Reflections on the CAPTURE Falls Project: Lessons Learned from Implementing Organizational Change

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

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

1. Classify the evidence-base for inpatient fall risk reduction into structure, process, and outcomes.

2. Describe initial lessons learned from the CAPTURE Falls project.

3. Understand factors that support and inhibit implementation of organizational change.

Definition of fall: For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient’s body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).\(^1\)
Background and Rationale²

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Risk of falls greater in CAHs than non-CAHs

1. CAHs care for a higher proportion of older adults
2. CAHs provide skilled nursing care with goal of rehabilitation to a higher functional status
3. CAHS have limited resources to devote to quality improvement
4. CAHs are less likely to externally benchmark fall rates
5. CAHs continue to receive payment for healthcare acquired conditions including falls with injury
CAPTURE Falls

- **Collaboration And Proactive Teamwork Used to Reduce Falls**
- Partner with 18 Nebraska Hospitals (16 CAHs)
  - Develop a customized CAPTURE Falls Action Plan
  - Support implementation of Action Plan
  - Evaluate implementation of Action Plan
  - Develop and disseminate a toolkit

Ultimate Goal

Decide Risk of Harm from Falls in CAHs
Figure 1. Falls Prevention Supported by Safe Practices to CAPTURE Falls
Quality is inferred by measuring elements of care

- **Structure**—conditions under which care is provided (human resources, equipment, environment); capacity for work—primary determinant of the average quality of care a system can offer

- **Process**—what was done (diagnosis, treatment, rehabilitation, prevention, patient education)

- **Outcome**—changes in individuals and populations that are due to health care
Fall Rates as a Quality Outcome

- Relatively rare, negative outcome with random component\(^5\)
- All falls cannot be prevented

- Goal is to minimize risk and harm to patients
  - Implement evidence-based structures and processes
  - Audit reliability of those structures and processes
  - Report all outcomes....assisted and unassisted falls
  - Learn from multiple sources of data
    - Fall event reports, process audits, post-fall huddles
Structure to Support Fall Risk Reduction

Multi-Team System\textsuperscript{6} supports a chain of accountability

- **Patient/Family**
- **Core Team**
- **Coordinating Team**
- **Administration**
- **Board of Directors**

Contingency Team = Post Fall Huddle
Coordinating Team Processes

Develop policy/procedures
• Risk assessment tools
• Choose interventions based on evidence from multiple disciplines
• Fall event reporting form
• Conduct audits to assess reliability of interventions
• Collect and analyze data
• Conduct RCAs
• Modify policy/procedure based on data

Educate
• Policy/procedures
• Use of risk assessment tools (reliability?)
• Match interventions to severity and cause of risk
• REPORT ALL FALLS
• Provide feedback to core team
• Annual competencies
• New employee orientation
Core Team Processes

Universal Interventions\(^7-13\)
- Assess & reassess risk
- Call light in reach
- Appropriate lighting
- Declutter environment
- Patient/Family education
- Communicate risk to patient/family/across shifts & departments
- Purposeful rounding
- Nonskid footwear
- Post-fall huddles

Targeted Interventions\(^{14,15}\)
- Signage
- Communicate level of assist for transfers and assistive devices
- Alarms
- Low beds, mats
- Gait belts for transfers/ambulation
- Medication Review
- OT/PT consults, evaluation
- Sitters
Changing Attitudes about Reporting

Trends in Reporting Assisted and Unassisted Falls by 17 Small Rural Hospitals Aug. 2012 – Oct 2013 (n=208)

- Assisted Fall
- Unassisted Fall

Q1 Aug-Oct 2012
Q2 Nov-Jan 2013
Q3 Feb-Apr 2013
Q4 May-July 2013
Q5 Aug-Oct 2013
Prevalence of Harm by Fall Type for 17 Small Rural Hospitals Aug. 2012 - Oct 2013

- **Assisted Fall (n = 59)**
  - No Harm: 48
  - Mild Harm: 11
  - Mod - Severe Harm: 0

- **Unassisted Fall (n = 144)**
  - No Harm: 93
  - Mild Harm: 46
  - Mod - Severe Harm: 5

Assisted Falls Less Likely to Result in Harm
Changing Practice

Proportion of Falls with a Post-Fall Huddle (n=208)

Q1 Aug-Oct 2012
Q2 Nov-Jan 2013
Q3 Feb-Apr 2013
Q4 May-July 2013
Q5 Aug-Oct 2013

Proportion
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Learning from Fall Events

Error Type Contributing to Patient Falls Reported by 17 Small Rural Hospitals Aug. 2012 – Oct 2013 (n=208)
Panel Discussion

1. The structure of fall risk reduction includes the people used to implement the program and how they are organized, the tools you use for risk assessment, and your policies/procedures.
   – What have you learned about the structure of fall risk reduction during the CAPTURE Falls program?
   – What has been the impact of having other disciplines collaborate with nursing to implement your fall risk reduction program?
   – What have you done to improve the structure of fall risk reduction in your hospital?
Theme: Fall risk reduction requires an interprofessional team that includes the patient/family

• “It’s not just nursing...yes, we implement [the fall risk reduction program] but there are many people in the hospital that can be of value to your culture of safety.”

