AGENDA ITEMS

1. Housekeeping
   - Reminder to submit Fall Rate Data if you have not done so already. Please email Anne at askinner@unmc.edu if you need additional time to complete the worksheet.
   - The Hospital Survey on Patient Safety Culture is currently in the field. You should be receiving regular updates on your response rate.

2. Please be prepared to share with the group:

   * What has your team done during the CAPTURE Falls project that has provided your hospital with the most bang for your buck?

   - Post-fall huddles have been a major help in the identification of errors. Now not just nursing is involved; the patient’s family, physical therapy and pharmacy are all involved. Falls are not recognized as just a nursing problem anymore. They are considered a hospital issue and everyone is helping to find other ways to prevent falls, not just sticking an alarm on patients. We are implementing more multidisciplinary solutions and now are able to customize interventions for patients.
   - Post fall huddles have increased interdisciplinary communication. Staff are now asking questions and updating fall risk based on any change in patient’s medications or after surgeries (blocks).
   - Pharmacists are reviewing medications (remote pharmacy if after hours) for potential interactions and for potential of medications to increase fall risk. For example, 90 year-old male cognitively intact patient was given one or two doses of morphine. Shortly thereafter, patient started trying to get up and got caught up in lines, was terribly confused, and experienced a fall. During post-fall huddle involving pharmacy, the role of medication increasing fall risk was discussed. Nurses are first to think bed alarms, chair alarms; involving pharmacy allows for different types of thinking and involvement.
   - Established decreased fall rate as an organizational goal. We now provide quarterly education to ALL staff. It’s everyone’s responsibility to know if someone is wandering the halls with yellow booties on that that is not supposed to be happening.
   - Baby video monitor placed in patients to observe patients from nurse’s station. Bed/chair alarms are also in place.
   - After a patient is dismissed, Housekeeping is responsible for ensuring that a bag containing a chair alarm, chair pad, fall signage, yellow booties, and gait belt is complete and in the patient room cabinet. Aide knows that they can open the cabinet and find what they need.
• One thing done, change from pull tab alarms that patients could pull off their gowns. Switched to pressure alarms after hearing people talk about them on the calls. System is working much better. As soon as alarm goes off, staff runs. They now know when patient is wiggling and may be about to get up.

**What has been the biggest challenge your team has faced?**

• New hospital layout causing challenges. Private rooms, which are more spread out, make it more difficult to constantly monitor patients.

• Biggest issue was buy-in from everyone—that falls are not just a nursing problem. Involving everyone and making it more multi-disciplinary. Not so much push back, they were listening but it was still viewed as the responsibility of nursing and nursing assistants and other disciplines were not involved. We held educational sessions and communicated the message that fall risk is all about what is best for the patient.

• Our challenge has been actually having staff make a change after there is a fall. They discuss but actually don’t make any changes. Rewrote policy on options available to reduce the risk of falls. One on one follow-up needed. Need for documentation on thought processes and changes implemented. Pharmacy and PT not available to them to make post fall huddles more interdisciplinary.

**What has your team learned from participating in CAPTURE Falls that could apply to other safety and quality issues?**

• We learned how event reports could help us to learn about our system. During our quarterly we learned that we had a pattern with assisted falls resulting in harm. Further analysis revealed that gait belts were not being used with unassisted falls.