CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #2
November 27, 2012  2:00 p.m. CST

Post-fall Huddle
AGENDA

• Post-fall Huddle
  • Who
  • What
  • When
  • Why
  • Your experience

• Event Report

• Lessons to share with the community
  • Barriers and Successes in Implementation
Post-Fall Huddle – Who?

Contingency Team – Time limited team for specific/emergent events composed of members from various teams

- Patient/family
- Nurse/CNA
- Others as available/desired including QI, pharmacy, PT
Post-Fall Huddle – What?

• Suggested best practice for reducing fall risk*

• TeamSTEPPS definition of huddle
  • Ad hoc meeting to regain situation awareness
  • Discuss critical issues and emerging events
  • Anticipate outcomes and likely contingencies
  • Assign resources
  • Express concerns

Post-Fall Huddle – When?

Ideal—as soon as possible after patient care is provided but prior to leaving the shift

Post-Fall Huddle – Why?

Post fall huddles provide a mechanism to learn from falls by immediately assessing the situation and reviewing the event.

Learning Domains

- Task Error
- Judgment Error
- Coordination Error
- System Error


Post-Fall Huddle – Debrief your experience

• Communication clear about post-fall huddles?
• Roles and responsibilities understood?
• Do post-fall huddles increase situation awareness?
  • What happened?
  • Previous falls?
  • What interventions were in place? Was everything intended actually implemented?
  • How could the fall have been prevented?
  • What will be done differently?
Event Report

Facts…unassisted, noninjurious fall

- 84 y/o female
- Fell backwards while standing in bathroom and reaching for toilet tissue to care for her colostomy
- Initial fall risk assessment results—Not at risk!
- Did use an assistive device
- No admitting dx
- Rationale: patient cares for colostomy at home so no assistance offered in hospital
Lessons to Share...

- Something important/surprising that you learned during site visit
- A change you have made that is working well
- A change you made that didn’t work well
- What can we improve on?
REMINDERS

Monthly Call: January 22, 2013 at 2:00 p.m. CST

Webinar #1: December 11, 2012 at 10:00 a.m. CST
Fall Risk Assessment: Best Practices for Nursing Staff in the Acute Care Setting

Webinar #2: January 15, 2013 at 10:00 a.m. CST
Fall Risk Reduction Interventions: Best Practices for Nursing Staff in the Acute Care Setting

Continuing Education Units Available for Webinars 1 & 2 if viewed live.

CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls
CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce