WHITE PAPER

Building Clinical Capacity and Competency: Fall and Fall Injury Prevention

Advance Your Fall and Injury Program Management Through 6 Key Steps

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Inpatient Fall Prevention Is Overdue for an Overhaul

Healthcare leadership is well aware of the toll inpatient falls take on clinical and financial outcomes–yet few organizations have taken focused steps to improve their fall and injury prevention programs. What obstacles are blocking progress in this critical area, and what steps can organizations take to overcome them?

Inpatient falls and resulting injuries continue to occur at unacceptable rates across all settings of care, with organizations averaging 3.3 to 11.5 falls per 1,000 patient days.[1] Falls that occur in inpatient environments comprise 30 to 51 percent of injurious falls, resulting in over 250,000 injuries per year.[2] These events often result in rehospitalization, loss of function and independence, increased morbidity, and even death, especially among the elderly. Falls also place a heavy financial burden on patients and organizations alike: medical costs for fall-related injuries totaled over $50 billion in 2015, and continue to increase with patient age.[3]

Despite this and other data, inpatient fall prevention has yet to reach the level of executive priority within healthcare organizations. A deficit of specialized knowledge is at the heart of the problem. Staff education on falls, limited across the healthcare workforce, fails to increase clinical competencies in assessment, prevention, and post-fall treatment.

Evidence is conclusive that fall risks are multifactorial and that effective fall prevention programs are interdisciplinary. However, most organizations still rely on universal, nurse-led methods that are ineffective and create a false sense of safety. As a result, falls remain one of the most frequent and harmful health events among the inpatient population.

Fortunately, although inpatient falls are more common and costly than ever, the research-based strategies now available to care teams mean they are also more preventable. In this guide, we will discuss today's biggest obstacles to the advancement of fall prevention and six proven ways for healthcare leaders to address them.

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[1] Ganz, D. A., Huang, C., Saliba, D., Shier, V., Berlowitz, D., VanDeusen Lukas, C., et al. (2013). Preventing falls in hospitals: a toolkit for improving quality of care. Rockville, MD: Agency for Healthcare Research and Quality.
[2] LeLaurin, J. H. & Shorr, R. I. (2019). Preventing falls in hospitalized patients. *Clinics in Geriatric Medicine*, 35(2): 273–283.
[3] Oliver, D., Healey, F., & Haines, I. (2010). Preventing falls and fall-related injuries in hospitals. Clinics in Geriatric Medicine, 26(4): 645–695.

Blockers to Effective Fall Programs

Since 2010, CMS has provided funding for organizations to implement safety practices that reduce hospital-acquired conditions (HACs) such as falls. Results showed only an eight percent decline in HACs as of 2016, leaving much to be accomplished to meet CMS's national goal of reducing harm by 20 percent overall by 2019.[10] This slow progress in reducing adverse conditions, particularly injurious falls, confirms the shortcomings of current practices.

1. **Limited clinical education on fall management:** Institutional training on falls generally consists of using a fall risk screening tool, determining a risk score, and implementing a set of universal precautions. These simplistic steps, compounded by the fact that nurses are left to manage them with little interdisciplinary involvement, fail to accommodate the complexity of inpatient falls.

2. **A lack of population-specific methodology:** The epidemiology of the higher-risk populations we will discuss in this guide, such as elderly, frail, and post-surgical individuals, requires specialized clinical knowledge and application not widely found in today's organizations. As a result, the patients requiring the most protection from fall-related harm are severely underserved.

3. **A universal approach to post-fall care planning:** Traditional post-fall practices are inadequately focused on identifying and responding to the root causes of falls. A lack of interdisciplinary expertise in this area results in a superficial analysis, increasing the likelihood of future falls and injuries.

