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DEVELOPMENT OF A POST-FALL MULTIDISCIPLINARY CHECKLIST TO EVALUATE THE IN-PATIENT FALL

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BACKGROUND

Falls suffered by hospitalized patients are important reportable events. Approximately 4 - 6 % of inpatient falls result in serious injury. Recurrent falls or delayed recognition of injury can harm patients and represent a medico-legal risk. In 2010, our tertiary-care academic medical center reviewed current practice regarding falls prevention and assessment in order to develop a comprehensive falls prevention program. The committee found that there was no consistent practice in the assessment by nurses or physicians of inpatients who had fallen, either for injury or for conditions which might have led to the fall. A new systematic checklist for evaluation of the hospital faller was developed by a team consisting of nurses, hospitalists, and a medical unit director. We wished to develop an evidence-based multi-disciplinary checklist to facilitate evaluation, implementation of secondary prevention interventions and documentation following a hospital fall.

DESCRIPTION

The hospitalist and the general medical unit director reviewed relevant literature, consulted national experts, and drafted a multidisciplinary checklist, the UNMH Post-Fall/Huddle Tool, to be used by nurses and physicians in post-fall patient evaluation. The checklist was reviewed and revised with further input from key stakeholders including hospitalists, housestaff, and the adult Medical/Surgical Shared Governance Committee. It was implemented as part of a comprehensive falls prevention program 3 month pilot. The checklist prompts a three step process:

(1) an initial 7-item assessment by nursing staff to determine factors which would necessitate immediate evaluation by cross-covering physicians versus deferring evaluation to the primary team;
(2) a 5-item focused physical examination to be performed by a physician to assess the likelihood of injury and suggested diagnostic tests based on this examination; and
(3) an interdisciplinary face-to-face meeting between the evaluating physician and nurse to review 7 specific possible precipitating events and implement potential interventions.

The UNMH Post-Fall/Huddle Tool will be adapted into the electronic health record after pilot completion and evaluation. An educational presentation about falls and how to use the checklist was developed for residents and hospitalists. Use of the checklist was implemented in November, 2010. To date, nurses and residents report that the checklist is easy to use and that it facilitates a timely, multidisciplinary evaluation of patients who have fallen in the hospital.

POST - FALL ASSESSMENT TOOL

University of New Mexico
POST-FALL INTERDISCIPLINARY ASSESSMENT/HUDDLE TOOL

PART 1 – RN to complete this section (1 – 6)

1. Admitting Diagnosis(s): _____
2. Date & Time of fall: _____
3. Brief Description of fall: _____
4. Location of patient when fell: □ at bedside □ in bathroom □ in hallway □ other _____

5. Initial Nursing Assessment for Injury. *All falls should be evaluated by a physician or nurse practitioner/PA. Generally patients should have this evaluation urgently. Patients who fall and have ALL of the following characteristics may be evaluated less urgently (answer should be YES to all 7 characteristics), but always within 24 hours:*

□Yes □No Witnessed or assisted fall
□Yes □No Patient did not hit head
□Yes □No Patient did not experienced loss of consciousness
□Yes □No Patient is alert
□Yes □No No obvious laceration
□Yes □No No obvious new extremity deformity
□Yes □No Patient does not complain of pain

6. Date & Time Provider notified of fall: _____

PART 2 – Provider to complete this section (7-8)

7. Evaluation for consequences (Evaluate all of the following) **Date/Time of Provider Notified of fall**_____ **Signature of Provider** _____

□Yes □ No Laceration *Assess need for closure*
□Yes □ No Possibility of cervical spine injury (neck pain, new extremity numbness, diagnosis of rheumatoid arthritis) *CONSIDER cervical collar and C-spine series*
□Yes □ No Suggestion of rib fracture (chest wall pain, positive sternal compression test) *CONSIDER CXR or rib series*
□Yes □ No Suggestion of extremity fracture (decreased ROM, unable to bear weight) *CONSIDER extremity x-ray*
□Yes □ No Possibility of intracranial bleed (on anticoagulants, coagulopathy, thrombocytopenia, new focal neurological findings) CONSIDER *neuro vital signs, CT of head*

PART 3 – Provider to complete this section

8. Evaluation of fall prevention ***(With nursing staff)*** **Date/Time of Provider Evaluation** _____ **Signature of Provider** _____

□ ***Review if patient suffered loss of consciousness and if so, consider telemetry***
□ Review meds – consider stopping or decreasing sedatives, narcotics, anti-cholinergics
□ Review if patient has urinary catheter and whether it can be discontinued
□ Review if patient has SCDs (sequential compression device) and whether it can be discontinued
□ Review if patient is on telemetry and whether it can be discontinued
□ Review if patient has an IV, and whether it can be stopped or converted to a saline lock
□ Review if patient receiving PT/OT, if not, consider ordering PT evaluation

FINDINGS FROM PILOT IMPLEMENTATION

1. Improved confidence among nurses and residents evaluating in-patients who had fallen.
2. More consistent evaluation and treatment of in-patients who have fallen.
3. Better documentation of this evaluation.
4. Improved communication between physicians and nurses.
5. Desire to move from paper-based systems to an electronic health record

PLANNED NEXT STEPS

1. Web-based training of emergency medicine and surgical housestaff in use of the tool.
2. Dissemination of tool via POGOe
3. Development of electronic version.
4. Study comparing outcomes of in-patients who feel before and after implementation of tool.

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