Quarterly Collaborative Call #20
Jan. 27, 2015  2:00 – 2:30 p.m. CST

Plans for Sustainment and Next Steps!
AGENDA

1. Housekeeping

2. Next Steps…

3. Event Report Review: This event shows effective use of post-fall huddle

4. Open discussion … Challenges and successes in sustaining gains
Housekeeping

- Web site updates
  - Post fall huddle tools
  - Mobility Training Videos (16)

- Reports
  - 404 fall event reports from 17 small rural hospitals
    8/12 – 1/15

- Scorecards
  - 16/17 returned…need this data to complete evaluation

- Audits of fall reports
  - 15/17 returned…importance of bed type (is bed type associated with fall risk?)
Percent of Bed Types for Fall Event Reports (n=404)

- Acute, 57.7%
- Swing, 24.3%
- Observation, 4.2%
- Hospice, 1.5%
- Missing, 12.4%
Association Between Bed Type and Harm for Fall Event Reports (n=355)

- **Moderate-Severe Harm**
  - Acute (n=226): 30.1%
  - Hospice (n=6): 50.0%
  - Observation (n=17): 47.1%
  - Swing (n=98): 30.6%

- **Mild Harm**
  - Acute (n=226): 68.1%
  - Hospice (n=6): 50.0%
  - Observation (n=17): 52.9%
  - Swing (n=98): 66.3%

- **No Harm**
  - Acute (n=226): 45.9%
  - Hospice (n=6): 0.0%
  - Observation (n=17): 42.9%
  - Swing (n=98): 0.4%
Next Steps

• Dissemination of Results
  – Rural Health Leadership Conference (Phoenix) 2/9/15
  – 5th Annual International Improvement Science and Research Symposium (London) 4/21/15
  – TeamSTEPPS National Conference (Denver) 6/17/15

• Develop “Know Falls” Online Information system
  Initiative for funding to expand fall event reporting, analysis, and benchmarking to other interested Critical Access Hospitals (CAHs) in the state

• Further research
  – Learning across the multi-team system
  – Patient Perceptions of fall risk

• Keep Reporting!!!
Fall Event Report...learning from the huddle

- 65 year/old male with dx of anemia, falls
- *At risk for falls*
- **What Happened?**
  
  CNA assisted to standing with gait belt and walker so patient could void. CNA left room to provide privacy. Pt. began yelling for help; CNA returned to room. Pt’s knees buckled, CNA attempted to scoot him up on bed but feet slipped and he slid to the floor suffering abrasion to back.

- **Contributing Factors**
  - Organization: lack of clarity regarding whether to leave pt at risk alone while urinating? Admitted for falls but no PT/OT eval until after fall; post-fall huddle positively identified issues for learning!
  - Patient: urgency, weakness
http://news.discovery.com/tech/virtual-moderator-helps-discussions-130506.htm
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REMINDERS

Quarterly Call: March, 24, 2015 at 2 p.m. CST

Review the tools creating with your assistance

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