Guide to conducting a post fall huddle

What is a Post Fall Huddle?

A Post Fall Huddle is a multidisciplinary team review which takes place as soon as possible after a fall.

The huddle involves multidisciplinary team members and the patient/carer/family. Ideally it occurs before the end of the shift, while the event is still fresh in people's minds.

Post Fall Huddles occur after the immediate post fall care for the patient has been provided.

The purpose of the huddle

- Discuss contributing factors leading to the fall and hear the incident from the patient's perspective.
- Staff to quickly review/develop care plans in collaboration with the patient and /or families / cares to prevent future falls.
- Identify whether the harm or risk of harm was related to patient factors, environment or processes.
- Enhance teamwork and communication.
- Communicate fall risk factors and new strategies at safety huddles and clinical handover.

What do huddles look like?

Post Fall Huddles are a safe space encouraging open and honest conversation. They are an opportunity to reflect on the event and learn from errors. They are facilitated by a team leader, such as the nurse in-charge, an experienced clinician, or the Unit Manager.

Huddles start with an introduction to ensure all participants understand the purpose and process.

It is important to include the patient, carer, family

Where appropriate, the patient and their carer/family are included as part of the Post Fall Huddle. Multiple perspectives exploring why the fall occurred helps the teams to understand the contributing factors. It also promotes a partnership model in developing a sustainable risk mitigation plan developed in partnership with. the patient/carer/family.

What questions are explored in the huddle?

Questions include:

- What was happening at the time of the fall? – how, where and why did the patient fall?
- What was the patient attempting to do at the time of the fall?
- Are there signs of clinical deterioration that need investigating that may have contributed to the fall?
- Consider the 5 whys to find the root cause.
- Importantly - What can we learn from this incident?
- What can we do now to reduce the risk of another fall?
- Has the care plan been revised, documented and communicated?

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Welcome

- The registered nurse/team leader welcomes, patient and family and/or carer (if available) and muilti discilinary team to the huddle and explains the purpose of the post fall huddle

What happened

- If possible have the patient/family/carer explain what happened in their own words
- The clinician who was present or who found the patient describes the fall and environment
- Identify the root cause by repeatedly asking "why" until the underlying cause is revealed (5 Whys)

Identifying contributing factors

- Multiple perspectives explore why the fall occurred and identify any contributing factors or clinical deterioration for further investigation.
- Discuss prevention strategies to reduce the risk of another fall
- Provide the patient/family /carer in discussion about their ongoing care needs and how to communicate with staff for assistance if required

Actions following huddle

- Identify who is responsible to ensure the patients care actions are followed up
- Update patient care plan and implement revised strategies
- Document the post fall huddle
- Communicate contributing factors to the fall and updated care plan at clinical handover and safety huddles

Lessons Learnt

- Identify any lessons learnt and communicate these at team meetings
- Use the information to inform improvement intitatives

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