Contributing Organizational Factors

According to The Joint Commission, the frequency and severity of inpatient falls can be attributed to six main organizational issues. After an analysis of 465 sentinel alerts of patient falls revealed that 63 percent of falls resulted in death, the TJC's 2015 Sentinel Alert 55 identified the following as the leading contributors:[11]

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, supervision, staffing levels, or skill mix
- Deficiencies in the physical environment
- Lack of leadership

The Impact of Inpatient Falls

700,000

to 1 million patient falls occur in US hospitals, resulting in up to 11,000 deaths each year.[4]

- Up to 20% of patients in hospitals fall at least once;[5] of those, 30-51% are injured.[6]
- From 2014 to 2017, fall sentinel events were the third highest reported harm event in the nation.[7]
- Injuries from falls are the most common condition in long-term care settings, accounting for an estimated 40% of potentially preventable emergency department visits.[8]
- Falls are one of the 20 most expensive conditions, costing hospitals an average of $14,000 per patient.[9]

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[4] LeLaurin, J. H. & Shorr, R. I. (2019). Preventing falls in hospitalized patients. *Clinics in Geriatric Medicine*, 35(2): 273–283.
[5] Inouye, S. K., Brown, C. J., & Tinetti, M. E. (2009). Perspective: Medicare nonpayment, hospital falls and unintended consequences. *New England Journal of Medicine*, 360(23): 2390–3.
[6] Oliver, D., Healey, F., & Haines, I. (2010). Preventing falls and fall-related injuries in hospitals. *Clinics in Geriatric Medicine*, 26(4): 645–695.
[7] The Joint Commission. (2017). Sentinel alert data. General information. Quarter 2 update. Retrieved from: https://www.jointcommission.org/assets/1/18/SEA_55.pdf
[8] Caffrey, C. (2010). Potentially preventable emergency department visits by nursing home residents. NCHS Data Brief: 2010 Apr. (33):1-8.
[9] The Joint Commission. (2017). Sentinel alert data. General information. Quarter 2 update. Retrieved from: https://www.jointcommission.org/assets/1/18/SEA_55.pdf
[10] Agency for Healthcare Research and Quality. (2019). AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2017. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf
[11] The Joint Commission. (2017). Sentinel alert data. General information. Quarter 2 update. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_55.pdf

Why Redesign Your Fall Prevention Program?

The healthcare industry can be slow to adopt evidence into practice, but there is much to be gained from implementing the latest research on fall and injury prevention. Though hospitals have garnered the most attention on this topic, it is important to note that skilled nursing facilities, long-term care facilities, and home care-based organizations also benefit from reworking their staff education on falls and injuries.

Leaders who commit to providing robust staff education on fall and injury management can anticipate improvements in the following areas:

- **Reimbursements:** Especially under new Value-Based Care models, helping patients get better as quickly as possible is more critical than ever. Organizations seeking to elevate care while reducing costs will benefit from the reduced rehospitalizations and recovery time that result from improved fall programs.
- **Patient and Employee Experience:** Patients who receive thorough and personalized fall-related care are more satisfied with their experience at your facility. In addition, involving multiple disciplines in fall prevention alleviates an undue burden on nursing staff, helping reduce nurses' high levels of burnout and attrition.
- **Clinical Outcomes:** Holistic fall risk assessments, in-depth training, and a leadership-driven approach combine to remove barriers to successful care. When falls and fall injuries decrease, it is easier for patients, staff, and entire organizations to thrive.

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The Core Solution: Organization-Wide Knowledge is Power

Effective fall prevention programs are championed predominantly by nurses but carried out in close partnership with interprofessional teams. From comprehensive assessment and care planning to the integration of patient-to-nurse communication technology, collaboration is crucial—all the more so when caring for at-risk populations.

To facilitate this teamwork, leadership must implement clinical education programs that increase staff's expertise of risk assessment, population-specific risk factors, and interdisciplinary care management. Through the use of evidence-based, peer-reviewed certification programs, organizations will be able to expand, validate, and certify the clinical skills of those involved in fall management.

