Falls: The Series

May-October 2023

Redesigning Post Fall Management

Learning Session 2 – June 7, 2023

This material was prepared by the IPRO NQIIC, a Network of Quality Improvement and Innovation Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication #IPRO-HQIC-Tsk56-23-318

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NQIIC
Network of Quality Improvement and Innovation Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

IPRO HQIC

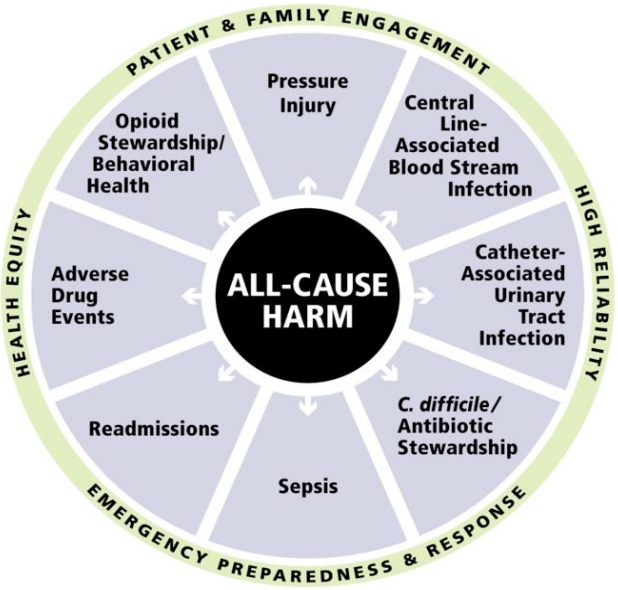
What are HQICs?

Data-driven. It's the data that help hospitals measure progress toward quality improvement (QI) gains. Hundreds of thousands of patients and families benefit from CMS-supported QI projects that make today's hospital stays safer and improve the quality of hospital care.

Dynamic and collaborative. HQICs partner with small, rural and critical access hospitals and facilities that care for vulnerable and underserved patients. Their quality improvement consulting and expertise – offered at no cost to the hospitals – help hospital leaders and clinical teams develop local QI projects designed to:

- Reduce opioid misuse and adverse drug events.
- Increase patient safety with a focus on preventing hospital-acquired infections.
- Refine care coordination processes to reduce unplanned admissions.

HQICs also share their QI resources to assist hospitals with pandemic responses and emergency preparedness.



The federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states

IPRO (joined by)

- Healthcentric Advisors
- Kentucky Hospital Association
- Qlarant
- Q3 Health Innovation Partners
- Superior Health Quality Alliance
- American Institutes for Research (AIR)
- QSource

States

- MA
- NE
- NY
- OH
- KY
- NJ
- PA
- DE
- MD
- MI
- MN
- WI

The IPRO QIN-QIO

The IPRO QIN-QIO

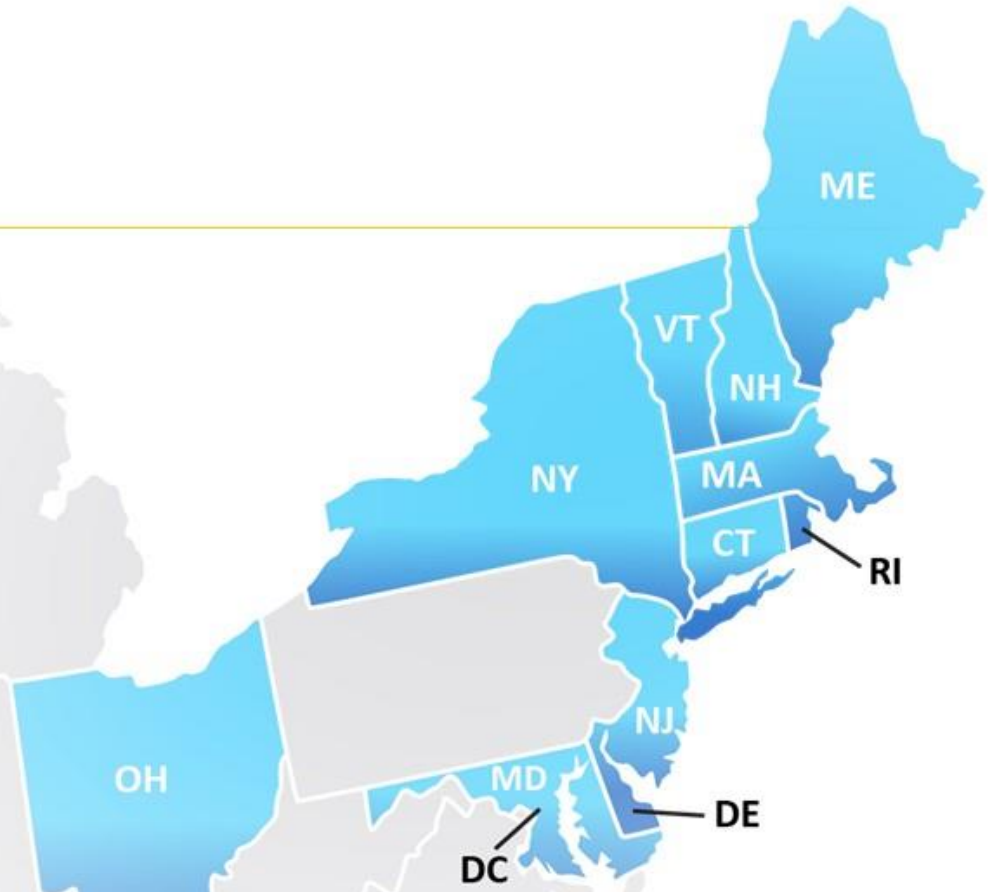
- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

IPRO:
New York, New Jersey, and Ohio

Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries



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Series Schedule: 2-3p.m. EST

Date	Session #/Topic
Wednesday, May 3	1. Enhancing Capacity – Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability
Wednesday, June 7	2. Redesigning Post-Fall Management: Prevent Repeat Falls
Wednesday, July 5	3. Best Practices to Reduce Falls Associated with Toileting
Wednesday, August 2	4. Safe Mobility is Fall Prevention
Wednesday, September 6	5. Population-Specific Fall and Injury Prevention
Wednesday, October 4	6. Reducing Fall-Related Injuries: Protective Interventions' Evidence, Application and Success

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Your participation will:

- Support organizational systems and teams to expand program infrastructure and capacity;
- Help you redesign your fall prevention and injury reduction program;
- Complement your evaluation program; and
- Provide access to an online learning community to increase exchange of experiences, innovations, and best practice implementations.

Series Speaker

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

Nurse Consultant

- Dr. Quigley is the President and Managing Member of Patricia A. Quigley, Nurse Consultant, LLC, which provides consultation to healthcare systems and patient safety organizations to advance patient safety programs and re-engineer integration of innovation at the point of care.
- For more than 45 years, Dr. Quigley has practiced in the field of rehabilitation nursing. She is recognized for her leadership as a speaker, scholar, researcher, author, educator, and mentor.
- Dr. Quigley's contributions to patient safety, nursing, and rehabilitation are highly respected both nationally and internationally. She is known for her emphasis on clinical practice innovations designed to promote independence and safety for the elderly.
- Dr. Quigley is currently a member of the National Quality Forum's Prevention and Population Health Committee.

Redesigning Post Fall Management: Getting to Types of Falls, Repeat Falls, and Determining Preventability
June 7, 2023

Pat Quigley, PhD, MPH, APRN, CRRN, FAAN, FAANP, FARN
Nurse Consultant

E-Mail: pquigley1@tampabay.rr.com

Our Webinar Schedule

- Webinar 1: May 3. Enhancing Capacity: Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability,
  - Coaching Session: May 17, Open Forum, Discussion
- Webinar 2: June 7. Redesigning Post Fall Management
  - Coaching Session: June 21, Open Forum, Discussion
- Webinar 3: July 5. Best Practices to reduce Falls Associated with Toileting
  - Coaching Session: July 19, Open Forum, Discussion

Our Webinar Schedule (con't)

- Webinar 4: Aug. 2. Safe Mobility is Fall Prevention
  - Coaching Session: Aug. 16, Open Forum, Discussion
- Webinar 5: Sept. 6. Population-Specific Fall and Fall-injury Prevention
  - Coaching Session: Sept. 20, Open Forum, Discussion
- Webinar 6: Oct. 4. Reducing Fall-related Injuries: Protective Interventions, Evidence and Application
  - Closing Coaching Session: Oct. 18 Open Forum, Discussion
- Thank you!

My Hope

- *Change your post-fall management practices to differentiate Post-Fall Huddle as an essential and core intervention.*

- Increase precision in your application of your post-fall huddle to mitigate and eliminate causes of falls and injury.

Objectives

- Examine post-fall practices as key intervention to reduce repeat falls
- Differentiate:
  - Post-Fall Huddles
  - Post-Fall Management
  - Post-Fall Documentation
  - Incident Report

Burden

- Falls affect between 700,000 - 1,000,000 patients each year (AHRQ, Patient Safety Network [PSNet], Patient Safety Primer: Falls. Updated Sept. 2019).
- Fall Rates: 3-5/1000 patient days (AHRQ, PSNet, Sept 2019).
- More than 1/3 of in-hospital falls result in injury (AHRQ, PSNet, 2019).
- Ranked among the most reported incidents in hospitals and other facilities (AHRQ, PSNet, Sept 2019).
- Falls can lead to severe injuries, hip fractures, and head trauma.

Let’s Share!

- How do you know your fall prevention program is working?
- Can you affirm that patients who fall more than once are not falling for the same reason?
- How is your post-fall program working?
- How do you measure success?

