

Decision-Tree: Determining Type of Falls and Preventability

Draft 3

As part of the post fall interventions, the VISN 8 Patient Safety Center is designing an algorithm for decision-making that will result in classification of the fall by type of fall based on the immediate cause(s) of a fall.

This algorithm also provides two classifications of preventability for accidental and anticipated physiological falls: clearly or likely preventable, and clearly or likely unpreventable. Determination of preventability is guided by DHHS Office of Inspector General's, Determining Preventability¹.

Application

This algorithm guides two decisions: Type of Fall and Preventability, through a 4 step, group decision process.

After a fall occurs, begin with Step 1.

Step 1: Conduct the Post Fall Huddle. A post fall huddle takes place as soon as possible, within 15 minutes after the fall. This immediacy is VERY IMPORTANT because events of fall are fresh in the mind of the patient, nursing staff, and anyone who may have witnessed the fall), to determine the immediate cause(s) for the patient's fall to occur. Usually the post fall huddle is lead by the patient's RN. Other members of the unit's interdisciplinary team, such as Hospitalist, PT, etc., if present on the unit should participate. The PATIENT should be a part of the huddle if all possible, and family if present.

Step 2: Determine the Immediate Cause of the Fall. During the Post Fall Huddle, determine the immediate cause of the fall. The guiding question to this analysis is: What was different this time the patient was doing the activity (getting out of bed, transferring to the chair, walking to the bathroom) , compared to all the other times the patient did the very same activity, but this time the patient fell (all other times the patient did not fall). That guiding question will inform the huddle team and patient about the immediate cause.

Step 3: Determine the Type of Fall. Based on the immediate cause, the type of fall is determined: Accidental, Anticipated Physiological, Unanticipated Physiological² and Intentional (Behavioral Fall).

**Accidental Fall:* Fall that occur due to due extrinsic environmental risk factors or hazards: spills on the floor (such as water or urine), tripping on clutter, tubing / cords on the floor, or errors in judgment, such as not paying attention or leaning against a curtain or unlocked furniture.

**Anticipated Physiological Falls:* Factors associated with known fall risks as indicated on the Morse Fall Scale that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur due to the patient's existing physiological status, history of falls, and decreased mobility upon assessment.

**Unanticipated Physiological Falls:* Factors associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale: unexpected orthostasis; extreme hypoglycemia; stroke; heart attack; seizure, etc.

** Intentional (Behavioral) Fall:* Patient who has behavioral issues and intentionally positions his/her body from a higher level to a lower level.

Step 4. If Accidental and Anticipated Physiological Falls, determine Preventability After team consensus about immediate cause and type of fall, the post fall huddle team should determine if the fall was preventable or unpreventable. The framework for this determination is as follows:

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

This decision-strategy will enable clinicians, administrators, patient safety and risk managers to learn from fall events by examining circumstances and causes of a fall (and resulting injury).

¹ Levinson, D. R., (2010, Nov). Adverse events in hospitals: National incidence among Medicare beneficiaries. DHHS. OEI-06-09-00090

² Morse J. (1997). *Preventing patient falls*. CA: Sage.

Decision Tree for Types of Falls

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