Quarterly Collaborative Call #21
March 24, 2015  2:00 – 2:30 p.m. CST

Changes in Fall Rates and Sensemaking in Post-Fall Huddles!

AGENDA

1. Housekeeping

2. Evaluation Progress

3. Next Steps…


5. Open discussion …
   - Feedback about post-fall huddle forms
   - Challenges and successes in sustaining gains
Housekeeping

- Web site updates
  - Presentations posted
  - Post fall huddles videos in development

- Reports
  - 423 fall event reports from 17 small rural hospitals
    8/12 – 3/15...Thank you and keep reporting!

- Evaluation
  - All scorecards and audits returned...thank you!
  - Data sets assembled (there is a lot of data!)
  - Framework for evaluation (next slide)
    - Characteristics of MTS components (coordinating team, core team, contingency team)
    - Development of MTS components
    - Linkages between components of MTS

MTS Components and Linkages

- IP Coordinating Team
- IP Core Team
- IP Contingency Team

Event Information
Who, What, When, Where

Event Sensemaking
How, Why

Patient Information

Patient Sensemaking

Patient Action

Patient Outcome (Fall ?)

System Information

System Sensemaking

System Action

System Outcome (Fall Rate)

Data

Conduct Annual /New Emp. Training
Assess Competencies
Integrate Evidence from Multiple Disciplines
Develop Policies/Procedures (e.g. Communication of Fall Risk)
Develop Fall Event Reporting Forms
Collect, Analyze Fall Event Data
Choose Fall Risk Assessment Tool
Provide Feedback about Actions Taken

Audit Bedside Interventions
Conduct Root Cause Analysis
Benchmark Rates
Change in Fall Rates Over Time for 17 Small Rural Hospitals in CAPTURE Falls

<table>
<thead>
<tr>
<th>Years</th>
<th>Total Falls/1000 Patient Days</th>
<th>Injurious Falls/1000 Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2012</td>
<td>5.9</td>
<td>2.1</td>
</tr>
<tr>
<td>2013-2014</td>
<td>4.1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Change in Fall Rates 2010 vs. 2014 According to Baseline Accountability Structure

- No One: Change in Total Fall Rates 2010 vs. 2014 = -7.43
- Individual: Change in Injurious Fall Rates 2010 vs. 2014 = -3.84
- Team: Change in Total Fall Rates 2010 vs. 2014 = -0.96, Change in Injurious Fall Rates 2010 vs. 2014 = -0.94
Next Steps

- Dissemination of Results
  - Rural Health Leadership Conference (Phoenix) 2/9/15
  - American College of Medical Quality (Alexandria, VA) 3/27/15
  - 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...how to learn from the huddle

- 85+ yr/old male with dx of weakness, dehydration
- At risk for falls; visually assessed < 1 hour before
- What was the patient doing?
  Attempting to transfer from bedside recliner to bed at 1915; TABs unit alarmed, patient found in sitting position in front of recliner.
- Outcome?
  No harm
- Determine root causes...what was different this time?
  Unknown...patient impulsive, incr. confusion
# Post-Fall Huddle Facilitation

**Post-Fall Huddle Facilitation Guide Section 1**

**Purpose:** To lead a post-fall huddle with staff and the patient/family to a conversation to determine why a patient fell and what can be done to prevent future falls.

**Directions:** Complete after ALL (assisted and unassisted) patient falls as soon as possible after patient care is provided but prior to leaving the shift.

**Participants:** Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, and family members as appropriate.

**Remember:** Patients fall because their center of mass is outside their base of support.

***During the huddle look for specific answers and continue asking “why?” until the root cause is identified.***

## 1. Establish facts:

| 1.a. Did we know this patient was at risk? | Y | N |
| 1.b. Has this patient fallen previously doing this stay? | Y | N |
| 1.c. Is this patient at high risk of injury from a fall? (ABCD) | | |
| Age 85+ | | |
| Nociception | | |
| Coagulation | | |
| Surgical Post Op Patient | | |

**NOTES**

1. **ASK:** What was the patient doing when he/she fell?
   - Be specific, e.g., transferring to/from the bedside chair, without their walker. Ask why multiple times.

2. **ASK:** What were staff caring for this patient doing when the patient fell? Ask why multiple times.

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**EXCELLENT DOCUMENTATION:**

*Note high risk of injury from falls.*

## 2. Establish what patient and staff were doing and why:

**NOTES**

- Attempting to transfer from bedside recliner to bed.
- Finishing report.
- Falls alarm went off - staff regard alarm immediately.

## 3. Determine underlying root causes of the fall:

**NOTES**

- Unknown - pt. impulsive
- Ht. Dementia

**ASK:** What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.

- What was different about environment, time of day, changes in patient's medications/procedures/sleep.

**ASK:** How could we have prevented this fall?

- Had a talk with the patient.

**ASK:** What changes will we make in this patient's plan of care to decrease the risk of future falls?

- Consider: I fall sitter, utilizing huddle, code, meeting the team, medication review, pharmacies, pt. confused, impulsive, and wandering needs close monitoring.

**ASK:** What changes can we make to environment, chair?

**ASK:** What patient or system problems need to be communicated to other departments, units or disciplines?

- Gait belt, walker, transfer

**ASK:** How many other patients have fallen/slipped from chair in past year? What do they have in common?

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**3/23/2015**
Excellent documentation...notes tell us the story of what was done.
Discussion

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

REMINDERS

Quarterly Call: June, 23, 2015 at 2 p.m. CST

Review the tools created 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/