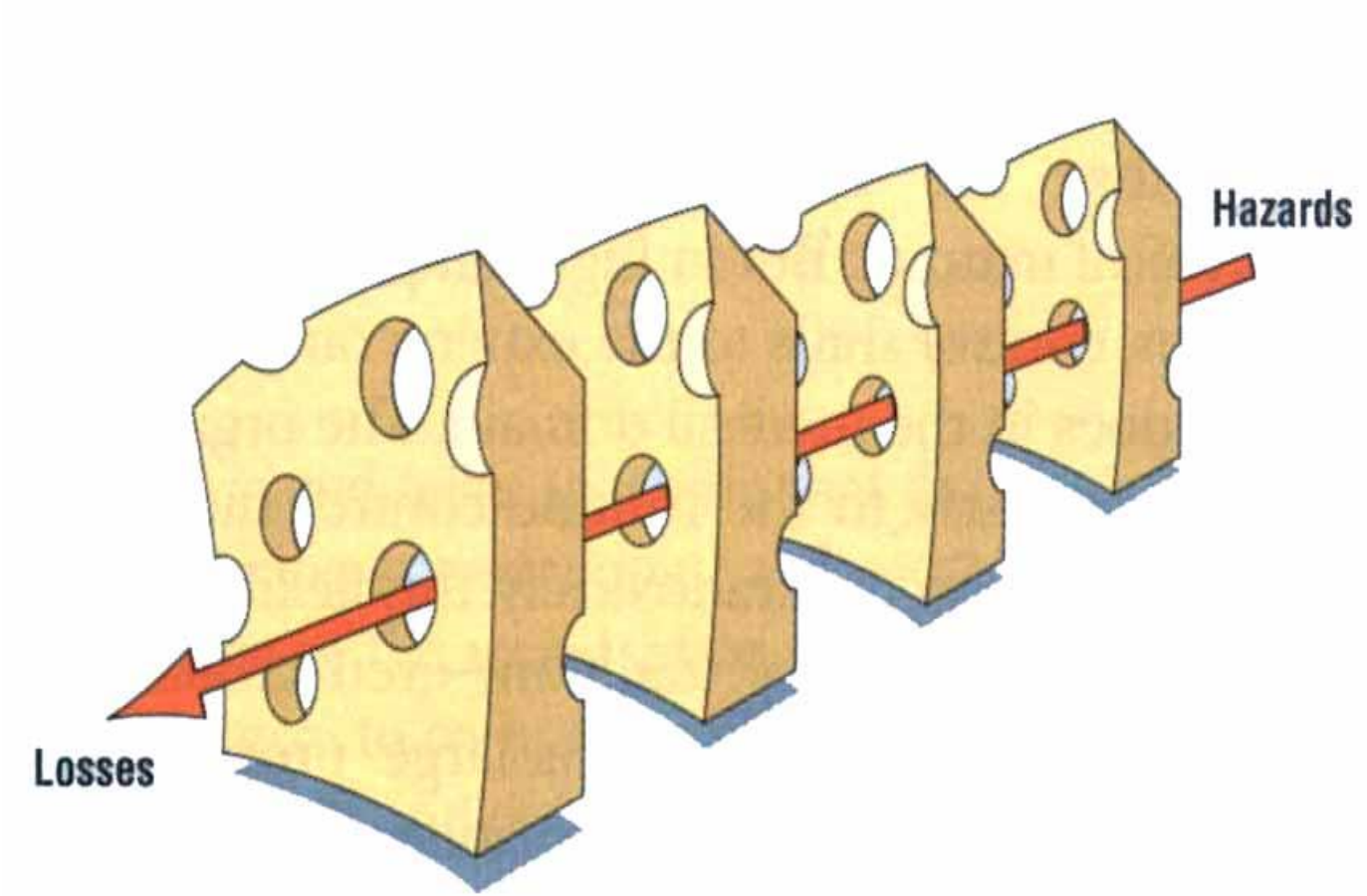
Post Fall Practices

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

Safety Huddles – How Many Do You Do?

- **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



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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?**

Steps to the Post Fall Huddle (PFH)

1. Team Leader makes announcement

2. Convene within 15 minutes with the patient/resident in the environment where the patient/resident fell

3. Conduct Analysis: Determine root cause of fall, injury and type of fall

4. Team Leader summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.

5. Team Leader completes the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.

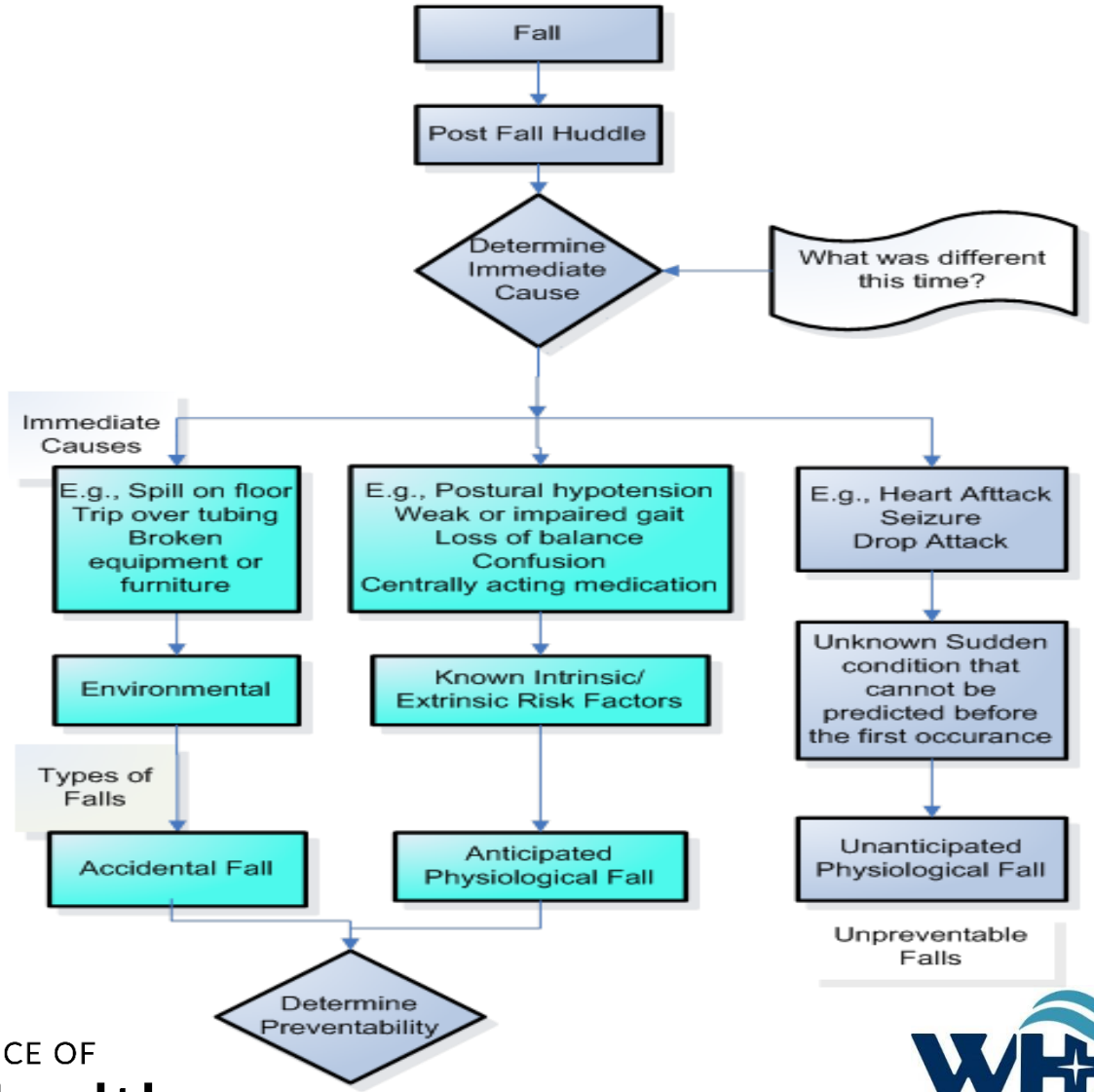
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall

7. Communicates updated plan of care in patient/resident hand-off reports.

8. Completes EMR Post Fall Note

Decision Tree for Types of Falls

Tuesday, April 22, 2014



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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-06-09-00090

The Form

- Is Yours This One?

Post Fall Huddle Form

- Don’t Morph This Form to Be Something Else

Outcomes of Post Fall Huddles

- Specify root cause (proximal cause)
- Specify type of fall
- Identify actions to prevent reoccurrence
- Changed Plan 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

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Tools

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

Let's Take a Look

- My Audit Tool

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 implement changed plan of care
  - Time between repeat falls

Summative Outcome

- Prevent repeat fall: same root cause and same type of fall (reduced repeat fall rate)
- Reduce repeat fallers
- Reduce preventable falls
- Reduce costs associated with falls and fall related injuries

Building Evidence about PFH

- 2-year demonstration project – quasi experimental study
- 16 small rural hospitals (average beds 26)
- Determine associations between conducting post fall huddles on repeat fall rates and perceptions of teamwork and safety culture

(Jones, Crose, et al., 2019)

Study Purpose

Collaboration and **Proactive Teamwork Used** to **Reduce** (CAPTURE) **Falls** purpose was to decrease the risk of falls in small rural hospitals by using a multi-team system (MTS) to implement evidence-based fall-risk-reduction practices.

MTS: core team, contingency team, coordinating team

Results

- 308 patients; 64% had PFH; 347 falls; 223 falls after PFH
- Aggregate mean repeat fall rate 1.12 (1.00-1.45)

  [12% chance of a repeat fall]
- Results demonstrate that the greater the proportion of falls in a hospital that are followed by a post-fall huddle, the lower may be the repeat fall rate.
- Staff perceptions of teamwork were consistently high regardless of participation in a post-fall huddle.

Post Fall Assessment - Different than PFH

- In-depth data gathering
- Circumstances of the fall
- Patient/resident presentation
- Assessment of patient/resident condition

Comprehensive Post-Fall Assessment

Includes:

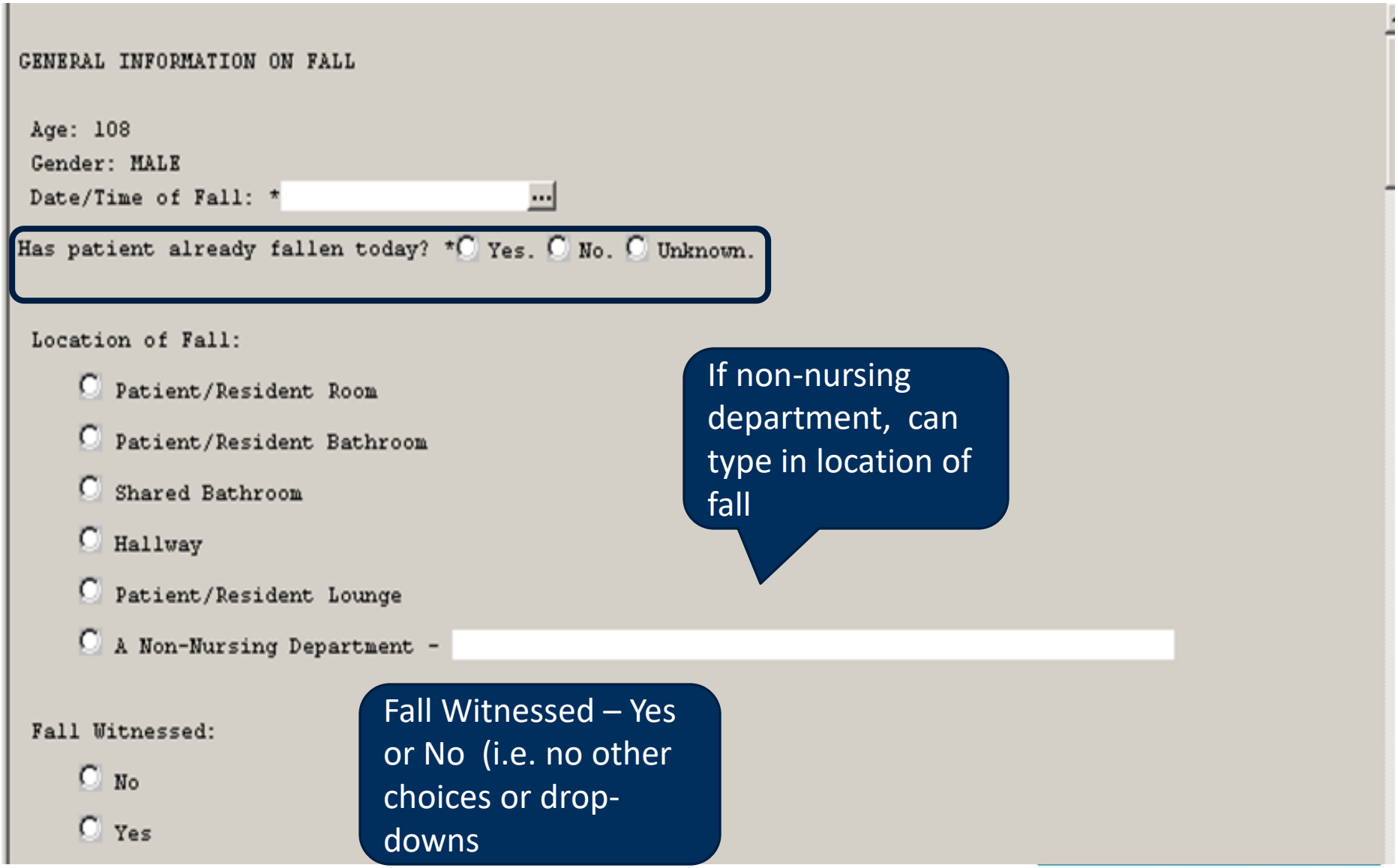
- General information about the fall
- Subjective & objective falls documentation
- Patient/resident assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based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