• Patient education; “getting directly in there with the person who could fall; providing them with education making them an active participant in their care.”

• “Preventing falls is every employee’s job that walks the halls of the hospital.”
Theme: Formal structures support shift from a focus on preventing falls to reducing risk

• “...Before we started this project, we were very unstructured;” now have formal team, updated policy, and valid fall risk assessment.”

• We have changed our focus from preventing falls to decreasing risk; “we’re a fall risk reduction team.”

• What information to collect and trend to evaluate program

• “We have an active team and an auditing system so we can see how this new program’s doing”
Theme: Ensure we engage the front line

• “Having a fall risk reduction team is key but front line staff are the key performers. Team processes have to include communicating with the front line, having them involved, making sure their schedules allow them to come to meetings.”

Theme: Processes must be proactive

• “…our processes cannot just be reacting to a fall. It has to begin with audits so we know if we are creating an environment that decreases task errors, reports assisted falls and decreases injury when a fall happens.”
Theme: Processes create a system to decrease risk
• “We learned how the pieces of our program—our incident report, our fall risk assessment, our audits—fit together to decrease risk.”

Theme: Process audits create accountability
• “Audits are an opportunity to give feedback for improvement and task assistance to increase learning about falls...we can address myths about falls.”
• “A member of the fall risk reduction team audits each day [because our processes are new]. We present our findings at patient care unit nursing meeting so nursing staff directly involved with the patients are informed.”
Theme: Learning from each fall

• “Post-fall huddles showed us the value of different perspectives—from nursing, the patient, and other disciplines to understand the factors that led to a fall.”

• “Post-fall huddles are teachable moments.”

• “Before, a fall would happen and we wouldn’t learn from it. And now a fall happens and we can learn patterns that help us develop processes to prevent that from happening again.”
Theme: Success is more than decreasing the number of falls

• “Our organizational goal is to decrease injurious falls, but first we had to define and communicate to our staff what an injurious fall was.”

• “Success is everybody in the facility understanding the program, participating in the program, filling out the incident report and huddle forms. With the huddle forms, the core team gives feedback to the coordinating team and makes it full circle...so the front line people, their ideas are getting into the program. Success is getting this interdisciplinary team all involved and having it grow. CAPTURE Falls is just a new way of looking at it.”
Theme: Success is more than decreasing the number of falls

• Start translating these concepts to something other than falls, including medication safety...the other great outcome of our team has been our interactions are a lot more purposeful than before.”

• “Not only do you have an interdisciplinary team but having the people on the team that wear many hats for the facility, that helps in having a diverse approach to communication that we have with our preventing these injuries.”
Panel Discussion: Challenges

Theme: Buy in from the front line

- “Initially we had a hard time with the buy in of our staff. They kind of felt like our committee was coming in and telling them how to do their job and making decisions for them that they had previously been able to make by themselves. But I think through education letting them know why we are doing the things that we’re doing, showing them the numbers of fall risk levels compared to other hospitals, really helped us in the process as well as educating ancillary departments.”
Factors that Inhibit Organizational Change

• LACK of....
  – Awareness of the problem/performance gap
  – Ability to match interventions to problems
  – Accountability
  – Action...nihilism...we can’t change this problem
  – Critical thinking and learning from data
  – Management support
  – Resources

• Social influences and emotion

“Ability is what you're capable of doing. Motivation determines what you do. Attitude determines how well you do it.” -- Lou Holtz
Read more at http://www.brainyquote.com/quotes/topics/topic_attitude.html#aSAPrJHFQ1KU4yHD.99
Factors that Support Organizational Change

- Recognize that change is a process\textsuperscript{16} that requires\textsuperscript{17}
  - Ongoing management support
  - Chain of accountability
  - Acknowledge the complexity of practice change
  - Flexibility/learning driven by an interprofessional team that understands your local context
  - Hardwire...integrate into established structures


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