CAPTURE Falls Virtual Educational Series
Session 6: Post-Fall Huddles

Victoria Kennel, PhD
Assistant Professor
College of Allied Health Professions, Department of Allied Health Professions Education, Research, and Practice

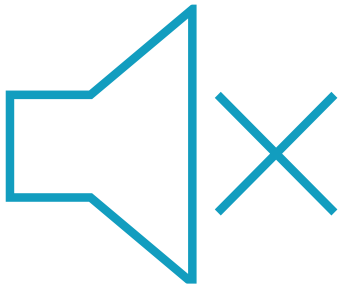
Dawn Venema, PT, PhD
Associate Professor
College of Allied Health Professions, Department of Rehabilitation Sciences

University of Nebraska Medical Center

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: Past and Current Funding for the CAPTURE Falls Program

This work has been/is supported by Grant numbers R18HS021429 and R03HS024630 from the Agency for Healthcare Research and Quality, and the Nebraska Department of Health and Human Services Office of Rural Health Medicare Rural Hospital Flexibility Program.

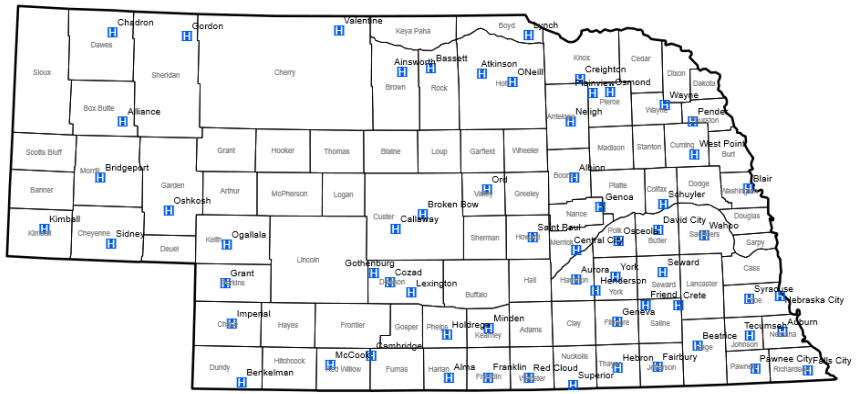


Image Credit: https://dhhs.ne.gov

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

University of Nebraska Medical Center
- Dawn Venema, PT, PhD
- Victoria Kennel, PhD
- Matt McManigal, BS, MS
- Anne Skinner, RHIA, MS
- Jenae Murry, OTR/L
- Fran Higgins, MA, ADWR
- Robin High, MBA, MA
- Jane Potter, MD
- Linda Sobeski, PharmD
- Mary Wood

Nebraska Coalition for Patient Safety
- Emily Barr, OTD, MBA, OTR/L, BCG
- Carla Snyder, MHA, MT(ASCP)SBB
- Katherine Jones, PT, PhD

Nebraska Medicine
- Kellie Clapper, OTR/L
- Christina Reames, ARPN, CNS
- Regina Nailon, RN, PhD

University of Nebraska-Omaha
- Roni Reiter-Palmon, PhD

Methodist Hospital
- Deborah Conley, MSN, APRN-CNS, GCNS-BC, FNGNA

University of Utah
- Joseph Allen, PhD

HD Nursing PSO
- Amy Hester, PhD, RN, BC
- Patricia Quigley, PhD, MPH, APRN

Nebraska Hospital Association
- Dana Steiner, BSN, MBA, CPHQ
- Amber Kavan , BSN, RN, CPHQ

Former and Current Students
- John Crowe, PhD
- Jill Knoell, PT, DPT
- Meagan Nyhoff, PT, DPT
- Caleb Schantz, PT, DPT
- Kristen Topliff, PT, DPT
- Michael Yoeger, PhD
- Yao Yao, BS, SPT

Introductions and Contact Information

Dawn Venema, PT, PhD

- 20+ years of experience in geriatric physical therapy
- Clinical expertise in fall risk management and mobility
  dvenema@unmc.edu

Victoria (Vicki) Kennel, PhD

- 10+ years of experience in industrial organizational psychology
- Quality improvement and organizational science expertise 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 3rd 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)

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.

