

# CAPTURE Falls Virtual Educational Series

## Session 5: Post-Fall Clinical Assessment and Fall Event Reporting

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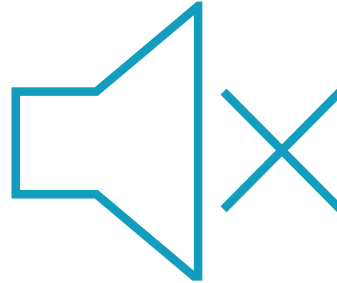
# Housekeeping for Today's Presentation



Add your facility's name to the chat



All presentations will be recorded and links to recordings distributed at a later time



Please ensure your audio is muted throughout the presentation



Use the chat feature to ask questions and dialogue with attendees and presenters



# Acknowledgements: Funding for This Virtual Educational Series

This work is supported by the Iowa Department of Health and Human Services Medicare Rural Hospital Flexibility Program.

*The content is solely the responsibility of the presenters and does not necessarily represent the views of any funding source.*





# Acknowledgements: Current and Former Collaborators

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# Introductions and Contact Information

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- Clinical expertise in fall risk management and mobility  
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## Victoria (Vicki) Kennel, PhD

- 10+ years of experience in industrial organizational psychology
- Quality improvement and organizational science expertise [victoria.kennel@unmc.edu](mailto:victoria.kennel@unmc.edu)



# What is the CAPTURE Falls Virtual Educational Series?

- 6-month education series on fall risk reduction in Critical Access and rural hospitals led by the University of Nebraska Medical Center's CAPTURE Falls program
- Invited by Wanda Hilton, the Rural Hospital Flex/SHIP Program Coordinator for the Iowa Department of Health and Human Services to provide this series.
- All sessions will be held on the 3<sup>rd</sup> Wednesday of the month, 1-2pm CT via Zoom.
- All session recordings are posted under the Quality Improvement tab on the following website: [Rural Hospital Programs | Health & Human Services \(iowa.gov\)](https://www.iodhs.gov/rural-hospital-programs/health-human-services)

Date	Fall Risk Reduction Topic
February 21, 2024	Interprofessional Approaches to Reducing Fall Risk; Defining a Fall
March 20, 2024	Fall Risk Assessment
April 17, 2024	Fall Risk Reduction Interventions
May 15, 2024	Auditing Fall Risk Reduction Practices
June 19, 2024	Post-Fall Clinical Assessment; Fall Event Reporting
July 17, 2024	Post-Fall Huddles



# CAPTURE Falls Roadmap



## Establish Readiness for Change

Explore the resolve of members of an organization to implement change to improve fall risk reduction practices, and their collective belief in their capacity



## Interprofessional Fall Risk Reduction Team

Create an inter-professional fall risk reduction team responsible for managing and implementing the facility's fall risk reduction program.



## Gap Analysis

Conduct an assessment of the current state of fall risk reduction practices in your facility compared to evidence-based best practices.



## Action Plan

Document and monitor the steps your team needs to take to reach your program goals.



## Fall Risk Reduction Policies and Procedures

Set expectations and influence decisions, actions, and activities necessary for your fall risk reduction program.



## Fall Definition

Specify what "counts" as a fall, and differentiate various types of falls (e.g. assisted vs. unassisted) as well as injuries.



## Fall Risk Assessment

Identify patients who are at risk for falls and recognize their respective risk factors.



## Fall Risk Reduction Interventions

Implement interventions to reduce the influence of patient risk factors for falls and fall-related injury.



## Auditing Fall Risk Reduction Practices

Identify if fall risk reduction practices are being implemented as intended in your facility.



## Post-Fall Clinical Assessment

Establish a protocol to guide staff in the assessment of patients for potential injury after a fall occurs.



## Post-Fall Huddle

Create a safe environment to understand the 'story' behind a fall in order to learn and take action to prevent a future fall.



## Fall Event and Rate Reporting

Report and monitor falls and fall rates to track progress within your organization and allow for external benchmarking.



## Learning from Data

Use data to understand how well your fall risk reduction program is working to reduce fall risk in your facility.



## Sustainment Strategies

Maintain an effective fall risk reduction program over time.





# Session 5 Objectives

1

Describe resources that can be used to guide post-fall clinical assessment

2

Determine strategies for education of staff on post-fall clinical assessment

3

Explain the importance of using a standardized definition of a fall and classifications of fall types and outcomes (*quick recap from session 1*)

4

Describe the practice of fall event and rate reporting

5

Determine strategies for education of staff on fall event reporting



# Objective 1:

**Describe resources that can be used  
to guide post-fall clinical  
assessment**



# Post-Fall Clinical Assessment

CAPTURE Falls Roadmap Post-Fall Clinical Assessment



- Assessment for injury should occur immediately
- Depending on the patient's injury risk factors, assessment may need to continue for several hours

Assess patients for potential injury after a fall occurs so that appropriate medical care can be provided

