CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls

Monthly Collaborative Call #6
April 23, 2013  2:00 – 2:30 p.m. CST

Updates and Potential Relationship Between Falls and CAUTI
AGENDA

• Updates
  • Web Site http://www.unmc.edu/patient-safety/capture_falls.htm
  • Teamwork Perceptions Questionnaire—Fall Risk

• Reminders
  • Event Reports
  • Data Collection…fall rates

• Lessons to share with the community
  • Fall event reveals multiple opportunities
  • Barriers and Successes in Implementation
What else would you like to see??

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PURPOSE AND AIMS OF CAPTURE FALLS

The purpose of the CAPTURE Falls project is to implement the safe practice of inpatient fall risk reduction supported by a culture of safety, teamwork, and sensemaking. We are training interprofessional teams to collaborate and “make sense” of the risks associated with inpatient falls at three levels: (1) the patient, (2) the microsystem (unit), and (3) the organization. We are implementing this intervention—Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls—in 19 Nebraska hospitals, 16 of which are Critical Access Hospitals (CAHs) with 25 or fewer beds.

AIMS:

- **Aim 1:** We are partnering with 19 Nebraska hospitals to develop a customized CAPTURE Falls action plan to improve the structure and process of fall risk reduction.
- **Aim 2:** We are supporting 19 Nebraska hospitals to implement a customized CAPTURE Falls action plan.
- **Aim 3:** We are evaluating the implementation of the CAPTURE Falls action plans in 19 Nebraska hospitals using the Context, Input, Process and Product (CIPP) model.

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All webinars recorded and available

Webinars

Action Plan
Fall Event Reporting
Webinars
Monthly Support Calls
Resources

Educational Webinars support Fall Risk Reduction Teams as they implement and sustain evidence-based changes in the structure and process of their fall risk reduction program. For practical tools to improve fall risk reduction, click on the Resources link in the left menu.

- March 13, 2013 — Integrating Management of Geriatric Syndromes and Frailty into Fall Risk Reduction Tools (Printable handout)

- February 12, 2013 — Medication Review: Best Practices for Fall Risk Reduction in the Acute Care Setting (Printable handout)
Teamwork Perceptions Questionnaire—Fall Risk Reduction

Why? Part of our research to....

1. Understand how hospital personnel think about the relationship between teamwork and fall risk reduction

2. We expect many staff not involved in direct patient care may answer "don’t know/not applicable"
   - We expect that the percent responding "don’t know/not applicable" will change over time as more staff become aware of their role in fall risk reduction
   - We will repeat the survey in June 2014 to measure these changes

3. Link perceptions of teamwork/fall risk reduction with HSOPS

4. New area of research related to patient safety....
Reminders

Fall event reports

1. Timely submission enables feedback
2. Definition of fall includes assisted falls (i.e. near misses that support system learning)
3. Minimize missing data
   - Primary dx
   - Age
   - Activity at time of fall
4. Post-fall huddle… One hospital reported that staff want to be included in huddles and appreciate that they are conducted to facilitate learning
Request 2012 data to calculate fall benchmarks

Aim 2: We will support 19 Nebraska hospitals to implement a customized CAPTURE Falls action plan by:

1. conducting site visits;
2. collecting, interpreting, and sharing aggregate de-identified information from reported fall data;
3. calculating benchmarks for fall and fall injury rates;
4. conducting webinars to improve knowledge and skills regarding fall risk reduction;
5. conducting monthly conference calls to share successes and barriers to implementation;
6. conducting a “Lessons Learned” conference at the end of the first year of the project;
7. disseminating resources on our website (www.unmc.edu/patient-safety/capture_falls.htm).
Calculating 2012 Fall Benchmarks

FALL RATE DATA - Please complete the table below

<table>
<thead>
<tr>
<th>Inpatient Patient Days</th>
<th>Based on midnight census. Include acute and skilled (swing bed) patients. Do not include newborns and acute rehab.</th>
</tr>
</thead>
</table>

Observation Hours

Observation Hours / 24 = Obs Patient Days

Total Patient Days (Patient Days + Obs Patient Days)

Number of All Inpatient Falls - Include Injurious, non-Injurious and assisted falls.

Fall Rate per 1,000 Patient Days - ($\text{# of All Inpatient Falls} / \text{Total Patient Days}) \times 1000$

Number of INJURIOUS Inpatient Falls

INJURIOUS Fall Rate per 1,000 Patient Days - ($\text{# of INJURIOUS Falls} / \text{Total Patient Days}) \times 1000$

INJURIOUS Fall Rate per 1,000 Patient Days - ($\text{# of INJURIOUS Falls} / \text{Total Patient Days})$
Event Report

Unassisted fall in bathroom

- 65 y/o male; primary dx recurrent accidental falls (??)
- Initial fall risk assessment results—At high risk; noted to be “weak, confused”
- PT/OT not noted to be interventions
- Multiple medications known to increase risk
- Pt. found on floor in bathroom, stating he “had to go right now” but foley catheter in place (why? indication?)
  - Increase risk of infection when urinary catheter in place
    - Per day = 5%; per week = 25%; per month = 100%
Foley Catheters ARE indicated for:

- ✔ Acute urinary retention or obstruction
- ✔ Perioperative use in selected surgeries
- ✔ Assist healing of perineal and sacral wounds in incontinent patients
- ✔ Hospice/comfort/ palliative care
- ✔ Required immobilization for trauma or surgery
- ✔ Chronic indwelling urinary catheter on admission
- ✔ Accurate measurement of urinary output in the critically ill patients (intensive care)

Foley Catheters ARE NOT indicated for:

- ✔ Urine output monitoring OUTSIDE intensive care
- ✔ Incontinence (place on toileting routine, change frequently)
- ✔ Prolonged postoperative use
- ✔ Patients transferred from intensive care to general units
- ✔ Morbid obesity
- ✔ Immobility (turn patient q 2 hours, up in chair)
- ✔ Confusion or dementia
- ✔ Patient request
Lessons to Share…

- A change you have made that is working well
  - 2 hospitals reported improvements in signage using magnets to communicate that a patient is at risk of falls and the level of assist required (see picture on next slide). Hospitals are making their own magnets, ordering from local print shop, or ordering them from vendor.
  - 1 hospital reported using yellow non-slip bootie to indicate fall risk and green to indicate that the patient is not at risk; presence of booties supplements the yellow wrist band, which can be hard to see.

- Factors that make it easy/hard to implement changes in fall risk reduction
  - 1 hospital wants to implement the Johns Hopkins Tool but they are not receiving a response from the contact….UNMC will follow up with a contact that we have.
CAPTURING Falls with improved signage

- Falling man – pt at risk for falls
- B – Bed rest
- H – Hoyer Lift
- 1 – Transfers with assist of 1
- 2 – Transfers with assist of 2
- I – Independent in transfers
- SBA – Stand by assist with transfers

All items defined per policy
REMINDERS

Monthly Call: May 28, 2013 at 2:00 p.m. CST

Webinar #4: May 7, 2013 at 10:00 a.m. CST
Best Practices in Conducting Effective Meetings to Support Fall Risk Reduction
Victoria Kennel, MA
Register for this webinar at:
https://www2.gotomeeting.com/register/818083890

Resources posted at
http://www.unmc.edu/patient-safety/capture_falls.htm
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Enter “capture falls” in google