6 Steps to Building Clinical Capacity and Competency in Fall and Injury Prevention

Proven Solutions for Empowering Staff and Improving Outcomes

National Directives

A number of established guidelines are available to leaders seeking to rework their fall and injury prevention programs. The Joint Commission (TJC) and others have issued directives that, when widely implemented, will be pivotal in decreasing harm across settings of care. Consistent with existing national falls toolkits such as the ARHQ Toolkit,[12] VA National Falls Toolkit,[13] and the IHI How-to-Guide,[14] these directives include:

- Closing the gap between evidence and organizational practices
- Implementing individualized care plans with interventions to treat, mitigate and/or eliminate fall and injury risk factors
- Implementing population- and setting-specific fall prevention programs
- Redesigning post-fall management to include post-fall huddles
- Increasing patient education and partnership

Advancing Fall and Injury Prevention Through 6 Key Steps

For maximum impact, efforts should center on building nurses' and other team members' knowledge and skills in the following areas:

1. **Comprehensive Assessment**
2. **Population-Based Approach**
3. **Safe Toileting**
4. **Early Mobility**
5. **Individualized Post-Fall Care**
6. **Increased Patient Engagement**

The next sections of this guide will explore these solutions, provide actionable steps for applying them, and present samples of MedBridge's industry-leading educational resources on fall and injury prevention.

[12] AGanz, D. A., Huang, C., Saliba, D., Shier, V., Berlowitz, D., VanDeusen Lukas, C., et al. (2013). Preventing falls in hospitals: a toolkit for improving quality of care. Rockville, MD: Agency for Healthcare Research and Quality.
[13] U.S Department of Veterans Affairs. (n/d). VA National Center for Patient Safety: Falls Toolkit. Retrieved from https://www.patientsafety.va.gov/professionals/onthejob/falls.asp
[14] Boushon, B., Nielsen, G., Quigley, P., Rutherford, P., Taylor, H., Shannon, D., & Rita, S. (2012). How-to Guide: Reducing Patient Injuries from Falls. Cambridge: MA: Institute for Healthcare Improvement.

Solution #1: Conduct Comprehensive Risk Assessments

STOP	Relying on simplistic Fall Risk Scores
START	Taking comprehensive measures for prevention

Transition from Fall Risk Scores to Fall to Multifactorial Injury Risk Assessments

A high-impact step toward a more multidisciplinary and multifactorial approach is replacing fall risk scores, the standard for most organizations, with more holistic fall and injury risk assessments. The latter allows an interdisciplinary care team to identify the underlying cause of the identified risk factors, including population-specific ones such as age, diagnoses, and functional ability. This evidence enables nurses to provide targeted interventions to reduce injury, such as hip protectors, floor mats, and helmets.

Qualities of Effective Fall and Injury Risk Assessments

Fall risks are multifactorial and therefore call for the involvement of an interdisciplinary care team. Whenever possible, staff should work collectively to develop care plans that connect the assessment findings to specific interventions needed to modify or eliminate the risk factors present.

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Fall and Injury Risk Assessment Is More than a Score

Course presented by Patricia Quigley

To maximize the effectiveness of fall and injury risk assessments, frequency is key. Reassessments by nursing staff and other members of the care team are required to implement, modify, and evaluate care plans with changes in fall and injury risk. Frequent reassessment identifies and prevents emergent risk factors that contribute to injurious falls, loss of function, and loss of life.

Comprehensive Risk Assessment Takeaways

To support more thorough and actionable risk assessments, organizations need to more intentionally educate and engage interprofessional teams. This can be achieved by implementing training programs that increase clinical expertise in assessment methods, clinical fall risk factors, and interdisciplinary care management.

> **Whenever possible, staff should work collectively to develop care plans that connect the assessment findings to specific interventions needed to modify or eliminate the risk factors present.**

Solution #2: Focus on Population-Based Risk Factors

STOP Relying on universal risk assessments

START Implementing a population-based approach

No two patients are exactly alike in fall and injury risk, yet traditional approaches to prevention are largely one-size-fits-all. Fall assessment and management must differentiate and segment vulnerable patients, most notably elderly and frail individuals, in order to protect them from injury.[15]

Basing decisions on population-specific risk factors such as age, diagnosis, and functional ability allows interdisciplinary teams to deliver more individualized and effective solutions. For example, for persons without safety, transfer, and ambulation issues, the use of interactive patient-to-nurse communication technology can improve the speed and quality of care. Similarly, mobility aids may be beneficial depending on a patient's weight-bearing status.

