CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls

Monthly Collaborative Call #13
January 28, 2014  2:00 – 2:30 p.m. CST

1. Lessons Learned from Fall Event Reports through 2013
2. Revising and Sustaining the Reporting Process
AGENDA

• Housekeeping

• Lessons Learned from Event Reports

• Revising and Sustaining the Reporting Process

• Event Report
Housekeeping

- Week of Jan. 27 – Collect demographic information about your team, your hospital, and fall rates for 2012, 2013
- Jan. – Feb. 2014 Final quarterly call
- Feb. – March HSOPS
- April – May TPQ
- April – June 2014 Final site visit

LESSONS LEARNED FROM EVENT REPORTS
**Background and Rationale**

<table>
<thead>
<tr>
<th></th>
<th>Falls per 1000 Patient Days</th>
<th>p value</th>
<th>Injurious Falls per 1000 Patient Days</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE Hospitals 2010</td>
<td></td>
<td>.025</td>
<td></td>
<td>.029</td>
</tr>
<tr>
<td>Non-CAHs (n = 14)</td>
<td>4.2</td>
<td></td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>CAHs (n = 56)</td>
<td>6.3</td>
<td></td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

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\textsuperscript{11}

• **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

= Decrease Risk of Harm from Falls in CAHs

- Pt. Age <65 Yrs (n=62): 18% Physical Injury, 82% No Injury
- Pt. Age 65-80 Yrs (n=74): 31% Physical Injury, 69% No Injury
- Pt. Age 81+ Yrs (n=83): 37% Physical Injury, 63% No Injury

p = .012 Chi Square Test for Trend
Data Summary

Association Between Pt. Activity and Harm for 225 Falls

<table>
<thead>
<tr>
<th>Activity</th>
<th>All Falls (n=225)</th>
<th>Physical Injury (n=68)</th>
<th>No Injury (n=157)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toileting</td>
<td>25%</td>
<td>19%</td>
<td>25%</td>
</tr>
<tr>
<td>Ambulating</td>
<td>23%</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Transferring (bed/toilet/chair to stand)</td>
<td>14%</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>Changing Position</td>
<td>12%</td>
<td>6%</td>
<td>15%</td>
</tr>
</tbody>
</table>

All Falls (n=225) vs Physical Injury (n=68) vs No Injury (n=157)


Physical Injury (n=68) vs No Injury (n=157)

All Falls (n=225) vs Physical Injury (n=68) vs No Injury (n=157)

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Physical Injury (n=68) vs No Injury (n=157)

All Falls (n=225) vs Physical Injury (n=68) vs No Injury (n=157)

All Falls (n=225) vs No Injury (n=157)


Physical Injury (n=68) vs No Injury (n=157)

All Falls (n=225) vs Physical Injury (n=68) vs No Injury (n=157)

All Falls (n=225) vs No Injury (n=157)

Contributing factors reflect high prevalence of frailty.
Changing Attitudes about Reporting


Assisted Fall  Unassisted Fall

Q1 Aug-Oct 2012 (n=44)  Q2 Nov 2012 - Jan 2013 (n=41)  Q3 Feb - Apr 2013 (N=40)  Q4 May - Jul 2013 (n=41)  Q5 Aug-Oct 2013 (n=46)

Project Quarter
Assisted Falls Less Likely to Result in Harm


- No Physical Injury
- Mild Physical Injury
- Mod-Severe Physical Injury

Assisted Fall (n=64):
- 80% No Physical Injury
- 20% Mild Physical Injury
- 0% Mod-Severe Physical Injury

Unassisted Fall (n=161):
- 66% No Physical Injury
- 31% Mild Physical Injury
- 3% Mod-Severe Physical Injury

p = .024 Chi Square Test for Trend
Changing Practice

Proportion of Falls with a Post-fall Huddle by Project Quarter

Q1 Aug-Oct 2012 (n=44) 28%
Q2 Nov 2012 - Jan 2013 (n=41) 44%
Q3 Feb - Apr 2013 (N=40) 50%
Q4 May - Jul 2013 (n=41) 82%
Q5 Aug-Oct 2013 (n=46) 85%
Learning from Fall Events