Post Fall Practices

- Post-Fall Huddle
- Post-Fall Assessment
- Patient/Resident/Family Education
- Staff Education

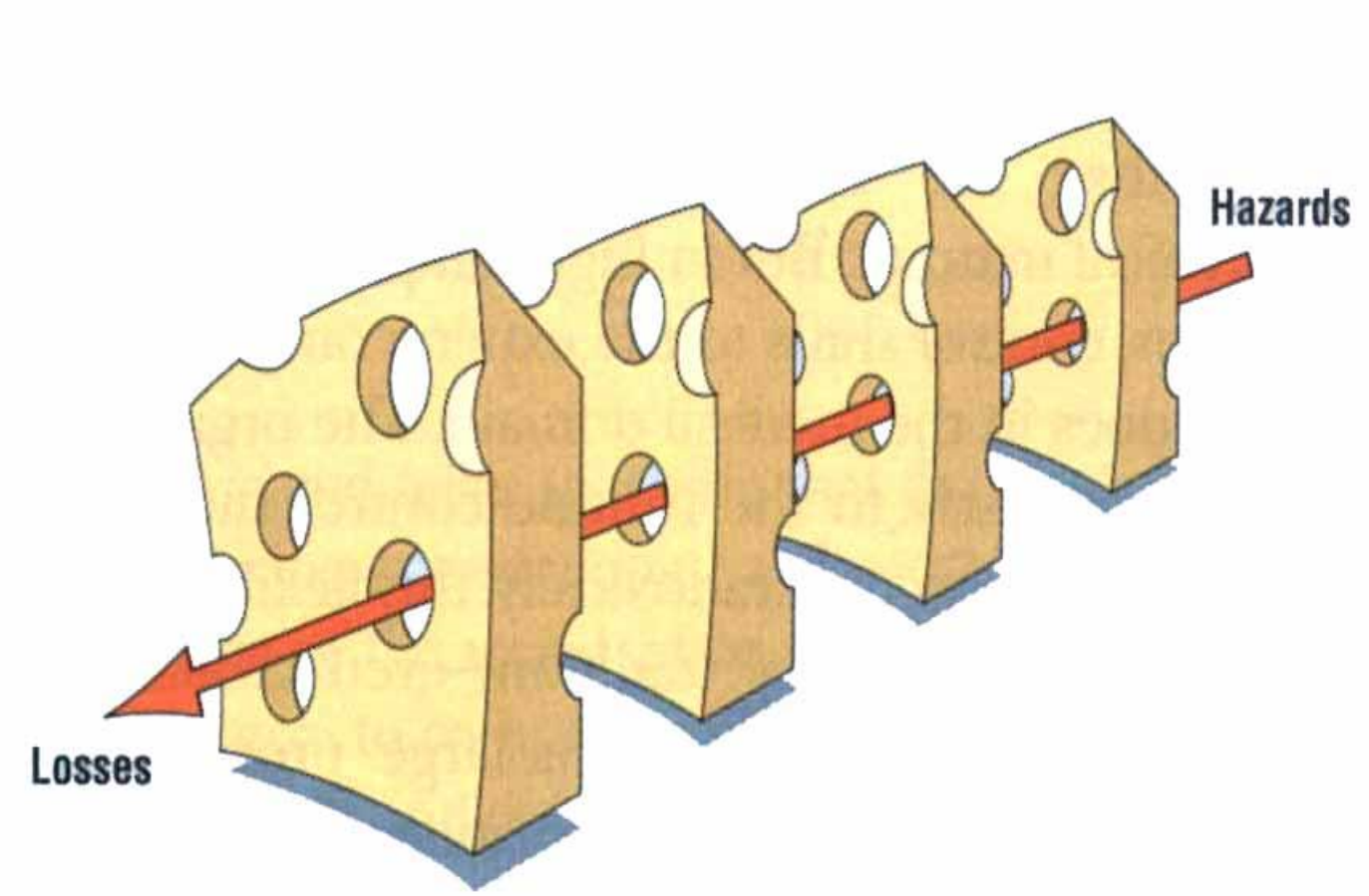
Huddles

How Many Huddles Are You Doing?

Safety Huddles

- **Pre-Shift Huddles**
- **Post-Fall Huddles**
- Conducted with the patient/resident where the fall occurred within 15 minutes of the fall
- Post-Fall Analysis
  - What was different this time?
  - When
  - How
  - Why
  - Prevention: Protective Action Steps to Redesign the Plan of Care

Accident Theory



Post-Fall Huddle (PFH): Essential Components

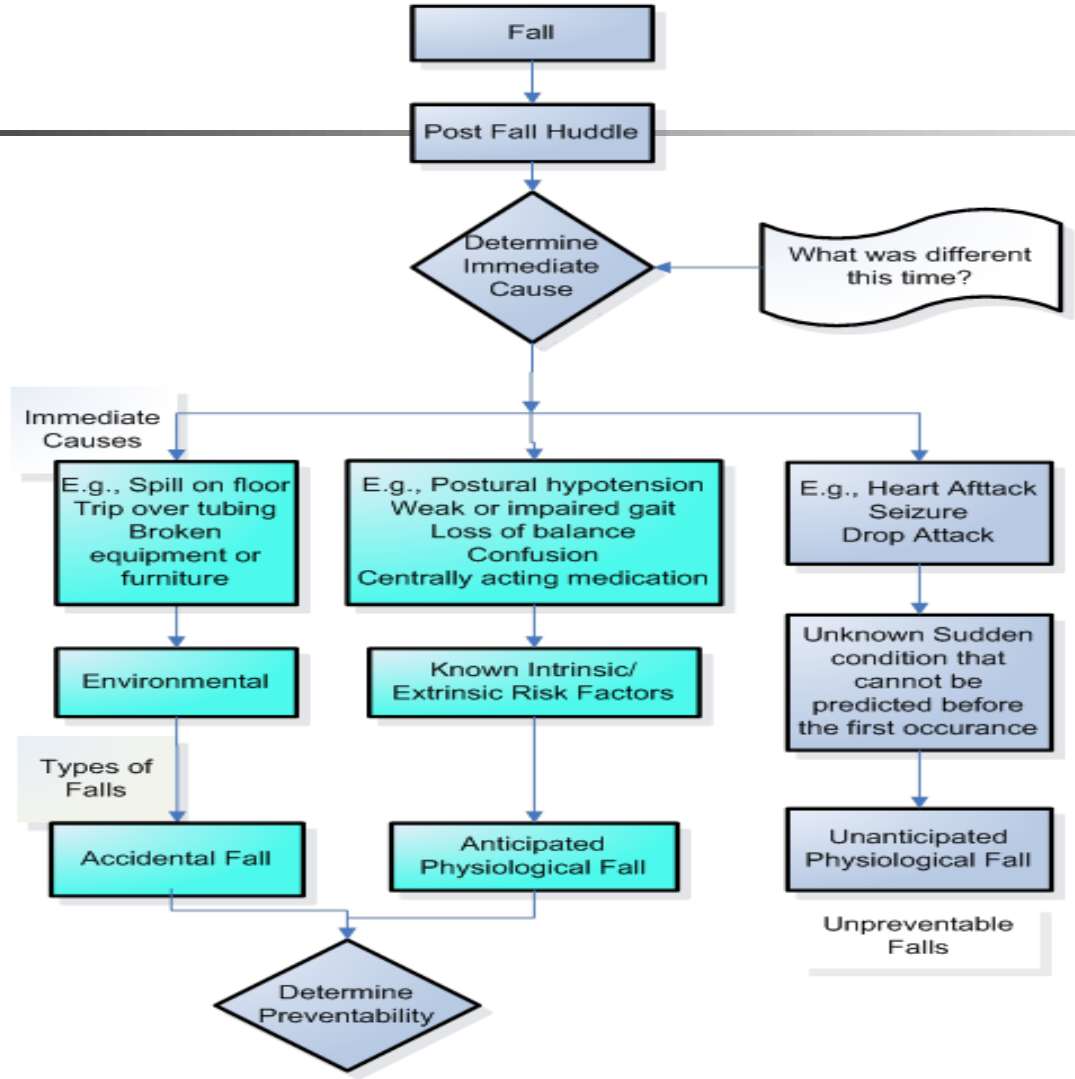
- A brief staff gathering, interdisciplinary when possible, that immediately follows a fall event.
- Convenes within 15 minutes of the fall event.
- Clinician(s) responsible for patient/resident during fall event leads the PFH.
- Involves the patient/resident whenever possible in the environment where the patient/resident fell.
- Requires Group Think to discover what happened.
- Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient/resident fell.
- Guiding question to ask: **What was different this time you were doing this activity, compared to all the other times you performed the same activity (and did not fall), but this time you fell?**

Steps to the Post Fall Huddle

1. TL makes announcement
2. Convene within 15 mins with the pt/resident in the environment where the patient/resident fell
3. Conduct Analysis: Determine root cause of fall, injury and Type of Fall
4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.
5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall
7. Communicate updated plan of care in patient/resident hand-off reports.
8. Complete EMR Post-Fall Note

Decision Tree for Types of Falls

Tuesday, April 22, 2014



Determine Preventability

Step 1: Conduct the Post-Fall Huddle.

Step 2: Determine the Immediate Cause of the Fall.

Step 3: Determine the Type of Fall.

Step 4. If Accidental and Anticipated Physiological Falls, determine preventability:

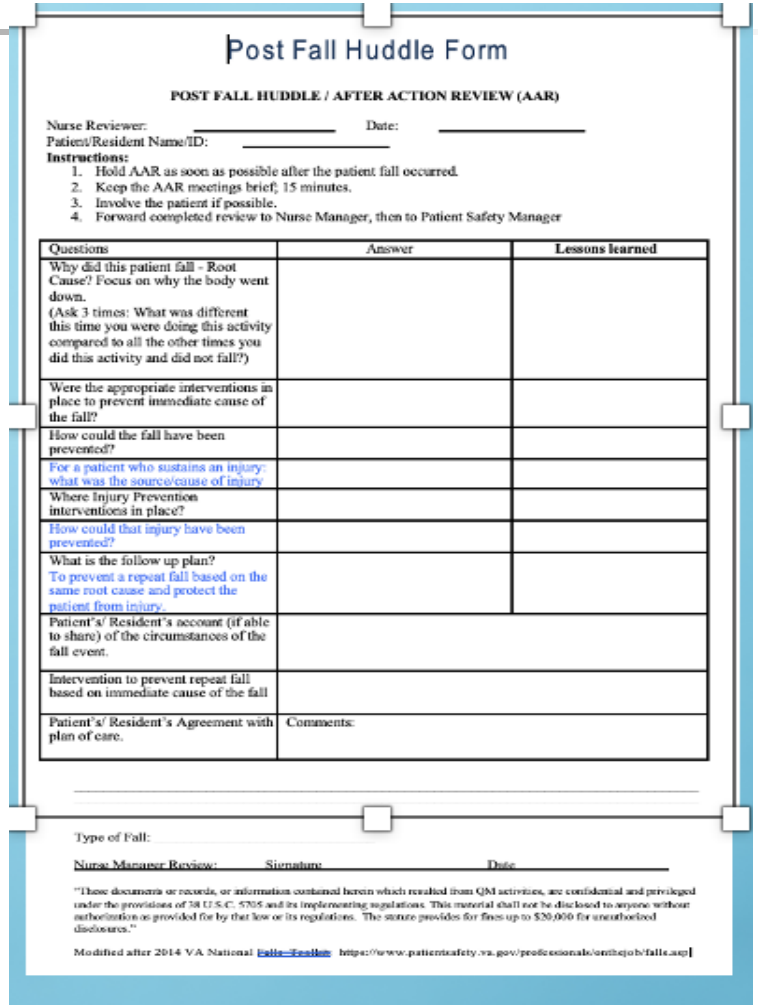
Could the care provider (direct care provider) have anticipated this event with the information available at the time?