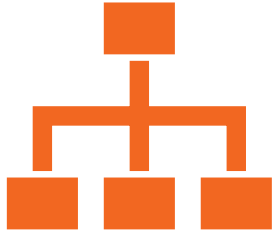


# Post-Fall Clinical Assessment

CAPTURE Falls Roadmap Post-Fall Clinical Assessment



- Various checklists and decision trees exist
- Common components
  - Check vital signs
  - Assess for bleeding and clean/dress any wounds
  - Assess for bruising or swelling
  - Assess for signs/symptoms of fracture or spinal injury (pain to palpation, bone or joint deformities)
  - Assess for signs/symptoms of head injury if known to hit head or if fall was unwitnessed (neurological assessment)
  - Notify physician/PA/APRN and family
  - Provide analgesia as needed
  - Consider imaging



# Post-Fall Clinical Assessment: Resources



## CAPTURE Falls Roadmap Post-Fall Clinical Assessment

### Agency for Healthcare Research and Quality Tool 3N Postfall Assessment Clinical Review

- Example protocol to assess injury risk when a patient has fallen
- Provides separate recommendations for patients with or without head trauma or those with an unwitnessed fall

### US Department of Veterans Affairs Post Fall Procedures/Management

- Example post-fall management protocol (See Section VII and Attachment 3)
- Differentiates follow-up for patients with and without head trauma

### The VIP treatment: A Comprehensive Post-Fall Assessment Guideline (American Nurse Journal, 2023)

- VIP = Visualize, Palpate for Injuries, Proceed with Care
- QI protocol developed for falls in LTC, but could be applied to hospital setting
- Algorithm that guides nurses through assessment of consciousness, head-to-toe inspection for injuries, and scheduled re-checks
- Based on Advanced Trauma Life support algorithm by the American College of Surgeons Committee on Trauma



# Post-Fall Clinical Assessment: Resources



CAPTURE Falls Roadmap Post-Fall Clinical Assessment

## 2023 Post-Fall Multidisciplinary Management Guidelines (Western Australia Dept. of Health)

- Outlines steps to take immediately, and within various time intervals up to 48 hours post fall
- Includes specific considerations regarding whether to conduct a CT scan of the head or neck
- Differentiates course of action between witnessed and unwitnessed falls, whether head was struck and if the patient is on anticoagulants/antiplatelets

## Clinical Excellence Commission Post-Fall Assessment and Management Guide (New South Wales, Australia Ministry of Health)

- Guidance and algorithms for the immediate response and ongoing observation/monitoring after a fall
- Includes special considerations for patients at risk of bleeding, head injury, sepsis, and delirium



## **Objective 2:**

**Determine strategies for education  
of staff on post-fall clinical  
assessment**



# Post-Fall Clinical Assessment: Staff Education



CAPTURE Falls Roadmap Post-Fall Clinical Assessment



Describe the post-fall clinical assessment protocol used in your facility



Perform a post-fall clinical assessment using a simulated patient case



New employee orientation



Annual education



Fall Prevention Awareness Week (September)



Patient Safety Awareness Week (March)

*Also consider who needs this training (which professions, level of experience of staff, etc.)*





## **Objective 3:**

**Explain the importance of using a standardized definition of a fall and classifications of fall types and outcomes**

***A quick recap!***



# Fall Definition

CAPTURE Falls Roadmap Fall Definition



“A fall is a sudden, unintended, descent of a patient’s body to the ground or other object (e.g., onto a bed, chair, or bedside mat) that can be assisted or unassisted.”

- Agency for Healthcare Research and Quality Common Formats Version 2.0

- **Sudden** – happening or coming unexpectedly; an unexpected occurrence
- **Unintended** – not planned as a purpose or goal; not deliberate or intended
- **Descent** – the act or process of descending from a higher to a lower level, rank, or state; an inclination downward
- **Or other object** – would the patient have reached the ground if the other object was not there?



# Unassisted vs. Assisted Fall

CAPTURE Falls Roadmap Fall Definition

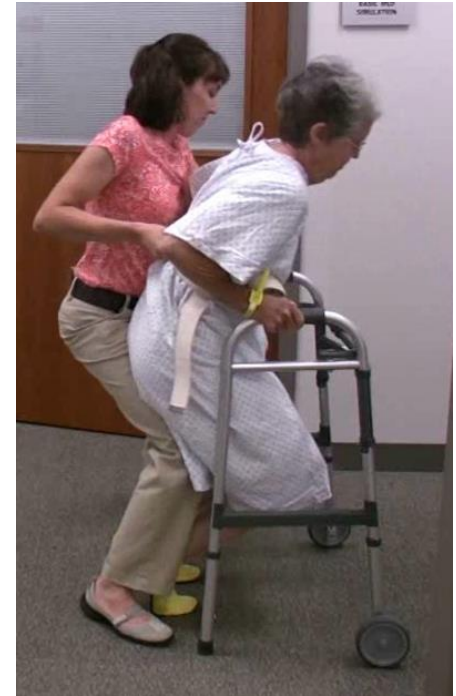


## Unassisted

- Fall occurs without hands-on assist from another person
- May or may not be observed

## Assisted

- When a patient begins to fall and is assisted to the ground or other object by another person
- Ideally occurs with a gait belt to allow the caregiver to control the patient's descent