https://www.unmc.edu/patient-safety/capturefalls/roadmap/index.html

Session 6 Objectives

1. Explain the purpose of a post-fall huddle
2. Discuss tools and strategies for facilitating and participating in post-fall huddles
3. Determine approaches for education of staff on post-fall huddles
4. Describe actions to support the implementation of post-fall huddles into practice

REVIEW: Post-Fall Clinical Assessment

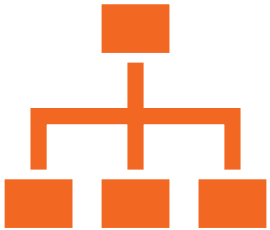
CAPTURE Falls Roadmap Post-Fall Clinical Assessment

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

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

REVIEW: 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

Objective 1:

Explain the purpose of a post-fall huddle

Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle

Team who convenes after a patient fall to gather and discuss information about the patient fall and factors that contributed to the fall, and to identify changes necessary to reduce the risk of another fall for that patient

Evidence to Support the Use of Post-Fall Huddles

CAPTURE Falls Roadmap Post-Fall Huddle

Recommended practice in many fall risk reduction toolkits	An intervention with good adoption over time	Associated with fewer repeat falls	Safety norms affect perceived success of huddles	Staff participation in huddles affects perceptions of teamwork and safety culture
VHA National Center for Patient Safety Falls Toolkit AHRQ Fall Prevention Toolkit (*root cause analysis) CAPTURE Falls Toolkit	Use of post-fall huddles increased from 40 to 80% in our first CAPTURE Falls cohort	Greater proportion of falls followed by a post-fall huddle was associated with a lower repeat fall rate	Organizational and group safety norms had a positive association with perceptions of huddle effectiveness, explained in part by demonstration of good leadership by the huddle leader	Participation in at least one or more huddle was associated with more positive perceptions of aspects of team structure, team leadership, situation monitoring, teamwork across departments, handoffs/transitions, and organizational learning

Reiter-Palmon R, Kennel V, Allen JA, Jones KJ, Skinner AM. Naturalistic Decision Making in After-Action Review Meetings: The Implementation of and Learning from Post-Fall Huddles. *J Occup Organ Psychol*. 2015;88(2):322-340. doi:10.1111/joop.12084

Allen JA, Reiter-Palmon R, Kennel V, Jones KJ. Group and Organizational Safety Norms Set the Stage for Good Post-Fall Huddles. *J Leadersh Organ Stud*. 2019;26(4):465-475. doi:10.1177/1548051818781820

Jones KJ, Crowe J, Allen JA, et al. 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 Serv Res*. 2019;19(1):650. Published 2019 Sep 9. doi:10.1186/s12913-019-4453-y

Objective 2:

Discuss tools and strategies for facilitating and participating in post-fall huddles

Post-Fall Huddle: Who to Include

CAPTURE Falls Roadmap Post-Fall Huddle

Ideal

All relevant parties

- Staff providing direct care for the patient at the bedside
- Other members of interprofessional team involved in the patient's care at the time of the fall
- Patient
- Family/caregiver(s)

Reality

Whomever is available

- Time of day and workload level often limits who participates in the huddle
- Patient ability to participate
- Family/caregiver(s) availability to participate
- Consider creative ways to engage members of the interprofessional team (e.g., use technology; team members 'on-call' for a huddle)

Post-Fall Huddle: Who to Lead

CAPTURE Falls Roadmap Post-Fall Huddle

Huddle facilitator

- Accountable for calling and leading the huddle
- Ensures all aspects of the fall event are reviewed
- Elicits and clarifies multiple versions of the story
- Encourages positive behaviors and limits negative behaviors from huddle team members

Ideal

Trained facilitator

- Experienced in guiding conversations about fall events
- Skilled in encouraging participation and dialogue among all team members in the huddle
- Ability to keep team focused on learning for improvement

Reality

Whomever is available even if not a trained facilitator

- Nurse assigned to the patient
- Lead/charge nurse
- Fall risk reduction team member

Post-Fall Huddle: What to Discuss

CAPTURE Falls Roadmap Post-Fall Huddle Pocket Guide

CAPTURE FALLS:
POST-FALL HUDDLE GUIDE

1. Establish facts…a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient's plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?