- *If the Answer is **NO,** the fall is not preventable.*
- *If the answer is **YES**, the provider must ask another question: Were appropriate precautions taken to prevent this event?*
- *Answer:*
  - *No, Clearly or likely Preventable;*
  - *Yes, Clearly or likely Unpreventable*

Levinson, D. R., (2010, Nov). Adverse events in hospitals: National incidence among Medicare beneficiaries. DHHS. OEI-06-09-00090

Post-Fall Huddle Form

- Don't Morph This Form to Be Something Else



Post Fall Huddle Form

POST FALL HUDDLE / AFTER ACTION REVIEW (AAR)

Nurse Reviewer: _____ Date: _____
Patient/Resident Name/ID: _____
Instructions:
1. Hold AAR as soon as possible after the patient fall occurred.
2. Keep the AAR meetings brief; 15 minutes.
3. Involve the patient if possible.
4. Forward completed review to Nurse Manager, then to Patient Safety Manager

Questions	Answer	Lessons learned
Why did this patient fall - Root Cause? Focus on why the body went down. (Ask 3 times: What was different this time you were doing this activity compared to all the other times you did this activity and did not fall?)		
Were the appropriate interventions in place to prevent immediate cause of the fall?		
How could the fall have been prevented?		
For a patient who sustains an injury: what was the source/cause of injury		
Where Injury Prevention interventions in place?		
How could that injury have been prevented?		
What is the follow up plan? To prevent a repeat fall based on the same root cause and protect the patient from injury:		
Patient's/ Resident's account (if able to share) of the circumstances of the fall event.		
Intervention to prevent repeat fall based on immediate cause of the fall		
Patient's/ Resident's Agreement with plan of care.	Comments:	

Type of Fall: _____

Nurse Manager Review: _____ Signature: _____ Date: _____

"These documents or records, or information contained herein which resulted from QM activities, are confidential and privileged under the provisions of 38 U.S.C. 5705 and its implementing regulations. This material shall not be disclosed to anyone without authorization as provided for by that law or its regulations. The statute provides for fines up to $20,000 for unauthorized disclosures."

Modified after 2014 VA National Falls-Freedom https://www.patientsafety.va.gov/professionals/onthejob/falls.asp

Outcomes of Post-Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Plan of Care
- Patient / Resident (family) involved in learning about the fall occurrence
- Prevent repeat fall
- Reduce repeat fall rate

Post-Fall Huddle Resources

VA: Falls Toolkit

Post-Fall Huddles

www.patientsafety.va.gov

AHRQ Falls Toolkit 2013

Tools

- Post-Fall Huddle Process
- Decision Tree
- Post-Fall Huddle Form
- Determine Preventability
- Case Study Exercises
- Audit Tool

Let's Take a Look

- My Audit Tool

Post Fall Audit Tool - For Reliability of the Protocol	Protocol	Type of Measure	Reliability of the Protocol		Quality Improvement Data	Notes
Steps of the Post Fall Huddle	Actions during each step					
Step 1:Announcement			Yes	No		
	Staff Member in charge of the patient makes an announcement to convene the post fall huddle	Process			List Leader (RN, CN, etc.)	
	Staff Member becomes the Team Leaders of the Huddle	Structure				
Step 2: Gathering	3-4 members of the clinical team who know the patient gather for the huddle	Structure			List Who Attends	
	The huddle includes the patient/resident	Structure				
	If family present, family is included in the huddle	Structure			List Who Attends	
	The huddle occurs where the patient fell	Structure			Identify Location of Fall	
	The huddle convenes within 15 minutes of the fall	Process				
Step 3: Analysis	Team analyses the fall event to determine root cause of the fall	Process			Document Root Cause	
	Team determines type of fall that occurred based on root cause	Process			Document Type of Fall	

Outcomes of Post-Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Root Cause of Injury
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Plan of Care
- Patient/Resident (family) involved in learning about the fall occurrence
- Prevent repeat fall

Formative Measures

- Structures:
  - Who attends: Nursing and others – count them
  - Changed Plan of Care: Add actions to your run-chart: Annotated run chart; Capture interventions
- Processes:
  - Timeliness of Post-Fall Huddle (number of minutes)
  - Timeliness of changing plan of care
  - Time to implemented changed plan of care

Summative Outcome

- Prevent Repeat Fall: Same Root Cause and Same Type of Fall
- Reduce costs associated with falls and fall-related injuries

Building Evidence about PFH

- 2-year demonstration project – quasi experimental study
- 16 small rural hospitals (avg beds 26)
- Determine associations between conducting post-fall huddles on repeat fall rates and perceptions of teamwork and safety culture

(Jones, Crose, et al., 2019)

Study Purpose

Collaboration and **Proactive Teamwork Used** to **Reduce** (CAPTURE) **Falls** purpose was to decrease the risk of falls in small rural hospitals by using a multi-team system (MTS) to implement evidence-based fall-risk-reduction practices.

MTS: core team, contingency team, coordinating team

Results

- 308 pts; 64% had PFH; 347 falls; 223 falls after PFH
- Aggregate mean repeat fall rate 1.12 (1.00-1.45)
  [12% chance of a repeat fall}
- Results demonstrate that the greater the proportion of falls in a hospital that are followed by a post-fall huddle, the lower may be the repeat fall rate.
- Staff perceptions of teamwork were consistently high regardless of participation in a post-fall huddle.

Post-Fall Assessment

Different than a Huddle!

Post-Fall Assessment

- In-depth Data Gathering
- Circumstances of the Fall
- Patient/Resident Presentation
- Assessment of Patient/Resident Condition

Comprehensive Post-Fall Assessment

Includes:

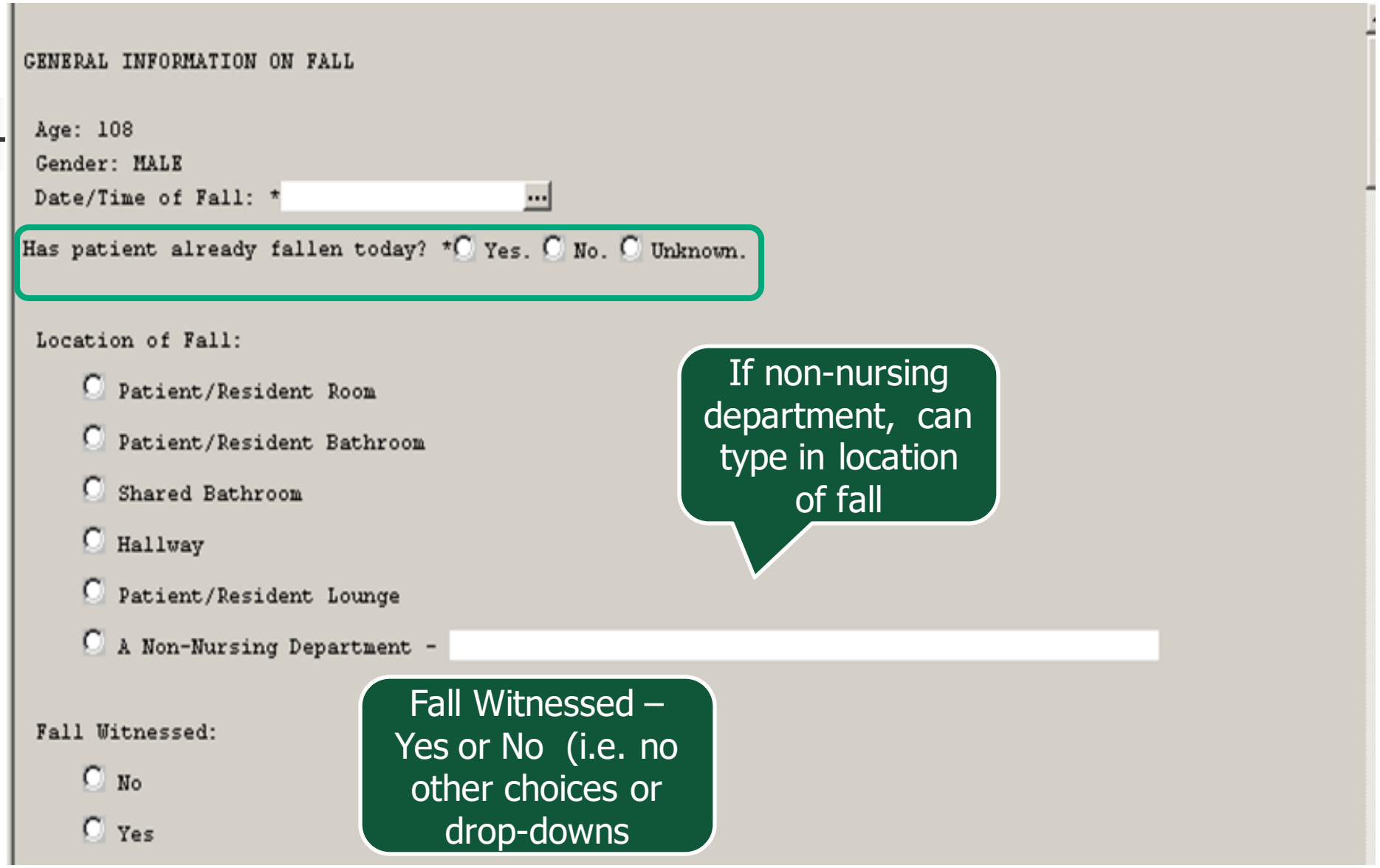
- General information about the fall
- Subjective & objective falls documentation
- Patient/Resident Assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based on Fall Risk Scale/ Morse falls scale
- Facility personnel and family notification

Post-Fall Assessment: History: Review of Systems

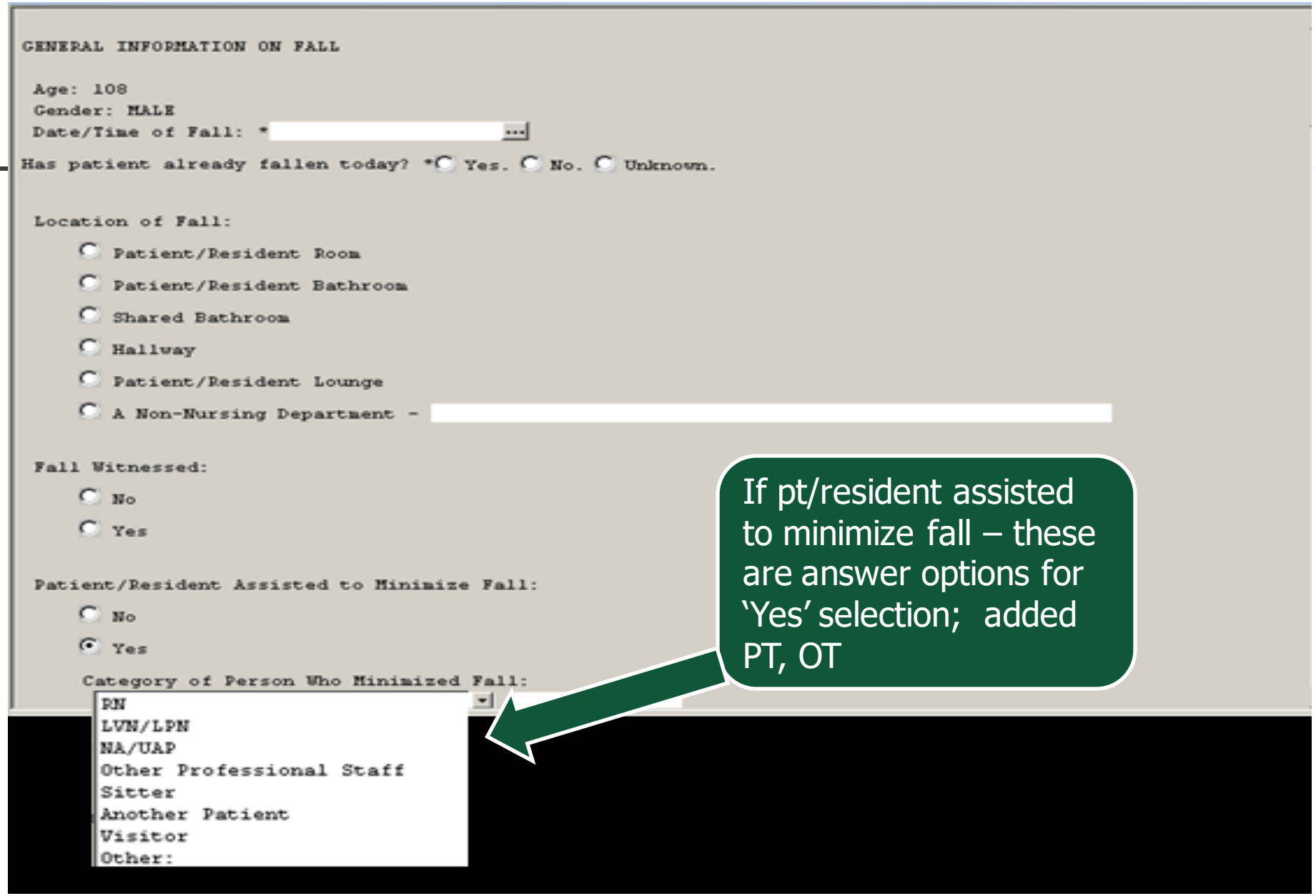
- Patient Symptoms to Elicit on History Linked to Risk Factors