Types of Errors Identified in Post-Fall Huddles Over Time

- Task error = process deviation when processes are certain
- Judgment error = Wrong decision when processes uncertain
- Coordination error = Lack of communication about uncertain processes

Aug 2012 - Jan 2013 (n = 33)
- Task Error Reported - UNMC: 50%
- Judgment Error Reported - UNMC: 40%
- Coordination Error Reported - UNMC: 10%

Feb 2013 - July 2013 (n = 56)
- Task Error Reported - UNMC: 40%
- Judgment Error Reported - UNMC: 50%
- Coordination Error Reported - UNMC: 10%

Aug 2013 - Dec 2013 (n = 46)
- Task Error Reported - UNMC: 30%
- Judgment Error Reported - UNMC: 50%
- Coordination Error Reported - UNMC: 20%
## Revising and Sustaining Reporting

How effective is your hospital in doing the following? (n=23)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all effective or DK / NA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a database to collect data from the fall event reporting forms</td>
<td>38%</td>
</tr>
<tr>
<td>Using software such as Excel, Access, or SPSS to aggregate data from a database and answer questions about fall events</td>
<td>43%</td>
</tr>
<tr>
<td>Constructing easy to understand graphs and charts to communicate information about fall events</td>
<td>33%</td>
</tr>
<tr>
<td>Placing information about your fall event reporting system into the context of your scorecard gap analysis</td>
<td>48%</td>
</tr>
<tr>
<td>Implementing changes to your fall risk reduction program based on information and knowledge</td>
<td>4%</td>
</tr>
</tbody>
</table>
### Revising and Sustaining Reporting

**Importance of sustaining the following CAPTURE Falls activities beyond the end of the project (n = 24)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Ranked Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting fall events to UNMC for data analysis and benchmarking</td>
<td>83%</td>
</tr>
<tr>
<td>Receiving quarterly summaries of your fall events from UNMC</td>
<td>63%</td>
</tr>
<tr>
<td>Receiving feedback about the types of errors identified in the post-fall huddle from UNMC</td>
<td>75%</td>
</tr>
<tr>
<td>Developing easy to use Excel spreadsheets to automatically summarize fall event data</td>
<td>67%</td>
</tr>
<tr>
<td>Identifying the minimum data elements needed to track for fall event reporting</td>
<td>63%</td>
</tr>
</tbody>
</table>
Comments

• I thought it was very interesting to view one hospital's data and from our perspective identify interventions we felt helped us overcome some of the challenges they are still facing based on their reports. We would be very interested in other facilities evaluating our event reports in a similar way to identify something we might not be seeing and offer suggestions on what they have found helpful to further reduce our fall rates.

• We have had 1 fall event per quarter on average. We have not created a data base for these as the numbers are so low, it does not seem appropriate to graph the data. We do take each fall individually and look for areas of improvement in our fall prevention program.
Revising and Sustaining Reporting

Future Plans / Ideas for Sustainment

• Revise Fall Event Reporting Form to include only items useful in creating knowledge about the system
• Simplify Post-Fall Huddle Form
• Create Fall Event Reporting and Analysis Tool for CAHs to share Knowledge and Wisdom
• Create Fall Rate Benchmarks for Project Hospitals
• Discuss creation of Fall Rate Benchmarks for Nebraska and Nebraska’s Critical Access Hospitals
• Other Ideas?
Event Report

Fall event report reveals need for clarification of fall risk reduction during hospice care

- Female > 90 years at end of life
- Found on floor at foot of bed 0650 resulting in mild harm
- Thought to be sleeping
- No fall risk assessment done, no interventions indicated prior to fall
- Bed alarm not turned on...
- Judgment error if there is no policy to assess fall risk for hospice patients; task error if there is a policy
REMINDERS

Monthly Call: Feb. 25, 2014 at 2:00 p.m. CST

Webinar #10: Best Practices in Health Literacy and Patient Education
Denise Britigan, MA, PhD, CHES
Assistant Professor Department of Health Promotion, Social, and Behavioral Health
College of Public Health
University of Nebraska Medical Center

Resources posted at http://www.unmc.edu/patient-safety/capturefalls/
CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce Falls

Enter “capture falls” in google

http://unmc.edu/patient-safety/capturefalls/