Monthly Collaborative Call #18
June 24, 2014  2:00 – 2:30 p.m. CST

Progress in Safety Culture and Next Steps
AGENDA

1. Housekeeping

2. Assessing progress….fall rates and safety culture

3. Revising and Sustaining the Reporting Process

4. Next Steps

5. Event Report Review: Could this happen in your hospital? How can we improve reflection in huddles?

6. Open discussion
Housekeeping

- HSOPS results sent June 3 – 6, email with questions
- TPQ in the field now except 2 hospitals delayed (includes questions about post-fall huddles)
- Final site visits completed this week
- July – Dec. 2014 Huddle Quality Improvement Project; visits with 4 hospitals
- July 1, 2014 Best Practices in Health Literacy and Patient Education posted on Learning Modules – New Patient Teaching Tool posted on Tool Inventory
- Fall 2014...chart review project
NICHE-AgeWISE Collaborative

Focus on Transitions: Best Practices in Gerontological and Geropalliative Care

August 15, 2014; 8 am - 4:30 pm

Scott Conference Center, 6540 Pine St., Omaha

Purpose: provide best-practices in care of older adults across the continuum.
1. Discuss current evidence based practices related to fall risk reduction.
2. Explore the impact of advanced practice nurses in managing transitions of care for older adults.
3. Identify new knowledge in perioperative care of older adults.
4. Examine ways to effectively implement the AGS Beer's Criteria For Potentially Inappropriate Medication Use in Older Adults.
5. Discuss assessment and intervention strategies in fall risk reduction.
6. Review the impact of family care giving as well as community support resources.
8. Compare and contrast the various options for treating alcohol withdrawals.

Register

http://www.methodistcollege.edu/professional-development/course-calendar/niche-agewish-collaborative-focus-on-transitions

Cost: $87 with promo code 70PD

Key Note Speaker: Dr. Patricia Quigley
Key Note Speaker:
Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP

Associate Director, VISN 8 Patient Safety Center of Inquiry, is both a Clinical Nurse Specialist and a Nurse Practitioner in Rehabilitation. As Associate Chief of Nursing for Research, she is also a funded researcher with the Research Center of Excellence: Maximizing Rehabilitation Outcomes, jointly funding by HSR&D and RR&D. Her contributions to patient safety, nursing and rehabilitation are evident at a national level – with emphasis on clinical practice innovations designed to promote elders’ independence and safety. She is nationally known for her program of research in patient safety, particularly in fall prevention.

http://www.nursingworld.org/EspeciallyForYou/Nurse-Researchers/Patricia-Quigley-PhD-MPH-ARNP-CRRN-FAAN-FAANP.html
CAPTURE Falls Hospital Trends in Fall Rates 2010 - 2013

Trends in Fall Rates 17 NE Small Rural Hospitals
2010 - 2013

*Since 8/12 injurious falls included mild harm. Prior to 8/12, injurious falls may not have included mild harm.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012 Q1 - Q2 (n=15)</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fall Rate</td>
<td>7.08</td>
<td>5.50</td>
<td>6.78</td>
<td>5.31</td>
<td>4.08</td>
</tr>
<tr>
<td>Injurious Fall Rate*</td>
<td>2.54</td>
<td>1.95</td>
<td>2.89</td>
<td>1.82</td>
<td>1.15</td>
</tr>
<tr>
<td>Total Fall Rate NE CAHs (n=47)</td>
<td>5.90</td>
<td>5.90</td>
<td>5.90</td>
<td>5.90</td>
<td>5.90</td>
</tr>
<tr>
<td>Injurious Fall Rate NE CAHs (n=47)</td>
<td>1.70</td>
<td>1.70</td>
<td>1.70</td>
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<td>1.70</td>
</tr>
</tbody>
</table>

Note: 2013 definition of injury includes mild harm
Assessing Progress...Fall Rates

• Fall Rate Audit to validate
  – Fall Counts to verify what was reported vs actual number of reports received
  – Inpatient Days (NOT Admissions) Calculated from midnight census + Observation Hours/24
  – Admission Type for each fall event reported using MRN, admit date, fall date...please report from now on! See UNMC CAPTURE Event Form 3.0 on website.
    • Acute
    • Swing
    • Hospice
    • Observation
    • Outpatient
CAPTURE Falls Hospital Safety Culture Baseline to 2014