A Better View of Population-Based Risk Assessment with A.B.C.S.

The "A.B.C.S." approach, already in use at many organizations, is a population-based guide to fall and fall injury risk assessment. A.B.C.S. indicates the four patient populations at the greatest risk for loss of function or loss of life after experiencing a fall:

- **A** Age (85 and older)
- **B** Bones (risk or history of fracture)
- **C** Anti-Coagulation (anti-coagulation or bleeding risk)
- **S** Post-Surgical

Using this model as the basis for fall risk assessment and care planning instills greater familiarity with the types of patients who require more specialized fall prevention strategies.

Fall assessment and management must differentiate and segment vulnerable patients, most notably elderly and frail individuals, in order to protect them from injury.[15]

[15] Zubkoff, L., Neily, J., Quigley, P., Delanko, V., Young-Xu, Y., Boar, S., & Mills, P. D. (2018). Preventing falls and fall-related injuries in State Veterans Homes: Virtual breakthrough series collaborative. *Journal of Nursing Care Quality*, 33(4): 334–340. Oliver, D., Healey, F., & Haines, I. (2010). Preventing falls and fall-related injuries in hospitals. Clinics in Geriatric Medicine, 26(4): 645–695.

Responding to Geriatric Patients' Unique Fall Risks

Gaps in fall and injury expertise are especially detrimental to elderly individuals. Fall-related death rates among adults 65 and older increased by 31 percent from 2007 to 2016; even more alarming is that the fastest-growing death rate, 3.9 percent per year, was found in the over-85 age group. This is also the fastest-growing age group in the US, projected to reach approximately 8.9 million in 2030, making the need to redesign geriatric fall prevention even more urgent.[16]

To better protect these individuals, it is imperative that healthcare teams are able to detect, assess, and respond effectively to elderly patients' population-based fall risks. Age-related issues requiring special attention in the inpatient setting include:

- Multisensory integration, delirium, confusion, and gait and balance deficits, which can be exacerbated following surgery due to postoperative orthostasis (dropping blood pressure)
- Individuals with a current hip fracture and/or surgical repair may experience muscle weakness, well as incisional and referred limb pain with potential loss of sensation
- Challenges with toileting, which will be covered in the next section
- Because fall injuries are extremely common in long-term care settings, any nursing home resident admitted to an emergency room must have added protections from future falls.

Basing decisions on population-specific risk factors such as age, diagnosis, and functional ability allows interdisciplinary teams to deliver more individualized and effective solutions.

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Population-Based Risk Factor Takeaways

Ensure healthcare teams have the capacity to assess and respond to population-based fall risks, especially those of patients over the age of 85. This will allow staff to select the right methods for each individual, improving both clinical outcomes and patient experience.

Learn with MedBridge

Balance Training and Fall Prevention for the Active Geriatric Population

Course presented by John O'Halloran

[16] Burns, E. & Kakara, R. (2018). Deaths from falls among persons aged ≥ 65 years—United States, 2007–2016. *Morbidity and Mortality Weekly Report*, 67(18), 509–514.

Solution #3: Emphasize Safe Toileting Practices

STOP Using outdated training on safe toileting

START Investing in this critical area

The highest rates for inpatient injuries occur in or around tubs and showers, and on or near the toilet. Between 50 and 70 percent of patient falls occur from a bed, from a bedside chair, or while transferring between the two, while 10 to 20 percent occur in toilets or bathrooms; this is a disproportionately high number given the short amount of time patients spend in bathrooms.[17] The likelihood of toileting-related injury increases with age, with individuals over 85 experiencing the highest rates. Falls cause 81 percent of bathroom injuries among this population, and of those who fall, 84.9 percent are treated in the ER.[18]

Although many hospital-based fall prevention programs include toileting rounds, falls in bathrooms still comprise 38 to 47 percent of inpatient falls.[19] This data should compel healthcare leadership to provide education in patient handling and mobility skills required for safe and individualized supervised and assisted transfer, mobility and sit-to-stand toileting.

38 to 47 percent

of inpatient falls occur in bathrooms although many hospital-based fall prevention programs include toileting rounds.

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Reducing Fall Risks Associated with Toileting

Course presented by Patricia Quigley

Understanding the Risks of Toileting Environments & Activities

With a thorough understanding of the following bathroom-specific factors, nurses and other staff can intervene more effectively—ultimately preventing more falls and injuries.

- Falls in bathrooms are primarily tied to navigating the physical environment, transferring on and off the toilet, the physical act of elimination, and personal hygiene, all of which should be included in fall prevention training.
- Navigating a small space can be problematic for both patients and staff, making it critical to provide education on maximizing safety in this environment.
- Grab bars are ineffective, as they are positioned away from the body in a way that limits proper biomechanical use to safely transfer to, ascend, and descend the toilet. In addition, grab bars can result in injury and/or trauma when struck during a fall.

Safe Toileting Takeaways

This complex area of fall prevention should be prioritized given the number of toileting-related falls that occur in inpatient settings. Nursing staff is the primary workforce that manages patients' elimination, personal hygiene, and toileting needs, and as such should be empowered with the skills and structures to implement individualized toileting plans of care.

[17] Inouye, S. K., Brown, C. J., & Tinetti, M. E. (2009). Perspective: Medicare nonpayment, hospital falls and unintended consequences. *New England Journal of Medicine*, 360(23): 2390–3.
[18] Stevens, J. A., Haas, E. N., & Haileyesus, T. (2011). Nonfatal bathroom injuries among persona aged ≥ 15 years—United States, 2008. *Morbidity and Mortality Weekly Report*, 60(22): 729–733.
[19] Tzeng, H-M. (2010). Understanding the prevalence of inpatient falls associated with toileting in adult acute care settings. *Journal of Nursing Care Quality*, 25(1): 22–30.

30 percent

of adult patients were educated via teach-back in 2015 compared to 24 percent in 2011.

> **Evidence confirms that healthcare outcomes improve when patients are fully involved as partners in their care.[20]**

Therefore, fall prevention programs should equip staff with the skills to educate and engage patients, family members, and other caregivers.

[20] Hibbard, J. H. & Greene, J. (2013). What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Affairs*, 32(2): 207–214.
[21] Centers for Medicare and Medicaid Services. (2016). Person and Family Engagement Strategy. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategic-Plan-12-12-16.pdf
[22] Agency for Healthcare Research and Quality. (2019). AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2017. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf
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Solution #4: Engage Patients in Fall Prevention

STOP	Traditional one-way instruction
START	Building meaningful patient engagement

Evidence confirms that healthcare outcomes improve when patients are fully involved as partners in their care.[20] Therefore, fall prevention programs should equip staff with the skills to educate and engage patients, family members, and other caregivers. This includes the steps and resources needed to implement, conduct, and sustain patient engagement programs based on the principles of health literacy and adult education.

To this end, CMS has launched a campaign called "Putting Patients First" to bring patients and their families into the healthcare team as contributors to the design, delivery, and evaluation of care. By placing patient engagement at the forefront of transforming healthcare, CMS seeks to help organizations meet patient-centered goals for each individual.[21]

Use Interactive Methods to Enrich Patient Education

Healthcare organizations are gaining traction in redesigning patient education throughout the care process, from admission to rounds to sit-down conversations about fall risk, care planning, and partnership. The 'teach-back' method has played a notable role in this evolution; according to the Agency for Healthcare Quality and Research, 30 percent of adult patients were educated via teach-back in 2015 compared to 24 percent in 2011.[22] Teach-back identifies what the patient has learned—and most importantly, what they had difficulty learning—by utilizing return demonstration and feedback.