Ideal

Structured questions for each huddle

- Generate a clear understanding of the fall based on multiple perspectives
- Ask clarifying questions and 'why?' to identify actual issues and contributing factors

Reality

Minor modifications as needed

- Stick as close to the guide as possible
- Avoid getting 'stuck' in checklist mode
- Accommodate unexpected variations in the situation
- Allow space for ambiguity and follow-up needed

Post-Fall Huddle: What to Discuss

CAPTURE Falls Roadmap Post-Fall Huddle Guide and Documentation Form

Medical Record Number _____ **Date of Fall**_____ **Time of Fall**_____

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

Remember: Patients fall because their center of mass is outside their base of support.

During the huddle look for specific answers and continue asking "*why?*" until the root cause is identified.

1. Establish facts:

1.a. Did we know this patient was at risk? ___ YES ___ NO

1.b. Has this patient fallen previously during this stay? ___ YES ___ NO

1.c. Is this patient at high risk of injury from a fall? (ABCS)

___ Age 85+ ___ Brittle Bones ___ Coagulation ___ Surgical Post-Op Patient

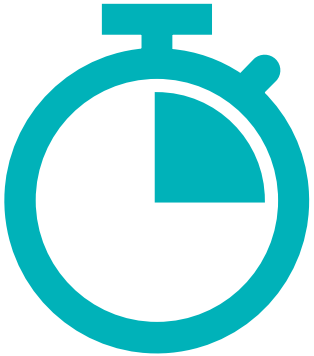
2. Establish what patient and staff were doing and why.	HAND WRITTEN NOTES
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). **Ask why multiple times.**	
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	

3. Determine underlying root causes of the fall.	HAND WRITTEN NOTES
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	

4. Make changes to decrease the risk that this patient will fall or be injured again.	HAND WRITTEN NOTES
ASK: How could we have prevented this fall? ☐ Need to consult with physical/occupational therapy about mobility/positioning/seating ☐ Need to consult with pharmacy about medications	
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	
Ask: What patient or system problems need to be communicated to other departments, units or disciplines?	

Post-Fall Huddle: When to Conduct

CAPTURE Falls Roadmap Post-Fall Huddle



Ideal

As soon as possible

- Immediately after the fall
  - Within 15 minutes
- Preserve adequate recall of important details relevant to the fall
- Changes identified to reduce fall risk should be implemented as soon as possible

Reality

It depends

- The nature of the fall
- Time necessary to complete post-fall clinical assessment
- Emotional state of huddle team members
- Availability of members of the interprofessional team

Post-Fall Huddle: Where to Meet

CAPTURE Falls Roadmap Post-Fall Huddle

Ideal

Location where the fall occurred

- Similar environment may trigger better recall of the circumstances of the fall
- Allows for adequate assessment of environmental factors that may have contributed to the fall

Reality

A feasible physical/virtual space

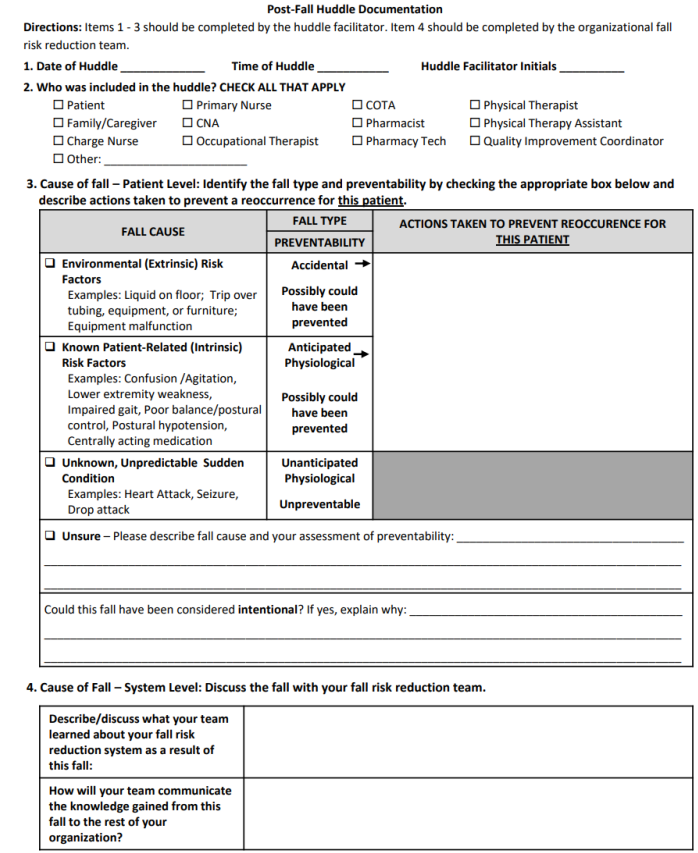
- A space similar to where the fall occurred or space for the team to openly discuss the event
- Consider patient ability to engage/be involved
- Consider use of technology to engage other team members and/or family

