

## Post-Fall Huddle Tool

### Post-Fall Huddle Facilitation Instructions:

- **Purpose:** The huddle is to be a positive and safe learning environment to understand why the patient fell and determine the immediate or root cause factor that caused the fall and if the patient was injured during the fall, what was the immediate source of injury. The intent is for the patient/family and clinical care team to identify immediate opportunity to prevent a recurrent fall (based on the same root cause) and injury.
- **Participants:** Three to four clinical team members, interdisciplinary when possible, who know the patient (unless the patient's condition is urgent or emergent upon rescue) and family if present.
- **Guideline:** Conduct the post-fall huddle after all patient falls whether unassisted or assisted, within 15 minutes, or as soon as possible after patient care is provided.

### Environmental and Interview Factors:

Utilize discovery to determine the root cause / immediate cause of the fall

<b>What was the patient doing when the fall occurred?</b> (In patient's words)	
<b>What was different this time?</b> <ul style="list-style-type: none"> <li>• Ask patient what is different compared to prior times when patient engaged in same activity? (This question is only to the patient)</li> </ul>	

### Strategy/Communication/Reliability:

<b>Patient Care Plan</b> <ul style="list-style-type: none"> <li>• What changes will we make in this patient's plan of care to decrease this patient's risk for recurrent fall based on the immediate cause of the fall?</li> <li>• What injury reduction intervention will we make to protect the patient from recurrent injury?</li> </ul>	
<b>Shared Learning</b> <ul style="list-style-type: none"> <li>• Is this a system-wide learning event?</li> <li>• What patient or system problems need to be communicated to other departments, units?</li> <li>• How will we share?</li> </ul>	
<b>Creating Accountability</b> <ul style="list-style-type: none"> <li>• What are you implementing now?</li> <li>• Is your implementation sustainable?</li> </ul>	

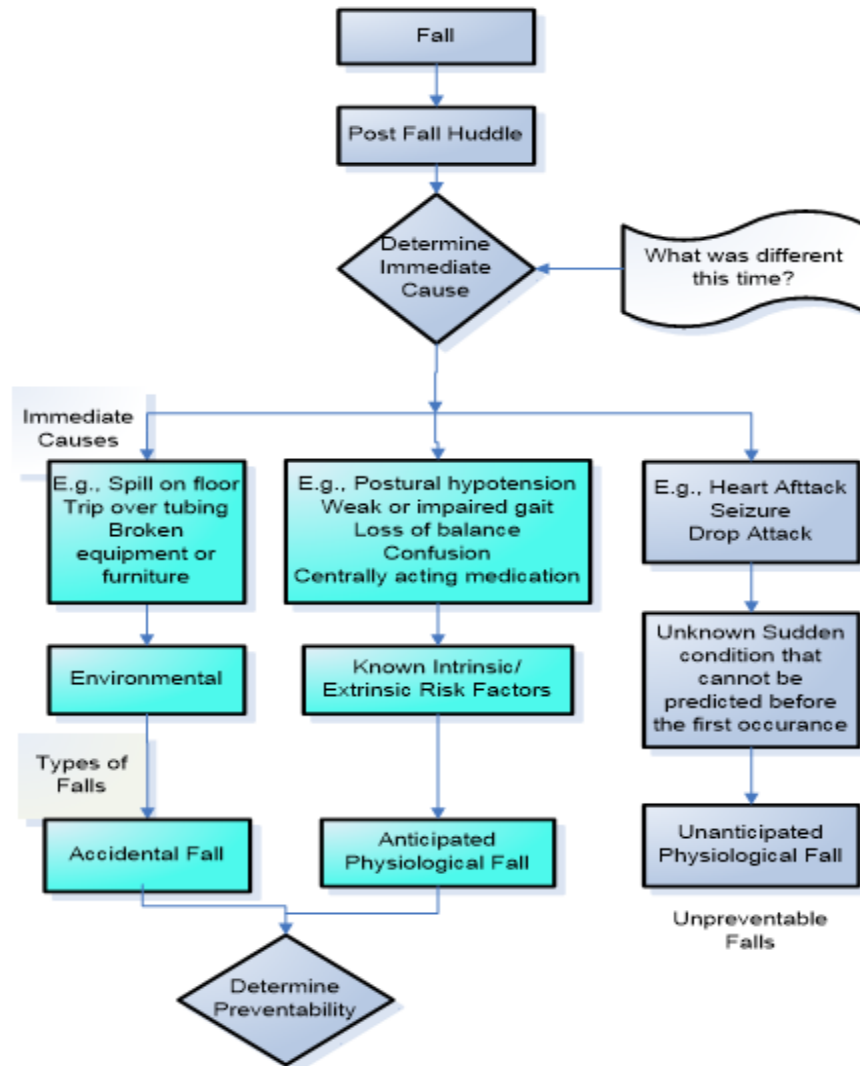
### Inter-Professional Participants:

- Post-Fall Huddle Facilitator = \_\_\_\_\_
- Check Participants in Attendance:
 

<input type="radio"/> Patient	<input type="radio"/> Certified Nursing Assistant	<input type="radio"/> Physical Therapist
<input type="radio"/> Family/Caregiver	<input type="radio"/> Charge Nurse	<input type="radio"/> Pharmacist
<input type="radio"/> RN assigned to patient	<input type="radio"/> Provider	<input type="radio"/> Occupational Therapist

## Decision Tree for Types of Falls:

(<https://www.patientsafety.va.gov/professionals/onthejob/falls.asp>)



### Using the Decision Tree for Types of Falls (Circle One):

Accidental fall due to environment	Anticipated physiological fall due to known risk factors	Unanticipated physiological fall due to unpredictable factors	Unsure
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Submit this **quality improvement tool** to your fall prevention program coordinator. Use the tool to address types of falls from a quality improvement and system-wide approach to learn, communicate and educate in continuous fall prevention strategies.

<b>What is your fall rate for?</b> <ul style="list-style-type: none"> <li>○ Accidental due to environment</li> <li>○ Anticipated physiological</li> <li>○ Unanticipated physiological</li> </ul>	<b>Also Consider:</b> <ol style="list-style-type: none"> <li>1) Trending root causes of falls and injuries</li> <li>2) Fall rate by type and injury rate by injury severity for:               <ul style="list-style-type: none"> <li>○ Clinical unit</li> <li>○ Population-based</li> <li>○ Age-stratified</li> <li>○ Repeat fall</li> <li>○ Recurrent faller</li> </ul> </li> </ol>
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