This participatory approach increases patient retention and enables the provider to address any gaps through ongoing education.[23] Ask Me 3, and Falls T.I.P.S. are similar methods for enhancing patients' understanding of fall causes and prevention.[24, 25]

In addition, healthcare organizations are seeing success in integrating technology at the point of care to empower and protect patients. Patient-engaged video surveillance technology can be a highly effective tool for strengthening engagement, improving patient-nurse communication, and reducing falls and injuries.[26]

Fostering Sensitivity to Patients' Perceptions

Efforts to reduce falls are limited by insufficient understanding of patients' views regarding falls and the preventive initiatives dictated by healthcare providers. In an interview of 100 medically stable, cognitively intact patients one day after a fall, individuals expressed these and other reactions:

- Apathy toward falls
- Self-blaming
- Risk-taking behavior
- Reluctance to impose on busy nurses

When overlooked, these perceptions can interfere with fall prevention and overall care. Nurses can deliver more appropriate, compassionate, and individualized support when they have a strong understanding of the mental and emotional impact of patient falls.

Nurses can deliver more appropriate, compassionate, and individualized support when they have a strong understanding of the mental and emotional impact of patient falls.

Engaging Patients Takeaways

Help shift nurse-patient communication by emphasizing interactive methods such as teach-back, along with providing staff education on patients' perceptions of falls. Integrating technology at the point of care can further increase patient engagement and safety.

Learn with MedBridge

What You Can Do to Prevent Falls
Instructional Guide for Patients

[26] Quigley, P., Votruba, L., & Kaminski, J. (2019). Outcomes of patient engaged video surveillance on falls and other adverse events. Clinics in Geriatric Medicine, 35(2): 253–263.

Solution #5: Keep Patients Moving

STOP Keeping patients in bed

START Progressive mobility

Despite research indicating that limiting patient mobility increases the likelihood and severity of falls, patients still spend approximately 80 percent of their care in bed.[27] This practice, a staple of most nurse-led fall prevention programs, has several negative consequences:

- Functional decline
- Confusion
- Pressure injury
- Hospital acquired infections
- Institutionalization[28]

Personal Alarms and Sitters: Helpful, But Not Sufficient

Personal alarms and/or call lights are frequently used to alert nursing staff of impending falls or patient mobility status linked to intention to exit the bed, chair, or toilet. However, these solutions are limited as they are dependent on the timeliness of the staff's response.[29] Call light response time averages 13 minutes and 18 seconds—too long for a patient to wait when needing to get out of bed.[30] To improve the effectiveness of alarms and call lights, usage should be revised based on clinical criteria such as confusion, impulsivity, and mobility status, rather than a fall risk assessment score.

Sitter use, another common strategy in fall prevention, is cost-intensive but often unsuccessful: in a study conducted across 75 hospitals, most patient falls that occurred during sitter-supervised time were unassisted.[31] Transitioning sitters to mobility assistants helps organizations make more efficient use of their resources while improving safety.

Early Mobility Programs Make a Powerful Impact

Nurses have a responsibility to initiate early mobility, as this intervention has been proven to decrease fall and injury risks.[32] A critical component of safe patient handling, early mobility helps patients gain strength and build on positive feedback with each day the program is implemented. Healthcare organizations must develop structures and processes that enable care teams to conduct multifactorial assessment prior to mobilization, including postural hypotension, lower extremity sensory neuropathy, and the ability to follow complex demands.

Mobility Takeaways

To target the mobility-related causes of inpatient falls, organizations must turn from standard practices to proven solutions that prioritize clinical criteria over fall risk scores.

Learn with MedBridge

Early Mobility in the ICU

Course presented by Ellen Hillegass

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[28] Growdon, M. E., Shorr, R. I., & Inouye, S. K. (2017). The tension between promoting mobility and preventing falls in the hospital. Journal of the American Medical Association, 177(6): 759–760.
[29] Shorr, R. I., Chandler, A. M., Mion, L. C., Waters, T. M., Liu, M., Daniels, M. J., et al. (2012). Effects of an intervention to increase bed alarm use to prevent falls in hospitalized patients: a cluster randomized trial. Annals of Internal Medicine, 157(10): 692–9.
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[32] Inouye, S. (2019). Mobility Change Package and Toolkit. Retrieved from https://www.hospitalelderlifeprogram.org/for-clinicians/mobility-change-package/

