CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce Falls

Monthly Collaborative Call #16
March 25, 2014  2:00 – 2:30 p.m. CST

Risk Assessments…what are hospitals using and how good are they at assessing fall risk?
AGENDA

1. Housekeeping
2. Fall Rates… sneak peak at progress
3. Risk Assessments…what are hospitals using and how good are they at detecting risk?
4. Revising and Sustaining the Reporting Process
5. Event Report Review: Does this happen in your hospital
6. Open discussion
Housekeeping

- Feb. – March HSOPS; results end of May
- April – May TPQ
- April – June 2014 Final site visit
- Jan – March Progress reports...
  - What did we provide that would have been difficult/impossible for you to calculate?
  - What was helpful what wasn’t?
- Fall Rate Reporting
Feedback on Progress Reports

- Providing trends for fall rates quantified progress

- Providing recommendations for future actions provided direction

- Providing charts where two factors are displayed (cross tabs) such as patient activity and time of day helps identify system issues (see example on next slide)
Association Between Patient Activity and Time of Day
Aug 2012 - Mar 2014 (n=14)

- Fell while transferring w/o assistance: 1
- Fell while toileting/on commode w/assistance: 1
- Fell while left alone toileting/on commode: 1
- Fell while ambulating w/o assistance: 1
- Fell while ambulating w/assistance: 1
- Fall related to Chair/Recliner: 2
- Rolled out / Slipped off of bed: 1
- Fell while ambulating to bathroom w/o assistance: 3
CAH benchmark rates from the 2011 survey were 6.3 total falls/1000 pt. days and 1.8 injurious falls/1000 pt. days.
# Change in Use of Assessments

<table>
<thead>
<tr>
<th>Tool</th>
<th>Beginning of Project</th>
<th>Current</th>
<th>Determined to be at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Judgment/No specific tool</td>
<td>2</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>FRASS</td>
<td>0</td>
<td>2</td>
<td>91.7%</td>
</tr>
<tr>
<td>Home Grown Tool</td>
<td>5</td>
<td>2</td>
<td>89.1%</td>
</tr>
<tr>
<td>Hendrich II</td>
<td>1</td>
<td>1</td>
<td>51.6%</td>
</tr>
<tr>
<td>Johns Hopkins</td>
<td>0</td>
<td>2</td>
<td>88.9%</td>
</tr>
<tr>
<td>Morse</td>
<td>9</td>
<td>7</td>
<td>87.6%</td>
</tr>
<tr>
<td>Schmid</td>
<td>0</td>
<td>3</td>
<td>96.3%</td>
</tr>
</tbody>
</table>
Hendrich II

- Get Up & Go Test not being scored based on performance

1. Sit comfortably in a straight-backed arm chair.
2. Rise from the chair (can use arm rests).
3. Stand still momentarily.
4. Walk a short distance (approximately 3 meters).
5. Turn around.
6. Walk back to the chair.
7. Turn around.
8. Sit down in the chair.

**Scoring:** Observe patient's movements for any deviation from a confident, normal performance.
Critical Thinking about Risk

• Assess inter-rater reliability of your tool...would all score a paper case the same?

• Move beyond “is this patient at risk?” To....
  – Why is this patient at risk?
  – What intrinsic factors increase the likelihood that patient will have difficulty maintaining center of gravity inside base of support?
  – Which interventions address these factors?
Why is this patient at risk?

• Age...65 – 79, 80+

• Mental Status
  – Intermittent confusion
  – Limited insight into impairments
  – Poor short term memory

• Emotion/depression
  – Agitated
  – Anxious, uncooperative

• Toileting
  – Catheter/ostomy
  – Ambulatory with urge incontinence

• Hx of falls w/in 6 mos.

• Sensory Impairment
  – Vision
  – Hearing

• Activity
  – Level of assist transfers, gait
  – Steadiness of gait
  – Weak/Deconditioned

• Medications
  – Cardiovascular
  – Antidepressants
  – Psychotropics
  – Sedatives
  – Anticoagulants
  – AntiParkinsons
  – Opioids
  – Diuretics
  – Polypharmacy
Moral of the Story

• All risk assessments are doing a reasonable job of identifying patients at risk EXCEPT when there is a systematic error in conducting the assessment as in one facility’s use of the Hendrich II

• Risk assessments are most useful when interventions are linked to the risk factors and personnel take action based on their knowledge of these factors (ie, intermittent confusion, weakness, and anticoagulants = DO NOT LEAVE PATIENT ALONE WHILE TOILETING)

• Ensure the reliability of interventions with audits
Two Elements Reveal Systems

1. What happened/how did the patient fall capturing activity and assistance (17 scenarios)
   - Fell while ambulating to bathroom w/o assist
   - Fell while ambulating to bathroom w/ assist
   - Fell while transferring w/o assist
   - Fell while transferring w/assist
   - Fell while left alone on toilet/commode
   - Fell while toileting/on commode w/assist
   - Fall related to chair/recliner
   - Fell while dressing/undressing related to shower
   - Fell while reaching
   - Rolled out/slipped off of bed
2. How was the fall discovered?
   - Patient found on floor
   - Notified by family/friend/another patient
   - Notified by non-clinical staff
   - Notified by ancillary staff
   - Reported by patient
   - Patient calling for help
   - Alarm sounding
   - Patient call light
   - Staff assisting
   - Staff observed
Discussion

• Specificity of these two factors will help identify systems issues contributing to falls.

http://news.discovery.com/tech/virtual-moderator-helps-discussions-130506.htm
Could this happen?

- 89 y/o male
- (L) sided weakness due to CVA; SNF for PT/OT
- Fell one day after admission approx. 9:00 pm
- Pt. taken to bathroom, left alone. Pt. got up and fell backwards striking head; walker had been removed from bathroom to remind pt. not to get up on own, reminded to use call light.
- Contributing factors: melatonin given 15 min. before, on anticoagulants
- 3 days later CT revealed frontal lobe hemorrhage
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?
Goal

Reporting system for falls to provide benchmarking, analysis, and quality improvement support for CAHs

http://www.rightthisminute.com
REMINDERS

Monthly Call:  April 22, 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
Enter “capture falls” in google
http://unmc.edu/patient-safety/capturefalls/