# Non-Injurious vs. Injurious Fall

CAPTURE Falls Roadmap Fall Definition

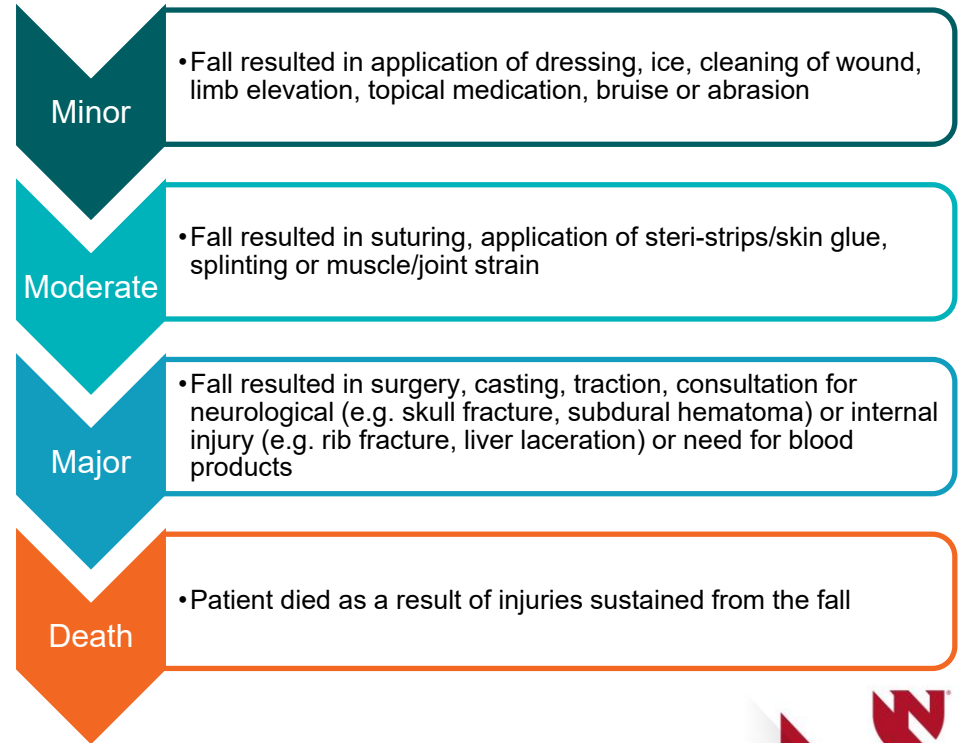


## Non-Injurious

- Patient is not harmed by the fall

## Injurious

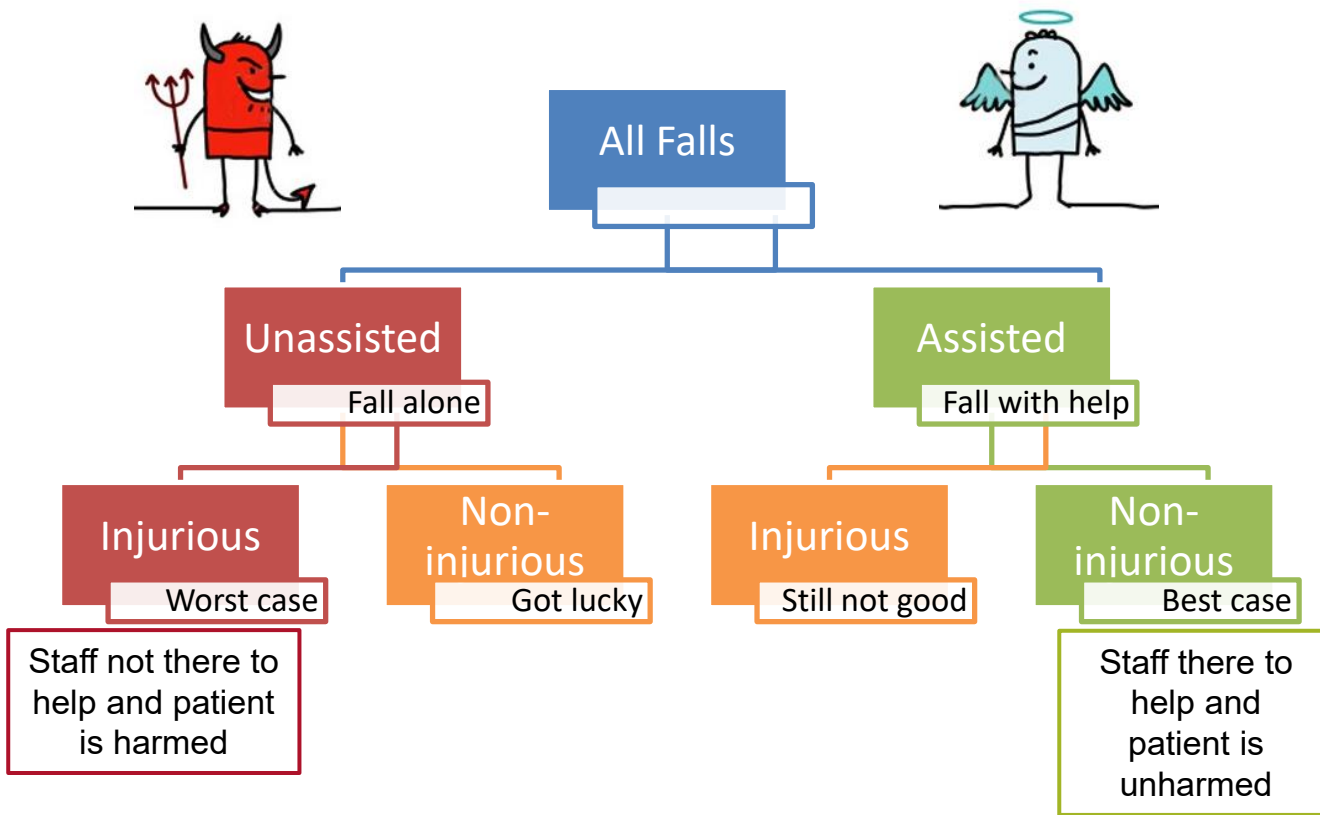
- Patient is harmed by the fall
- Harm ranges from minor injury to death