Post-Fall Assessment: History: Review of Systems

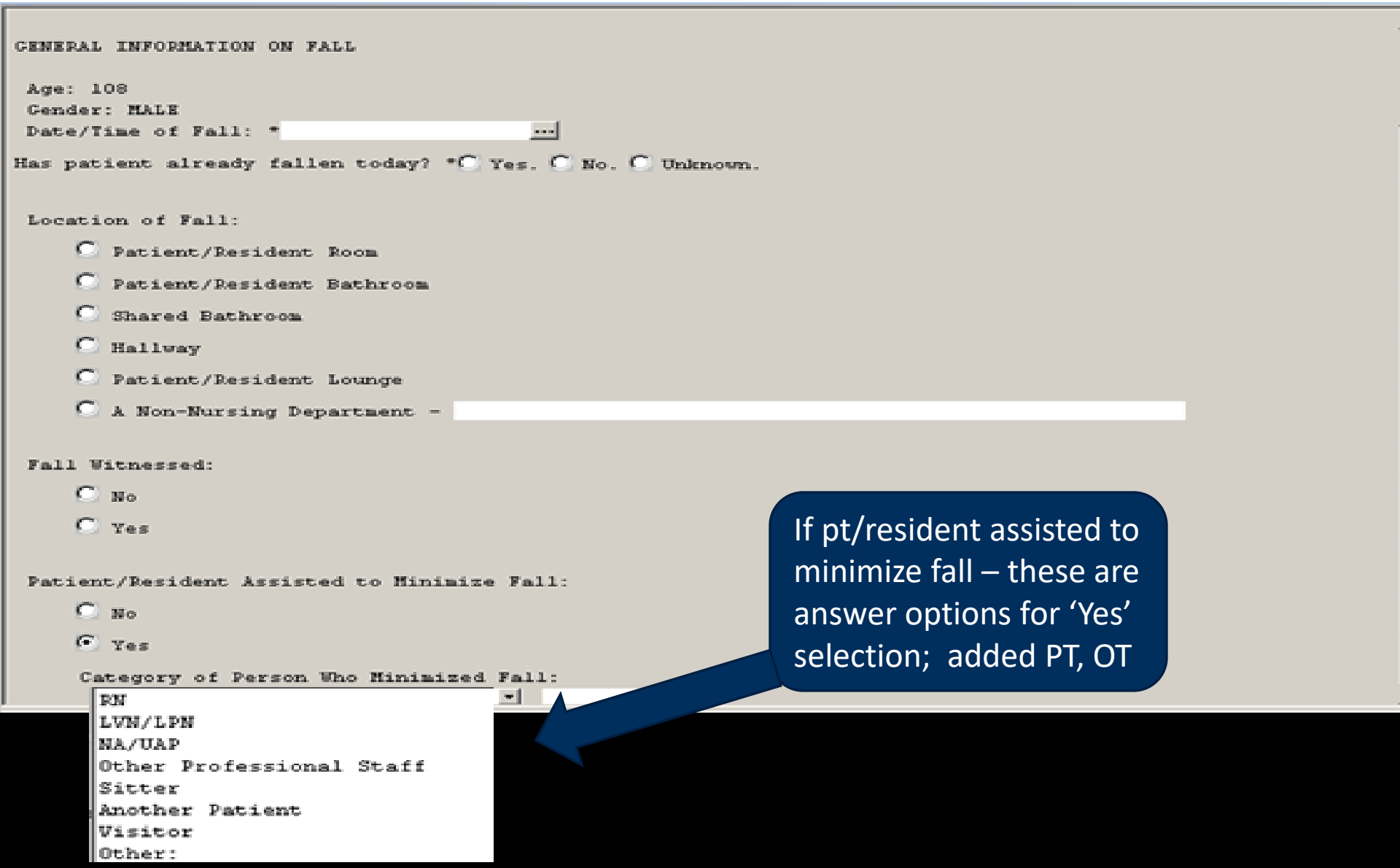
- Patient Symptoms to Elicit on History Linked to Risk Factors

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

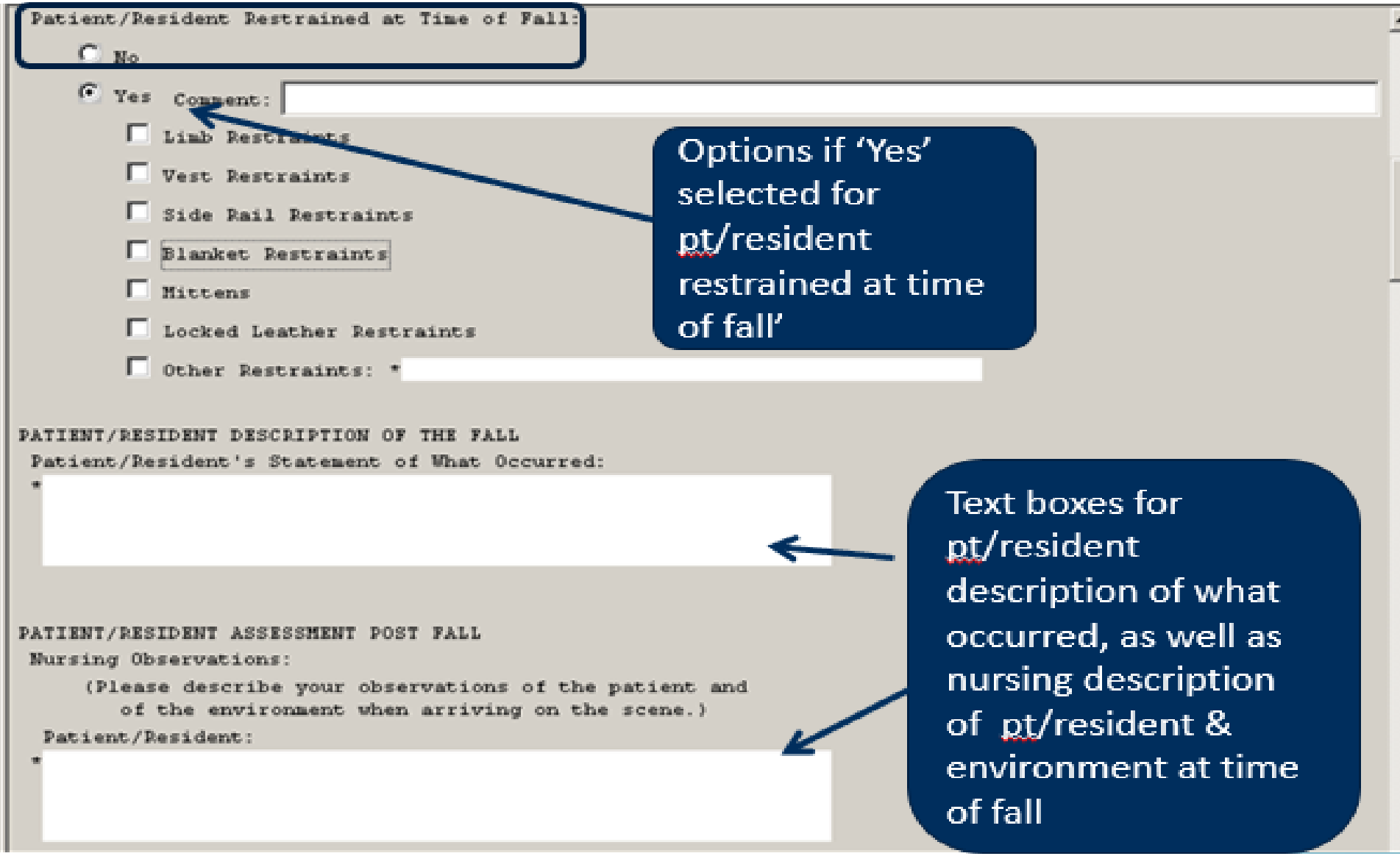
Post Fall Note (EMR)



