# FALLS WALKING ROUNDS: TEAM-BASED INVESTIGATION AND ACTION PLANNING

The last time we all checked there probably were still only 24 hours in a day. At work we have our 8 or 12 hour shift to "git 'er done" as Larry the Cable Guy repeatedly reminds us. A resident/patient fall in skilled nursing facility or other healthcare location causes considerable distress to the resident/patient who fell, their family and their team of care givers. This event also consumes a lot of time that could be spent in a much better way for everyone involved, most importantly the resident/patient.

Healthcare facilities have now spent years focusing on what to do to prevent falls and minimize injury from falls that unfortunately continue to occur in our settings. We have fine tuned the environmental, clinical and people issues connected to fall prevention and appropriate response after a fall has occurred. Most teams are making significant progress in this area. The hurdle that remains in most organizations is the lack of an organized team approach to this problem when it does occur.

Team based walking rounds for falls are what some teams have come to describe as "proactively reactive" because the information revealed sets the tone for continued proactive changes in systems for fall prevention and individualized care planning.

Who is on our Trans-disciplinary Team? The Resident, the Family, the C.N.A., Licensed Nurse, Therapy representative, Recreation/Activities, Dietary, Social Services, Restorative, Maintenance, Housekeeping, Laundry, Pastoral Care, Administrator, DNS and Physician. WOW, that is a very big team!

Think about the current post fall process in your organization. When a fall occurs, the front line working at the time of the fall does a good job of assessing the person for injury, notifying the family and MD, they document the post fall assessment, fill out the paper work inclusive of the event report and dutifully place said form in the appropriate box/file folder/clip board/or under the appropriate door. There is a chance that there was even an action taken to prevent recurrence, usually in the form of an environmental approach such as an alarm, mat at the bedside, low bed, or maybe an educational approach. We are grateful when the front line takes action in a timely fashion. The action taken will meet the requirements until the person responsible for oversight of this system gets to work the next day to assure the investigation, "i" dotting, "t" crossing, and care

*"Falls Walking Rounds: Team-Based Investigation and Action Planning"*
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plan updates to prevent recurrence are done correctly and completely. The person charged with this responsibility may lead a weekly or daily team conference regarding the fall. This person might contact team members not present at this conference to update them on the fall, ask them how they can help, inform them of what others are doing to prevent another fall. It is not surprising to learn that each fall takes a minimum of 2.5 hours of collective staff time to assure the correct assessment, documentation, communication, investigation, action and follow up has occurred. The problem related to a post fall process done in this manner is that it is fragmented and frequently ineffective.

Falls Walking Rounds needs to be a daily habit. It is sufficient to have the rounds on Monday through Friday to get consistency. Each day, the team will review the fall(s) from the day previous. Friday, Saturday, and Sunday falls are reviewed on Monday. The reason this works is that if your team routinely has many falls to review on a Monday and it is very time consuming. The risk prompts teams to temporarily or permanently implement a process on weekends.

The team members mentioned above all attend. This large group of professionals takes the medical record, the event report, and WALKS TO THE RESIDENT/PATIENT. Note the difference here from team members at varying times in varying locations discussing the fall with or without the chart and with or without the resident/patient and their environment. The fragmented approach makes teams feel as if they are chasing their tail.

An organized approach includes the identification of a time daily for these rounds to occur. Effective Meeting Rules apply. Establish a start time and end time. Most facilities are now averaging 15 minutes daily, but no longer than 30 minutes. There are often days where you do not have rounds because nobody fell. Teams have established a rule of 5 Minutes per Resident or maybe even 10 minutes per resident as they get started and establish a rhythm. They determine where the team will initially gather, who will bring the medical record, who is the attendance taker, who is the note taker who will document in the Interdisciplinary Progress Note and update the care plan, and who is the time keeper. Detailed planning and adherence to meeting rules results in good participation. We do not have time to waste and team members will be more likely to not attend if the meeting is not well run. The Administrator must hold all team members accountable for showing up and taking an active role. Varying team members may otherwise not feel obligated to attend because the fall process owner is not their boss. Each team member has a role, which may overlap the roles of others and indeed the expertise of others. For instance, maintenance checks w/c and bed brake function, bed rail or bath grab bar security, call light function and lighting. The housekeeper would look at room layout, clutter and the condition of the floor (housekeepers know a lot about the resident/patient), the C.N.A. would review the current plan of care for compliance, the dietary representative looks at lab results and nutritional/hydration status, the nurse reviews any changes in condition and medication, inclusive of pain management and urinary status, the therapist looks at positioning, function and devices already utilized, the social worker at behavior, depression and socialization needs, the activities professional at the need for individualized meaningful life activities, the restorative staff at the success of current restorative programs. Never underestimate who will notice what on any given day.

Rarely is the resident/patient overwhelmed by the presence of this large team if you set up the scenario correctly. Explain the team's concern about identifying the cause of the fall and doing what we can to prevent more falls and do this in advance of entering the resident/patient's room. HIPPA rules apply, and most teams look at this just like they do if a physician is going to see a resident in their room. If your facility HIPPA Policy precludes team members such as housekeepers and maintenance to have access to clinical information, CHANGE IT, it is your policy.

The beauty of this process is the efficiency and effectiveness of a team based approach to identifying causal factors, action to be taken to prevent recurrence, and establish if there is any evidence of abuse or neglect. The involvement of all disciplines results in a well rounded knowledge of overall fall prevention approaches for individual residents.
This process can be expanded to include other events such as skin tears, bruises, burns, elopement, pressure ulcer identification and other events which occur and demonstrate risk to resident care and safety.

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