# Classification of Falls: Type and Outcome



CAPTURE Falls Roadmap Fall Definition



# Repeat Falls, Intentional Falls

CAPTURE Falls Roadmap Fall Definition



## Repeat Fall

- Patient has more than one fall during a respective admission
- Count each fall as an independent event
- These contribute to fall rates

## “Intentional” Fall

- “A patient aged 5 years or older falls on purpose or falsely claims to have fallen”
- Patient intentionally descends to the ground or other object
- These do *not* contribute to fall rates



## **Objective 4:**

**Describe the practice of fall event  
and rate reporting and  
benchmarking**



# Fall Event Reporting



CAPTURE Falls Roadmap Fall Event and Rate Reporting



Mechanism to track  
fall events when  
they occur

- Report to document standardized data about the facts and circumstances surrounding a fall
- Information about the incident + information to facilitate learning
- Paper and/or electronic
- Track fall events over time
- Need to know number of fall incidents to calculate fall rates





# What Information to Include in a Fall Event Report?



CAPTURE Falls Roadmap Fall Event and Rate Reporting

## AHRQ Common Formats for Event Reporting – Hospital Version 2.0:

- Developed for use by providers and organizations who work with Patient Safety Organizations (PSOs)
- Collect patient safety information in a standardized way
- Core and supplemental fields for reporting
  - Core required for all incidents
  - Supplemental are event specific types of additional questions (e.g., falls)

## AHRQ Fall Prevention Toolkit Recommendations:

- The fact that the incident being reported was a fall
- The patient in whom the fall occurred
- Date the fall occurred
- Unit the patient was assigned to at the time of the fall
- Location of the fall
- Detailed report about the circumstances of the fall
- Level of injury (if any)



# Example Fall Event Report Form

CAPTURE Falls Roadmap Fall Event and Rate Reporting

## CAPTURE Falls Fall Event Learning Form



Report Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

### CAPTURE Falls Event Learning Form

**Definition of fall:** A fall is a sudden, unintended, descent of a patient's body to the ground or other object (e.g., onto a bed, chair, or bedside mat) that can be assisted (e.g., when a patient begins to fall and is assisted to a lower surface by another person) or unassisted.

1. Date of fall: \_\_\_\_\_ 2. Time of fall (military time): \_\_\_\_\_

3. Admission type at time of fall:  Acute  Swing  Observation  Hospice  Outpatient  ED  
 Ambulatory Care Clinic  Visitor  Other: \_\_\_\_\_

4. Patient medical record number: \_\_\_\_\_ 5. Patient admission date: \_\_\_\_\_

6. Patient age (if older than 90, simply indicate >90): \_\_\_\_\_ 7. Patient Sex:  Male  Female

8. Reason for hospitalization: \_\_\_\_\_

9. Other conditions/co-morbidities: \_\_\_\_\_

10. Was the patient taking any of the following medications that are known to increase the risk for falls or fall-related injury? (Mark all that apply)

Anticoagulants  Antidiabetic agents  Cardiovascular agents  Corticosteroids  
 Psychotropics  Analgesics  Anticonvulsants  Anticholinergics  
 Other: \_\_\_\_\_  No, the patient was not taking any of these medications

11. Ambulatory status at time of fall (Mark all that apply)  Not ambulatory  With assist of 2 (hands-on)  
 With assist of 1 (hands-on)  With assistive device  Stand by assist  Independent  Unknown

12. Where did the fall occur?  Inpatient care area  12a. Where specifically in inpatient care?

Emergency department  
 Therapy area (PT, OT, ST)  
 Radiology/imaging area, including mobile  
 Outside area  
 Other: \_\_\_\_\_

Beside  
 Chairside  
 Bathroom  
 Hallway  
 Other: \_\_\_\_\_

13. Did staff assist the patient (hands on) during the fall?

Yes  No  
 Yes  No  
 Unknown

13a1. If a gait belt was not used, was one available?  
 Yes  No  
 Unknown

13b. Was the fall observed?  Yes, by staff  Yes, by family, visitor or other patient  No

14. If unassisted and not observed, how did staff discover the fall?

Patient found on floor  Notified by family/friend/other patient  
 Reported by patient  Patient calling for help/pusing call light  
 Alarm sounding  Unknown  
 Other: \_\_\_\_\_

15. Describe the fall (Provide details on how and where the fall occurred, how it was discovered, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Was the patient injured as a result of the fall?

