Welcome to the KHC HIIN Falls Sprint

- Our Goals
  - Create a learning community
  - Support ACTION!
    - Testing
    - Innovation
    - Sharing

Mobility  PFE  Post Fall Huddles
**Timeline**

October 24  
Introduction and kick-off webinar  
Introduction to Falls Discovery Tool,  
Creating a Culture of Mobility

November 30  
Learnings from using Falls Discovery Tool,  
Develop AIM, Plan PDSA

December 13  
PDSA Learnings and intro to Teach-back

**January 24**  
PDSA Learnings and intro to post-fall huddles

February 28  
PDSA Learnings and next steps

March 22  
Wrap up and celebration!

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**Measuring Success**

**Outcome:**  
- HIIN Falls with Injury Measure

**Processes:**  
- Development of a SMART aim statement for preventing falls with injury  
- Completion of monthly PDSA cycles  
- Share a summary of your experience and learnings  
  (*Completion of brief summary template*)
Learnings and Observations

- Observations
  - Bedside handoff
  - Call lights
  - Bedside tripping hazards
  - Bedside delirium prevention
  - Post Fall Huddle
- Surprises?

PDSA Cycle #1
Hospital sharing
Intro to Post Fall Huddles

The aftermath of a fall

- Embarrassment
- Fear of Potential Serious Injury
- Fear of personal, professional liability
- Learning opportunity
- Lots of available data
  - Patient
  - All staff on unit
  - Environment
  - Equipment

How do we learn in these conditions?
Post-fall huddle is a structured method to collect data and learn from the fall

**Structure**
- Post Fall Clinical Assessment
- Post Fall Huddle Policy
- Post Fall Huddle Form

**Process**
- Post Fall Huddle Process
  - who leads, records
  - Follow ups to prevent reoccurrence

**Outcome**
- No repeat falls
- System learning and correction of defects

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**Post Fall Clinical Assessment**

- Assess before mobilizing
- Rapid Response Team
- Protocol for VS, Neuro checks for patients on anti-thrombotics or suspected head injury
- Communicate anti-thrombotics to provider when reporting fall
- Consider escalating unwitnessed falls, or falls with thrombotics to admin on duty, supervisor
**SAFE from FALLS 3.0**

<table>
<thead>
<tr>
<th>Audit Questions</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Falls screening &amp; assessment of fall AND injury risk factors</td>
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<tr>
<td>1a) The organization requires, and has a designated place to document, screening of all patients for fall risk factors within 8 hours of admission for inpatients.</td>
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<tr>
<td>1b) The organization requires, and has a designated place to document, screening of all patients for injury risk factors (i.e., ABCs – Age; Bones; Coagulation; post-Surgical) within 8 hours of admission for inpatients.</td>
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<td><strong>Anticoagulants (Increased injury risk for patients taking anti-coagulants)</strong></td>
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<td>2a) Inpatients on anticoagulants are identified within 4 hours of admission during the medication reconciliation process.</td>
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<td>2b) Anticoagulation usage is flagged within the electronic medical record to increase awareness across providers and nursing staff.</td>
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<td>2c) The care plan is reviewed for patients on anticoagulants to include interventions specific to anti-coagulant risk:</td>
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<tr>
<td>• Patient is evaluated for discontinuation of anti-platelets by the provider</td>
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<td>• Patients are encouraged to wear shoes during ambulation versus slippers</td>
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<td>• Perform environmental checks to make sure any possible environmental hazards are mitigated (e.g., no sharp corners, reduce equipment/furniture by bed that patient could hit if they do fall, obstacles between bed and bathroom)</td>
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<td>• Institute &quot;Within Arms Reach&quot; with toileting and ambulation for all patients on anticoagulants</td>
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<td>• Video-monitored bed if available; if meets following criteria: on anticoagulants; impulsive or confused; risk of falling</td>
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<td>• If video-monitoring is not available, evaluate for bedside/alarms</td>
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<td>2x) Patient and family education is provided outlining increased risk for injury for patients on blood thinners along with fall and injury prevention strategies and steps to take if the patient does fall.</td>
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**Linking interventions to specific risk factors**

Safe From Falls Roadmap - Anticoagulation

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**Learning from events (Post-fall huddles)**

A post-fall policy and process is in place that includes, at minimum:

4a) A fall with suspected injury to the head, or an unintended fall, experienced by a patient taking anticoagulants is included as part of a Rapid Response Team or Rapid Response Process (if a fall was witnessed, it is assumed the patient hit their head).