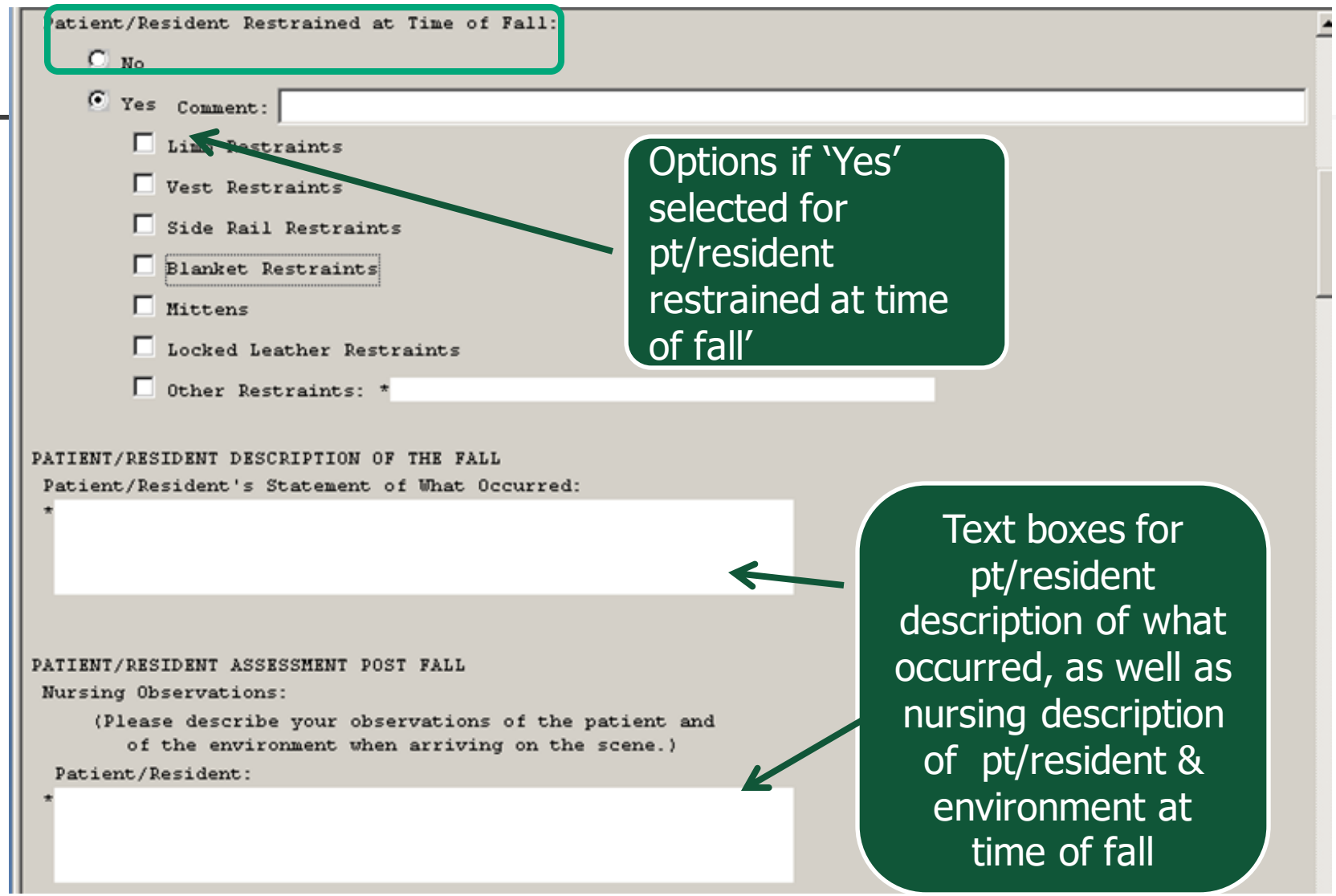
Symptom	Fall Risk Factor
Visual disturbance (double vision, blurry vision, loss of vision)	Visual impairment?
Dizziness/lightheadedness	Orthostatic hypotension? Abnormal vital signs?
Leg weakness	Gait or balance instability?
Urinary urgency or frequency	Urinary incontinence?
Syncope/loss of consciousness	One or more chronic diseases

Post-Fall Note (EMR)



Gen Info


GENERAL INFORMATION ON FALL
Age: 108
Gender: MALE
Date/Time of Fall: *
Has patient already fallen today? * Yes. No. Unknown.
Location of Fall:
Patient/Resident Room
Patient/Resident Bathroom
Shared Bathroom
Hallway
Patient/Resident Lounge
A Non-Nursing Department -
Fall Witnessed:
No
Yes
Patient/Resident Assisted to Minimize Fall:
No
Yes
Category of Person Who Minimized Fall:
RN
LVN/LPN
NA/UAP
Other Professional Staff
Sitter
Another Patient
Visitor
Other:
If pt/resident assisted to minimize fall – these are answer options for 'Yes' selection; added PT, OT


atient/Resident Restrained at Time of Fall:
No
Yes
Comment:
Vest Restraints
Side Rail Restraints
Blanket Restraints
Mittens
Locked Leather Restraints
Other Restraints: *
PATIENT/RESIDENT DESCRIPTION OF THE FALL
Patient/Resident's Statement of What Occurred:
*
PATIENT/RESIDENT ASSESSMENT POST FALL
Nursing Observations:
(Please describe your observations of the patient and of the environment when arriving on the scene.)
Patient/Resident:
*
Options if 'Yes' selected for pt/resident restrained at time of fall'
Text boxes for pt/resident description of what occurred, as well as nursing description of pt/resident & environment at time of fall

PATIENT/RESIDENT ASSESSMENT POST FALL

Nursing Observations:

(Please describe your observations of the patient and of the environment when arriving on the scene.)

Patient/Resident:

*

Environment:

*

Vital Signs (Pulse/Blood Pressure)

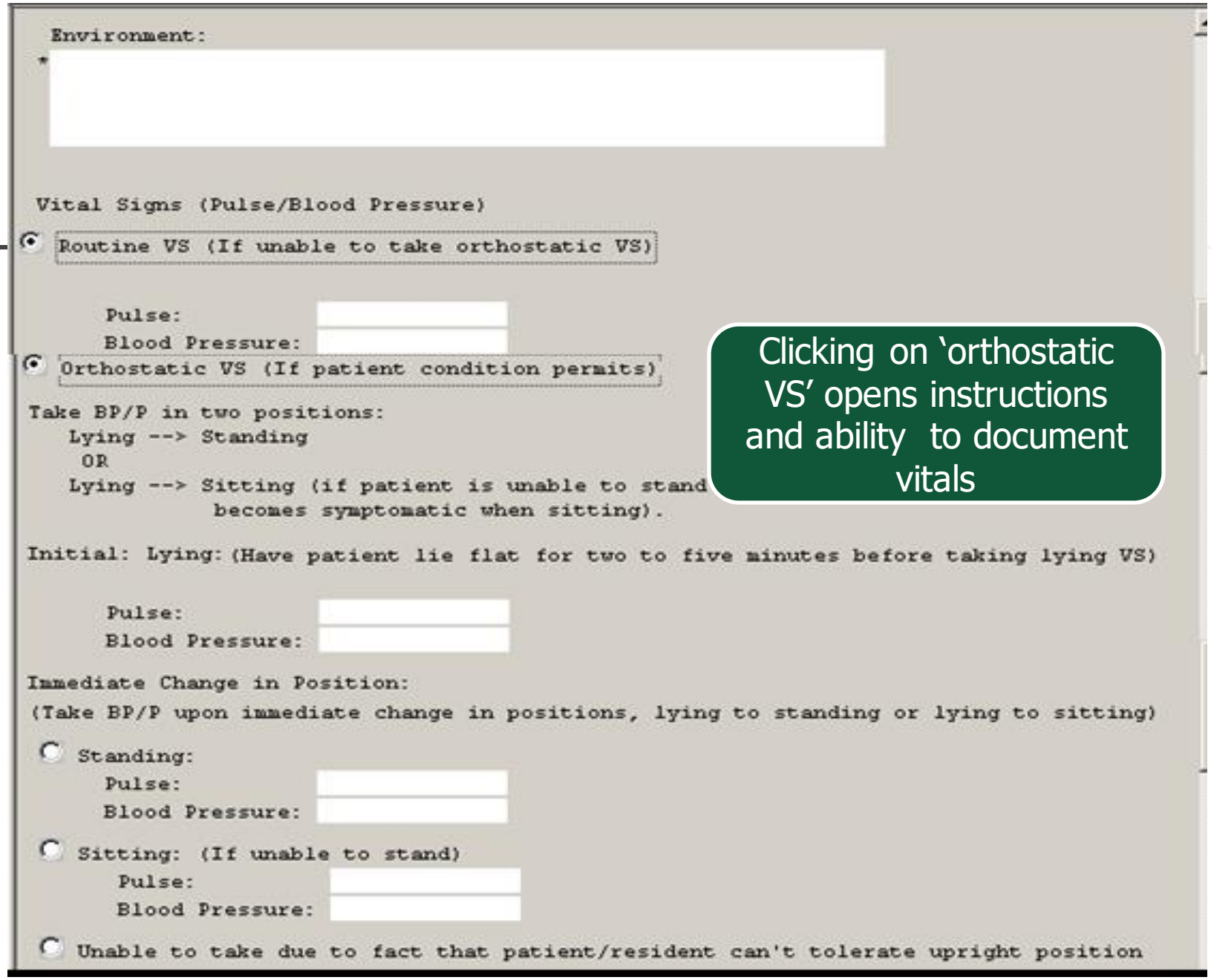
Routine VS (If unable to take orthostatic VS)