General Information



Restraints


Patient/Resident Restrained at Time of Fall:
No
Yes
Comment:
Limb Restraints
Vest Restraints
Side Rail Restraints
Blanket Restraints
Mittens
Locked Leather Restraints
Other Restraints: *
PATIENT/RESIDENT DESCRIPTION OF THE FALL
Patient/Resident's Statement of What Occurred:
*
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:
*
Options if 'Yes' selected for pt/resident restrained at time of fall'
Text boxes for pt/resident description of what occurred, as well as nursing description of pt/resident & environment at time of fall

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)

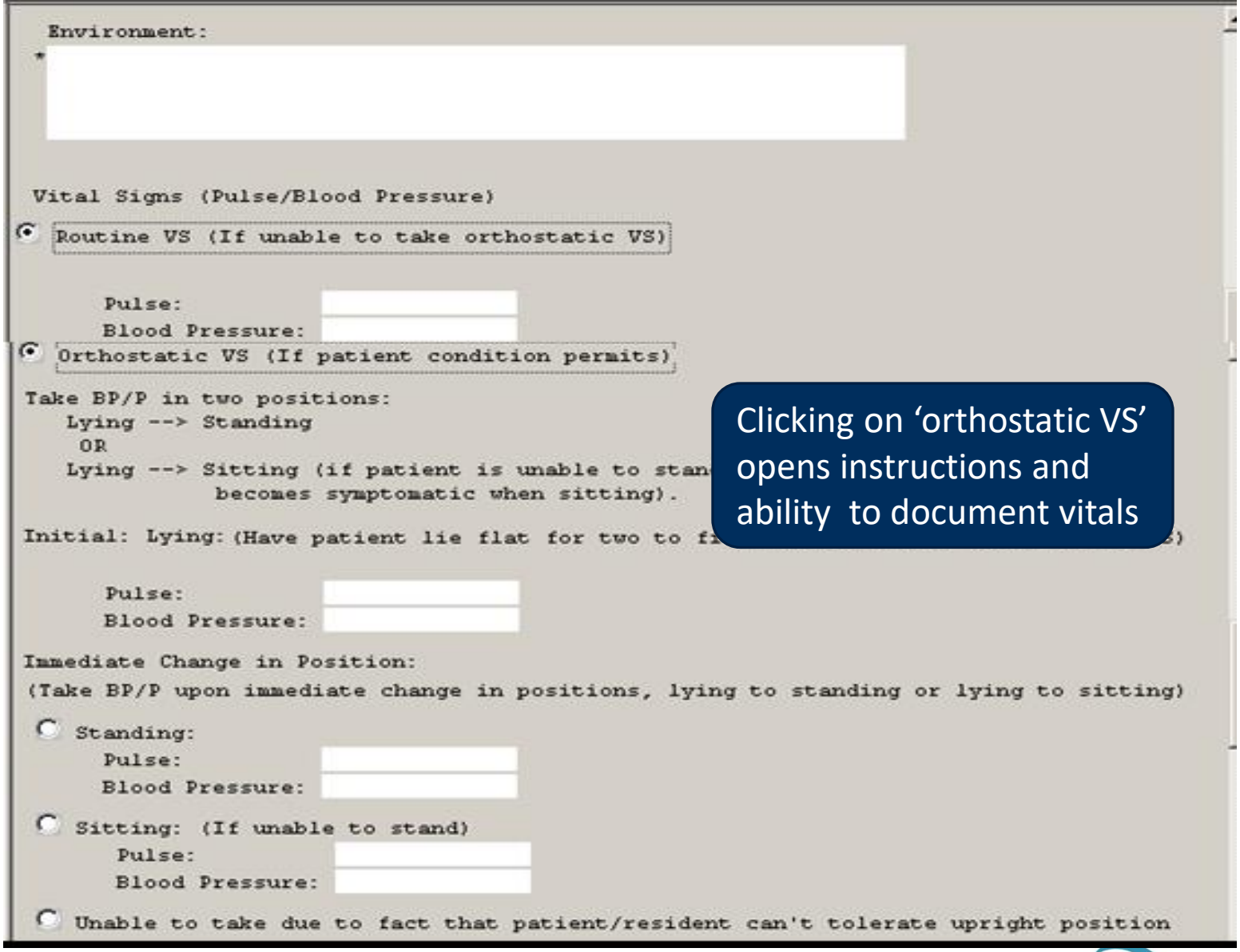
Routine VS (If unable to take orthostatic VS)

Pulse:

