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 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
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

1. TL makes announcement
2. Convene within 15 mins. with the patient/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 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


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

Tools

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

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 the Post Fall 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

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

Post Fall Note (EMR)

GENERAL INFORMATION ON FALL

Ages: 100
Gender: MALE
Date/Time of Fall: [__] [__] [__]

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 -

Fall Witnessed:
☐ No
☐ Yes

If non-nursing department, can type in location of fall

Fall Witnessed – Yes or No (i.e., no other choices or drop-downs)
Gen Info

If pt/resident assisted to minimize fall – these are answer options for ‘Yes’ selection; added PT, OT

Restrained at Time of Fall

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

Clicking on 'orthostatic VS' opens instructions and ability to document vitals
Orthostatic BP Reference/instructions

Wording changed to:
“If not diabetic, may enter reading next to ‘No’ “
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

Try adding comment box after injury location list

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

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

If no suspected or actual head impact, select ‘no’ and move on
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.

Scoring options for Best Eye Response:

- No eye opening
- Eye opening to pain
- Eye opening to verbal command
- Eye opening spontaneously

The score is often expressed as a sum of individual components: E4 + V5 + M6 = 15.
Scoring options for Best Verbal Response

Best Motor Response
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

Other Interventions – Text Option

Patient/Resident forgets limitations (Mental Status Assessment) = (positive response to Morse Fall Scale Question #1)
- Choose at least one:
  - Re-educate/reminders regarding safety
  - More closer to Morse’s Priming
  - Provide clocks and calendars
  - Use a wandering monitoring device
  - Arrange for directional activities
  - Observe every one hour
  - Others:

Other Fall Prevention Interventions (based on clinical judgment):

Injury Prevention Interventions:
- Select all that apply
  - Injury Prevention:
    - Height adjustable bed (low position when resting in bed)
    - Hip protectors
    - Floor mat
    - Rail
    - Patient Education about anticoagulation and fall occurrence
Patient/Resident / Family Education

- Fall Prevention
- Post Fall Management
- Engagement
Partnering

• Patients/Residents
  – Need support and education to make good choices
  – Benefit from easy to use directives
  – Need to be accountable
  – Need practical examples to put principles into place

• Family
  – Partners in Care – Advocates, Information Gatherers
  – Messengers
  – Provide ongoing assessment in the home
  – Teach clinicians about their safe practices

Autonomy

• What does this mean to you?
• What choices do patients/residents have?
• What are the consequences of choices?
• What choice do you think the patient/resident will make?
• What happens after a fall?
“Teach Back”

• “Teach Back” Testing: what are the trends in patients’/residents’ difficulty to understand what is taught?
  Ask the patient/resident to describe or repeat back in his or her own words what has just been told or taught. Return demonstration is a similar technique used by diabetic educators, physical therapists, and others. When the health professional hears the patient’s/resident’s description in her/his own words, further teaching can be accomplished to correct misunderstandings. Never ask whether pts/residents understand; they always say “yes”.

When “Teach Back” Is Especially Important:

• New medications
• A new diagnosis
• Instructions for calling for help to BR
• Instructions for self care
  – e.g. ask, “How can you stay safe from falling?”
• Patients/Residents are cautioned on how to prevent falls in the facility
  – e.g. young male patients/residents who suddenly have high doses of pain meds but want to toilet themselves. Ask, “How will you best prevent yourself from falling when you are given this powerful drug for pain that is known to cause falls?”
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?

Communication With Patients/Residents/Staff About Fall Reduction/Injury Prevention

Signage for Patients/Residents: known fallers and those at risk of fall or injury
• Use signage/other visual indicators (bracelets, colored socks, special blankets, etc.)

Ensure Safe Handoffs
• Verbalize and repeat-back risk of fall and risk of harm from fall at change of shift
• Verbalize and repeat-back risk of fall and risk of harm from fall between departments
Communication with Patients/Residents/Staff about Fall Reduction/Injury Prevention

Verify Understanding
• Use teach-back strategies to verify what patients/residents/families understand and customize education about harm risk accordingly

Learn from Failures and Transfer Learning
• Use unit-based post-fall team huddles to learn what happened and how to prevent injuries from future falls
• Discuss post-fall huddle findings at house-wide nurse manager meetings

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