Post-Fall Huddle: After the Huddle

CAPTURE Falls Roadmap Post-Fall Huddle

Post-Fall Huddle: Documentation

CAPTURE Falls Roadmap Post-Fall Huddle Guide and Documentation Form



Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 should be completed by the organizational fall risk reduction team.

1. Date of Huddle _____ **Time of Huddle** _____ **Huddle Facilitator Initials** _____

2. Who was included in the huddle? CHECK ALL THAT APPLY

☐ Patient ☐ Primary Nurse ☐ COTA ☐ Physical Therapist
☐ Family/Caregiver ☐ CNA ☐ Pharmacist ☐ Physical Therapy Assistant
☐ Charge Nurse ☐ Occupational Therapist ☐ Pharmacy Tech ☐ Quality Improvement Coordinator
☐ Other: _____

3. Cause of fall – Patient Level: Identify the fall type and preventability by checking the appropriate box below and describe actions taken to prevent a reoccurrence for this patient.

FALL CAUSE	FALL TYPE / PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
❑ **Environmental (Extrinsic) Risk Factors** Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	**Accidental** → **Possibly could have been prevented**	
❑ **Known Patient-Related (Intrinsic) Risk Factors** Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	**Anticipated Physiological** → **Possibly could have been prevented**	
❑ **Unknown, Unpredictable Sudden Condition** Examples: Heart Attack, Seizure, Drop attack	**Unanticipated Physiological** **Unpreventable**	

❑ **Unsure** – Please describe fall cause and your assessment of preventability: _____

Could this fall have been considered **intentional**? If yes, explain why: _____

4. Cause of Fall – System Level: Discuss the fall with your fall risk reduction team.

Describe/discuss what your team learned about your fall risk reduction system as a result of this fall:	
How will your team communicate the knowledge gained from this fall to the rest of your organization?	

Key Data to Document

- Date
- Time
- Participants
- Causes/factors that contributed to the fall
- Actions to implement to reduce the risk of another fall

Fall Cause and Type

Accidental	Anticipated Physiological	Unanticipated Physiological
• Falls that occur due to environmental hazard (e.g. slip, trip)	• Falls that occur in patients with known intrinsic risk factors (weakness, cognitive impairment, medication side effect, etc.) • Most in-hospital falls are in this category	• Falls that occur due to an unpredictable medical event, such as seizure, stroke, or syncope

Morse JM, Tylko SJ, Dixon HA. Characteristics of the fall-prone patient. Gerontologist 1987;27:516-22.
Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHSA290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.

Objective 3:

Determine approaches for education of staff on post-fall huddles

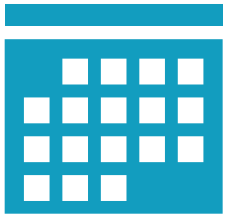
Post-Fall Huddle: Staff Education

CAPTURE Falls Roadmap Post-Fall Huddle

- Describe the purpose of a post-fall huddle
- Identify common factors that contribute to fall events and respective appropriate interventions
- Demonstrate effective huddle team member behaviors during a practice post-fall huddle

New employee orientation

Annual education



Fall Prevention Awareness Week (September)

Patient Safety Awareness Week (March)

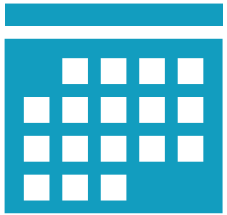
Post-Fall Huddle: Facilitator Education

CAPTURE Falls Roadmap Post-Fall Huddle

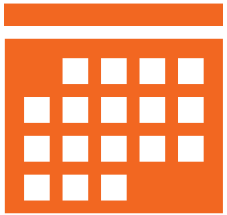
- Explain the intent of the questions that guide conversation in a post-fall huddle
- Create a climate in the huddle to encourage open and honest sharing and supportive discussion
- Structure the conversation to focus on ‘what’ and ‘why’, and not ‘who’, to identify areas for improvement
- Facilitate dialogue to ensure all perspectives and aspects of the fall event are reviewed and integrated
- Manage any negative team behaviors among attendees (e.g., blaming, overly critical comments, etc.)
- Summarize actions to implement to reduce the risk of another fall for this patient