Pulse:

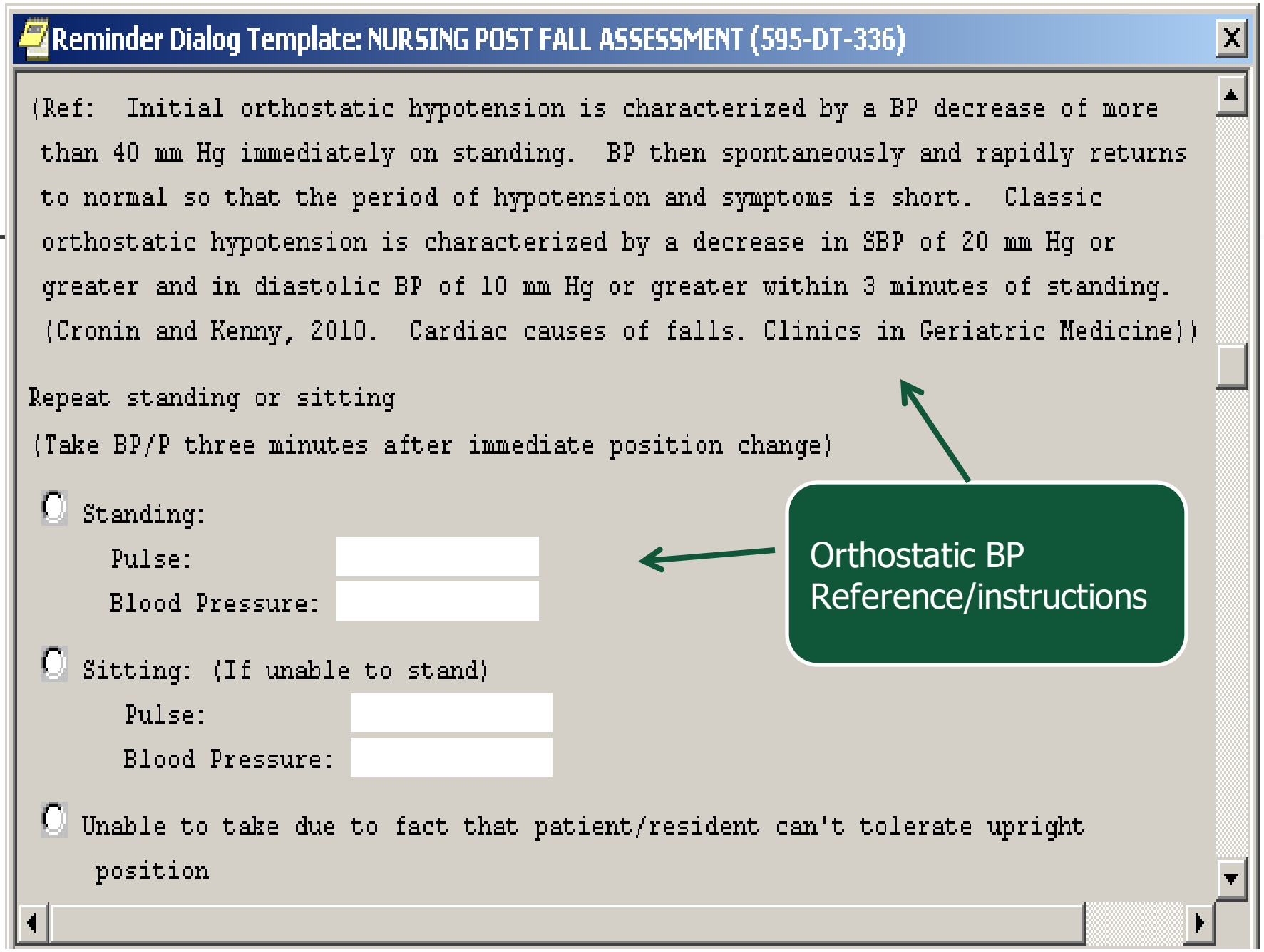
Blood Pressure:

Respirations:

Enter routine Vital Signs (VS) if unable to take orthostatic VS



Clicking on 'orthostatic VS' opens instructions and ability to document vitals


Reminder Dialog Template: NURSING POST FALL ASSESSMENT (595-DT-336)
(Ref: Initial orthostatic hypotension is characterized by a BP decrease of more than 40 mm Hg immediately on standing. BP then spontaneously and rapidly returns to normal so that the period of hypotension and symptoms is short. Classic orthostatic hypotension is characterized by a decrease in SBP of 20 mm Hg or greater and in diastolic BP of 10 mm Hg or greater within 3 minutes of standing. (Cronin and Kenny, 2010. Cardiac causes of falls. Clinics in Geriatric Medicine))
Repeat standing or sitting
(Take BP/P three minutes after immediate position change)
Standing:
Pulse:
Blood Pressure:
Sitting: (If unable to stand)
Pulse:
Blood Pressure:
Unable to take due to fact that patient/resident can't tolerate upright position
Orthostatic BP Reference/instructions

Glucometer Reading

Is patient/resident diabetic?

(If not diabetic but reading was taken, you may enter)

- ( ) No
- (•) Yes

Glucometer Reading *

Is Patient/Resident Hypoglycemic? (blood glucose level equal to or below 70 mg/dl)

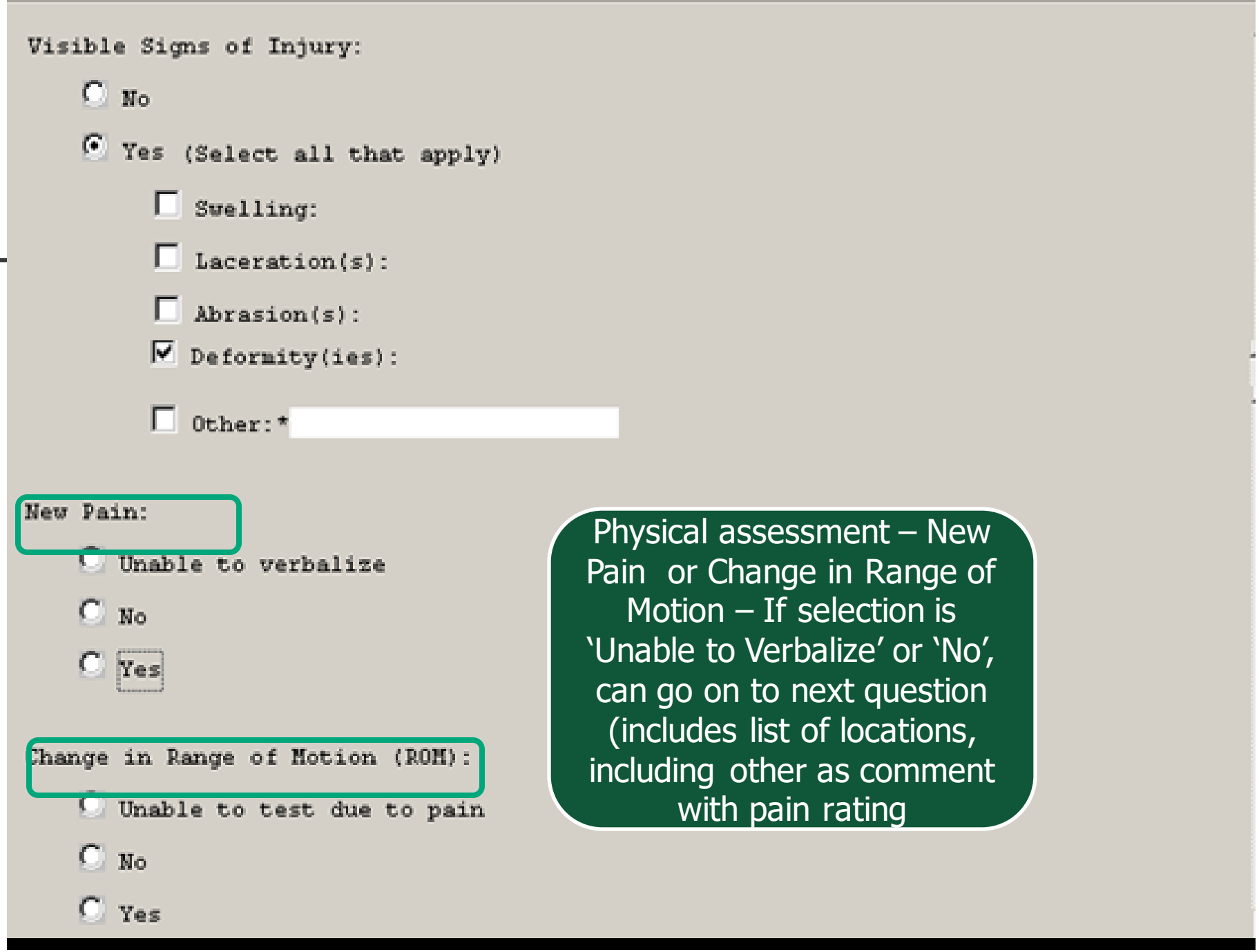
- ( ) No
- ( ) Yes

Visible Signs of Injury:

- ○ No
- ◉ Yes (Select all that apply)
  - ☑ Swelling:

    Location: (Select all that apply)
    - ☐ Torso - Front
    - ☐ Torso - Back
    - ☐ Head
    - ☐ Neck
    - ☐ Shoulder - Right
    - ☐ Shoulder - Left
    - ☐ Arm - Right
    - ☐ Arm - Left
    - ☐ Elbow - Right
    - ☐ Elbow - Left
    - ☐ Wrist - Right
    - ☐ Wrist - Left
    - ☐ Hand - Right
    - ☐ Hand - Left
    - ☐ Hip - Right
    - ☐ Hip - Left
    - ☐ Knee - Right
    - ☐ Knee - Left
    - ☐ Leg - Right
    - ☐ Leg - Left
    - ☐ Foot - Right
    - ☐ Foot - Left

If yes to visible signs of injury, type of injury can be selected (e.g. deformity); selection prompts nurse to select location on pt/resident body



Physical assessment – New Pain or Change in Range of Motion – If selection is 'Unable to Verbalize' or 'No', can go on to next question (includes list of locations, including other as comment with pain rating

New Pain – if yes, can select location and pain rating for that location (1-10) scale

New Pain:

- ○ Unable to verbalize
- ○ No
- ◉ Yes

Location: (Select all that apply)

☐ Torso - Front	Pain Rating: *	
☐ Torso - Back	Pain Rating: *	
☐ Head	Pain Rating: *	
☐ Neck	Pain Rating: *	
☐ Shoulder - Right	Pain Rating: *	
☐ Shoulder - Left	Pain Rating: *	
☐ Arm - Right	Pain Rating: *	
☐ Arm - Left	Pain Rating: *	
☐ Elbow - Right	Pain Rating: *	
☐ Elbow - Left	Pain Rating: *	
☐ Hand - Right	Pain Rating: *	
☐ Hand - Left	Pain Rating: *	
☐ Hip - Right	Pain Rating: *	
☐ Hip - Left	Pain Rating: *	
☐ Knee - Right	Pain Rating: *	
☐ Knee - Left	Pain Rating: *	
☐ Foot - Right	Pain Rating: *	
☐ Foot - Left	Pain Rating: *	
☐ Other: *	Pain Rating: *	

Change in Range of Motion (ROM):

- ( ) Unable to test due to pain
- ( ) No
- (•) Yes
  - [ ] New decreased range of motion right upper extremity.
  - [ ] New decreased range of motion left upper extremity.
  - [ ] New decreased range of motion right lower extremity.
  - [ ] New decreased range of motion left lower extremity.
  - [ ] New decreased range of motion back.
  - [ ] New decreased range of motion neck.

