Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #7
June 25, 2013  2:00 – 2:30 p.m. CST

More Lessons Learned from Event Reports…
and information about staffing levels
AGENDA

• Housekeeping

• Aggregate summary of event reports to date

• Discussion of specific event report

• Lessons to share with the community
Housekeeping

- Email Katherine if you are interested in participating in a panel discussion at CAH Quality Conference Nov. 6 – 7, 2013 regarding your hospital’s lessons learned from participation in CAPTURE Falls
  - CAPTURE Falls will support your travel to the conference located in Kearney, NE

- Update on Teamwork Perceptions Questionnaire
  - 57% Response rate all responses
  - 52% Response Rate complete responses
  - Results will be sent to your hospital by Aug. 31 or sooner
As compared to one year ago, our hospital's current fall risk reduction practices seem...

- Don't know: 16.5%
- Much Worse: 0.1%
- Worse: 0.5%
- About the Same: 31.8%
- Better: 42.9%
- Much Better: 8.3%
Summary of Event Reports to Date

- 143 events reported by 15 hospitals
- Mean 9.5/hospital
- Range 4 – 24/hospital
- 76% Unassisted
- 74% known at risk

Harm Levels
- 68% No Harm
- 26% Mild Harm
- 1% Mod Harm
- 2% Severe Harm
## Summary of Event Reports to Date

<table>
<thead>
<tr>
<th>Contributing Factors</th>
<th>All Events (n=143)</th>
<th>No Harm (n=97)</th>
<th>Harm (n=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>66%</td>
<td>66%</td>
<td>71%</td>
</tr>
<tr>
<td>Weakness</td>
<td>43%</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Sensory Impairment</td>
<td>32%</td>
<td>31%</td>
<td>38%</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>27%</td>
<td>27%</td>
<td>31%</td>
</tr>
<tr>
<td>Impulsive Behavior</td>
<td>24%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Policies</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Alarms</td>
<td>21%</td>
<td>25%</td>
<td>14%</td>
</tr>
<tr>
<td>Incontinence/urgency</td>
<td>12%</td>
<td>11%</td>
<td>14%</td>
</tr>
</tbody>
</table>
### Summary of Event Reports By Harm

<table>
<thead>
<tr>
<th>Activity at Time of Fall</th>
<th>All (n=143)</th>
<th>No Harm (n=97)</th>
<th>Harm (n=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toileting</td>
<td>29%</td>
<td>23%</td>
<td>45%</td>
</tr>
<tr>
<td>Ambulating</td>
<td>19%</td>
<td>22%</td>
<td>12%</td>
</tr>
<tr>
<td>Changing Position</td>
<td>11%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Transferring</td>
<td>10%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Missing</td>
<td>11%</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>9%</td>
<td>11%</td>
<td>1%</td>
</tr>
</tbody>
</table>
# Summary of Event Reports By Harm

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No Harm (n=97)</th>
<th>Harm (n=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>72</td>
<td>79.5</td>
</tr>
<tr>
<td>Female</td>
<td>57%</td>
<td>67%</td>
</tr>
<tr>
<td>Judgment Error</td>
<td>24%</td>
<td>50%</td>
</tr>
<tr>
<td>Assisted</td>
<td>28%</td>
<td>10%</td>
</tr>
<tr>
<td>Time of Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0001 - 0600</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>0601 - 1200</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>1201 - 1800</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>1801 - 0000</td>
<td>21%</td>
<td>38%</td>
</tr>
</tbody>
</table>
Factors Associated with Harm

Slightly more likely that

1. medications contribute
2. sensory impairment contribute

Somewhat more likely that

1. Patient is toileting
2. Patient is 75 years of age or older
3. Judgment is involved
4. It is in the evening 1801 - 0000

(Caveats: These are patterns; they do not imply causation; it is possible that reporting about harmful falls is more complete than reporting about nonharmful falls.)
Event Report

Unassisted fall in patient room reveals need to include family in the team

- 84y/o female; primary dx Cancer
- Initial fall risk assessment results—At high risk
- At 2120, patient found on floor during hourly rounding attempting to toilet
  - Bed alarm not on; alarm often off when family in room because son likes to sit on edge of bed
  - Hospitalized approx. 2 weeks
  - Medications include cardiovascular meds and diuretics
Event Report Discussion

Should family member be educated and empowered to arm bed alarm?

Pro: Provides clear role designation for family

Con: From a legal/risk management standpoint we should not delegate direct patient care to a family member. Sitting on the bed is an infection control issue.

Resolution: Offer family member an alternative seat next to bed and explain need for bed alarm. Explain family member role as performing a hand off to staff when they leave patient.

Goal: Clarity of family member’s roles/responsibilities as a member of the multiteam system.
Lessons to Share…

- A change you have made that is working well
- A change that you plan to make
- Organizational factors that make it easy/hard to implement changes in fall risk reduction
Lessons to Share…

Organizational factors that make it easy/hard to implement changes in fall risk reduction

One hospital inquired about the associate between nurse staffing and falls. The literature is mixed.

- Some studies indicate an inverse relationship (ie greater numbers of nursing care hours per patient are associated with fewer falls; and greater numbers of RNs relative to LPNs and CNAs are associated with fewer falls).
- Other studies indicate no relationship but note the inability to find a relationship may be due to the multifactorial nature of falls, or the fact that many studies use average staffing rates over time, which “smoothes out” high and low spikes in staffing.
Lessons to Share…

More info on staffing….  
A recent well-done study that used staffing data at the shift level (did not average it over time or across units) reported the following for med-surg units:

- A 7% ↑ in falls for every 1 hour ↓ in nursing care hrs per pt shift  
- A 15% ↑ in injurious falls for every 1 hr ↓ in nursing care hrs per pt shift  
- A 11% ↑ in falls for every 10% ↓ in RN hrs relative to LPN/CNA hrs  
- A 30% ↑ in injurious falls for every 10% ↓ in RN hrs relative to LPN/CNA hrs

This study also controlled for patient acuity, census, hospital size, and time of day.

Lessons to Share...

Organizational factors that make it easy/hard to implement changes in fall risk reduction

One hospital reported that their physicians would like patients to be independent in their rooms to facilitate discharge. However, they often put patients on “auto pilot” without regard for their level of fall risk.

Suggestions:

1. Use CUS to advocate for the patient. “I’m concerned that this patient is encouraged to be up independently when we know that they are at high risk for falls.”

2. Ensure a shared mental model: Explain that the “auto pilot” approach is not consistent with your policy/procedure to use the fall risk assessment to determine activity level; is putting the patient’s safety at risk; and is exposing the hospital to risk.
REMINDERS

Monthly Call: July 23, 2013 at 2:00 p.m. CST

Webinar #7: July 9, 2013 at 10:00 a.m. CST
Best Practices in Mobility Assessment to Decrease Fall Risk
Dawn M. Venema, PT, PhD
Jill Hassel, DPT

Register for this webinar at:
https://www2.gotomeeting.com/register/738194794
REMINDERS

Webinar #8: August 20, 2013 at 10:00 a.m. CST
Best Practices in Safe Transfers and Mobility to Decrease Fall Risk

*Dawn M. Venema, PT, PhD*
*Jill Hassel, DPT*

Register for this webinar at:
[https://www2.gotomeeting.com/register/790512042](https://www2.gotomeeting.com/register/790512042)
CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

http://unmc.edu/patient-safety/capture_falls.htm