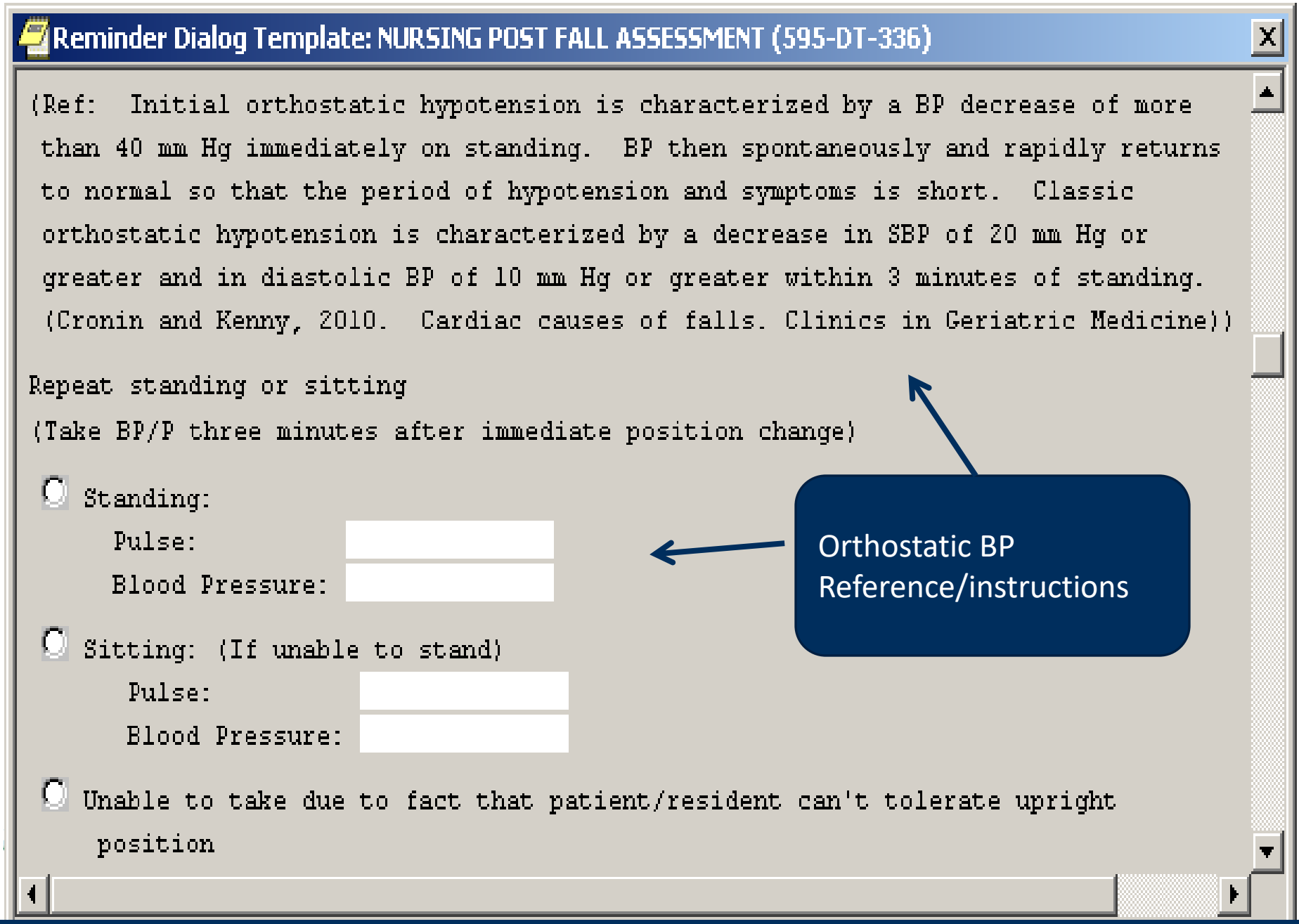
Blood Pressure:

Respirations:

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



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

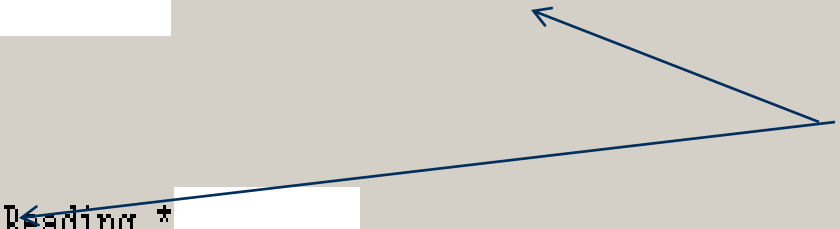

Reminder Dialog Template: NURSING POST FALL ASSESSMENT (595-DT-336)
(Ref: Initial orthostatic hypotension is characterized by a BP decrease of more than 40 mm Hg immediately on standing. BP then spontaneously and rapidly returns to normal so that the period of hypotension and symptoms is short. Classic orthostatic hypotension is characterized by a decrease in SBP of 20 mm Hg or greater and in diastolic BP of 10 mm Hg or greater within 3 minutes of standing. (Cronin and Kenny, 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

Glucometer Reading

Is patient/resident diabetic?

(If not diabetic but reading was taken, you may enter)