Solution #6: Create Individualized Post-Care Plans

STOP Treating all falls the same

START Utilizing interdisciplinary post fall huddles

Understanding the specific context of each fall is critical to preventing future occurrences. However, most post-fall evaluations are limited to established fall rates and fail to address a number of important factors.[33] **Staff capacity in post-fall management must be enhanced so that administrative, clinical, patient safety, and risk management can intentionally correct root causes of falls and harm through quality improvement efforts.**

Post-Fall Huddles: Leveraging Data to Target Root Causes

Post-fall huddles (PFH) allow clinicians to act quickly and effectively when a patient fall occurs. The definition of PFH varies from study to study, but in general, a huddle is an immediate evaluation of each fall by a team—preferably an interprofessional one—with the patient in the environment in which they fell. The purpose of the PFH is to determine the cause of the fall and the source of injury, allowing for the mitigation and elimination of contributing issues.[34] PFHs can be conducted in all settings of care to identify causes of falls and intervene appropriately.[35]

The data assessed in a PFH may include:

- The type of fall, such as an accidental, anticipated physiological, or unanticipated physiological fall
- The source and severity of injuries sustained
- Characteristics of the patient environment that may have contributed to the fall

Analysis of these and other factors enables clinicians, administrators, and risk managers to profile population risk at the patient, unit, hospital and system level. Valid and reliable data is required to examine patterns and trends surrounding fall occurrence, program structure, and processes needed for program evaluation.

Post-Care Plans Takeaways

Implement education programs that build staff's ability to conduct post-fall huddles, ensuring the fidelity and reliability of this intervention. Because nurses are the predominant emergent responder to patient falls and the leaders of the PFH process, equipping them with this knowledge is essential.

Learn with MedBridge

Post-Fall Management for Rehabilitation Nurses

Course presented by Patricia Quigley

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Putting it Together: Applying These Findings to Create Real-World Impact

Healthcare organizations that embrace these recommendations commit to the moral imperative to protect patients by investing in critical workforce skills. In review, a successful fall program redesign is driven by high-quality staff education in the following areas:

1 Conducting Comprehensive Risk Assessments

- ☐ Transition from fall risk scores to multifactorial, population-specific risk assessments
- ☐ Involve an interdisciplinary team in assessment and care planning rather than relying solely on nurses
- ☐ Conduct frequent reassessments to keep knowledge and precautions up to date

2 Focusing on Population-Based Risk Factors

- ☐ Apply the A.B.C.S. method to identify patients with elevated levels of fall risk
- ☐ Educate staff on fall risks common in vulnerable populations, particularly those over 85
- ☐ Prevent falls in long-term care settings by educating nursing home residents treated in the ER

3 Emphasizing Safe Toileting Practices

- ☐ Equip staff to safely assist with the specific activities involved in patient toileting
- ☐ Avoid reliance on grab bars, which are ineffective and can even cause injury
- ☐ Honor patient independence and privacy in the toileting plan of care

4 Engaging Patients in Fall Prevention

- ☐ Use teach-back and other interactive methods to enhance patient education
- ☐ Familiarize nurses and other staff with common patient perceptions regarding falls
- ☐ Utilize patient-engaged technology to further build patient participation and safety

5 Keeping Patients Moving

- ☐ Give staff the knowledge, skills, and structure to implement early mobility programs
- ☐ Reduce reliance on and tailor the utilization of personal alarms and call buttons
- ☐ Phase out the use of traditional sitters, instead providing training on mobility assistance

6 Creating Individualized Post-Care Plans

- ☐ Increase both nurses' and non-nursing staff's ability to conduct post-fall huddles
- ☐ Analyze a variety of data to identify patterns and trends surrounding patient falls
- ☐ Correct root causes of harm through targeted and interdisciplinary quality improvement efforts

Providing high-quality staff education and patient engagement, such as those offered through MedBridge's complete Fall Prevention Solution, will rapidly improve your organization's clinical and financial outcomes. When clinicians and leadership work together in pursuit of these goals, all members of the team—and of course, patients—see measurable benefits.