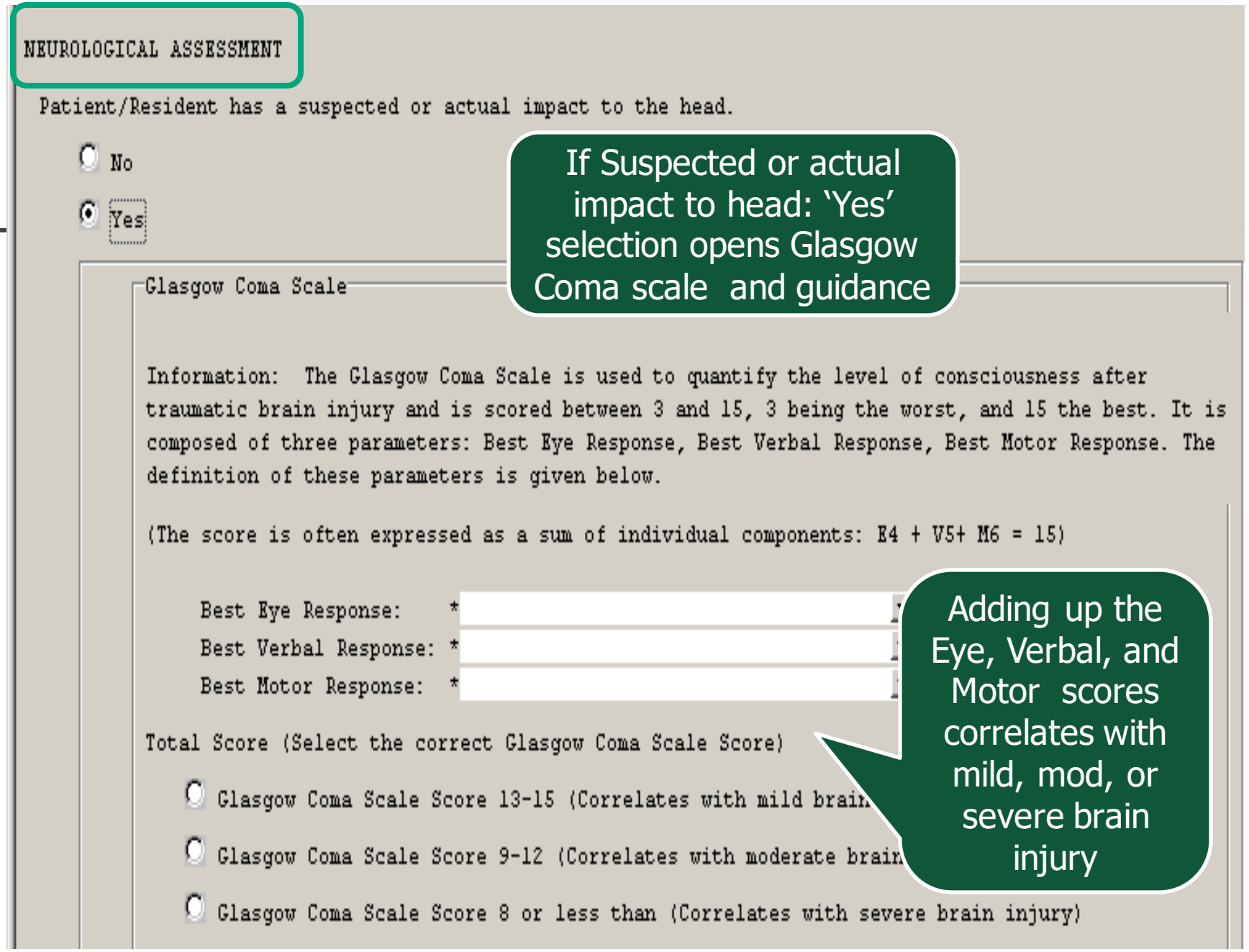
Change in ROM: if yes, select body area involved –

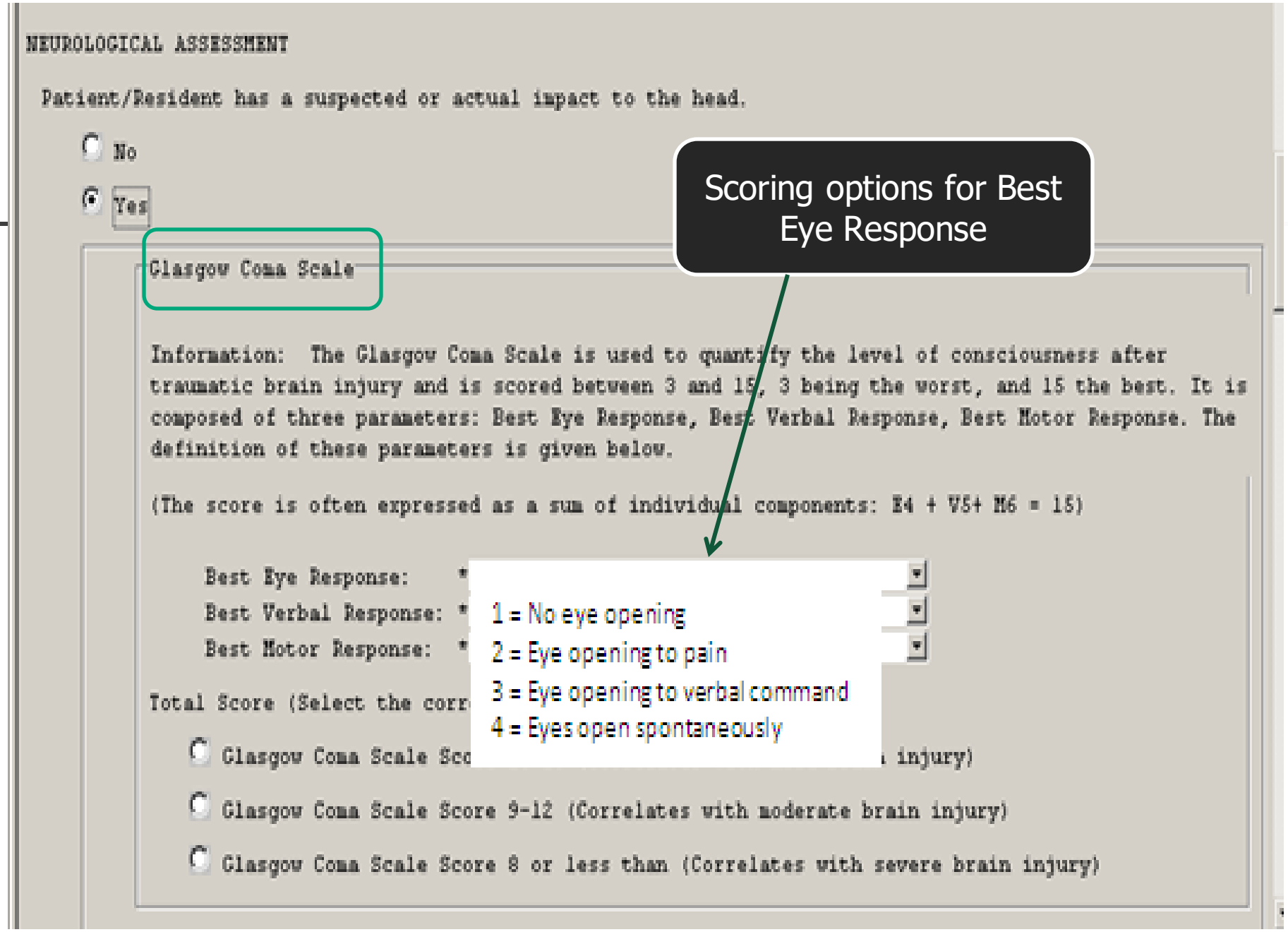
NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