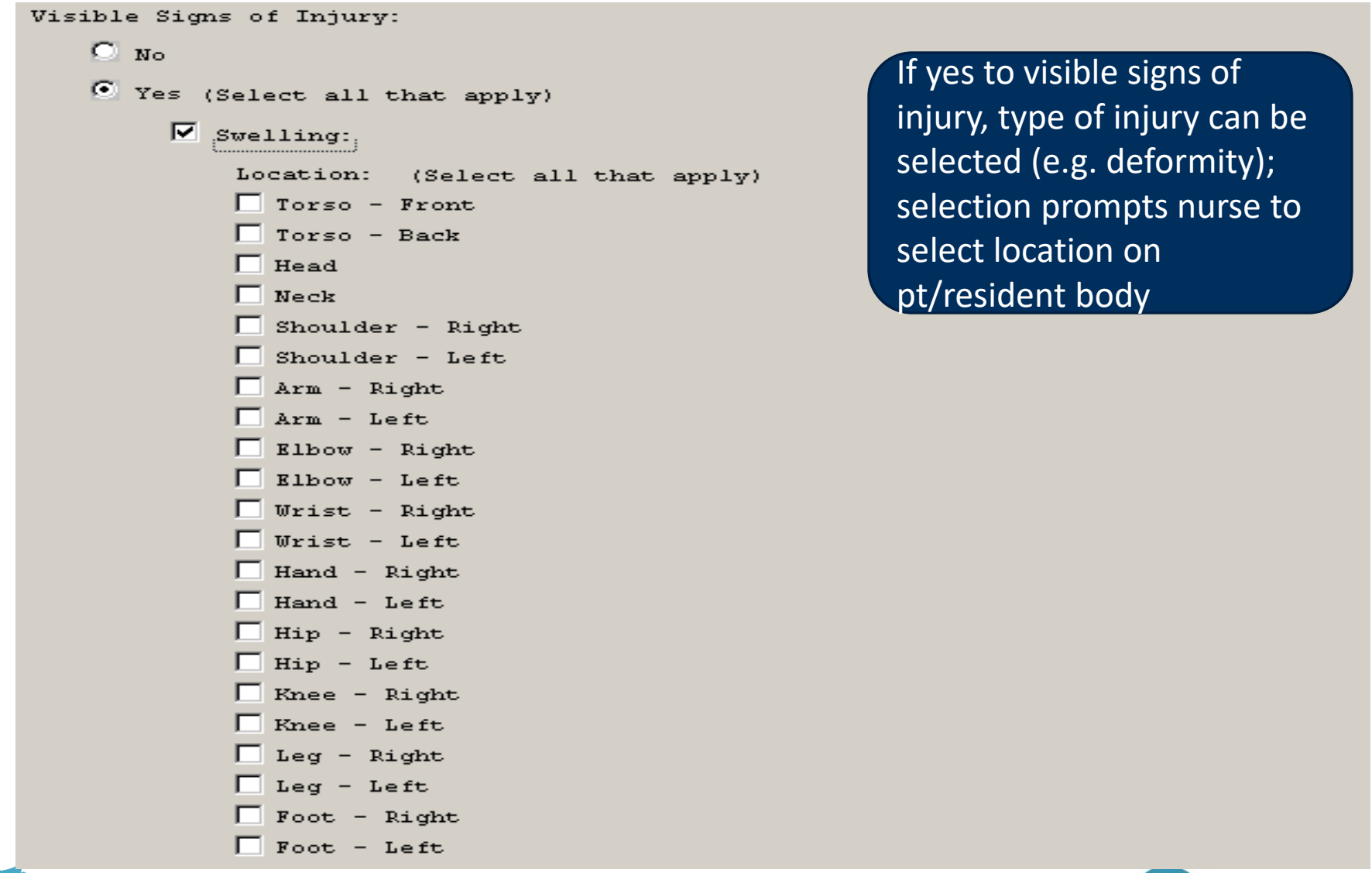
- ( ) No
- (•) Yes



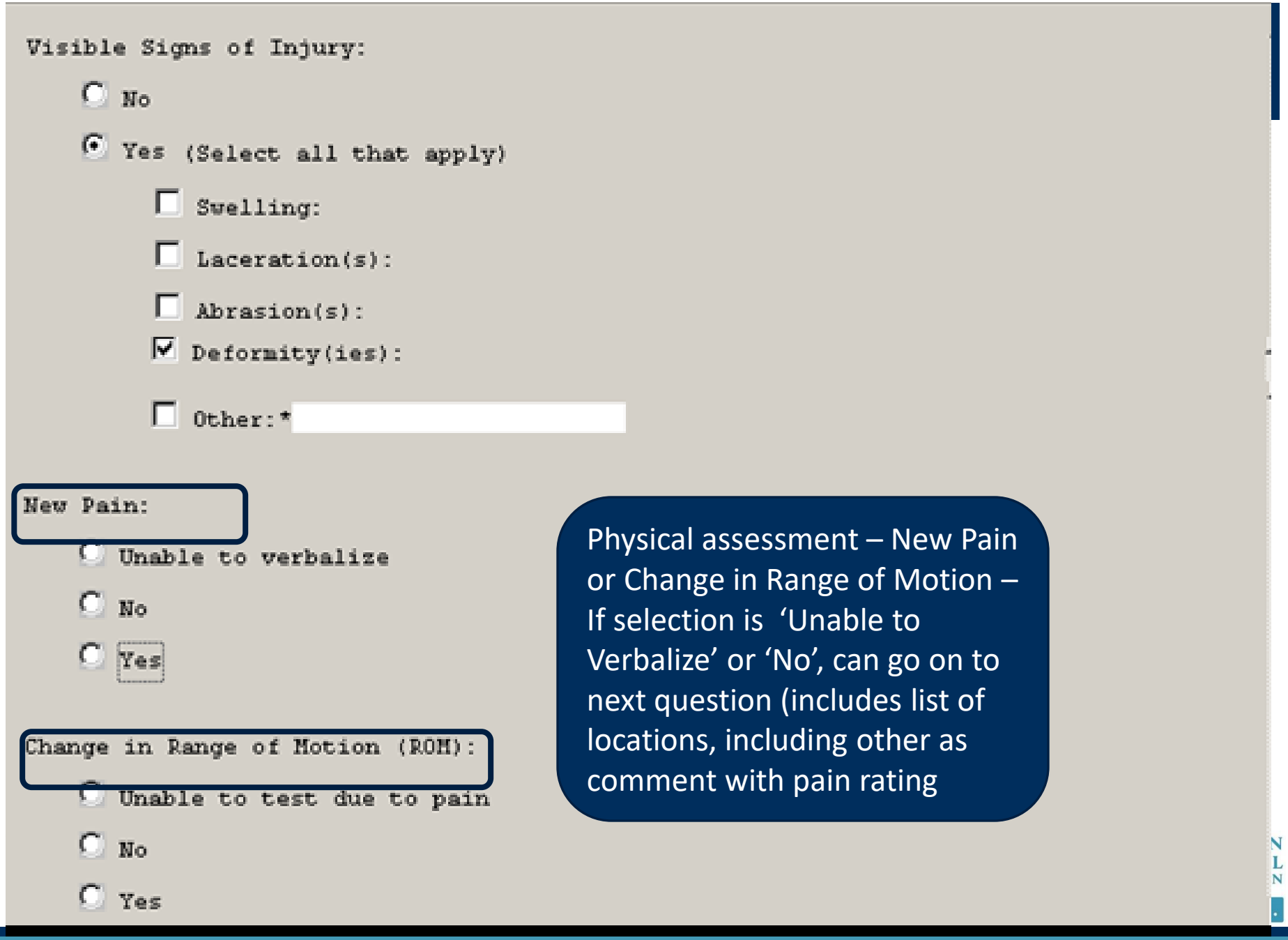
Glucometer Reading *

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

- ( ) No
- ( ) Yes



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



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

New Pain:

- ○ Unable to verbalize
- ○ No
- ◉ Yes

Location: (Select all that apply)

☐ Torso - Front	Pain Rating: *	
☐ Torso - Back	Pain Rating: *	
☐ Head	Pain Rating: *	
☐ Neck	Pain Rating: *	
☐ Shoulder - Right	Pain Rating: *	
☐ Shoulder - Left	Pain Rating: *	
☐ Arm - Right	Pain Rating: *	
☐ Arm - Left	Pain Rating: *	
☐ Elbow - Right	Pain Rating: *	
☐ Elbow - Left	Pain Rating: *	
☐ Hand - Right	Pain Rating: *	
☐ Hand - Left	Pain Rating: *	
☐ Hip - Right	Pain Rating: *	
☐ Hip - Left	Pain Rating: *	
☐ Knee - Right	Pain Rating: *	
☐ Knee - Left	Pain Rating: *	
☐ Foot - Right	Pain Rating: *	
☐ Foot - Left	Pain Rating: *	
☐ Other: *	Pain Rating: *	

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

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.

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

NEUROLOGICAL ASSESSMENT

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

- ( ) No
- (•) Yes

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

NEUROLOGICAL ASSESSMENT

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

- ○ No
- ◉ Yes

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

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: *

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

Total Score (Select the correct Glasgow Coma Scale Score)

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

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: *

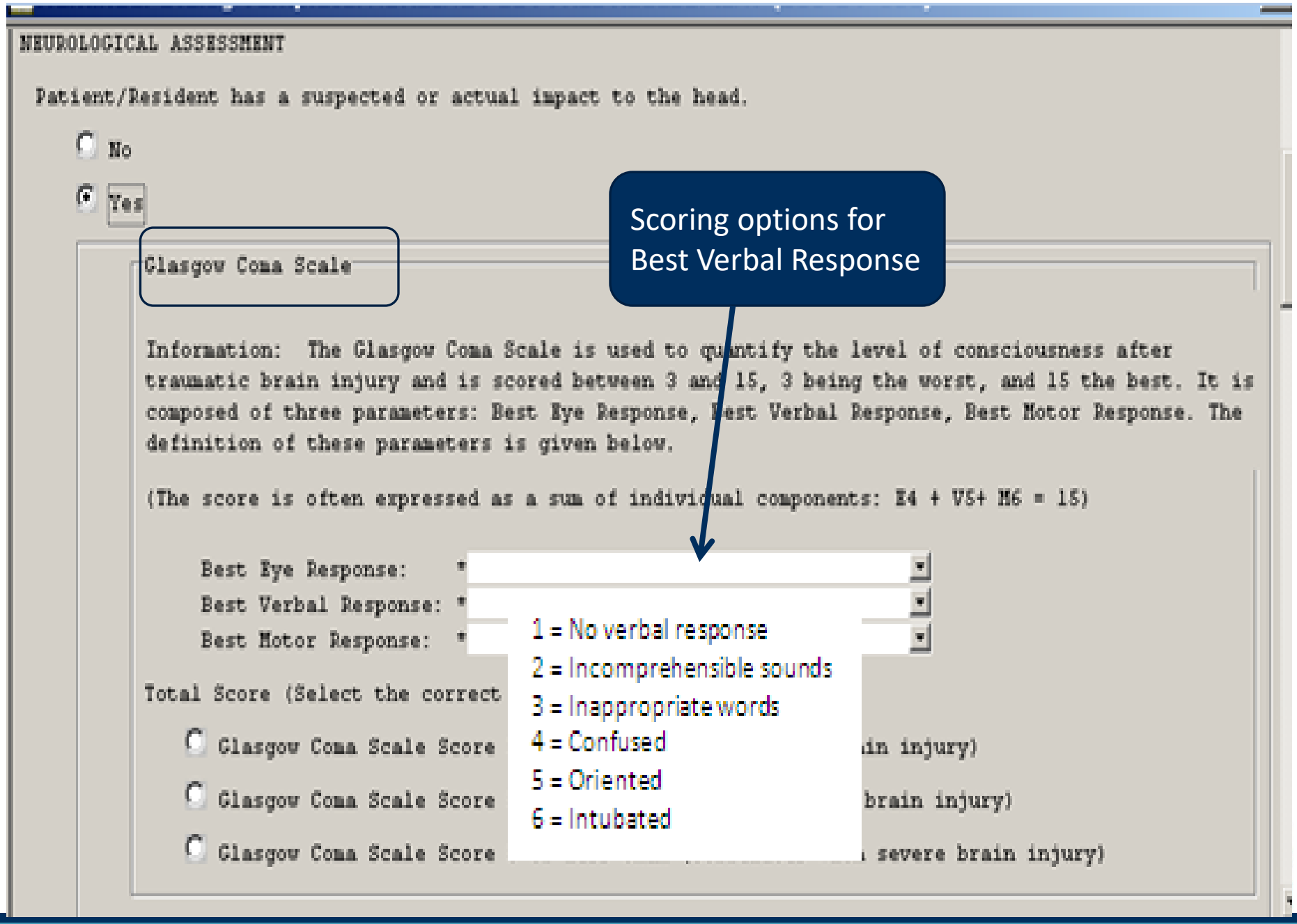
Best Motor Response: *

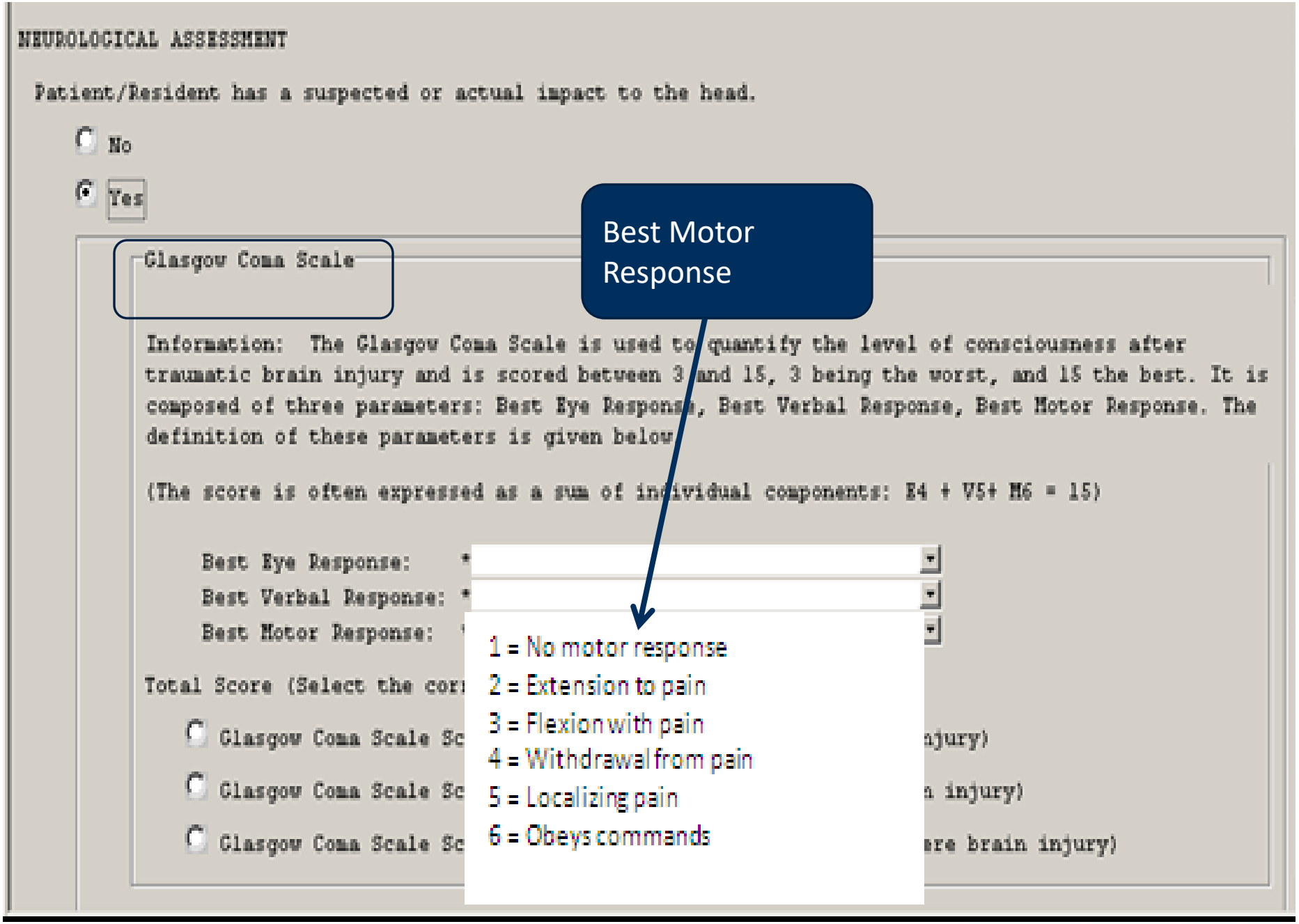
1 = No eye opening
2 = Eye opening to pain
3 = Eye opening to verbal command
4 = Eyes open spontaneously