MedBridge: Your Go-To Resource for Fall and Injury Prevention

MedBridge offers a comprehensive solution for optimizing fall and injury prevention, featuring both clinician and patient resources on the topics discussed in this guide. A subscription to MedBridge empowers your organization with:

Best-in-Class Continuing Education

MedBridge's library of 1,000+ video-based courses includes numerous clinician resources on preventing falls and injuries across settings of care. Presented by Patricia Quigley and other industry-leading experts, these courses provide not only detailed information but also realistic demonstrations to aid in implementation. Like all MedBridge courses, they are optimized for adult online learning and viewable on any device using our Clinician Mobile App—resulting in a streamlined, cost-effective solution for increasing staff knowledge.

Explore our courses on fall and injury prevention, including the following presented by Patricia Quigley:

- How Effective is Your Fall Prevention Education?
- Stopping Falls: Evidence-Based Fall Prevention
- Hip Stability and Fall Prevention
- Understanding Postural Control and Risk of Falling

Patient Education and Engagement

MedBridge's Patient Education and Home Exercise Programs enable patients to play an informed and active role in preventing harm. Sharing our easy-to-understand educational materials with patients and their caregivers instills critical knowledge about fall risks and prevention. Using MedBridge HEP, clinicians can further improve engagement and outcomes by assigning the right exercises for each individual, tracking adherence, and making it as convenient as possible to complete the program.

MedBridge's Patient Education on Fall and Injury Prevention includes the following resources:

- Check for Safety
- Postural Hypotension
- Stay Independent
- What You Can Do to Prevent Falls
- How to Get Up After a Fall
- How to Fall Safely

Continuing Education and Patient Engagement on Fall and Injury Prevention

MedBridge provides an all-in-one platform for empowering your staff, engaging your patients, and improving quality of care. We believe that education is the most effective way to improve lives, and we're proud to partner with organizations like yours to move healthcare forward every day.

Learn More about MedBridge's Fall Prevention Solution

ABOUT

Patricia A. Quigley, PhD, MPH, APRN, CRRN, FAAN, FAANP

Nurse Consultant, LLC

Dr. Patricia A. Quigley's decades-long nursing career demonstrates cutting-edge patient safety clinical practice that has forcefully impacted healthcare and policy at the national level through research studies, publications, national standards, educational and outreach initiatives, and policy making. For over two decades, Dr. Quigley has magnified the scope of practice for patient safety and nursing, been an advocate for the rights and needs of persons with disabilities, and instilled nurses with pride in their work.

Dr. Quigley's voice for autonomy and advocacy of the rights of people with disabilities has shaped evidence-based patient- and family-centered practice contributing to improved patient outcomes, safety and function related to fall prevention, and reduction in workplace injuries for healthcare workers and patients. She has been widely recognized for her pioneering work in this area. Dr. Quigley's continued work has benefited many by reducing healthcare costs related to fall awareness and prevention, and by bringing national awareness to fall injury prevention.

Over the years, Dr. Quigley has become well-known for her sustained program of research in fall prevention and management, rehabilitation outcomes, and implementation science. Early on, she recognized the need for assessment of and interventions for fall potential in clients. An innovative and creative clinician, Dr. Quigley developed a model for clinical falls teams designed to develop interventions and best practices in the prevention and management of falls. Under her direction, this team model has received continuous funding of over 5 million dollars since 1999. The team has developed clinical and educational tools to translate falls research into clinical practice. Dr. Quigley's clinical expertise has been sought through invitations of membership on national expert panels and policy committees from prestigious organizations such as CDC, NQF, NCOA, IHI, ANA, AAN, ARN and the Veterans Health Administration Extended Care.

Dr. Quigley's roles are many: Nurse Consultant, Rehabilitation Clinical Nurse Specialist, Advanced Practice Registered Nurse, Nurse Educator, and Nurse Scientist. She has helped shape the practice, policy, and science of fall management and prevention through nationally deployed toolkits, over 70 peer-reviewed publications and 50 non-peer reviewed products and resources. She is a highly sought-after lecturer, nationally and internationally, sharing her knowledge to inspire and challenge innovation at the point of care to improve patient safety. Over the years, her prominence and contributions have been honored with over 60 awards and recognitions.