Yes  No  
16a. What was the type of injury? (Mark all that apply)  
 Abrasion or Skin Tear (not requiring sutures or steri-strips)  Hematoma/Bruising  
 Laceration (requiring sutures or steri-strips)  Pain  
 Fracture  Dislocation  
 Intracranial injury  Other: \_\_\_\_\_

16b. What was the extent of harm to the patient as a result of the fall?  
 Minor: Application of dressing, ice, cleaning of wound, limb elevation, topical medication, bruise or abrasion  
 Moderate: Suture, application of steri-strip/skin glue, splinting or muscle/joint strain  
 Major: Surgery, casting, traction, consultation for or internal injury or need for blood products  
 Death

17. Additional clinical treatments and/or monitoring that occurred as a result of the fall (Mark all that apply):

No additional treatments and/or monitoring  
 Transfer, including transfer to higher level care area within facility, or transfer to another facility  
 Increased observation  Additional physiological exams  
 Lab tests  Imaging studies  
 Surgical/procedural intervention  Respiratory support  
 Increased length of stay  Additional medication therapy, including change in pre-incident doses  
 Other: \_\_\_\_\_

18. Mark the action that most clearly describes what the patient was doing or trying to do when the fall occurred.

Undergoing a procedure/treat  Changing position (e.g. in bed, chair)  
 Reaching for an item  
 Ambulating w/assistance  Toileting/on commode w/assistance  
 Ambulating w/o assistance  Toileting/on commode w/o assistance (left alone)  
 Transferring w/assistance  Transferring w/o assistance (left alone)  
 Transferring w/o assistance  Ambulating to bathroom w/assistance  
 Dressing/undressing  Ambulating to bathroom w/o assistance  
 Dressing/undressing related to showering  Dressing/undressing related to toileting  
 Showering  Performing personal hygiene in bathroom (unrelated to toileting)  
 Other: \_\_\_\_\_

19. If the fall was related to toileting, when was the last time, prior to the fall, the patient was toileted?

Two hours or less  More than two hours  Unknown

20. Was the patient using an assistive device at the time of the fall (i.e. cane, walker, wheelchair, etc)?

Yes  No  Unknown  
20a. What was the assistive device? \_\_\_\_\_  
20b. Did the assistive device contribute to the fall? If so, how? \_\_\_\_\_

21. Did any equipment or furniture contribute to the fall (i.e. alarm, bed rail, call light, IV pole, chair, etc)?

Yes  No  Unknown  
21a. What was the equipment or furniture? \_\_\_\_\_  
21b. How did the equipment or furniture contribute to the fall? \_\_\_\_\_

22. Was a fall risk assessment documented for this patient?

Yes  No  Unknown  
22a. What was the patient's score on the fall risk assessment? \_\_\_\_\_  
22a1. Was the patient determined to be at risk for a fall?  
 Yes  No  Unknown  
22b. Why was no fall risk assessment documented? \_\_\_\_\_

23. Prior to this fall, has the patient fallen while hospitalized?

Yes, during this admission  No  
 Yes, during a previous admission  Unknown

24. Which of the following interventions were in place and being used to prevent falls or fall injury for this patient? (Mark all that apply)

Assistive device  Patient and family education  
 Bed alarm  Patient placed close to nurses' station  
 Chair alarm  Physical/occupational therapy, includes exercise or mobility program  
 Bed in low position  Purposeful rounding  
 Call light/personal items within reach  Sitter  
 Gait Belt  Supplemental or area lighting  
 Hip and/or joint protectors  Toileting regimen  
 Medication change  Non-slip floor mats  Video monitoring  
 Non-slip footwear  Supplemental or area lighting  
 Commode  Visible identification of patient as being at risk for fall (e.g., falling star)  
 Not to be left alone while toileting  Orthostatic vital signs monitoring  Other: \_\_\_\_\_

25. Which organizational factors may have contributed to the event? (Mark all that apply)

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 manager)  
 Health information technology (e.g. electronic health record)

26. Which patient factors may have contributed to the event? (Mark all that apply)

Dizziness/vertigo  Weakness  
 Hypotension  Incontinence/urgency  
 Cognitive impairment  Procedure within last 24 hours  
 Overestimated ability  Sensory impairment (vision, hearing, balance, etc.)  
 Impulsive behavior  Other: \_\_\_\_\_  
 Neurological comorbidities (e.g. previous CVA, MS, Parkinson's Disease)

CAPTURE Falls Collaborative Members: Please use the Know Falls System at <https://unmcrcap.unmc.edu> to complete this form electronically. Contact the UNMC CAPTURE Falls Team at [capture\\_falls@unmc.edu](mailto:capture_falls@unmc.edu) for assistance.



