

# CAPTURE Falls Post-Fall Huddle Education: Discussion Guide for Fall Case Study #1

**Discussion Leader Instructions:** This case study can be used to provide staff with an opportunity to practice working together toward the two primary purposes of a post-fall huddle:

- Gathering information about factors that contributed to a patient fall, and
- Identifying changes necessary in the patient’s plan of care to reduce risk of another fall.

Consider having staff discuss the fall within small groups. Ideally, these groups are interprofessional, if possible. The following step-by-step guide will help you lead staff through the case.

**1. Remind staff that the purpose of a post-fall huddle is to:**

- a. gather information about factors that contributed to a fall, and
- b. identify changes needed in the patient’s fall risk reduction plan of care to reduce risk of another fall

**2. Share the following facts from the table below about the patient and fall event with the group:**

|   |   |
|---|---|
| <b>Admission Type</b>   | Swing bed   |
| <b>Age Category</b>   | < 65 years old  |
| <b>Reason for Admission</b>   | Sepsis  |
| <b>Patient conditions/comorbidities</b>   | Cardiovascular, Infection, Cognitive impairment   |
| <b>Medications</b>  | Cardiovascular agents, psychotropics, analgesics  |
| <b>Fall Screening Tool Result</b>   | At risk   |
| <b>Ambulatory Status at the Time of the Fall</b>                                      | With assist of 2 (hands-on)   |
| <b>Time of Fall</b>   | Morning   |
| <b>Description of Fall</b>  | Family was present visiting the patient in his room. Family assisted the patient with ambulation to/from bathroom without notifying staff. Patient was unable to get back to the bedside chair after using the bathroom. Family lowered the patient to the floor in front of the chair. Patient was using his walker, but the family did not have a gait belt on the patient. |
| <b>Injury Due to Fall</b>   | None  |
| <b>Fall Risk Interventions Documented in the Plan of Care at the Time of the Fall</b> | Alarm<br>Assistive device<br>Bed in low position<br>Call light/personal items in reach<br>Gait belt<br>Medication review<br>Non-slip footwear<br>Patient/family education<br>Patient close to nurses’ station<br>PT/OT including exercise and mobility program<br>Purposeful rounding   |

**3. Share the following information with the group: “A post-fall huddle was conducted following the fall. Huddle participants included the patient, family, charge nurse, primary nurse, CNA, OT, PT, Pharmacists and a QI professional. What information would be useful for them to discuss in the huddle?”**

**Allow time for group discussion. The goal of this part of the discussion is to consider what factors may have contributed to the fall.**

**Possible questions\* the group might ask to gather information about the fall:**

- Was the patient at risk of falling? What specific fall risk factors does this patient have?
- Has the patient fallen previously during this hospitalization?
- Is the patient at significant risk for injury (ABCs: age, bone health, coagulation, recent surgery)
- What was the patient doing when he/she fell? Why?
- What were staff doing at the time of the fall? Why?
- What was different about this time that the patient used the bathroom compared to other times?
- Did the care plan include interventions to address each of the patient’s known risk factors for falling?
- Were staff effective in delivering the intended interventions to address those risk factors?
- Have we potentially missed anything in our assessment and intervention?
- Are there any organizational factors that could contribute to this fall? These could include:
  - Communication, other than at the time of handoff
  - Handoff
  - Data issues (e.g. availability, accuracy)
  - Environment (e.g. culture of safety, physical surroundings)
  - Human factors (e.g. fatigue, stress, inattention, cognitive factors)
  - Policies and procedures, including clinical protocols (e.g. absence, adequacy, clarity)
  - Staff qualifications (e.g. competence, training)
  - Staff supervision/support (e.g. clinical, managerial)
  - Health information technology (e.g. electronic health record)

*\*Note that several of these questions are also on our CAPTURE Falls [Post-Fall Huddle Pocket Guide](#). The list of possible organizational factors to consider are from the [Agency for Healthcare Research and Quality Common Formats](#) for reporting and analysis of patient safety data.*

**The table below provides the list of questions from above, along with answers that were discovered during the huddle. You may share the answers as questions (such as those above) are raised, or you may share the answers altogether once a complete list of questions is generated.**

| <b>Potential Questions to Discuss in the Huddle</b>   | <b>Answer Discussed in the Huddle</b>  |
|---|--|
| Was the patient at risk for falling?<br>What specific fall risk factors does this patient have? | Yes, the fall risk assessment indicated the patient was at risk. Specific risk factors that were identified with the fall risk assessment included cognitive impairment, mobility impairment, and medications. |
| Has the patient fallen previously during this hospitalization?                                  | No.  |

