Post Fall Huddles

# Description

Many studies point out that a major determinant of a future fall is the history of previous falls (Degelau, et al., 2012; Gates, et al., 2008; Oliver, et al., 2004). Finding the right intervention to prevent falls requires a multidisciplinary review to identify and intervene on modifiable risk factors (Ganz, et al., 2013; Oliver, Healey, & Haines, 2010). Because older adults continue to fall despite the implementation of evidence-based guidelines to prevent falls, identifying the causes of each fall is critical to preventing future falls. Within the inpatient settings, clinicians are able to act when a patient fall occurs, to quickly determine the event with the patient, using the post-fall huddle process. Implementing post-fall huddles (PFH) shows promise for reducing repeat falls in individuals. Once a fall occurs in our care, the etiology and/or cause of the fall and injury must be investigated to prevent future occurrences. Evidence reviews of post-fall assessments is available (Ganz, et al.; Cameron, et al. 2012).

# Purpose

This resource guide details essential components of a post fall huddle (PFH), outcomes that can be linked to this intervention, and steps for implementation. Additionally, resources have been prepared to help clinicians with staff education and implementation. Examples of these resources include case studies, clinical decision algorithm, and samples of post fall huddle templates.

Post-fall huddles are used in inpatient settings of care to determine the cause of the fall and injury, and intervene appropriately (Ganz, et al, 2012; AHRQ, 2010; Quigley, et al., 2009; Anderson, Mokracek, & Lindy, 2009). The definition of huddle varies from study to study; but, a huddle is an immediate evaluation of each fall, by a team, preferably interdisciplinary, with the patient in the environment where the patient fell.

It is NOT:

A comprehensive post fall assessment Recorded in the medical record

An incident report

# Essential Components

The PFH as a brief staff gathering, interdisciplinary when possible, that immediately follows a fall event. The essential components of the post fall huddle are:

* Convenes within 15 minutes of the fall event
* Clinician(s) responsible for patient during fall event leads the PFH
* Involves the patient whenever possible in the environment where the patient fell
* Requires individuals to gather and use “Group Think”, consensus of a group rather than a decision by an individual, to discovery what happened.
* Involves interdisciplinary team members whenever possible (such as RN, MD, PT, members of nursing staff (LPN, CNA), who know the patient, no more than 3-4 people to not overwhelm the patient)
* Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient fell.
* Guiding question to the patient: 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.

# Outcomes

* Root cause(s)/immediate cause(s) of the fall is determined
* Root cause/source of injury is determined
* Type of fall is decided
* Patient’s plan of care is changed
* Patient is engaged in determining cause of fall and prevention of repeat fall (same cause and type)
* Repeat fall is prevented due to same root cause/immediate cause (reduce repeat fall rate)

Within and between units, root cause (s) of falls can be trended to determine clinical practice opportunities for improvement using quality improvement and program evaluation.

# Steps for Conducting the Post Fall Huddle

Staff present at the time of the fall are the persons who have the most information regarding the etiology of the fall, and this of course includes the patient. Since most repeat falls occur under similar circumstances as the first fall, elimination of those circumstances is instrumental in preventing further falls (Hook & Winchel, 2006).

The first action is to determine need to emergency care an act accordingly. Whenever possible, proceed to conducting the post fall huddle.

1. The staff member in charge of the patient, such as an RN, makes an announcement of an immediate huddle when a patient experiences a fall. This staff member because the Post Fall Huddle Team Leader (TL).
2. Within 15 minutes of the announcement, staff critical to discussion of the fall event convene, including staff present at the time of the fall, the prescribing provider, the patient, any visitors, and ancillary services (if appropriate), present at the time of the fall. This group comprises the team to conduct the huddle, and should include 3-4 individuals only. Too many people could worry the patient; so include key individuals to determine the root/immediate cause of the fall with the patient.
3. The team completes an analysis of the fall event and factors leading to the fall and injury with the patient in the environment where the patient fell, and determines the type of fall.
4. The TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall and injury are decided by the huddle team.
5. The TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Based on analysis of the fall event, the appropriate clinician modifies the fall prevention plan of care to include interventions to prevent repeat fall and injury from occurring based on the root cause/immediate cause of the fall and injury.
7. The update of the patient’s care plan is communicated in patient hand-off reports.
8. Documentation of the fall event is completed in the EMR per hospital policy and guidelines. After the post fall huddle, the Nurse Manager should follow-up with staff to ensure

interventions are implemented, and with the patient to make sure the patient understands the interventions being implemented to prevent a repeat fall from occurring. This follow-up process engages the patient as a partner in the fall prevention strategies. The Nurse Manage can also answer any questions or concerns the voiced by patient or family.

Case Studies (Attachments). Two Case studies have been developed as educational tools when teaching staff the post fall huddle process.

## Case Study: Scenario #1

Post Fall Case Study: Scenario “Alert Patient walking with Nurse”

Mr. Ambulatory, 73 years old, is an inpatient on surgical unit, admitted June 19, for a surgical procedure the next day. His past medical history includes HTN, DM II, OA, CHF, PVD, and BPH. On June 20, at 09:00am, Mr. Ambulatory, was ambulating down the hallway with the nurse for the first time, 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 orthostatic vital signs, but he stated that he was still dizzy but felt that he could get up into the wheel chair 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.

Please see attachment to work through the post fall steps 1-8.

## Case Study: Scenario #2

Post Fall Huddle Case Study: 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. His diagnoses are morbid obesity, DM II, CHF, lower leg ulcers secondary to vascular insufficiency, hypertension, mild BPH and increasing muscle weakness in his lower extremities. He weighs 370 pounds and is 6 feet 3 inches tall. He lives with his wife who has been assisting him with his care but can no longer manage him at home, and his provider admitted him until he can make arrangements to be admitted to the CLC. Mr. Patriot is alert and oriented, and agreed to call for help if needed, and accurately performed a return demonstration for call light usage. Mrs. Patriot states the patient uses a walker in his home to help him get around safety, but needs help to stand up and sit down.

During the admission process, the RN was discussing toileting needs with Mr. Patriot, confirming his use of a walker for weakness. The nurse instructed the patient about urinals as an option. He insisted he must use the bathroom “like a man” and that he would not use the urinal.

The RN verified through physical exam that the patient could not hold either leg up against resistance. Verifying lower extremity weakness, the nurse next mentioned about a standing mobility aid they could use to help him stand and transfer to the bathroom safely with the nursing staff. The RN expressed concern about his ability to make it to the bathroom due to difficulty getting around and lower extremity weakness, and started to evaluate if the patient would accept use of a lift mobility aid to stand and transport him to the bathroom. Mr. Patriot stated he has been getting himself up for 60 years and was not going to ask a nurse to help him now.

On the evening shift Mr. Patriot reported to the CNA that he did get up several times during the day by himself to go to the bathroom. He continued with this activity without incident through the evening shift. However, Mr. Patriot was reminded to call for nurses’ help before getting up out of bed.

During the night shift, around 2:00 AM the nursing staff heard a loud noise in Mr. Patriot’s room. When the CNA entered his room, Mr. Patriot was 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, he 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 with the CNA present, called for additional staff assistance. 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. Together, the RN and CNA assisted the patient to a standing position – to the bathroom. 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.

Please see attachment to work through the post fall steps 1-8.

# Algorithm

Visually graph post fall huddle (see VISN 8)

# Post Fall Huddle Forms

(Resources solicited from VA)

# References

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