# Factors that Influence Staff Decisions to Report Fall Events



CAPTURE Falls Roadmap Fall Event and Rate Reporting



**Falls more likely to be recorded in incident reports**

**Falls less likely to be recorded in incident reports**

- Staff belief that reporting improves patient safety
- Staff belief that reporting protects against legal responsibility

- Poor access to computerized reporting
- Non-reporting by role models
- Absence of training on reporting
- Absence of a fall definition
- Self-perceived responsibility for a fall
- Perceived blame from others



# Fall Rates

CAPTURE Falls Roadmap Fall Event and Rate Reporting



Key outcome of your  
fall risk reduction  
program

- Calculate falls as a rate
  - Considers impact of census
- Normalized rates (x falls/1000 patient days) allow for valid comparisons:
  - With hospitals of varying size and/or census
  - Over time within hospitals when census varies
- Standardized definitions allow for valid comparisons with peer hospitals



# How to Calculate a Fall Rate?



CAPTURE Falls Roadmap Fall Event and Rate Reporting

## CAPTURE Falls Fall Rate Calculator

### **Total Falls**

*Include all unassisted, assisted, non-injurious and injurious falls that occur in inpatients (acute care, skilled (swing bed), observation, and inpatient hospice)*

$$\text{Total Fall Rate} = \frac{\text{\# total falls}}{\text{total patient days}} \times 1000$$

### **Inpatient Days**

*Number of days inpatients received care based on midnight census; include acute, skilled (swing bed), and inpatient hospice patients; exclude newborns and acute rehab patients*



### **Observation Hours / 24**

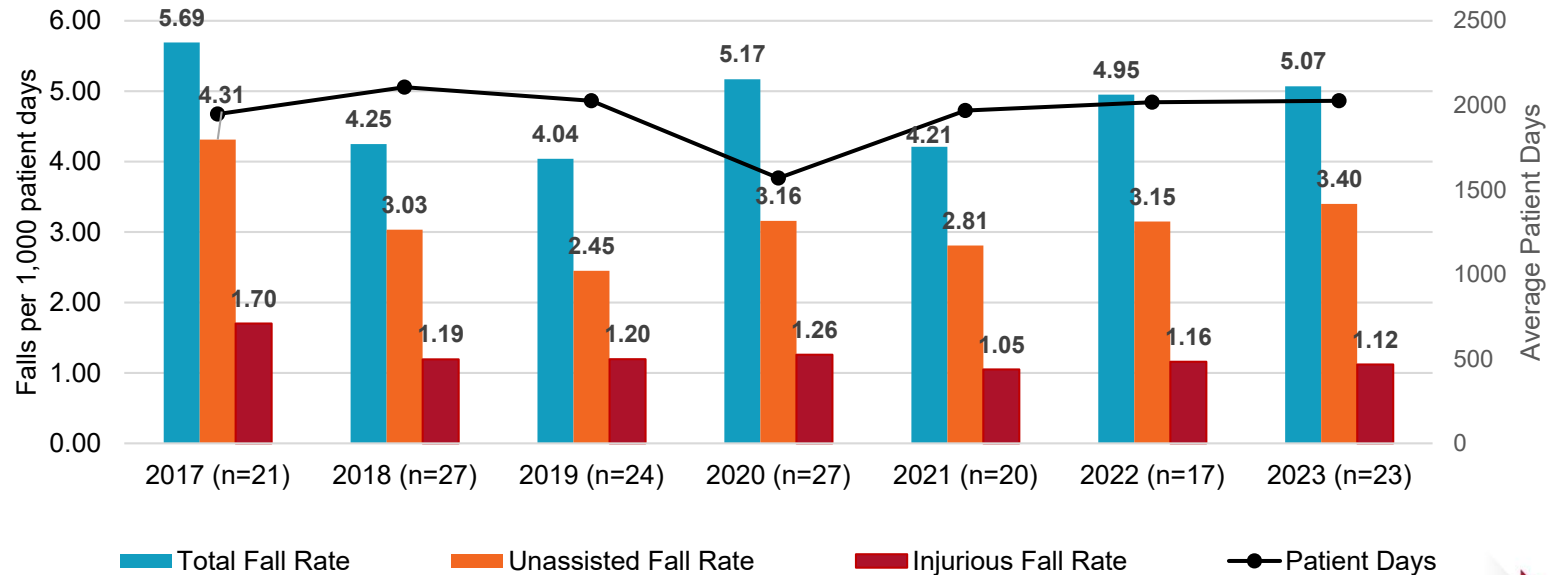
**to Establish Observation Patient Days**  
*Number of hours patients who are not admitted as inpatients and not counted in the midnight census receive care in the hospital setting*



# CAPTURE Falls Collaborative Annual Rate Benchmark



**CAPTURE Falls Collaborative  
Fall Rate Benchmarks 2017 - 2023**



# Why Track an Unassisted Fall Rate?

CAPTURE Falls Roadmap Fall Event and Rate Reporting



## All Falls Are Not Created Equal

“When falls tend to occur with assistance, it suggests that staff have identified at-risk patients and are in attendance during mobilization activities....”

“...a more appropriate patient safety goal is reducing unassisted falls, which pose the greatest preventable risk of injury.”

“...we would argue that an assisted fall, particularly during mobilization, is not necessarily a failure for the hospital staff and should not be treated as such.”



# Why Track an Unassisted Fall Rate?



CAPTURE Falls Roadmap Fall Event and Rate Reporting

## All Falls Are Not Created Equal

“Unassisted falls...uniquely reflect quality of care in that they occur when staff members are absent, unaware that the patient needs assistance, or unable to help for some other reason.”

“...attempts to prevent all falls could discourage appropriate patient mobilization.”





