Summary of the Structures and Processes Used to Improve Outcomes
AGENDA

1. Housekeeping

2. Summary of the structures and processes used in your action plans

3. Event Report Review: What do your events tell you about the need to redefine and clarify to achieve sustained change?

4. Open discussion
Housekeeping

• HSOPS results sent June 3 – 6; please review!
• TPQ response rate 45%...encourage response!
• Reports we will send you
  – 7/31: Final Site Visit Evaluations (Action Plan, Team Reflexivity)
  – 8/31 TPQ Results
  – 11/14 Fall Event Summary
• Monthly Calls now quarterly,
  – Next Call Sept. 23, 2014 at 2 pm CST
• End of Project Analyses
  – Scorecard Update and Fall Rate Audit
  – Fall Event Reports....Keep Reporting and send reports promptly to support our evaluation!
Keep Reporting through 2014!

Where will we go in 2014?

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

Cost: $87 with promo code 70PD
Best Practices in Health Literacy and Patient/Family Education now posted...3 Parts

1. Intro and Background

2. National Initiatives to Improve Health Literacy
   - CLAS Standards
   - Plain Language Act
   - CDC Clear Communication Index
   - AHRQ Patient Education Materials Assessment Tool

3. Best Practices in Written and Verbal Patient and Family Education
   - Definitions, terms, tools
   - Video from Minnesota Hospital Association

http://www.healthyroadsmedia.org/titles/EngFallsHosp/EngFallsHosp.htm
Toolkit Updates

• Safe Transfers and Mobility Videos
  – Available on Tool Inventory Page
    http://www.unmc.edu/patient-safety/cf_tool_inventory.htm
  – Plan is for 3 groups of 5 videos; Group 1 currently posted
  – General introduction and disclaimer for each video
Action Plan Items to Change Structure and Process

Standardized Action Plan Item Count by Hospital

- Implement fall prevention equipment: 14
- Educate staff on fall risk reduction policies/procedures: 14
- Update fall risk reduction policies/procedures: 13
- Improve reliability of interventions: 12
- Implement fall risk assessment tool: 12
- Communicate fall risk status: 11
- Learn from fall-related data: 10
- Educate pt/family on fall risk prevention: 7
- Implement post fall huddles: 5
- Implement purposeful rounding: 5
- Implement fall risk intervention: 5
- Implement medication review: 4
- Educate staff on safe transfers and mobility: 4
- Implement PT evaluation: 3
- Educate staff on fall risk reduction interventions: 3
- Clarify roles/Designate responsibility: 6
- Create a fall risk reduction team: 6
- Update fall risk reduction policies/procedures: 6
- Implement fall prevention equipment: 14
Clarify roles/Designate responsibility
Implement fall risk intervention
Educate staff on fall risk reduction interventions
Improve reliability of interventions
Update fall risk reduction policies/procedures
Learn from fall related data
Communicate fall risk status
Implement fall risk assessment tool
Create a fall risk reduction team.
Educate pt/family on fall risk prevention
Implement medication review
Implement post fall huddles
Communicate fall risk status
Implement fall prevention equipment
Educate staff on safe transfers and mobility
Implement purposeful rounding
Implement PT evaluation
Educate staff on fall risk reduction policies/procedures
Implement purposeful rounding
Implement post fall huddles
Implement fall prevention equipment
Communicate fall risk status
Implement fall risk assessment tool
Create a fall risk reduction team.
Educate pt/family on fall risk prevention
Implement medication review
Learn from fall related data
Update fall risk reduction policies/procedures
Improve reliability of interventions
Educate staff on fall risk reduction interventions
Implement fall risk intervention
Clarify roles/Designate responsibility
Extent of Implementation

Perceived Extent to which Action Plan Items are Implemented

- Create a fall risk reduction team: 93%
- Implement fall risk assessment tool: 90%
- Implement medication review: 86%
- Update fall risk reduction policies/procedures: 85%
- Implement purposeful rounding: 83%
- Implement PT evaluation: 81%
- Educate pt/family on fall risk prevention: 80%
- Educate staff on fall risk reduction policies/procedures: 80%
- Implement post fall huddles: 77%
- Learn from fall related data: 76%
- Communicate fall risk status: 76%
- Improve reliability of interventions: 75%
- Implement fall prevention equipment: 75%
- Educate staff on safe transfers and mobility: 69%
- Clarify roles/Designate responsibility: 69%
- Educate staff on fall risk reduction interventions: 66%
- Implement fall risk intervention: 57%

% AP items rated Mostly/Completely Implemented
## Ease of Implementation

### Perceived Ease of Implementation Action Plan Items

<table>
<thead>
<tr>
<th>Standard Action Plan Item</th>
<th>Process</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement medication review</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>Implement PT evaluation</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Implement post fall huddles</td>
<td>67%</td>
<td></td>
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<tr>
<td>Educate pt/family on fall risk prevention</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Update fall risk reduction policies/procedures</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Implement purposeful rounding</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Implement fall prevention equipment</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Implement fall risk intervention</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Educate staff on fall risk reduction interventions</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Educate staff on safe transfers and mobility</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Communicate fall risk status</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Implement fall risk assessment tool</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Improve reliability of interventions</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Create a fall risk reduction team.</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Educate staff on fall risk reduction policies/procedures</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Learn from fall related data</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Clarify roles/Designate responsibility</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

% Action Plan Items Rated as Easy to Implement
Fall Event Report

- 75 year/old female with dx of humerus and pelvic fractures due to fall in community; admitted to swing bed
- Moderate risk for fall; amb. with hemi walker
- Fell on day of admission at 1815
- Pt. requested to have privacy in bathroom; stood to wipe and fell resulting in mild harm; post-fall huddle not completed
- Contributing Factors
  - Organization: lack of compliance with policy
  - Patient: Impulsive behavior
Redefine and Clarify to Routinize

• Policy in place...if at moderate and high risk, patient not to be left alone in bathroom
• Behavior indicates need for redefining, clarifying
  – Recognize competing goals (pt satisfaction vs pt safety)
  – Provide scripting for staff
  – Set expectation with patient: you will not be left alone
  – Audit by asking pts...are you left alone in bathroom?

Initiation

Agenda Setting:
Identify need for innovation (performance gap as a trigger)

Matching:
Find innovation to meet need and bridge performance gap

Redefining/Restructuring:
Re-invent innovation to match context, restructure organization to fit innovation

Clarifying:
Make roles and tasks associated with innovation clear

Routinizing:
Innovation is hard-wired into organization's policies and procedures
http://news.discovery.com/tech/virtual-moderator-helps-discussions-130506.htm
REMINDEERS

Monthly Call: Sept. 23, 2014 at 2 p.m. CST
Webinar #10: Posted July 21, 2014
Best Practices in Health Literacy and Patient Education

Videos: Safe Transfer and Mobility Videos … Available on Tool Inventory Page http://www.unmc.edu/patient-safety/cf_tool_inventory.htm

Resources posted at http://www.unmc.edu/patient-safety/capture_falls.htm
CAPTURE

Collaboration and Proactive Teamwork Used to Reduce Falls

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