CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Monthly Collaborative Call #11
October 22, 2013  2:00 – 2:30 p.m. CST

Update on Post-Fall Huddles
AGENDA

- Housekeeping
  - Web Site Feedback
    http://www.unmc.edu/patient-safety/capturefalls/
  - CAH Quality Meeting
  - Special topics for future webinars
- Update on Post-fall Huddles
- Fall event review
- Lessons to share with the community
  - Barriers and Successes in Implementation
Safe Transfers & Mobility

BEST PRACTICES IN SAFE TRANSFERS AND MOBILITY TO DECREASE FALL RISK
August 20, 2013 Webinar - Best Practices in Safe Transfers and Mobility to Decrease Fall Risk

Video instructions:
Housekeeping

• CAH Quality Conf. Nov. 6, 2013 CAPTURE Falls Activities
  • Sallie Weaver, PhD Key Note Address…”You never step in the same river twice: Examining the myths, legends, and what actually works when it comes to organizational change in healthcare.”
  • Dr. Weaver is an Industrial/Organizational psychologist at Johns Hopkins School of Medicine and Armstrong Center for Patient Safety. Her research focuses on organizational factors that influence team performance and interventions to improve patient.
  • Panel Discussion: Lessons Learned from CAPTURE Falls
    ✓ Box Butte General Hospital, St. Francis Memorial Hospital, Providence Medical Center, Pender Community Hospital
    ✓ Topics: Learning about fall risk reduction, learning about role of coordinating team in implementation, learning about implementation of change in general
Potential Special Topics for Future Webinars

Recognition of gait impairments
Alcohol withdrawal syndrome
Managing the cognitively impaired patient
Coordination of care and transition to home
Patient and family education
Safe patient handling
Agreement?
What else?
Potential Special Topics – Feedback to Share re: Alcohol Withdrawal Syndrome

One hospital inquired what additional steps could be taken with this difficult patient population

Deb Conley shared the following points:

1st step – identify that alcohol withdrawal is the issue

2nd step – ask if the medication regime to control withdrawal symptoms and delirium is appropriate

3rd step – take measures to reduce risk of injury in the event of a fall (examples: low beds, floor mats)

Also consider if sitter is needed
Potential Special Topics – Feedback to Share re: Coordination and Transitions in Care

One hospital reported that they do complimentary home visits for all patients who are discharging home. Purpose of home visits is to assess home environment, make recommendations on modifications, identify need for services after d/c.

One hospital reported standardizing transfer documentation re: falls and fall risk between hospital and area nursing homes and assisted living facilities. They also ensure patient's primary care physician is aware of fall risk status at d/c.
Coordinating Team (Fall Risk Reduction Team) holds core team accountable for conducting post-fall huddles.

Contingency Team = Post Fall Huddle
Falls are relatively rare events in Critical Access Hospitals, and it is difficult to learn from aggregating small numbers. Conducting audits, obtaining feedback from the core team and, learning from each fall in real time using post-fall huddles are ways to learn about the effectiveness of your fall risk reduction processes.

Hospital Level Knowledge about Fall Risk Reduction Processes (Effective, Reliable)
Implementation is the hard part...

- 8/12 – 5/13: 47/117 (40%) falls included a huddle
- 8/12 – 10/13: 109/198 (55%) falls included a huddle

- 16 of 17 hospitals reported at least 1 huddle
  - Range of huddles per hospital = 1 – 16
  - Median number of huddles = 6

- Presence/absence of injury not related to conducting huddle
  - 50% (29/58) of injurious falls had a post-fall huddle
  - 57% (80/140) of noninjurious falls had a post-fall huddle

Some hospitals that have been successful in implementing huddles have a charge nurse that has taken ownership of conducting post-fall huddles.
Progress in Implementing Huddles

Progress in including other professions in post-fall huddles...

- **Nursing and Patient/Family**: 51% (8/12-5/13 n=47) 50% (8/12-10/13 n=109)
- **Nursing + Other Discipline(s)**: 15% (8/12-5/13 n=47) 28% (8/12-10/13 n=109)
- **Only Nursing**: 13% (8/12-5/13 n=47) 17% (8/12-10/13 n=109)
- **Nursing and Therapy**: 11% (8/12-5/13 n=47) 17% (8/12-10/13 n=109)
- **Pharmacy Included**: 6% (8/12-5/13 n=47) 17% (8/12-10/13 n=109)
Huddles may reveal improved reliability of tasks and focus on judgment and coordination...

Progress in Implementing Huddles

![Bar chart showing progress in implementing huddles]

- Task Error: 53% (8/12-5/13, n=47) vs. 30% (8/12-10/13, n=109)
- Judgment Error: 48% (8/12-5/13, n=47) vs. 23% (8/12-10/13, n=109)
- Coordination Error: 27% (8/12-5/13, n=47) vs. 19% (8/12-10/13, n=109)
- Consult PT: 2% (8/12-5/13, n=47) vs. 13% (8/12-10/13, n=109)
- Consult Pharmacist: 4% (8/12-5/13, n=47) vs. 9% (8/12-10/13, n=109)
Assisted fall in bathroom (2200) reveals missed opportunity to learn from huddle

- 87 y/o male; primary dx GI Bleed, anemia
- Initial fall risk assessment results—At high risk
- PT/OT not noted to be interventions
- Sedative medications
- Aide attempted to help patient to bathroom with walker. Patient became unsteady and fell backward, aide attempted to “catch” patient; aide and patient fell to floor. (No mention of gait belt).
- Post-fall huddle included charge nurse, primary nurse, CNA
- Action to be taken: bed alarm on most sensitive setting, frequent rounds, call light in reach
- Concerns: No mention of actual cause of fall, which occurred during ambulation; no mention of need to consult PT
Lessons to Share...

• What have you learned from conducting post-fall huddles?

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

• When is the best time to complete a huddle?

• What have you done that has led to success in implementing post-fall huddles?
Why Huddle?

- Interprofessional teams provide organizations with a greater ability to adapt and learn than do individuals.

- Fall are relatively infrequent; must learn from each fall in real time.
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; when to use equipment)
  – Coordination Error: Knowledge is not handed-off between shifts, disciplines, departments (e.g. information about previous fall not shared at shift change)
REMINDERS

CAH Quality Meeting: Nov. 6 – 7, 2013
Monthly Call: Nov. 26, 2013 at 2:00 p.m. CST

Webinar #9: Nov. 12, 2013 at 10:00 a.m. CST
Best Practices in Using Data to Reduce Fall Risk
Katherine Jones, PT, PhD
Victoria Kennel, MA

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