# Relationship between Fall Assistance and Patient Injury



## CAPTURE Falls Roadmap Fall Event and Rate Reporting

### Krauss et al (2007)

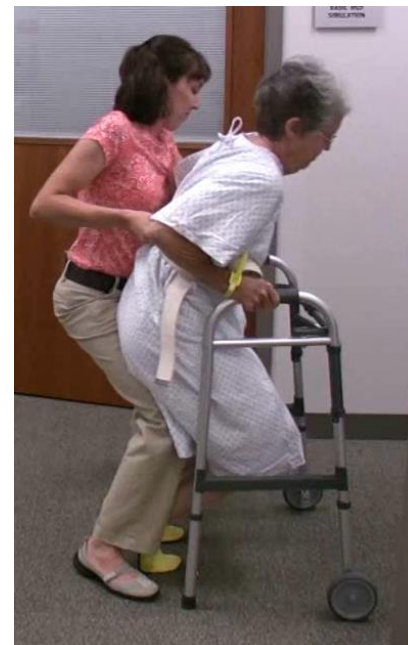
- Based on 3,962 falls from 8 Midwestern Hospitals from 2001-2003, the **odds of injury for an unassisted fall were 1.83 times that of an assisted fall**
- “Even if fall rates remain the same, increasing the proportion of falls that are assisted by a staff member could help decrease injury rates”

### Staggs et al (2014)

- Based on 154,324 falls reported to the NDNQI in 2011, the **odds of injury for an unassisted fall were 1.59 times that of an assisted fall**

### Venema et al (2019)

- Based on 353 falls reported by 17 rural Nebraska hospitals in 2012-2014, the **odds of a fall resulting in injury were 3.7 times greater if a fall was assisted without a gait belt vs. assisted with a gait belt**



# Fall Assistance as an Organizational Outcome



CAPTURE Falls Roadmap Fall Event and Rate Reporting



% of total falls that are **assisted** falls (*ideally* without injury)



% of total falls that are **unassisted** falls (with and without injury)



# Using Your Fall Rate Data



## CAPTURE Falls Roadmap Fall Event and Rate Reporting

### Monitor trends in rates

- How are rates changing over time?
- How do changes in practice relate to changes in events and rates?
- Consider using a run chart to examine trends over time

### Benchmarking

- External to similar organizations (ideally CAHs and small rural hospitals) who use the same fall definition
- *CAPTURE Falls Collaborative is the only CAH-specific benchmark of which we are aware!*

### Share information

- Communicate and share rates with staff, leaders, and board
- Keep these outcomes visible, but be mindful of what you recognize and reward



# Be Mindful of What You Recognize and Reward



CAPTURE Falls Roadmap Fall Event and Rate Reporting

*From:*

- \_\_\_ days since our last fall



*Toward:*

- \_\_\_ days since our last *unassisted* fall
- \_\_\_ % of assisted falls this quarter or year



## **Objective 5:**

**Determine strategies for education of staff on fall event reporting**



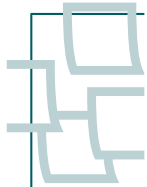
# Fall Definition and Types: Staff Education



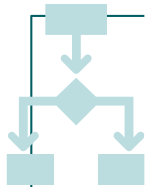
## CAPTURE Falls Roadmap Fall Definition



Describe the definition of a fall used your facility



Compare/contrast unassisted vs. assisted falls and non-injurious vs. injurious falls



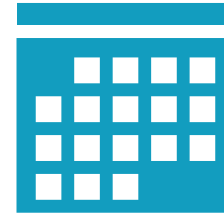
Classify falls based on type and outcome



New employee orientation



Annual education



Fall Prevention Awareness Week (September)



Patient Safety Awareness Week (March)



# Fall Definition and Types: Staff Education



CAPTURE Falls Roadmap Fall Definition

1

Unassisted fall  
with no injury

2

Unassisted fall  
with injury

3

Assisted fall  
with no injury

4

Assisted fall  
with injury

5

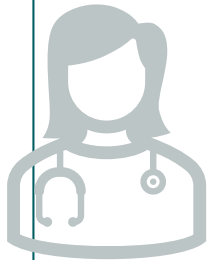
“Intentional”  
fall



# Fall Event and Rate Reporting: Staff Education



CAPTURE Falls Roadmap Fall Event and Rate Reporting



- Describe why fall events need to be reported and documented
- Explain what should be documented on a fall event report
- Practice completing and submitting a fall event report
- Describe what happens after a fall event report is submitted
- Interpret a fall rate



New employee  
orientation



Annual education



Fall Prevention  
Awareness Week  
(September)



Patient Safety  
Awareness Week  
(March)





# Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting



Lessons learned  
and anecdotes from  
our work



Shift in mindset for some regarding what 'counts' as a fall

- Assisted falls count as a fall
- Minor injuries counting as an injury



Change in definition and increased awareness can result in increased fall rates (at least initially)

- May be counting more incidences as falls than you did prior
- Increasing awareness of falls and what counts as a fall may contribute to increased reporting of falls



Mindful of different circumstances that might affect fall rates

- One or more patients who experience repeat falls
- Mobility program implementation – an increase in assisted falls
- Double-check your math when computing the fall rate denominator