Total Score (Select the corr

- ○ Glasgow Coma Scale Sco 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)

Scoring options for Best Eye Response


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 verbal response
2 = Incomprehensible sounds
3 = Inappropriate words
4 = Confused
5 = Oriented
6 = Intubated
Total Score (Select the correct
Glasgow Coma Scale Score
Glasgow Coma Scale Score
Glasgow Coma Scale Score
Scoring options for Best Verbal Response


NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Best Motor Response
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 cor
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc

☑ Patient/Resident forgets limitations (Mental Status Assessment) - (positive response to Morse Fall Scale Question #6)

choose at least one

- ☐ Re-educate/reminders regarding safety
- ☐ Move closer to Nurses' Station
- ☐ Provide clocks and calendars
- ☐ 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:

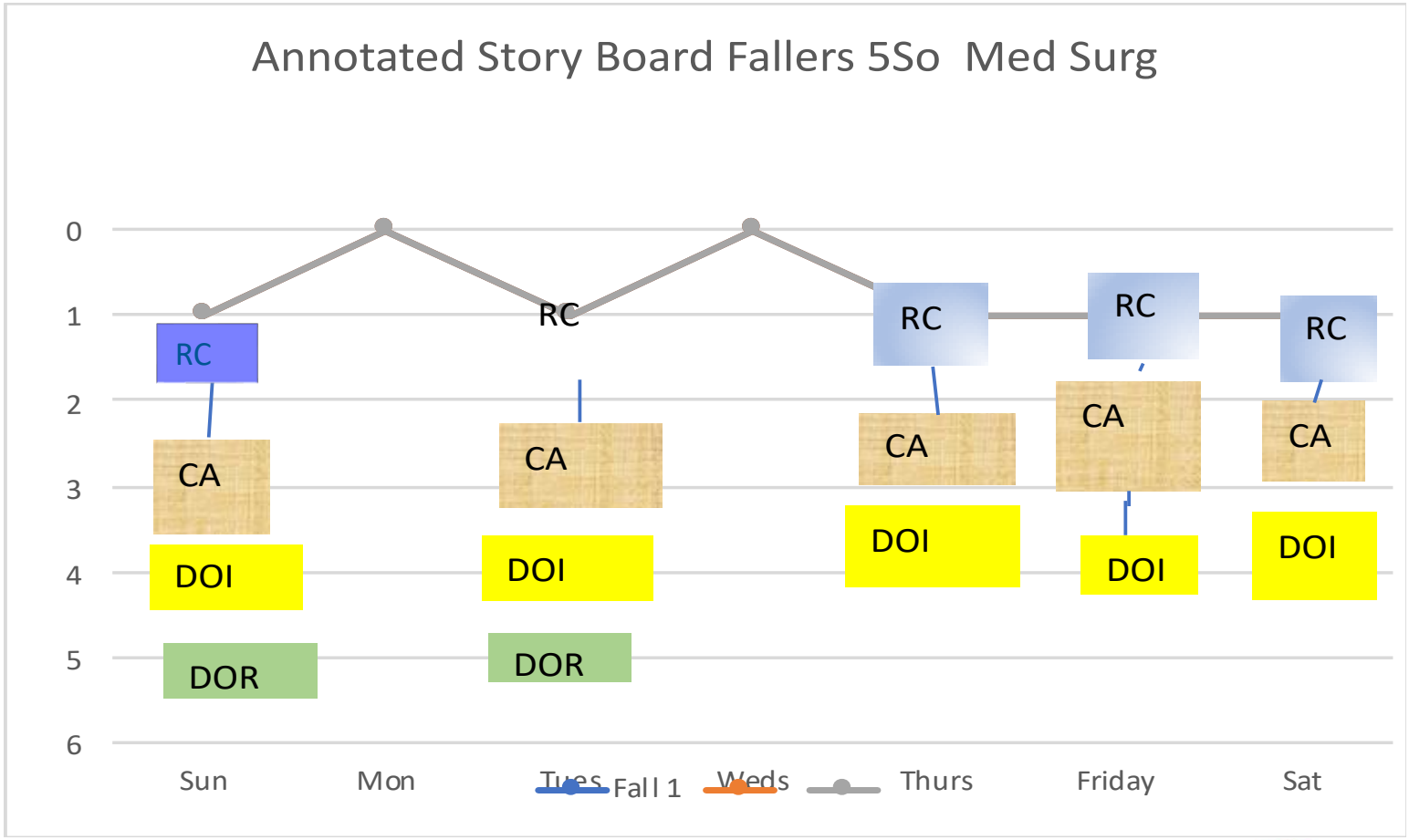
Select all that apply

☐ Injury Prevention:

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

Preventive intervention selections

My Unit Story Board



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Learn from Falls: Change Your Conversation

- Talk about and trend root causes
- Monitor interventions for mitigation/elimination of root causes
- Align interventions to type of falls
- Precision in program evaluation: Reduction
- Accidental falls
- Anticipated physiological falls
- Unanticipated physiological falls

To Change Practice is Not for the Faint of Heart

- It takes a lot of work: Patience, Perseverance, Champions, Positive Approach, and Data

My Asks of You – For Coaching Call

- Compare your PFH process with what was presented.
- Compare your Post Fall Management process with what was presented.
- Review the PFH Audit Tool for your use.

Upcoming Schedule

- Webinar 3 PFH Coaching Session: September 29, *11:00am, Central, 12noon Eastern
- Webinar 4: Program Evaluation: Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability – October 13
- Coaching Session: October 27

Thank you! You Can Always Reach Me!

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