

CAPTURE Falls Post-Fall Huddle Education: Discussion Guide for Fall Case Study #2

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:

Admission Type	Swing bed
Age Category	> 80 years old
Reason for Admission	Rehabilitation post intramedullary nailing of the right femur
Patient conditions/comorbidities	Cardiovascular, Gastrointestinal, Orthopedic, Renal/Urinary (incontinence), Trauma, Weakness
Medications	Analgesics
Fall Screening Tool Result	At risk
Ambulatory Status at the Time of the Fall	With assist of 1 (hands-on)
Time of Fall	Evening
Description of Fall	Patient was walking back to bed from the bathroom while using a walker and with assistance from an aide. The patient was trying to sidestep with the walker from the foot of the bed to the head of the bed, but the bedside recliner was in the way. The aide assisting the patient momentarily left the patient’s side to move the recliner out of the way. While the aide was moving the recliner, the patient lost her balance and fell onto the bed.
Injury Due to Fall	None, but imaging was ordered to rule out any issues to the surgical repair
Fall Risk Interventions Documented in the Plan of Care at the Time of the Fall	Assistive device Bed in low position Call light/personal items in reach Gait belt Medication review Non-slip footwear Not to be left alone while toileting Patient/family education PT/OT including exercise and mobility program Purposeful rounding Visible identification of patient as being at risk for a fall

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, Pharmacist, 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 was ambulating 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.

Potential Questions to Discuss in the Huddle	Answer Discussed in the Huddle
Was the patient at risk for falling? 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 mobility impairment, medications, and toileting needs.
Has the patient fallen previously during this hospitalization?	No.
Is the patient at significant risk for injury (ABCs: age, bone health, coagulation, recent surgery)	Yes. Risk of injury was increased due to age (> 80), bone health (recent femur fracture), and recent surgery (intramedullary nailing of femur fracture).

What was the patient doing when she fell? Why?	Standing up by the foot of her bed with her walker after ambulating back from the bathroom with assistance from an aide.
What were staff doing at the time of the fall? Why?	Aide was moving the recliner out of the way of the patient. The aide had momentarily stepped away from the patient's side to do this.
What was different about this time that the patient was ambulating compared to other times?	The aide left the patient standing alone in order to remove a barrier in the physical environment.
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"> • Mobility impairment: assistive device, gait belt, non-slip footwear, not to be left alone while toileting, patient/family education, PT/OT, purposeful rounding • Medications: medication review, patient/family education • Toileting needs: not to be left alone while toileting, purposeful rounding
Were staff effectively delivering the intended interventions to address those risk factors?	The following points were discussed in the huddle: <ul style="list-style-type: none"> • Staff was correctly providing assistance to patient with assistive device and gait belt, but momentarily stepped away from the patient to clear the physical environment. A better strategy would have been to call for a second person to assist, or have the patient temporarily sit at the foot of the bed while the aide moved the recliner. • In the past two days, the patient had attended the wake and funeral of a family member. That, coupled with the time of day, likely led to increased physical fatigue (and patient already experiences weakness). Two staff for assistance might have been prudent even though the patient typically required only one assist.
Have we potentially missed anything in our assessment and intervention?	No.
Are there any organizational factors that could contribute to this fall?	The following points were discussed in the huddle: <ul style="list-style-type: none"> • Environment (physical surroundings): The recliner had been pushed closer to the bed than it would normally be located. This was because the patient needed access to the call light while sitting in the recliner, and the call light cord was not long enough for the call light to reach the recliner in its original location. Longer cords for the call lights might be needed. • Staff qualifications: Consider having PT/OT provide a refresher to staff on assisting patients with mobility including strategies to address environmental barriers encountered during mobility tasks.

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:

Interventions to Continue	Risk Factor(s) Addressed	Rationale
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 she gets up without assistance.
Gait belt	Mobility impairment	Used to help stabilize the patient during a loss of balance and/or control her descent in the event of a fall.
Medication review	Medications	Patient is on one class 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 and assist with patient balance.
Not to be let alone while toileting	Mobility impairment and toileting needs	Ensure the patient does not lose balance while navigating transfers and mobility in the bathroom.
Patient and family education	All	Did not appear to be an issue given the circumstances of this fall, but reminds the patient and family about patient fall risk factors and interventions being used to prevent falls.
PT/OT including exercise and mobility program	Mobility impairment	For continued strengthening and mobility program.
Purposeful rounding	Toileting needs	Proactively meets the patient’s needs to reduce the chance he gets up without assistance.
Visible identification of patient as being at risk for a fall	All	Reminds staff, patient, and family members about fall risk
Interventions to Continue but Modify	Risk Factor(s) Addressed	Rationale
Call light/personal items within reach	All	Universal intervention to make it less likely the patient to get up without assistance. In this situation, purchasing a call light extender would eliminate the need to move the recliner closer to the bed so the patient can access the call light.
Interventions to Add and/or at Least Consider	Risk Factor(s) Addressed	Rationale
Declutter environment	All	Universal intervention to reduce possible environmental hazards. In this case, proactively planning for patient mobility by ensuring the recliner in the patient room is in a location that does not impede mobility.

- 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.).**