# Resources: Fall Definition



## [CAPTURE Falls Roadmap Fall Definition](#)

- ✓ AHRQ Common Formats for Event Reporting – Hospital Version 2.0 Definition of a Fall
- ✓ Fall Definition and Types Handout
- ✓ Research Paper – Factors Associated with Unassisted and Injurious Falls
- ✓ Editorial Paper – Tension Between Promoting Mobility and Preventing Falls



# Resources: Fall Event and Rate Reporting



[CAPTURE Falls Roadmap Fall Event and Rate Reporting](#)

- ✓ Agency for Healthcare Research and Quality Fall Prevention Toolkit Section 5.1 How do you measure fall and fall related injury rates?
- ✓ Fall Definition and Types Handout
- ✓ Research Paper – Factors that Influence Fall Event Reporting
  
- ✓ CAPTURE Falls Event Learning Form
- ✓ Fall Rate Calculator



# Summary

1

Multiple resources exist for post-fall clinical assessment. Checklists and decision trees may provide helpful structure to staff.

2

A standardized fall definition, including consideration of fall types and outcomes, can help create a shared understanding of what counts as a fall

3

Encourage staff to report all fall events to facilitate documentation of the incident *and* opportunities to learn from each fall

4

Track total, unassisted, and injurious fall rates and monitor trends over time to take a holistic view of the primary outcomes of your fall risk reduction program



# Post-Education Evaluation

Evaluation survey link:

<https://redcap.link/6loll0q7>

QR code:



- Responses are anonymous
- Feedback will be used to inform future improvements to this education



# Join us for Next Month's CAPTURE Falls Virtual Educational Series

- 6-month education series on fall risk reduction in Critical Access and rural hospitals led by the University of Nebraska Medical Center's CAPTURE Falls program
- All sessions will be held on the 3<sup>rd</sup> Wednesday of the month, 1-2pm CT via Zoom.
- All session recordings are posted under the Quality Improvement tab on the following website: [Rural Hospital Programs | Health & Human Services \(iowa.gov\)](https://www.ura.org/programs/health-human-services)

Date	Fall Risk Reduction Topic
February 21, 2024	Interprofessional Approaches to Reducing Fall Risk; Defining a Fall
March 20, 2024	Fall Risk Assessment
April 17, 2024	Fall Risk Reduction Interventions
May 15, 2024	Auditing Fall Risk Reduction Practices
June 19, 2024	Post-Fall Clinical Assessment; Fall Event Reporting
July 17, 2024	Post-Fall Huddles



# References and Resources

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2. Agency for Healthcare Research and Quality. Preventing falls in hospitals toolkit: 5. How do you measure fall rates and fall prevention practices? Available at <https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/measure-fall-rates.html#5-1> Accessed June 12, 2024.
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# References and Resources

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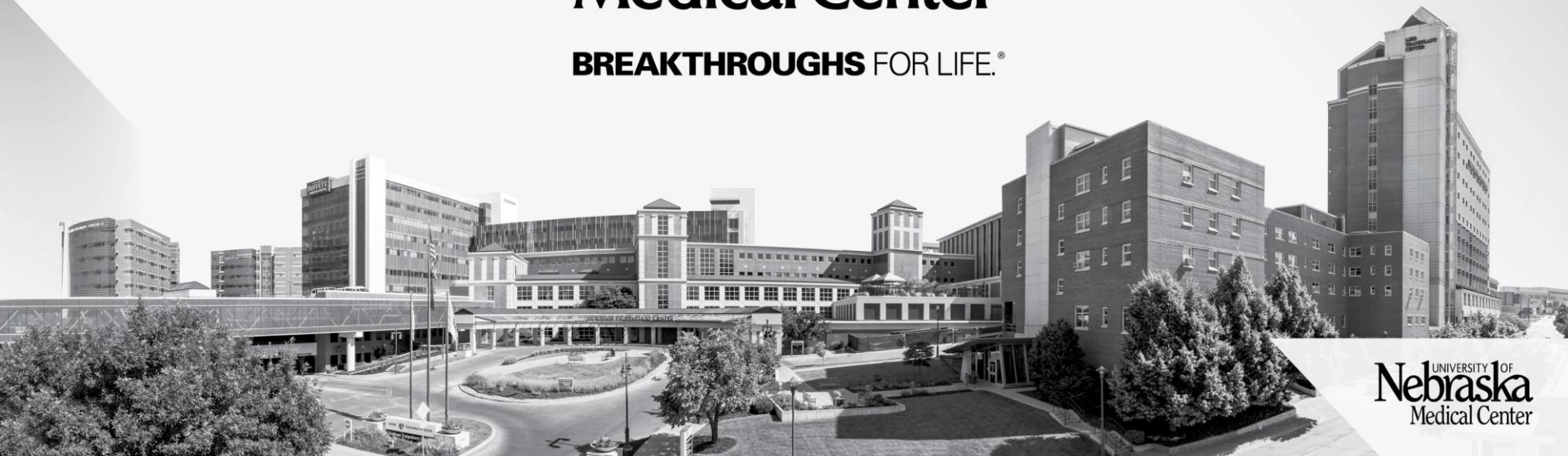






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