Quarterly Collaborative Call #21
June 23, 2015  2:00 – 2:30 p.m. CST

Effectiveness of fall risk reduction coordinating team was associated with fall rates
AGENDA

1. Housekeeping
2. Summer Research Project
3. Event Report Review
4. Evaluation Progress
5. Sustainment
Housekeeping

- Dissemination
  - TeamSTEPPS National Conference 6/16/15…Using TeamSTEPPS Tools to Partner with Patients and Prevent and Learn from Falls
  - Post fall huddles videos available for downloading at http://webmedia.unmc.edu/nursing/heroes/capturefalls/
  - Will be posted to CAPTURE Falls website http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

- Reports
  - 475 fall event reports from 17 small rural hospitals 8/12 – 6/22…Thank you and keep reporting!
  - Use revised post-fall huddle forms and pocket guide available at http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html
Summer Research Project

“Eliciting Patient and Caregiver Perceptions of Fall Risk in the Hospital”

Purpose: Elicit patient & caregiver perceptions of fall risk reduction interventions…3 research questions

1. How does implementation of evidence-based fall risk reduction interventions affect patient and caregiver perceptions of safety?
2. How does participation in post-fall huddles affect patient and caregiver perceptions of safety?
3. How does variation in techniques used by different hospital personnel for mobility and transfers affect patient and caregiver perceptions of safety?
Summer Research Project

Aims

1. To conduct interviews with 8 to 10 adults who were discharged from the hospital and their caregivers to determine their perceptions of being safe from falls.

2. To develop a self-report instrument (sample below) that quantifies patients’ and caregivers’ perceptions of safety in response to fall risk reduction interventions.

![Perception of Safety Rating Scale]

1 2 3 4 5

How safe do you feel?
Summer Research Project

- Recruiting Three Types of Participants
  1. adult patients identified as at risk for falls and who DID NOT FALL
  2. adult patients who FELL resulting in no harm or minor and participated in a post-fall huddle; and
  3. adult patients who FELL resulting in no harm or minor harm and who did not participate in a post-fall huddle
- Hospital sends letter to patient inviting participation; patient/caregiver contacts us to express interest...
- No further involvement from hospital
Event Reports

- 11 fall event reports from 9 patients listed alcohol withdrawal/detox as primary diagnosis
- Two repeat fallers...7 males, 2 females
- 10/11 falls were unassisted
- 3 mild harm, 8 no harm
- Age 33 – 81; average age = 49
- Are you using a symptom triggered benzodiazepine treatment protocol?


- Contact us for protocol references
Evaluation Progress (Ovretveit, 2014)

- Capture falls...complex social intervention
  - Multiple components
  - Multiple organizational levels
  - Requires behavior change
  - Multiple outcomes
  - Flexible...match needs, context of each hospital

- Evaluation of complex social interventions
  - Context...does culture support change?
  - Does extent of implementation explain outcomes?
  - Is outcome explained by theory
Change in Fall Rates Over Time for 17 Small Rural Hospitals in CAPTURE Falls

- **Total Falls/1000 Pt Days**
- **Injurious Falls/1000 Pt Days**

<table>
<thead>
<tr>
<th>Years</th>
<th>Total Falls/1000 Pt Days</th>
<th>Injurious Falls/1000 Pt 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>
## Extent of Implementation

<table>
<thead>
<tr>
<th>Fall Risk Reduction Team Activities</th>
<th>Team Performs Activity</th>
<th>Team Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create policies and procedures regarding fall risk reduction</td>
<td>0</td>
<td>Not Effective</td>
</tr>
<tr>
<td>Select interventions to reduce the risk of falls</td>
<td>0</td>
<td>Somewhat Effective</td>
</tr>
<tr>
<td>Select fall risk assessment tool(s)</td>
<td>0</td>
<td>Effective</td>
</tr>
<tr>
<td>Link targeted interventions to identified risk factors to reduce the risk of falls</td>
<td>0</td>
<td>Very Effective</td>
</tr>
<tr>
<td>Conduct audits to monitor adherence to fall risk reduction interventions</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Communicate results of audits to staff</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Select/Develop/Revise Fall Reporting Form</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Educate staff about fall risk reduction policies and procedures</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Educate staff to use fall risk assessment tool(s)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Educate staff to choose appropriate fall risk reduction interventions</td>
<td>0</td>
<td></td>
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<tr>
<td>Educate staff to report all falls (Unassisted &amp; Assisted)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Educate staff about outcomes of your fall risk reduction program</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Clearly communicate fall risk reduction program barriers and successes with hospital senior leadership and CEO</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Share fall risk reduction program and outcomes with hospital board members</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Extent of Implementation

- Extent of implementation of 16 fall risk reduction activities
  - Mean = 43.6/64
  - Range = 31-57/64
Extent of Implementation Associated with Outcome

Association Between Coordinating Team Activities and 2014 Total Fall Rates

Spearman rho = -0.53
Extent of Implementation Associated with Outcome

Association Between Coordinating Team Activities and 2014 Injurious Fall Rates

Spearman rho = -0.42
How are you sustaining?

Rogers’ Organization Innovation Process

**INITIATION**
- Agenda Setting/Need
- Matching

**DECISION**
- Redefining

**IMPLEMENTATION**
- Clarifying
- Routinizing

Implement Process Audits
- Monthly Support Calls Monitor Change
- Feedback on Fall Event Reports
- Share Innovations and Best Practices
- Evaluate Changes in Culture

CAHs have higher fall rates due to lack of team structure & org. processes

- MTS structure
- Evidence-based unit and org. processes

Re-invent innovation to match context, restructure organization to fit innovation

Make roles and tasks associated with innovation clear

Hard-wire: audits, policies, procedures, job descriptions, performance appraisals

(Rogers, 2003)
http://news.discovery.com/tech/virtual-moderator-helps-discussions-130506.htm
REMINDEERS

Quarterly Call: September 22, 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://www.unmc.edu/patient-safety/capturefalls/