CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #9
August 27, 2013  2:00 – 2:30 p.m. CST

National Fall Prevention Awareness Day
and Tips for Teamwork Perceptions
Questionnaire Interpretation
AGENDA

• Housekeeping
• National Fall Prevention Awareness Day
• Tips for Interpreting Your Teamwork Perceptions Questionnaire Results
• Event Review
• Lessons to share with the community
Housekeeping

• Email Katherine if interested in participating in a panel discussion at CAH Quality Conf. Nov. 6, 2013 regarding lessons learned from participation in CAPTURE Falls
  ✓ CAPTURE Falls will provide $100 to support your travel to Kearney

• Upcoming Webinars
  ✓ October Webinar Date Cancelled
  ✓ Webinar #9: November 12, 2013 at 10:00 a.m. CST Best Practices in Fall Data Collection, Interpretation, and Action

• Expect $2,000 stipend for Year 2 of project in September
  ✓ Email us who we should mail payment to
National Fall Prevention Awareness Day

September 22, 2013
(First Day of Fall)

Are you recognizing it?
If so, how?
Some Hospital Activities
National Fall Prevention Awareness Day

• Health Fair within hospital to promote activities of fall risk reduction team and assess balance

• Celebration of the CAPTURE Falls Team
  • Free meal to employees
  • Education about use of FRASS fall risk assessment scoring system and the signage in use to identify those at fall risk
  • Advertisement in newspaper, speaking to Senior Center

• Celebration of Progress in Fall Risk Reduction
  • Will share current fall rates and results from the TPQ
## National Fall Prevention Awareness Day

### Who is your audience?
- Older Adults
- Family or Caregivers
- Community-dwelling individuals vs. patients in your hospital
- Other HCP’s or hospital staff

### What could you do?
- Risk screening
- Educational handouts or presentations
- Give away items
- External press release
- Internal promotion of your hospital’s fall risk reduction program

Don’t forget to record what you do.....How many people did you reach? What was the response? Anything that you’d do again (or not!) next year?
National Fall Prevention Awareness Day: Resources

National Council on Aging: sample press releases, ideas for activities, samples of promotional materials

National Fall Prevention Awareness Day: Resources

Centers for Disease Control: STEADI toolkit:
includes patient education materials and screening tools for HCP’s

http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/about.html
National Fall Prevention Awareness Day: Resources

Nebraska Chapter of the National Safety Council, Fall Intervention: Reaching Seniors Together (F1RST): online resources for older adults and health care professionals

http://www.f1rst.org/index.html
National Fall Prevention Awareness Day: Follow-up

The National Council on Aging is collecting information about activities done throughout the country.

Contact Peg Ogea-Ginsberg at the Nebraska Department of Health and Human Services to share your activities.

Peg.OgeaGinsburg@nebraska.gov
Teamwork Perceptions Questionnaire – Fall Risk Reduction Interpretation

• Snapshot of the context of fall risk reduction
  • How healthcare providers and other hospital staff think teamwork, leadership, and organizational culture support fall risk reduction in your facility
  • Reflect on successes and opportunities for improvement in teamwork, leadership, and organizational culture to improve fall risk reduction in particular and patient safety initiatives in general
<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Questions and Reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff within my unit/department understand their roles and responsibilities related to fall risk reduction</td>
<td>88%</td>
<td>How do our staff know their roles and responsibilities specific to fall risk reduction?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How is fall risk reduction integrated into our education and training programs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How do team leaders reinforce staff roles and responsibilities in fall risk reduction?</td>
</tr>
<tr>
<td>Staff resolve their conflicts about fall risk reduction, even when the conflicts have become personal</td>
<td>59%</td>
<td>What tools or policies do we as a facility encourage to resolve conflict?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do we use the Two Challenge Rule &amp; CUS to resolve information conflicts?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do we use the DESC script to resolve personal conflicts?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How do team leaders intervene to facilitate personal conflict resolution?</td>
</tr>
</tbody>
</table>
Teamwork Perceptions Questionnaire – Fall Risk Reduction Interpretation

• October Fall Risk Reduction Team Meeting / CAPTURE Falls Quarterly Call

1. Review survey results
2. Discuss your facility’s strengths and opportunities for improvement
3. Invite leadership team to attend this meeting
Teamwork Perceptions Questionnaire – Fall Risk Reduction Interpretation

Feedback for us about the questionnaire and the way you received the results?

- One hospital reported that the open-ended comments demonstrated a positive shift in their culture.
Event Report

Unassisted fall during toileting reveals need to educate that all patients, regardless of age, should be assessed for fall risk

- 56 y/o female; primary dx migraine HA
- Initial fall risk assessment not performed
- Time of fall not reported, fell on first day of hospitalization, pt. left alone while voiding and fell while pulling pants up
- Fall resulted in no harm
- Because pt was young, assumed she was not at risk; reflects value of chart audits, reporting non-harmful falls
Pt. on sedatives, analgesics; hx of fall previous admission
Lessons to Share…

• One hospital reported that they have learned the most from implementing post fall huddles. They are learning more and faster than before implementing the huddles.

• They have implemented two key changes as a result of the huddles
  1. not to leave patients unattended in the bathroom
  2. Increased use of sitters for patients with a previous history of a fall including a trial use of a sitter for the first 12 hours of admission. They are using employees as sitters.
Lessons to Share…

• Another hospital asked about use of family as sitters
  
  • Findings from the literature (contact kjonesj@unmc.edu for copies of these articles)
    1. Some hospitals do not use family or volunteers as sitters for liability reasons
    2. Others have an extensive program to train volunteers as sitters
  
  • Whenever family is alone with a confused patient, they should be instructed to formally handoff care back to staff before they leave. They should put on the call light and exchange information with staff before leaving.
REMINDERS

Monthly Calls: September 24, 2013 at 2:00 p.m. CST
October 22, 2013 at 2:00 p.m.

October Webinar Date Cancelled

Webinar #9: November 12, 2013 at 10:00 a.m. CST
Best Practices in Fall Data Collection, Interpretation, and Action

Check the CAPTURE Falls Website for Updates
http://unmc.edu/patient-safety/capture_falls.htm

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

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