Case Study: Scenario #2

Post Fall Huddle Case Study: Scenario “**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.

**Steps: Based on this case study, let’s work through the 8 *steps for a post fall huddle*:**

1. Announcement of an immediate huddle when a patient experiences a fall: The RN Called the Post Fall Huddle within 20 minutes of the fall event.

2. Staff critical discussion of the fall including all staff present, the provider, ancillary services, the patient, and any visitors present at the time of the fall: Gathering for the post fall huddle on the night shift was the RN assigned to the patient, the CNA who assisted the patient to a standing position after the fall, an LPN, with the patient.

3. Analysis of scenario and factors leading to the fall, determining the root/immediate cause and type of fall: The RN reported her observations of the patient upon entry into the room: Patient was lying on his right side, close to the right side of the bed on the floor, right foot tangled in the sheet, and walker tipped over on the floor to his right side. The patient stated he was getting up out of bed to go to the bathroom, with no dizziness upon standing. The patient stated the RN placed the walker too far away from him to reach it; he was reaching for the walker and lost his balance.

Type of Fall: Accidental – His foot got caught and tangled in the sheet, he lost his balance and fell on his side.

4. Synthesis of information gleaned from PFH and decide on intervention(s) for prevention of repeat fall based on the same immediate/root cause: Based on the post fall huddle, the root cause of the fall was:

A. Placement of the walker outside of patient reach: Related to environment of care.

B. Patient’s right foot tangled in the sheet: Related to environment of care.

5. Completion of the Post-Fall Huddle Form and process within your medical center based on your policy: The hospital’s policy is to conduct the post fall huddle as soon as possible within 15 minutes. While the post fall huddle could not be conducted that quickly, as the patient needed to toilet, the huddle was completed within 20 minutes.

6. Implementation of patients’ care plan changed plan: Changes in the plan of care:

Placement of the walker within the patient’s reach was added to the care plan;

Reinforcement with patient to call for help prior to standing from the bed (or chair)

Examine patient foot placement when getting up out of bed, to ensure bed linen is secure and not a trip hazard.

**7.** Updated patient’s plan of care is communicated in patient hand-off reports. The RN reported the fall event, patient assessment, post fall huddle results, change in care plan to oncoming RN to ensure walker is always within patient’s reach.

8. Fall documentation and documentation of huddle with recommendations in EMR

by the patient’s team nurse: The Post Fall Huddle form was completed and the changed plan of care was completed to include the interventions 1 and 2 from question 4.

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