Monthly Collaborative Call #19
Sept. 23, 2014  2:00 – 2:30 p.m. CST

Sustainment through Learning is our Goal!
AGENDA

1. Housekeeping
2. Compare TPQ results from 2013 and 2014
3. Event Report Review: What can this event reveal about conducting post fall huddles?
4. Open discussion
Housekeeping

• TPQ response rate 50%, range 36% - 75%

• Reports
  – Sent: Final Site Visit Evaluations (Action Plan, Team Reflexivity)
  – 9/30/14 Individual TPQ reports comparing 2013 to 2014
  – 11/30/14 Fall Event Summary for first three quarters of 2014

• Calls now quarterly
  – Next Call Jan. 27, 2015 at 2 pm CST

• End of Project Analyses
  – Scorecard Update and Fall Rate Audit...receiving future grants is dependent upon publishing results from previous grants!
  – Fall Event Reports....Keep Reporting!
Comparing TPQ Aggregate Results

We are reporting a summary of aggregate results, which may not reflect the results for your hospital. The context of fall risk reduction varies within each hospital. Factors that affect context include safety culture, your use of teamwork, your use of learning tools such as post-fall huddles and RCA, and the extent to which leadership supports the work of the fall risk reduction team.
Change in Perceptions of Teamwork and Context for Fall Risk Reduction

University of Nebraska Medical Center

Team Structure  Team Leadership  Situation Monitoring  Mutual Support  Communication  Management/Sr. Leadership  Hospital Staff  Opinion Leaders  Hospital Resources

- 2013
- 2014
# The Survey
## Part 1: Perceptions of Teamwork

<table>
<thead>
<tr>
<th>Domain (Items)</th>
<th>Sample Item</th>
<th>% Positive* 2013</th>
<th>% Positive* 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Structure (7)</td>
<td>My unit/department has clearly articulated goals for fall risk reduction.</td>
<td>76%</td>
<td>80%</td>
</tr>
<tr>
<td>Leadership (7)</td>
<td>My supervisor/manager provides opportunities to discuss the unit/department’s performance after a patient fall.</td>
<td>69%</td>
<td>72%</td>
</tr>
<tr>
<td>Situation Monitoring (7)</td>
<td>Staff monitor each other’s performance when implementing fall risk reduction interventions.</td>
<td>69%</td>
<td>74%</td>
</tr>
<tr>
<td>Mutual Support (7)</td>
<td>Staff assist fellow staff to decrease the risk of falls during a high workload.</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>Communication (7)</td>
<td>Staff seek fall risk reduction information from all available sources.</td>
<td>66%</td>
<td>74%</td>
</tr>
</tbody>
</table>

* % who agreed/strongly agreed with the statement
# The Survey
## Part 2: Context for Fall Risk Reduction

<table>
<thead>
<tr>
<th>Domain (Items)</th>
<th>Sample Item</th>
<th>% Positive 2013</th>
<th>% Positive 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mgt/Senior Leadership (11)</td>
<td>Management rewards clinical innovation and creativity to improve fall risk reduction.</td>
<td>47%</td>
<td>56%</td>
</tr>
<tr>
<td>Mgt/Senior Leadership (11)</td>
<td>Management solicits opinions of clinical staff regarding decisions about fall risk reduction.</td>
<td>67%</td>
<td>74%</td>
</tr>
<tr>
<td>Opinion Leaders (4)</td>
<td>Opinion leaders believe that current fall risk reduction practices can be improved.</td>
<td>69%</td>
<td>66%</td>
</tr>
<tr>
<td>Hospital Resources (4)</td>
<td>We have the necessary support in terms of training.</td>
<td>77%</td>
<td>79%</td>
</tr>
</tbody>
</table>

* % who agreed/strongly agreed with the statement
Perceptions of Improvement...
Compared to 1 year ago, our hospital’s current fall risk reduction practices seem...

2013 2014

Don't know/Not applicable

Much worse

Worse

About the same

Better

Much better
Fall Event Report

• 50 year/old male with dx of lower extremity cellulitis admitted to swing bed

• Multiple comorbidities (MS, Cancer, CAD, DMII) resulting in inconsistency in functional mobility

• *High risk for fall (>13 on Johns Hopkins)*

• Fell 5 days after admission at 1120 while transferring from chair to bed with assist of 2 and no gait belt resulting in no physical harm

• Contributing Factors
  – Organization: Lack of compliance with policies
  – Patient: Multiple comorbidities
Redefine and Clarify to Routinize

• How to conduct effective post-fall huddles

• Conversation more important than completing a check list

• What was different for this patient this time?
Next Steps

1. Submit a grant application to Nebraska Research Initiative for funding to expand fall event reporting, analysis, and benchmarking to other interested Critical Access Hospitals (CAHs) in the state

2. Collaborate with CAH networks to create a strategy to sustain the fall event reporting, analysis, and benchmarking program.

3. Respond to your needs and share our results and findings.
   - Published two papers; contact me if you would like a hard copy. These papers represent new knowledge based on YOUR experience!
   - Presented to Nebraska Nursing Home Association/Nebraska Assisted Living Association
Discussion

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

Monthly Call: Jan. 27, 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/capturefalls/tool-inventory.html
CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce
Enter “capture falls” in google
http://unmc.edu/patient-safety/capturefalls/