CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls

Monthly Collaborative Call #12
November 26, 2013  2:00 – 2:30 p.m. CST

1. Summary: Lessons Learned from CAH Quality Conference
2. Barriers and Successes in …
   Patient/Family Education for Patients at Risk of Falls
   Managing Transitions in Care for Patients at Risk of Falls and/or Frailty
AGENDA

• Housekeeping

• CAH Quality Conference
  o Sallie Weaver’s Presentation
  o Panel Discussion Lessons Learned

• Barriers and Successes
  o Patient/Family Education for Patients at Risk of Falls
  o Managing Transitions in Care for Patients at Risk of Falls and/or Frailty
Housekeeping

• Jan. 2014 Collect demographic information about your team, your hospital, and fall rates for 2012, 2013
• Jan. – Feb. 2014 Final quarterly call
• April – June 2014 Final site visit
• What aspects of the project do we want to sustain?
“Reflections on the CAPTURE Falls Project: Lessons Learned from Implementing Organizational Change”

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.
Acknowledgement: Panel Members

• Box Butte General Hospital, Alliance, NE
  – Kate Brummer, OTD, OTR/L
  – Abby Keilwitz, PT, DPT
• Pender Community Hospital, Pender, NE
  – Stephanie Urwiler, RN, BSN
  – Traci Lueth, RN, BSN
  – Brenda Svoboda, PTA
  – Beth Boals Shively, DPh
• Providence Medical Center, Wayne, NE
  – Dani Frahm, LPN-C
  – Amy Bowers, PT, MPT
• St. Francis Memorial Hospital, West Point, NE
  – Cally Tejkl, MOT, OTR/L, CLT
  – Ashley Pokorny, RN, BSN
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.”
Outcome of Fall Risk Reduction

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.”

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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.”
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.”
Barriers to Patient/Family Education

- **Ask-Me-3 Fall Risk Reduction**
  - Why might I fall?
  - What do I need to do?
  - Why is it important for me to do this?

- **What are the barriers to Ask-Me-3 and Teach-Back for fall risk reduction?**
What are barriers and/or solutions for patient education?

• One hospital stated that health literacy is a barrier. They have worked to create educational handouts at an 8\textsuperscript{th} grade reading level. They also ask adult community members from their patient engagement committee to read these documents and give feedback.

• Another hospital stated that they have a patient/family advisory committee that sometimes provides feedback on patient education tools such as educational handouts or white boards.
• One hospital stated the biggest barrier is cognitive impairment: Teach back is difficult. It is hard to assess if patients with cognitive impairment really understand, and/or if they will be able to remember what was taught.

• There is a need to link the level of education to cognitive status: What is the appropriate amount and mode of delivery of education for patients with cognitive impairment?
What are barriers and/or solutions for patient education?

• One hospital stated that when people are admitted, they are often too sick or overwhelmed to benefit from education. Staff follow up on subsequent days to re-educate.

• One hospital noted difficulty using Ask-Me-3 with elderly patients because they didn’t understand what 3 questions to ask. This hospital turns the Ask-Me-3 framework around:

  1. You might fall because...
  2. You need to use the call light to ask for help and ...
  3. It is important to do this because patients often overestimate their abilities and suffer an injury form a fall
Event Report

Assisted fall reveals importance of considering fall risk in transitions in care

• 90+ female with dx of pneumonia
• Initial fall risk assessment results—at high risk
  – On an anticoagulant
• Patient was demonstrating her ability to perform a standing sponge bath prior to being discharged from Swing. Patient fell backward as she took her nightgown over her head. COTA assisted patient to floor.
• Therapies recommend use of gait belt during bathing demonstration
Barriers to Transitions in Care

• Transitions occur across levels and settings of care
• Effective transitions require teamwork
  – Communication between sending and receiving providers
  – Preparation of patient and caregiver
  – Reconciliation of medications AND Function
  – Follow-up plan for test results and appointments
  – Explicit education about warning signs and symptoms

• What are the barriers to managing effective transitions for patients at risk of falls and/or frailty?
  – System
  – Provider
  – Patient

What do you do to ease transitions in care?

• One hospital states they use verbal nurse to nurse hand-offs when a patient is transitioning to another facility or to home health. This hospital states verbal handoffs prevented confusion for the patient and receiving providers.

• Another hospital states that rehab therapies perform a home safety assessment with all swing bed patients who were admitted due to a fall, or who were at high fall risk while hospitalized.
• One hospital stated that it seems that the focus on discharge from acute care is on the diagnosis, medical needs, and reconciliation of meds. There is not always a focus on fall risk or functional status. There needs to be a trigger at discharge to consider functional status.

• Focusing on fall risk and/or function may help us be more patient-centered and consider the whole person, not just their diagnosis.
REMINDERS

Monthly Call: Jan. 28, 2014 at 2:00 p.m. CST

Webinar #9: Jan. 14, 2014 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/
CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce
Enter “capture falls” in google
http://unmc.edu/patient-safety/capturefalls/