CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #6
May 28, 2013  2:00 – 2:30 p.m. CST

Update on Post-Fall Huddles
AGENDA

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

• Lessons to share with the community
  • Fall event reveals multiple opportunities
  • Barriers and Successes in Implementation
Frailty and Geriatric

FALLS, FRAILTY AND GERIATRIC SYNDROMES
March 13, 2013 Webinar – Integrating Management of Geriatric Syndromes and Frailty into Fall Risk Reduction Tools

Video instructions:

- Make certain your speakers are turned on before you click the play button on the video above.
- The slides will change as the webinar progresses, but you can fast forward by hovering the cursor along the bottom of the slide and dragging the bar along.
- To watch the video in full screen, click the grey box in the lower right corner with the four arrows.
- To exit full screen mode, push your Escape key.
- A pdf version of the PowerPoint, labeled “Printable Handout,” is the first link in the
Teamwork Perceptions Questionnaire—Fall Risk Reduction

So Far…

Response Rate about 50%...

Please respond if you have not already done so!
Fall Risk Reduction Multi-Team System

**Patient & Family**
Teach back

**Core Team**
Physician
Nurse performs FRA
PT consults re mobility
Pharmacist reviews medications
All educate patient & family

**Coordinating Team = Fall Risk Reduction Team**
Holds core team accountable for reliability of processes

**Ancillary & Support Services**
Radiology is informed of fall risk and transfer strategy during handoff
Housekeeper can turn on alarms

**Administration**
Asks about fall rates
Provides time for coordinating team to meet
Holds coordinating team accountable for auditing reliability of fall risk interventions

**Contingency Team = Post Fall Huddle**
• Of 117 fall events reported 8/12 – 4/13, 47 (40%) included a post-fall huddle

• 13 of 17 hospitals reported at least 1 huddle
  – Range of huddles per hospital = 1 – 7
  – Median number of huddles = 3

• Presence/absence of injury not related to conducting huddle
  – 43% (18/42) of injurious falls had a post-fall huddle
  – 39% (29/75) of noninjurious falls had a post-fall huddle
Implementation is the hard part...

Not as interprofessional as we would like...

![Bar chart showing participation in post-fall huddles by discipline.](chart.png)
Lessons to Share...

• What are barriers to implementing post-fall huddles with multiple disciplines?

  – One hospital reported difficulty getting the huddle completed in a timely fashion due to difficulty getting desired staff together at the same time (e.g. direct care nursing staff, QI/RM, PT, Pharm). This is especially true for falls during nights or weekends.

  – This raised the question: When is the best time to complete a huddle? Immediately with fewer people, or later on with more disciplines?
Lessons to Share…

• When is the best time to complete a huddle?
  
  – One hospital reported using a “hybrid” model: convening a huddle immediately after the fall with those available (such as RN, CNA, charge nurse, patient/family). If others (PT, Pharm, etc) aren’t immediately available, their input is sought as soon as it is feasible.

  • This is helpful in making immediate changes to the plan of care. For example – should this patient have 2 assist the next time they are transferring?

  • This is also helpful in that it still allows for other disciplines to share their expertise, even if they weren’t available at the time of the fall.
Lessons to Share...

• What have you done that has led to success in implementing post-fall huddles?
  – One hospital reported that attaching huddle documentation to the fall event report has helped make their implementation more reliable.
  – One hospital reported that computerized documentation has helped staff who weren’t there at the time of the fall get information more quickly.
  – Hospitals were also reminded that the most current version of the CAPTURE Falls reporting form (available on the website) has triggering questions about whether PT or Pharm consult may be helpful. This may facilitate the “hybrid” huddle that was discussed.
Lessons to Share... A change you plan to make:

• One hospital asked if others are using a “fall kit” at admission (a packet of visible identifiers). If so, what are others including in their fall kit?
  
  • One hospital shared that their kit includes a yellow bracelet, blanket, and socks. These are given to all pts deemed to be at risk. Kits are sorted by sock size. Blankets are laundered and re-used. Patient education material is not truly part of the kit, but all patients are provided with a laminated sheet re: fall risk reduction with other admission paperwork.
  
  • One hospital suggested yellow gowns could also be used as a visual identifier. But, is there some point at which visual identifiers overstep patient privacy boundaries? See next slide...
• Are visual identifiers of fall risk (signage, yellow socks, etc) in violation of HIPPA?
  – The Nebraska Medical Center has raised this question with their legal counsel in the past, and it was determined that there are no HIPPA violation concerns.
  – The legal rep compared it to isolation signage: Being in the hospital requires certain signage to keep patients, staff, and visitors safe in that environment.
Lessons to Share... A change you plan to make:

• One hospital asked about alarms – are others using them, types, etc?
  • One hospital shared that in their facility, any patient who is at fall risk uses a bed alarm, a tab alarm in the chair, and a tab alarm in the bathroom. Maintenance staff have added brackets to walls behind toilets, so that tab alarms can hang there.
  • We also discussed hourly rounding to reduce frequency of alarms sounding because patient needs are already addressed, regular maintenance checks on alarm systems, and strategies to reduce failure to set alarms, such as empowering individuals (anyone – nursing, housekeeping, etc) to check if alarm is set anytime they are in the patient’s room.
Event Report

Assisted fall in bathroom (0248) resulted in no harm

- 84 y/o male; primary dx CHF exacerbation
- Initial fall risk assessment results—At high risk
- PT/OT not noted to be interventions
- Cardiovascular and diuretic medications
- While amb. to BR with 2 assist, gait belt, walker; pt. became weak in legs and was lowered to floor
- Post-fall huddle included charge nurse, primary nurse, CNA
- Action to be taken: Use bedside commode instead of amb. to BR
- Concerns: Increased weakness? PT consult? Orthostatic hypotension? Impact of continued mobility limitation on discharge planning?

- Good example of a fall that occurred when PT and Pharm were not available, yet they could provide valuable input using a hybrid huddle model.
Summary

• Conducting post-fall huddles supports immediate learning of front-line staff to address task, judgment, & coordination errors

  – Task Error: Forget to perform a well understood task (e.g. turn on bed alarm)

  – Judgment Error: The best decision not made in familiar/unfamiliar process (e.g. cognitively impaired pt. left alone in bathroom; amb. Pt. with COPD from shower to bed)

  – Coordination Error: Knowledge is not handed-off between shifts, disciplines, departments (e.g. information about previous fall not shared at shift change)
REMINDERS

Monthly Call: June 25, 2013 at 2:00 p.m. CST

Webinar #5: June 11, 2013 at 10:00 a.m. CST
Best Practices in Teamwork to Support Fall Risk Reduction
Katherine Jones, PT, PhD
Register for this webinar at:
https://www2.gotomeeting.com/register/821903898

Resources posted at
http://www.unmc.edu/patient-safety/capture_falls.htm
CAPTURE Falls

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