Hospital Survey on Patient Safety Culture Composite Positive Responses
CAPTURE Falls Pre- and Post-Project Assessment Comparison To National Database

- CAPTURE Falls Pre-Project (17 hospitals)
- CAPTURE Falls Post-Project (Spring 2014) (17 hospitals)
- 10th %ile 2014 National Database (653 hospitals)
- 90th %ile 2014 National Database (653 hospitals)

Survey dimensions: 612.0x792.0
17 open-ended comments from 10/17 hospitals referred to CAPTURE Falls or fall risk reduction

✓ “We work together, I mean everyone from laundry to lab to maintenance to nurses to doctors etc. If housekeeping sees someone trying to get out of bed, they bring this to nurse’s attention.”

✓ “Involvement of multidisplinary team members on a fall committee has been beneficial to initiation of additional safety practices incorporated from patient entry to the facility throughout the visit to discharge.”

✓ “I would like to see LARGER signs for Fall Risk whether it be a big Yellow Star on the door for Catch a falling star theme.”

✓ “Sometimes people need to remember that anyone can help a patient whose chair or bed alarm is going off.”

✓ “We are making great strides to improve our patient safety. Our management has been very proactive in incorporating various programs such as teamstepps, capture, etc.”

✓ “We have a rule to put on gait belts if patients are a fall risk. This rule is not always followed. I come on at 3p.m. and patients tell me ‘you don't need to put that on me-no one else has today.’”
Revising and Sustaining Reporting

• Send us copies of all reporting forms you are using for the project IF you have made modifications/additions
  – Email to kjonesj@unmc.edu
  – How best to collect changes in p/p?

• Advisory Panel to assist with revisions of form
  – Define data elements needed for incident reporting/RM vs. QI
  – Goal to create minimum data set needed for QI
  – Email to askinner@unmc.edu to participate 1 – 2 conference calls
• PLEASE...continue reporting through Dec. 2014
  – Will send you a quarterly report in Sept.
  – Serve as a resource
  – Goal: Create 2014 benchmark
Next Steps

• Huddle Quality Improvement

  – Objectives
  1. Identify best practices in facilitating post-fall huddles
  2. Evaluate the relationship between effective post-fall huddle processes and outcomes (e.g., team learning and patient safety).
  3. Develop a web-based training tool for promoting effective huddles

  – Steps
  1. Site Visits- Interview teams re: effective/ineffective huddles
  2. TPQ- assess quality of post fall huddles (questions developed for those who have participated in post-fall huddles)
  3. Analyze and share the results from the survey and interview protocols with interested fall risk reduction teams
  4. Develop an online training module for conducting effective post-fall huddles

How can huddles facilitate learning?

- 47 y/o female Dx of Orthostatic hypotension

<table>
<thead>
<tr>
<th>Day 2 Obs</th>
<th>Day 2 Obs</th>
<th>Day 10 Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>0410 Unassisted fall while amb from BR</td>
<td>0745 Unassisted fall off of toilet</td>
<td>1255 Unassisted fall off of commode; staff in room but unable to reach patient</td>
</tr>
<tr>
<td>Minor Harm</td>
<td>Minor Harm</td>
<td>No Harm</td>
</tr>
<tr>
<td></td>
<td>Stopped antihypertensive meds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BPs ordered q 4 hrs</td>
<td></td>
</tr>
</tbody>
</table>

- Last 2 falls included post-fall huddle of CNA and charge nurse
- Clarify if BPs ordered were at rest or with change in posture
- Actions taken: pt. education to use call light, staff to remain with pt. while toileting, use alarms if pt. up without assist, moved close to nurse’s station...none of these interventions address how to control the center of gravity when it is suddenly lost
Discussion

http://news.discovery.com/tech/virtual-moderator-helps-discussions-130506.htm
REMINDERS

Monthly Call: July 22, 2014 at 2:00 p.m. CST (no call in May)

Webinar #10: Posted July 1, 2014
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/capture_falls.htm
CA \ P \ T \ U \ R \ E  \ Falls

Collaboration and Proactive Teamwork Used to Reduce

Enter “capture falls” in google
http://unmc.edu/patient-safety/capture_falls.htm