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|--|---|
| Is the patient at significant risk for injury (ABCs: age, bone health, coagulation, recent surgery)      | None of these factors apply in this case.   |
| What was the patient doing when he fell? Why?  | Ambulating back to the bedside chair from the bathroom with assistance from family. The patient and family noticed that staff had suddenly become very busy, so they decided to not ask staff for assistance.   |
| What were staff doing at the time of the fall? Why?  | Staff were preparing for incoming patients to the emergency department. Local EMS had notified them of a motor vehicle accident in the area.  |
| What was different about this time that the patient used the bathroom compared to other times?           | The patient and family decided to attempt ambulation to the bathroom on their own, rather than calling for staff assistance. Staff were focused on preparing for incoming patients to the emergency department and were not readily available, nor were aware that family was assisting the patient.  |
| Did the care plan include interventions to address each of the patient's known risk factors for falling? | The following interventions as documented in the care plan matched the patient's risk factors: <ul style="list-style-type: none"> <li>• Cognitive impairment: alarm, patient close to nurses' station, patient/family education, purposeful rounding</li> <li>• Mobility impairment: assistive device, gait belt, non-slip footwear, patient/family education, PT/OT, purposeful rounding</li> <li>• Medications: medication review, patient/family education</li> </ul>  |
| Were staff effectively delivering the intended interventions to address those risk factors?              | The following points were discussed/discovered during the huddle: <ul style="list-style-type: none"> <li>• The chair alarm had not been set because family was present in the room with the patient and therefore staff assumed it wasn't necessary.</li> <li>• The patient's family, while being educated and aware of the patient's fall risk, had not been trained and cleared by staff to assist the patient with mobility. They were also not using a gait belt to assist the patient.</li> <li>• The last time staff had rounded on the patient was 1 hour previously, and they had assisted the patient to the bathroom at that time.</li> </ul> |
| Have we potentially missed anything in our assessment and intervention?                                  | The dry erase board used for communication within the room (to communicate fall risk status among other things) was not hanging up due to some remodeling being done at the hospital.   |
| Are there any organizational factors that could contribute to this fall?                                 | The following points were discussed during the huddle: <ul style="list-style-type: none"> <li>• Communication, other than at time of handoff and Environment (physical surroundings): Written communication/signage in the room about patient's fall risk was lacking due to the fact there was no dry erase board hanging in the room at the time.</li> <li>• Handoff: Staff did not handoff to family to let them know they were still available to assist with mobility, despite preparing for incoming patients to the emergency department.</li> </ul>   |

4. Share the following information with the group: “Now that further information was discovered about the fall during the discussion within the huddle, the huddle participants can turn their attention to ensuring the plan of care for fall risk reduction is appropriate to reduce risk of a repeat fall. For the patient’s plan of care for fall risk reduction, what interventions should be continued, modified, or added?”

Allow time for group discussion. The goal of this part of the discussion is to ensure the plan of care for fall risk reduction will reduce the risk of a repeat fall. You could consider using the tool [Linking Interventions to Fall Risk Factors](#) to prompt ideas and discussion.

Possible answers regarding what interventions to continue, modify, or add, include:

| <b>Interventions to Continue</b>                         | <b>Risk Factor(s) Addressed</b> | <b>Rationale</b>   |
|--|---------------------------------|--|
| Assistive device   | Mobility impairment             | Compensates for impaired strength and balance during ambulation and transfers.   |
| Bed in low position                                      | All                             | Universal intervention to ensure patient does not fall from a high surface if he gets up without assistance.   |
| Call light/personal items within reach                   | All                             | Universal intervention to make it less likely the patient will get up without assistance.  |
| Gait belt  | Mobility impairment             | Used to help stabilize the patient during a loss of balance and/or control his descent in the event of a fall.   |
| Medication review by pharmacy                            | Medications                     | Patient is on some classes of medications that can contribute to fall risk. It’s unclear if medication side effects were a major contributor to this fall. Regardless, the pharmacist could review again and make recommendations to the physician if indicated.       |
| Non-slip footwear  | All                             | Universal intervention to reduce risk of slipping.   |
| Patient close to nurses’ station                         | Cognitive impairment            | Increases likelihood of staff quickly getting to the patient if needed.  |
| PT and OT  | Mobility impairment             | For continued strengthening and mobility program, as well as family education and assessment of their ability to assist the patient with mobility (e.g. use of assistive device for ambulation, how to appropriately guard the patient during mobility and transfers). |
| Purposeful rounding                                      | Cognitive impairment            | Proactively meets the patient’s needs to reduce the chance he gets up without assistance.  |
| <b>Interventions to Continue but Modify or Reinforce</b> | <b>Risk Factor(s) Addressed</b> | <b>Rationale</b>   |
| Alarms (chair and bed)                                   | Cognitive impairment            | Alerts staff in case the patient (with or without family assistance) gets up without assistance. Consider using even when family is in the room.   |
| Patient and family education                             | All                             | Reminds the patient and family about patient fall risk factors and interventions being used to prevent falls. Should reiterate education with patient and family given the circumstances of the fall, and use teach-back to check understanding.                       |

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|--|---------------------------------|--|
|  |                                 | If patient is nearing discharge and is planning on returning home with family support, PT and OT might consider starting to train family on how to assist the patient with transfers and mobility                                  |
| <b>Interventions to Add and/or at Least Consider</b>   | <b>Risk Factor(s) Addressed</b> | <b>Rationale</b>   |
| Visible identification of fall risk, specifically use of temporary signage to communicate fall risk until dry erase boards are rehung. | All                             | Reminds staff, patient, and family members about fall risk.  |
| Orthostatic vital sign monitoring  | Medications                     | Patient has some cardiovascular comorbidities and is on cardiovascular medications. It's unclear if orthostatic blood pressure contributed to this fall. Regardless, it could be assessed to rule it out as a contributing factor. |
| Video monitoring   | Cognitive impairment            | Would be most useful when family is not in the room to alert staff if patient gets up on his own. The need for this would depend on how reliable patient has been at calling for assistance.                                       |

- 5. Wrap-Up. Briefly discuss how your group would document changes to the patient's fall risk reduction plan of care, and how your group would communicate these changes to the relevant members of the care team as needed (e.g., other staff members, patient, family member(s), etc.).**