CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #1
October 23, 2012

Event Reporting
CAPTURE Falls Event Reporting

- Event reports are for quality improvement purposes only. Not part of the medical record. Not discoverable by Nebraska Rev. Stat. Section 71-7904 to 71-7913. (See contract).
- IRB approved data collection form
- Completed forms are stored in a locked filing cabinet
- Data is stored in a secured server
CAPTURE Falls Event Reporting

Internal Purposes

- Organizational Learning
- Evaluate impact of hospital’s Fall Risk Reduction Program
- Internally Benchmark Fall Rates over time
- Ultimate Goal: Decrease Risk of Falls

External Purposes

- Generalize to all CAHs
- Evaluate impact of CAPTURE Falls across project hospital
- Externally Benchmark Fall Rates across hospitals
- Ultimate Goal: Decrease Risk of Falls
CAPTURE Falls Event Reporting

Definition of a fall:

For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient’s body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).

(Source: AHRQ Common Formats. Available at: 
https://www.psoppc.org/c/document_library/get_file?uuid=ba35e27f-3985-45b2-b1b6-2f0751d8d3ca&groupId=10218 )
CAPTURE Falls Event Reporting

Policy

1. Complete an Event Report for all falls that are consistent with the AHRQ definition of a fall.
   
   • Report both Unassisted and Assisted Falls
   
   • Report both Injurious and Non-injurious Falls
Why report assisted and noninjurious falls?

Hypothesis

- Rates of assisted falls will increase
- Rates of injurious falls will decrease
- Patients will be safer
CAPTURE Falls Event Reporting

Policy

2. Submit fall events to UNMC using the CAPTURE Falls Event Reporting form

• Standardized form elements enables valid aggregation and comparison of data within and across project hospitals
Form Elements

- Definition
- (1) Medical Record Number
- (5) Principal Dx
- (8) When last visually assessed? (audit rounding)
- (9) Where did fall occur….use other for outpatients as desired
- (13) Tell the story of the fall…most important
- (14 – 16) Include all minor harm…anything you have to monitor

Definition of fall: For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient’s body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).

CAPTURE Falls Event Reporting Form and Post-Fall Huddle Documentation

1. Patient Medical Record Number:  
2. Patient Admission Date:  
3. Patient Age (if over 10) notate + or –:  
4. Patient Gender: □ Male □ Female  
5. Patient’s principal admitting diagnosis:  
6. Date of Fall:  
7. Time of Fall:  
8. Prior to fall, when was the last time patient was visually assessed? □ < 1 hr □ 1–2 hrs □ > 2 hrs  
9. Where did the fall occur? CHECK ONE: □ Inpatient care area: Please specify (e.g., bedside, bathroom, etc.) □ Special care area (e.g., ICU, CCU, NICU) □ Lab, including pathology and blood bank □ Emergency department □ Operating room or procedure area □ Therapy area (PT, OT, ST) □ Radiology/imaging area, including mobile □ Outside area (i.e., grounds of this facility) □ Other: Please specify  
10. Was the fall unassisted or assisted? □ Assisted □ Unassisted □ Unknown  
11. Was the fall observed? □ Yes □ No □ Unknown  
12. Who observed the fall? □ Staff □ Visitor, family or another patient, but not staff  
13. Describe the fall, how it occurred, where it occurred, how it was discovered (a narrative may be attached):  
14. Did the patient sustain a physical injury as a result of the fall? □ Yes □ No □ Unknown  
15. What type of injury was sustained? CHECK ONE, IF MORE THAN ONE, CHECK MOST SEVERE: □ Dislocation □ Fracture or significant bruising □ Intracranial injury □ Laceration requiring stitches □ Other: Please specify  
16. After discovery of the fall, what was the extent of harm to the patient (i.e., extent to which the patient’s functional ability is expected to be impaired subsequent to the incident and any attempts to minimize adverse consequences)? CHECK FIRST OPTION THAT IS APPLICABLE: □ Death: Dead at time of assessment □ Severe harm: Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life. □ Moderate harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm. □ Mild harm: Minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay. □ No Harm: Event reached patient, but no harm was evident □ Unknown
Form Elements

• (18) Additional treatments (specify?)
• (20) Who was notified? (families frequently not notified)
• (21) What was the patient doing? (essential to understand causes)
• (22) Assisted and supervised are not the same!
• (25 – 27) Fall risk assessment documentation... are assessments useful?
• (28) Multiple fallers
• (29) Universal and targeted interventions
Form Elements

• (31 - 32) Feedback???
  • Polypharmacy in older adults is a huge problem
  • Request pharmacy assistance as needed

OR

• Include de-identified medication list and we will complete this section

• Non-compliance not informative
  • Education? Did they truly understand the risk?
  • Cognitive Impairment?
  • Overestimation of abilities?
Form Elements

1. Previous fall
2. Previous interventions
3. Preventable
4. How preventable (realistic)
5. Who is in the huddle?
6. What did you discuss?
7. Additional comments
8. Action plan
CAPTURE Falls Event Reporting

Submitting the Form to UNMC

1) Scan and email a copy to askinner@unmc.edu,

2) Mail a copy using the supplied postage-paid envelope. E-mail Anne Skinner at askinner@unmc.edu to request additional postage paid envelopes.

3) Mail a copy to: CAPTURE Falls, Attn: Anne Skinner
984420 Nebraska Medical Center
Omaha, NE 68198-4420
REMINDERS

Monthly Call: November 27, 2012 at 2:00 p.m. CST

Webinar #1: December 11, 2012 at 10:00 a.m. CST
Fall Risk Assessment: Best Practices for Nursing Staff in the Acute Care Setting

Webinar #2: January 15, 2013 at 10:00 a.m. CST
Fall Risk Reduction: Best Practices for Nursing Staff in the Acute Care Setting

Continuing Education Units Available for Webinars 1 & 2 if viewed live.

CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls
CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce