Monthly Collaborative Call #10
September 24, 2013  2:00 – 2:30 p.m. CST

National Fall Prevention Awareness Day
Review of Big Ideas in Implementation
Fall Event: Foot Drop & Non-skid Socks?
AGENDA

• Housekeeping
• National Fall Prevention Awareness Day
• Review of Big Ideas in Implementation
• Event Review
• Lessons to share with the community
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 safety including organizational culture and leadership.
  • Panel Discussion: Lessons Learned from CAPTURE Falls
    ✓ Box Butte General Hospital, St. Francis Memorial Hospital, Providence Medical Center, Pender Community Hospital
    ✓ We will be touching base with you mid-Oct re: planning for this
Housekeeping

• $2,000 stipends should arrive in next few weeks

• Upcoming Webinar

  ✓ October Webinar Cancelled

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

• October Conference Calls with hospitals

  • Send Agenda and previous Minutes ahead of call

  • We will send summary of fall event reports since last call

  • Teamwork Perceptions Questionnaire

• BEST PRACTICES IN SAFE TRANSFERS AND MOBILITY TO DECREASE FALL RISK now posted
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
National Fall Prevention Awareness Day

September 22, 2013
(First Day of Fall)

Activities to Report?
One hospital reported doing a “popcorn” party and having staff wear green or yellow t-shirts (which correspond to patient sock indicators of fall risk status). Also, educational handouts were provided to staff re: fall risk reduction program.
One hospital reported staff wore yellow, email blasts went out to educate hospital employees re: fall risk reduction program, and stars (their fall risk sign) were hidden around the hospital. Staff that found the stars and answered a trivia question re: the fall risk reduction program received a prize.
National Fall Prevention Awareness Day Activities Reported

One hospital has a community education program planned with the local senior center. Will incorporate education from physical therapy re: exercise (including Tai Chi), home safety checklists, and other materials from the CDC STEADI toolkit.
Big Ideas

Shifting paradigm of fall risk reduction from nursing-centric to organizational quality goal that reflects capacity for organizational learning and accountability

Using Donabedian’s Structure–Process–Outcome Quality Assessment Framework

Rogers’ Theory of Innovation in Organizations
Big Ideas…Donabedian’s Quality Framework

**STRUCTURES**
- Multi-team System
- Tools
  - Risk Assess
  - Performance Assess
- Culture (HSOPS, TPQ)

**PROCESSES**
- Universal Interventions
- Targeted Interventions
- Coordinating Team Processes
- Core Team Processes

**OUTCOMES**
- Changes in structure & process consistent with evidence
- Decrease in injurious fall rates
Do you incorporate Donabedian’s Quality Framework into Quality Improvement re: Falls?

One hospital reported that since being involved in CAPTURE falls, they have been more mindful of fall risk reduction being the job of ALL hospital employees – not just the core team at the bedside. This multi-team system (a structure) has been emphasized at employee education forums.
Event Report

Assisted fall during ambulation results in no harm; reveals need to understand nature of gait impairments

- 91 y/o female; primary dx CVA with (L) sided weakness
- Initial FRASS score = 10
- Pt. amb. from bathroom to chair when she caught her left foot on the floor and fell to left side; non-skid skid sock stuck to floor due to weakness in ankle dorsi flexion
- Time of fall 2000; fall resulted in no harm because gait belt used to lower patient to floor
- Post-fall huddle did not include PT
Without Ankle Foot Orthosis

http://homeafterstroke.blogspot.com/2012/04/arm-and-leg-synergies-are-different-and.html

With Ankle Foot Orthosis

Lessons to Share…

• A change you have made that is working well

• Organizational factors that help you to implement change

• Organizational factors that are barriers to change
Lessons to Share

One hospital reported that they are training nursing home staff re: gait belt use, guarding, transfers, etc. Nursing and administration supported this by coordinating space in which to do the training and freeing up staff time. Within one of the training groups, they brainstormed ideas for how to reliably have gait belts present in each patient room. Their grass-roots problem-solving led to the decision to have the admitting nurse be responsible for placing a gait belt in each room so that he/she could obtain one that is the appropriate size for the patient.
REMINDERS

Monthly Calls: October 22, 2013 at 2:00 p.m.
November 26, 2013 at 2:00 p.m.

October Webinar 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

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