Quarterly Collaborative Call #22
October 18, 2016 2:00 – 2:30 p.m. CST

Learning by Understanding Complex Systems and Spotlight on Falls in the Shower
AGENDA

1. KNOW Falls Debrief
2. Lessons Learned from Your Reporting
3. Spotlight on Falls in the Shower
KNOW Falls Purpose

1. Standardize definitions
2. Standardize data collection for benchmarking
3. Facilitate learning and critical thinking about complex patient and system factors that result in falls and fall-related injury

Where specifically in the inpatient care area?

- Bedside
- Chairside
- Bathroom
- Hallway
- Unknown
- Other

Did staff assist the patient (hands on) during the fall?

- Yes
- No
- Unknown

Was a gait belt used during the assist?

- Yes
- No
- Unknown

Describe the fall

Patient stood from wheelchair at bedside to transfer to bed. Patient’s pant leg caught on the wheelchair pedal/ RN bent down to untangle pant leg and patient fell to floor landing on her buttocks and hitting the back of her head on the night stand. X 3 assist to get off floor. Patient complained of pain on buttocks, assessed, no redness or deformity. Provider notified.
REDCap Online Reporting

- Research Electronic Data Capture (REDCap) web application
  - HIPAA compliant
  - Online fall event learning system
  - Real-time access to data and reporting functions
KNOW Falls Debrief

• What is going well?
  – Does using system facilitate critical thinking

• What is not going well?

• What should we improve?
Five Outcomes Product of System and Patient Factors

1. Reporting Fall Events
   – Unassisted Falls (injurious & non-injurious)
   – Assisted Falls (injurious & non-injurious)

2. Total Fall Rate

3. Injurious Fall Rate

4. Unassisted Fall Rate

5. Repeat Fall Rate

\[
\text{# falls (e.g. 10)/ # fallers (e.g. 7) = 1.4}
\]
Using Correlations to Reveal System Factors

• + as one factor increases so does the other
• - as one factor increases the other decreases

• .1 – .3 Weak
• .3 - .5 Moderate
• > .5 Strong
What Drives Reporting?

- Goal: ALWAYS report all falls...unassisted & assisted; injurious & non-injurious

**Train All Clinical Staff:** Safe Transfers & Mobility

**Train All Staff:** Fall Risk Reduction Program
- Purpose & Definitions
- Interventions
- Outcomes
- Each team member’s role

Report All Fall Events

- .65*
- .60*
What Drives Total Fall Rate?

• Moderately driven by fall risk reduction team coordination

Coordination by Fall Risk Reduction Team (21 activities)
• Create policies/procedures
• Select fall risk assessment tool
• Link targeted interventions to risk factors
• Conduct audits to monitor adherence
• Communicate results of audits to staff
• Educate all staff

(All Falls/ Pt. Days) *1000

-0.44
What Drives Unassisted Fall Rate?

• Strongly driven by fall risk reduction team coordination

Coordination by Fall Risk Reduction Team (21 activities)
• Create policies/procedures
• Select fall risk assessment tool
• Link targeted interventions to risk factors
• Conduct audits to monitor adherence
• Communicate results of audits to staff
• Educate all staff

(Unassisted Falls/ Pt. Days) $\times 1000$

-0.59*
What Drives Injurious Fall Rate?

- Strongly driven by educating nursing staff to think critically about the risk factors identified by the fall risk assessment tool

- Education about Fall Risk Assessment Tool

  \[-.52^*\]

  Injurious Falls/ Pt. Days *1000
**What Drives Repeat Fall Rate?**

- Strongly driven by conducting post-fall huddles, implementing universal interventions, educating staff to conduct huddles and implement mechanical lifts.

<table>
<thead>
<tr>
<th>Action</th>
<th>Effect Size</th>
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<tbody>
<tr>
<td>Conduct Post-Fall Huddles</td>
<td>-.73*</td>
</tr>
<tr>
<td>Educate about Mechanical Lifts</td>
<td>-.56*</td>
</tr>
<tr>
<td>Education about Post-Fall Huddles</td>
<td>-.55*</td>
</tr>
<tr>
<td>Implement Universal Interventions</td>
<td>-.52*</td>
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**Repeat Fall Rate Falls/Patients**

\[
\frac{20 \text{ falls in one year}}{16 \text{ patients}} = 1.25 \text{ falls/pt.}
\]
What is Relationship Between Fall Risk Reduction Team and Bedside Core Team?

• Coordinating Team drives reliability of core team

- Coordination by Fall Risk Reduction Team (21 activities)
  - Targeted Interventions
    - .83*

- Education by Fall Risk Reduction Team
  - Overall program
  - Use of Tool
  - Safe Transfers & Mobility
  - Mechanical Lifts
  - Conduct Post-Fall Huddles
  - Universal Interventions
    - .44*
    - .57*
Falls while showering…

• 21/658 falls occurred in the shower
• Average age 61.9 (range 19 – 82)
• 5/21 falls were assisted
• 8/21 resulted in injury
• Unassisted falls often described staff as just outside the bathroom, in arms reach; not directly assisting the patient.
Best Practices for Decreasing Fall Risk while Showering*

- Do not leave patients unattended if at high risk
- Appropriate shower chair/bench for patient
  - height, weight capacity, arm rests

*Provided by Cally Tejkl, OTR/L   St. Francis Memorial Hospital
Best Practices for Decreasing Fall Risk while Showering*

• If standing, always maintain at least one hand on grab bar
• Textured floor
• Waterproof gait belts
• Don grippy socks/footwear before exiting the bathroom
• Communicate patient-specific information about fall risk at shift change…
  – Assist level and transfer technique
  – Impulsiveness
  – History of previous falls

*Provided by Cally Tejkl, OTR/L  St. Francis Memorial Hospital
Best Practices for Decreasing Fall Risk while Showering

• Use shower shoes for best grip*

*Provided by Kate Brummer, OTR/L  Box Butte General Hospital
Discussion

Assistance is an email away!

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

• General implementation and best practices (including RCA) …Katherine (kjonesj@unmc.edu)

• KNOW Falls and Online Learning (RedCAP) … Anne (askinner@unmc.edu)

• Interpreting Teamwork Perceptions Questionnaire, Leadership, Team Learning and Functioning … Vicki (victoria.kennel@unmc.edu)

• If in doubt contact all of us!
Quarterly Collaborative Calls:

- Tuesday Jan 24, 2017 14:00 CST
- Tuesday April 18, 2017 14:00 CST
- Tuesday July 25, 2017 14:00 CST
- Tuesday Oct 24, 2017 14:00 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 Falls
Enter “capture falls” in google
http://www.unmc.edu/patient-safety/capturefalls/