New employee orientation

Annual education



Fall Prevention Awareness Week (September)



Patient Safety Awareness Week (March)

Post-Fall Huddle: Pocket Guide

CAPTURE Falls Roadmap Post-Fall Huddle Pocket Guide

CAPTURE FALLS:
POST-FALL HUDDLE GUIDE

1. Establish facts…a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient's plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation

POST-FALL HUDDLE
FACILITATOR TIPS

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the *front line to learn* about why a patient fell – actively listen and be slow to judge)
2. Ask probing questions (e.g., ask "*why?*" until root causes are identified)
3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person's contribution)
4. Give praise and acknowledge good work (e.g., say "thank you" and "nice job" when appropriate)
5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)

UNMC

Post-Fall Huddle: Staff and Facilitator Education

CAPTURE Falls Roadmap Post-Fall Huddle

CAPTURE Falls Post-Fall Huddle "Good" Example

*We also have a "Bad" Example Post-Fall Huddle

Objective 4:

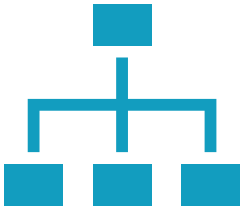
Describe actions to support the implementation of post-fall huddles into practice

Post-Fall Huddle: Implementation

CAPTURE Falls Roadmap Post-Fall Huddle

Incorporate use of post-fall huddles into fall risk reduction policies and procedures

Adopt the use of standard huddle guides and documentation forms



Conduct post-fall huddles after ALL types of falls – including those observed and assisted

Fall risk reduction team reviews post-fall huddle documentation in conjunction with each fall event report

Track completion of post-fall huddles as a fall risk reduction program process measure and monitor changes in repeat falls over time

Post-Fall Huddle: Implementation

CAPTURE Falls Roadmap Post-Fall Huddle

Lessons learned and anecdotes from our work

Creative approaches help to engage non-nursing professionals in a huddle

- Fall risk reduction team member 'on-call' for post-fall huddles
- Gather interprofessional team member input within 24 hours
- Email/system alert for written input on falls

Post-fall huddles after assisted falls are still helpful!

- Recognize behaviors that are consistent with safe transfer and mobility practices

Can reinforce what went well in addition to identifying areas for improvement

- Staff do a lot of things right – recognize adherence to policies and procedures

Resources: Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle

Education Resources:

- ✓ Webinar on Effective Huddles and Debriefs
- ✓ “Good” Post-Fall Huddle and “Bad” Post-Fall Huddle Videos
- ✓ Human Behavior and Fall Risk Reduction Handout

Example Huddle Tools:

- ✓ Post-Fall Huddle Guide and Documentation Form
- ✓ Post-Fall Huddle Pocket Guide
- ✓ Post-Falls Huddle Guide and Post-Fall Huddle/After Action Review

Summary

1. Post-fall huddles are intended to gather and discuss information about the patient fall and factors that contributed to the fall, and to identify changes necessary to reduce the risk of another fall for that patient

2. We can learn from all types of falls, so post-fall huddles should take place after every fall

3. Quality of the dialogue in a huddle matters – good huddle facilitation can help to clarify the story, contributing factors, and meaningful changes to reduce the risk of another fall

4. Track post-fall huddle completion and monitor repeat falls as indicators of success

Post-Education Evaluation

Evaluation survey link:
https://redcap.link/eo8dy3p4

QR code:

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

Thank You for Joining Us for the CAPTURE Falls Virtual Educational Series!