- ( ) No
- (•) Yes

If no suspected or actual head impact, select 'no' and move on


NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response: *
Best Verbal Response: *
Best Motor Response: *
Total Score (Select the correct Glasgow Coma Scale Score)
Glasgow Coma Scale Score 13-15 (Correlates with mild brain
Glasgow Coma Scale Score 9-12 (Correlates with moderate brain
Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)
If Suspected or actual impact to head: 'Yes' selection opens Glasgow Coma scale and guidance
Adding up the Eye, Verbal, and Motor scores correlates with mild, mod, or severe brain injury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No
Yes
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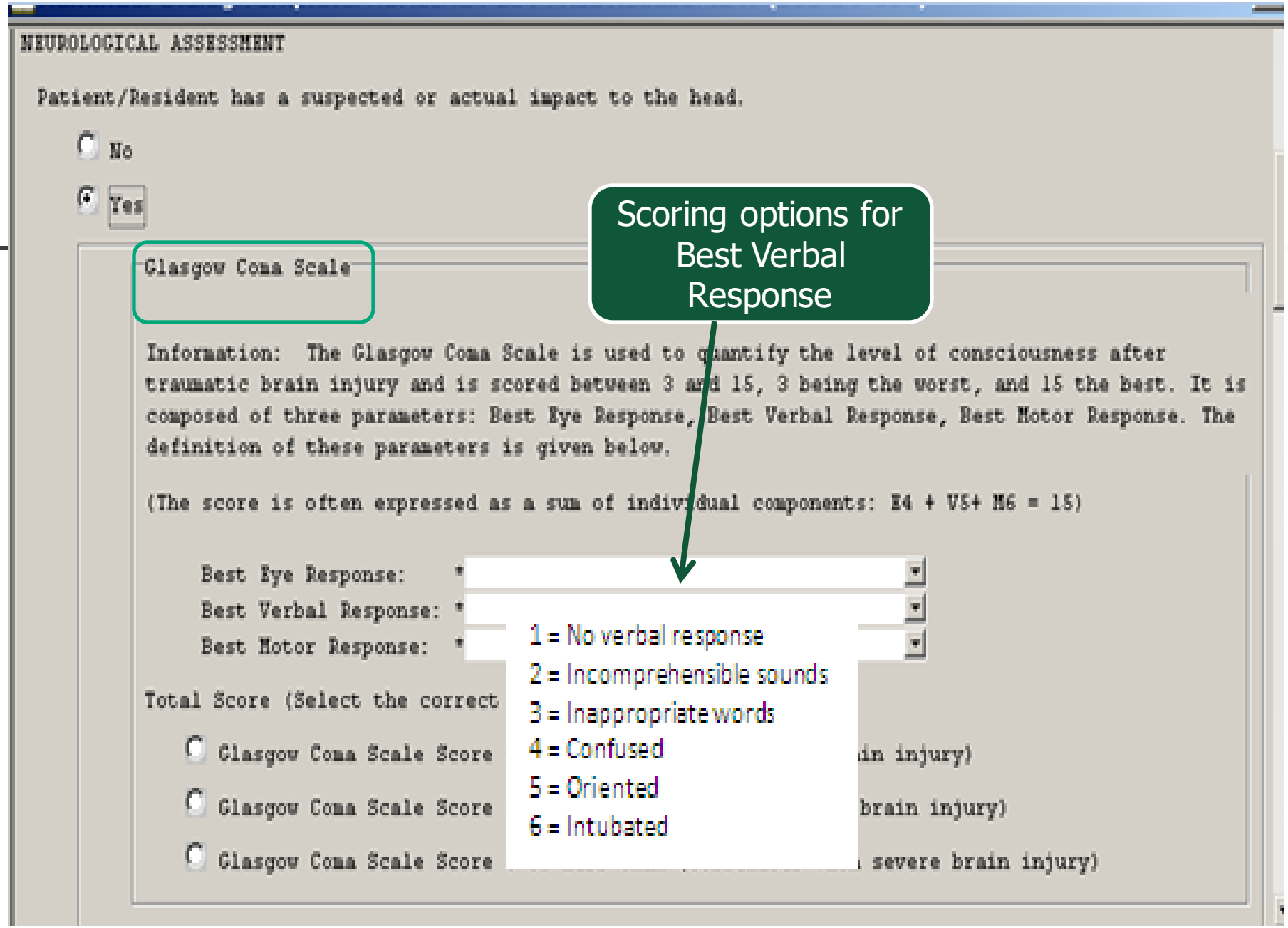
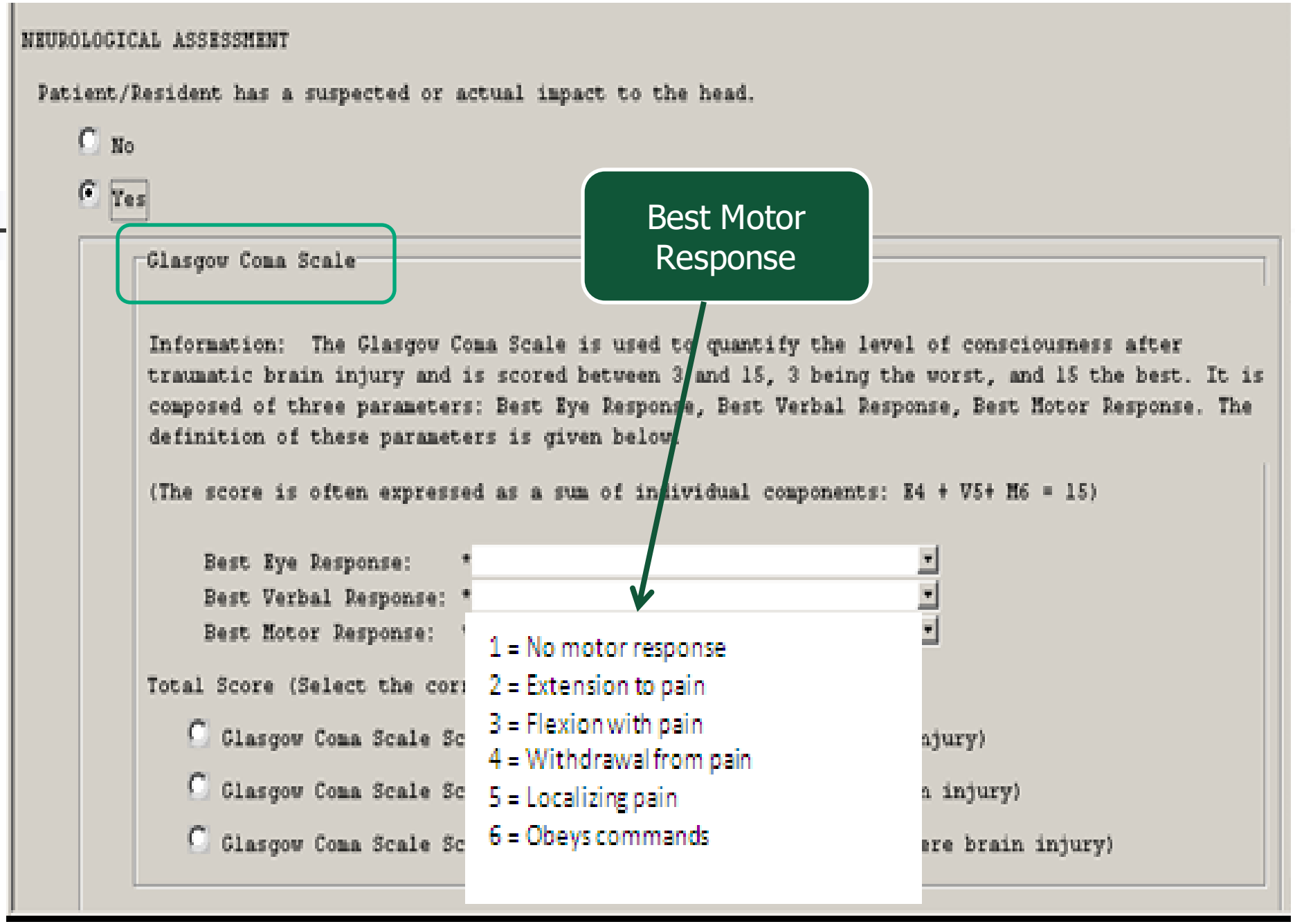
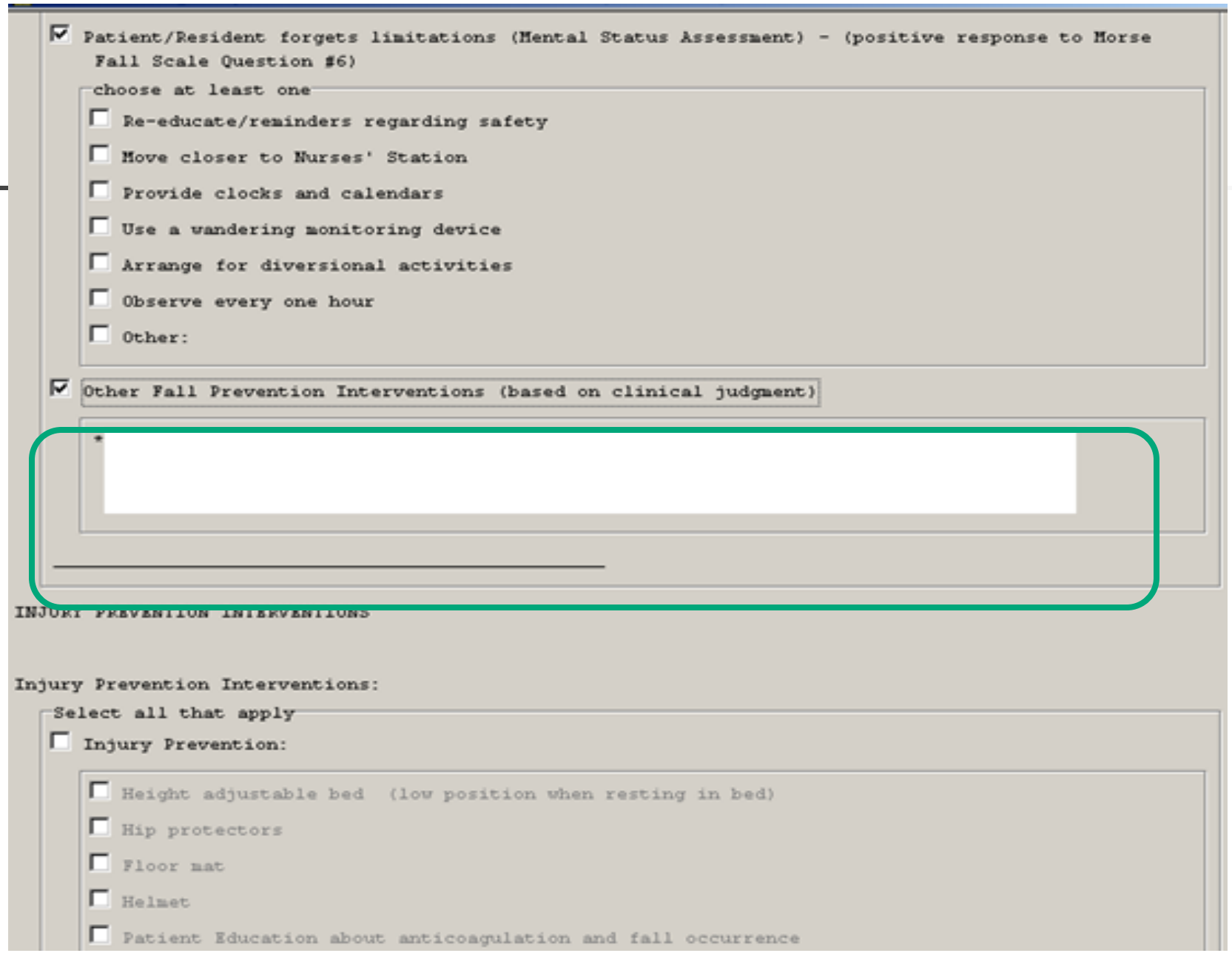
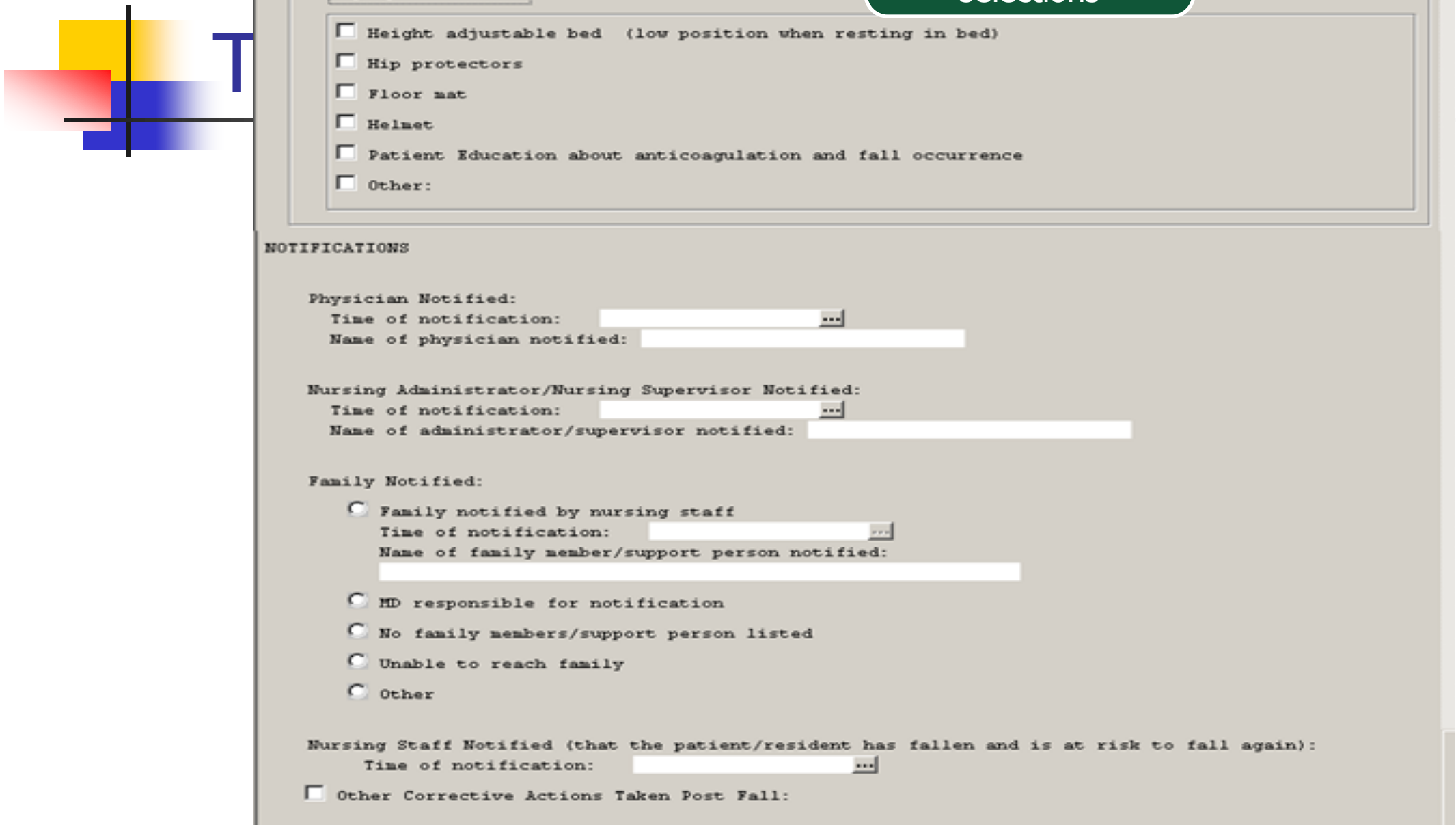
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response:
Best Verbal Response:
Best Motor Response:
1 = No eye opening
2 = Eye opening to pain
3 = Eye opening to verbal command
4 = Eyes open spontaneously
Total Score (Select the corr
Glasgow Coma Scale Sco injury)
Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)
Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)
Scoring options for Best Eye Response


NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response: *
Best Verbal Response: *
Best Motor Response: *
Total Score (Select the correct
Glasgow Coma Scale Score
Glasgow Coma Scale Score
Glasgow Coma Scale Score
1 = No verbal response
2 = Incomprehensible sounds
3 = Inappropriate words
4 = Confused
5 = Oriented
6 = Intubated
Scoring options for Best Verbal Response


NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Best Motor Response
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response: *
Best Verbal Response: *
Best Motor Response:
1 = No motor response
2 = Extension to pain
3 = Flexion with pain
4 = Withdrawal from pain
5 = Localizing pain
6 = Obeys commands
Total Score (Select the cor
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc


Patient/Resident forgets limitations (Mental Status Assessment) - (positive response to Morse Fall Scale Question #6)
choose at least one
Re-educate/reminders regarding safety
Move closer to Nurses' Station
Provide clocks and calendars
Use a wandering monitoring device
Arrange for diversional activities
Observe every one hour
Other:
Other Fall Prevention Interventions (based on clinical judgment)
*
INJURY PREVENTION INTERVENTIONS
Injury Prevention Interventions:
Select all that apply
Injury Prevention:
Height adjustable bed (low position when resting in bed)
Hip protectors
Floor mat
Helmet
Patient Education about anticoagulation and fall occurrence



Preventive intervention selections

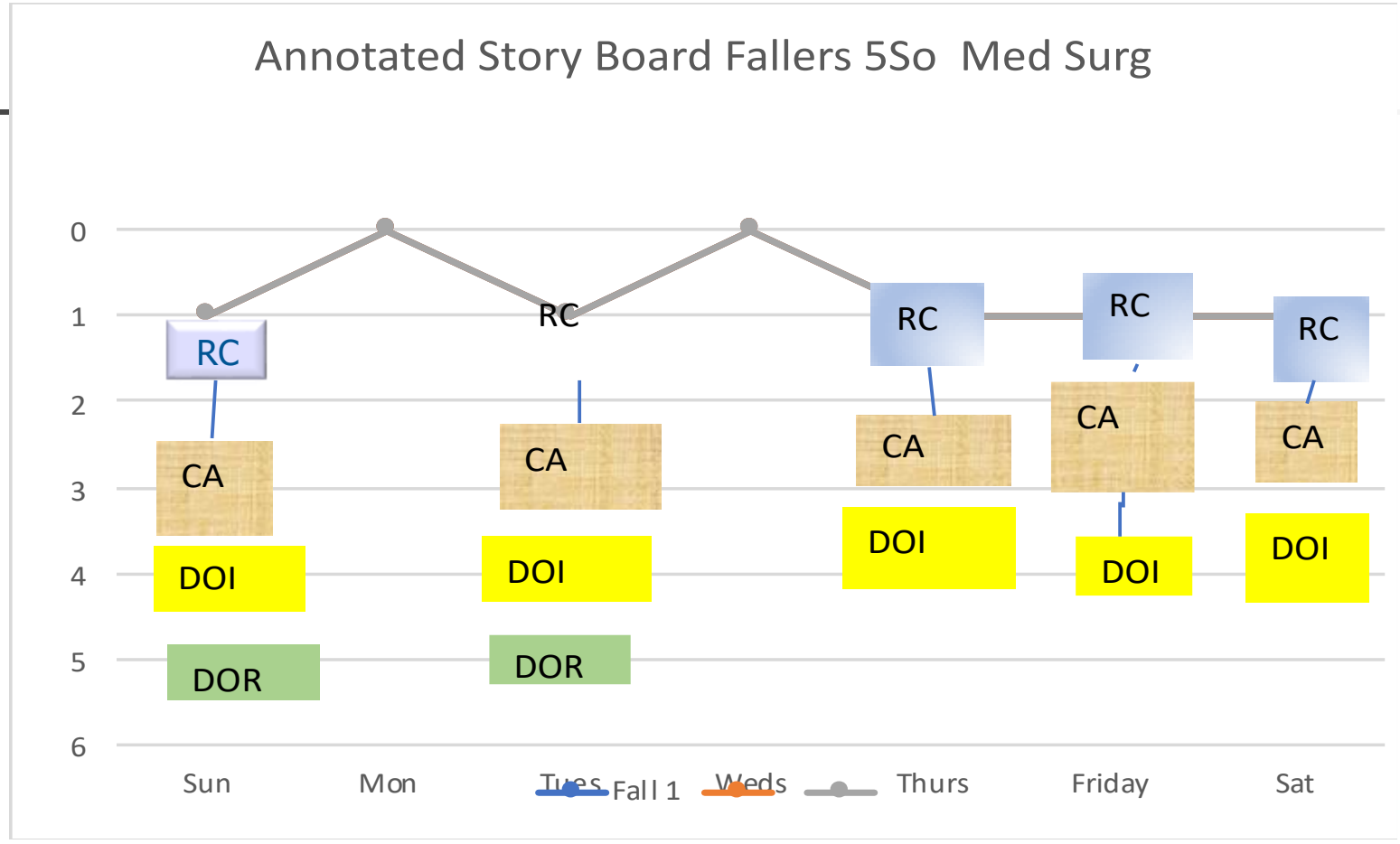
Teaching: After a Fall

- Reframe patient/resident education curricula to include "what happens after a fall?"
- What can we learn from this event?
- How can we work together to prevent this again?

Staff Education

- Universal Fall Prevention
- Individualized Fall Prevention
- Injury Reduction Strategies
- Root Cause Trends of Falls
- Interventions for Improvement
- Impact of Changes in Practices

My Unit Story Board



Learn from Falls: Change Your Conversation

- Talk About and Trend Root Causes
- Monitor Interventions for Mitigation/Elimination of Root Causes
- Align Interventions to Type of Falls
- Precision In Program Evaluation: Reduction
- Accidental Falls
- Anticipated Physiological Falls
- Unanticipated Physiological Falls

To Change Practice is Not for the Faint of Heart

- It takes a lot of work: Patience, Perseverance, Champions, Positive Approach, and Data

My Asks of You for Our Coaching Session

- Compare your PFH Process with what was presented.
- Compare your Post-Fall Management Process with what was presented.
- Review the PFH Audit Tool for your use.

Thank You and Please Share More!

- See you on June 21st for our Follow-Up Coaching Session – Please Join Me!
- Thank you for attending, be a Champion for Change, and keep me posted – I am here for you!
- pquigley1@tampabay.rr.com

You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, APRN, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com

References

- AHRQ, Patient Safety Network [PSNet], Patient Safety Primer: Falls. Updated Sept. 2019). Available: https://psnet.ahrq.gov/primer/falls
- Ellis S, Mendel R, Nir M. Learning from successful and failed experience: The moderating role of kind of after-event review. J Appl Psychol. 2006;91(3):669–80.
- Jones, K.J.,. Crowe, J., Allen, J.A., Skinner, A.M., High, R., Kennel, V., & Reiter-Palmon, R. (2019). The impact of post-fall huddles on repeat fall rates and perceptions of safety culture: a quasi-experimental evaluation of a patient safety demonstration project. BMC Health Services Research. 19: 650

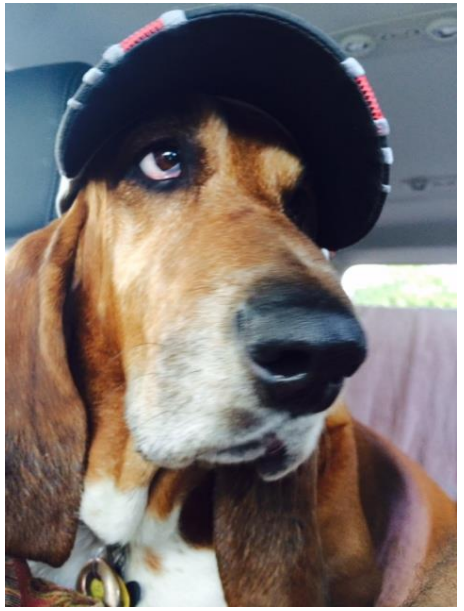
https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-019-4453-y

- Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. Hum Factors. 2013;55(1):231–45.

I Fall A lot! Why?

Oreo

Jethro



Next Steps

Join us for our next Coaching call: June 21,2023 2-3p.m. EST

Falls series recording and slides: https://qi.ipro.org/2023/04/19/fall-and-injury-prevention-a-6-part-webinar-series/

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CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Thank You for Attending Today's Event

We value your input!
Please complete the brief survey after exiting event.

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