4b) Vital signs and neurological checks are performed immediately post fall at the following intervals, at minimum:
   - q 15 minutes x 2, then
   - q 30 minutes x 2, then
   - q 1 hour x 4, then
   - q 4 hours for 24 hours

4c) Changes in patient's status are reported promptly to the physician, especially if patient is on anticoagulants.

**Safe environment (Rounding; equipment such as video monitoring and alarms; room design)**

5a) The organization has conducted an assessment of the bathroom, and pathways to the bathroom, identifying opportunities for reducing hazards.

5b) Environmental changes have been instituted in patient rooms and bathrooms to reduce hazards while in the bathroom or on the way to the bathroom.

5c) A process is in place for staff to perform fall prevention checks as part of their rounding process for every patient, which includes ensuring alarms are activated and working properly.

Safe From Falls Roadmap - Anticoagulation
Through the eyes of the patient

- Patients over-estimate their abilities and minimize their fall risk
- Patients over-estimate our ability to keep them safe
- Patients want privacy in the bathroom
- Patients respond positively to a nurse's authentic caring and concern

Post Fall Huddle

- Huddle defined by Team STEPPS: an ad-hoc meeting to regain situational awareness, discuss critical issues and emerging events
- A post fall huddle is a brief meeting immediately after a fall that includes nursing staff caring for the patient and ideally, the patient.
- Useful to patient, family, the care team and administration
Purpose of a Post Fall Huddle

- Guide critical thinking
- Identify root cause
- Decrease risk of a recurrent fall
- Revise the plan of care
- Apply what is learned to other patients and the system
- PLUS:
  - Improves teamwork and trust
  - Improves collaboration and coordination within the interprofessional team

Huddle Pitfalls

- Check-the-box approach - task orientation
- Blaming
- Critical Comments
- Unmanaged, challenging behaviors
Moving the Post Fall Huddles to the Bedside

Good Example of Post-Fall Huddle

Bad Example of Post-Fall Huddle

CAPTURE FALLS TOOLKIT
- Training videos and power point
- Forms
- Pocket Card
- CAPTURE Falls Website

Post Fall Huddle How-To’s

- Who leads: RN assigned to patient, charge RN, MD, Fall Team Member, Supervisor, Admin on Call
- Conduct ASAP by end of shift the latest
- Who must attend:
  - staff assigned to the patient
  - Ideally the patient unless this would overwhelm
- Other attendees
  - Everyone on the unit at the time
  - Rehab, Pharmacy, Physician
- Of care team members are not in house at the time of the fall conduct an interdisciplinary review within 24 hours
Post Fall Huddle Facilitation Guide

- What went right?
- What went wrong?
  - What was different this time?
- What almost went wrong?
- How do we do better next time?

Determine Immediate Cause

- Environmental / Accidental
  - Trip over tubing, cord, threshold
  - Liquid on floor
- Anticipated Physiological
  - Confusion / agitation
  - Impaired gait
  - Poor balance
  - Postural hypotension
  - CNS medication
- Unanticipated Physiological
  - LOC

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<thead>
<tr>
<th>Date of Fall</th>
<th>Time of Fall</th>
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Medical Record Number: [Blank]

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After the Huddle

- Revise the plan of care
- Communicate revised plan of care
- Disseminate information about the fall and root cause
- Round on the patient to assess understanding of new plan of care
- Interdisciplinary huddle within 24 hours
  - Rehab
  - Pharmacy
  - Physician

Remember, Go Slow to Go Fast
Next Steps

- Submit your Next PDSA Cycle to Michele
- Observe a Post Fall Huddle
- Present your PDSA learnings at session February 28, 2019

Resources – future topics

Tools to Test:

- Post-fall huddle
  - CAPTURE Falls mobility training videos, mobility tools – includes Post Fall Huddle training videos and documentation tools
Resources

Collaborative Tools:

- Monthly Virtual Learning Sessions
- List-serv
- Subject Matter Expert - Coach Jackie

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