All session recordings are posted under the Quality Improvement tab on the following website:

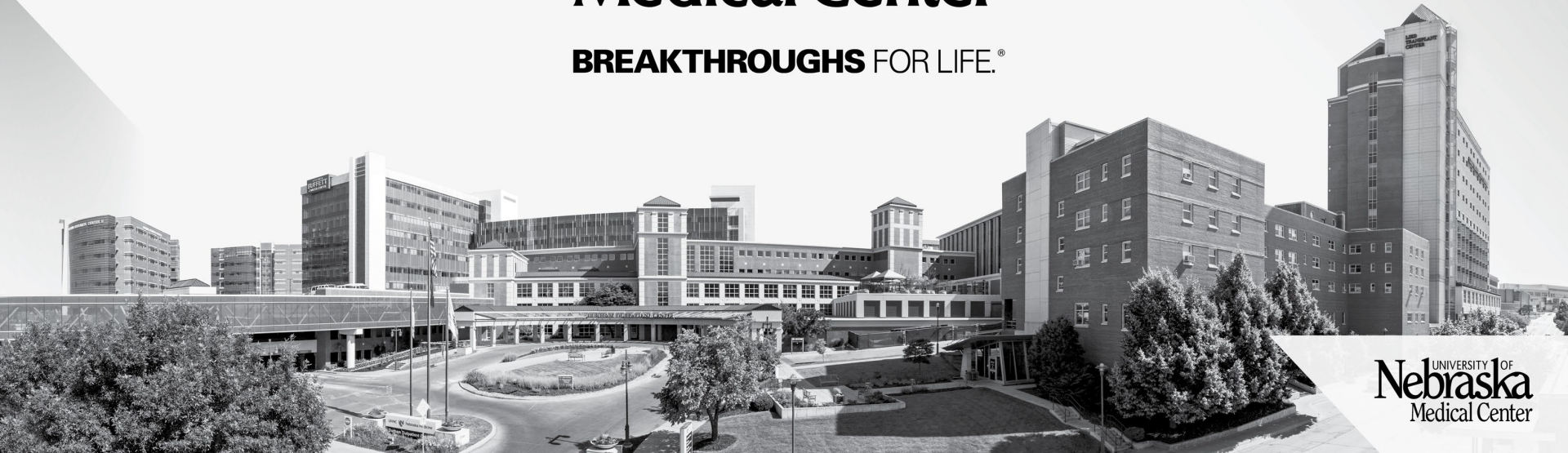
Rural Hospital Programs | Health & Human Services (iowa.gov)

References and Resources

1. CAPTURE Falls Website. Available at https://www.unmc.edu/patient-safety/capturefalls/ Accessed July 11, 2024.
2. CAPTURE Falls Roadmap. Available at https://www.unmc.edu/patient-safety/capturefalls/roadmap/index.html Accessed July 11, 2024.
3. US Department of Veteran's Affairs. VA National Center for Patient Safety Falls Toolkit Post Falls Huddle. Available at: https://www.patientsafety.va.gov/professionals/onthejob/falls.asp Accessed July 11, 2024.
4. Agency for Healthcare Research and Quality. Preventing falls in hospitals toolkit: 3.5 How should you assess and manage patients after a fall? Available at https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/practices.html#3-5 Accessed July 11, 2024.
5. Reiter-Palmon R, Kennel V, Allen JA, Jones KJ, Skinner AM. Naturalistic Decision Making in After-Action Review Meetings: The Implementation of and Learning from Post-Fall Huddles. *J Occup Organ Psychol*. 2015;88(2):322-340. doi:10.1111/joop.12084
6. Allen JA, Reiter-Palmon R, Kennel V, Jones KJ. Group and Organizational Safety Norms Set the Stage for Good Post-Fall Huddles. *J Leadersh Organ Stud*. 2019;26(4):465-475. doi:10.1177/1548051818781820
7. Jones KJ, Crowe J, Allen JA, et al. 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 Serv Res*. 2019;19(1):650. Published 2019 Sep 9. doi:10.1186/s12913-019-4453-y
8. CAPTURE Falls Post-Fall Huddle Pocket Guide. Available at https://www.unmc.edu/patient-safety/_documents/roadmap/post-fall-huddle-pocket-guide.pdf Accessed July 11, 2024.
9. CAPTURE Falls Post-Fall Huddle Guide and Documentation Form. Available at https://www.unmc.edu/patient-safety/_documents/roadmap/capture-huddle-guide-5-1.pdf Accessed July 11, 2024.
10. Morse JM, Tylko SJ, Dixon HA. Characteristics of the fall-prone patient. *Gerontologist* 1987;27:516-22.
11. Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHSA290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.

University of Nebraska Medical Center℠

BREAKTHROUGHS FOR LIFE.®



University of Nebraska Medical Center