Quarterly Collaborative Call #28
July 17, 2018 2:00 – 2:30 p.m. CST

In-House Communication about Falls and System Learning
AGENDA

1. Housekeeping: CAPTURE Falls Project Updates and Team Changes
2. In-house Communication about Falls
3. System Learning
CAPTURE Falls Project Updates and Team Changes

Thank you Katherine Jones!

CAPTURE Falls Research Team Members:
• Dawn Venema, PT, PhD
• Victoria Kennel, PhD
• Anne Skinner, RHIA, MS
• Mary Wood

Continued funding support from the Nebraska Department of Health and Human Services for the CAPTURE Falls project!
Activities planned through next fiscal year

• Continued improvement of KNOW Falls; Continue reporting!
• Individual calls with your hospital Fall 2018 and Spring 2019; Update of gap analysis scorecard
• Continued quarterly collaborative calls
• Request of 2018 and 2019 patient days for calculation of fall rate benchmarks
• Evaluation of factors related to assisted fall rates and strategies your team uses to learn from and take action on falls
• Continued updates to project website
How do we know when falls occur?

In-House Communication Flow

**Fall Event**

- **Convene Post-fall Huddle Team**
  - Who?
  - How?
  - When?

- **Complete Paper and/or Online Forms**
  - Who?
  - When?

- **Inform Fall Risk Reduction Team**
  - Who?
  - How?
  - When?

- **Conduct Post-fall Huddle**
  - Who?
  - When?

- **Fall Risk Reduction Team Review**
  - Who?
  - How?
  - When?
How do we know when falls occur?

In-House Communication Flow

• Facility 1:
  – Post-fall huddle conducted with staff present immediately after fall occurs
  – Fall shared with the rest of the team and reported to the rest of the staff
  – Incident report completed and sent to DON, and then to the safety officer
  – Fall risk reduction team convenes to discuss the fall, and then enter the data as a team
  – Still seeking mechanisms to fully incorporate interdisciplinary input into decision making process
How do we know when falls occur?

In-House Communication Flow

• Facility 2:
  – Conducting interdisciplinary stand-up rounds Monday-Friday
  – All care team members (nursing, therapy, pharmacy, lab, social services, dietary, mid-level providers, etc.) participate
  – Nurses report on each patient
  – Staff discuss patients at risk for falls to increase awareness of fall risk; all provide input into actions to mitigate fall risk
  – Discuss fall events and measures to implement to keep patients safe
  – Process enables interdisciplinary input into each fall
How do we know when falls occur?

In-House Communication Flow

- Facility 3:
  - Post-fall huddle conducted with available staff
  - Case studies created for each fall using the System Learning form
    - Distributed to all nursing staff via computer system
  - Enables continued education about falls and the opportunity for all staff to learn from falls
How do we know when falls occur?

In-House Communication Flow

• Facility 4:
  – Fall event form indicates staff must email completed event form to CAPTURE Falls team
  – Staff on duty conduct their post-fall huddle
  – Team convenes the morning after the fall, or if fall occurs over the weekend the team convenes on Monday, to further discuss and learn from the fall
How can we learn from falls and take action to prevent future falls?

1. Conduct Post-fall Huddles
   - Understand the cause of the fall and contributing factors
   - Take action to reduce the risk of a repeat fall

2. Conduct System-level Review
   - Review fall event and huddle
   - Identify error types that contributed to the fall
   - Reflect on how to reduce the risk of this type of fall for future patients in context of your system
   - Identify and implement system changes
System Learning Process

Know Falls - User Group Test Site

Actions: Download PDF of instrument(s) VIDEO: Basic data entry

System Learning Form

Editing existing Event ID 2220-1 06-21-2018 03:30:123456

Event ID 2220-1

CAUSE OF FALL - PATIENT LEVEL

CAUSE OF FALL - SYSTEM LEVEL
(To be completed by Fall Risk Reduction Team)

Did this fall occur because planned interventions were NOT in place as intended? (e.g. bed alarm not activated)

- Yes - Task Error
- No

Did this fall occur because an individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting the absence of a policy not to do so)

- Yes - Judgement Error
- No

Did this fall occur because communication among multiple staff members was incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)

- Yes - Care Coordination Error
- No

Did this fall occur because communication and multiple elements (tasks, knowledge, equipment) combined to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)

- Yes - System Error
- No

Please describe/discuss what your team learned about your fall risk reduction system as a result of this fall.

How will your team communicate the knowledge gained from this fall to the rest of your organization?
# Case Study 1: Fall Event

## Patient
- 87 y/o female
- Admitted for fall at home, dehydration
- FRASS score: 18 (+15 = Very High Risk for falls)

## Comorbidities and Meds
- OA, HTN, Type II DM, mild cognitive impairment
- Glipizide (DM), Lisinopril (HTN), Celecoxib (OA)

## Functional Status
- Ambulates and transfers with wheeled walker, assist of one

## Fall Interventions in Place
- Bed/chair alarm, gait belt, hourly rounding, personal items within reach, non-slip footwear, patient education, PT, assistive device, fall risk bracelet and signage, use of communication board

## Description of Fall
- Fall occurs at 4pm. Pt recently returned to room with PT. PT did not set chair alarm. Pt got up to amb to bathroom on own. Discovered by CNA leaning against fall next to toilet. Pt reports she lost her balance when turning to sit on the toilet. No injury.
### Case Study 1 continued: Post-Fall Huddle

<table>
<thead>
<tr>
<th><strong>Post-Fall Huddle Participants</strong></th>
<th>• Charge nurse, primary nurse, CNA, PT, and patient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause of fall (patient level):</strong></td>
<td>• Anticipated physiological (known patient related risk factors contributed)</td>
</tr>
<tr>
<td><strong>What was different this time?</strong></td>
<td>• Pt was unassisted in bathroom because alarm didn’t alert staff pt was getting up on own.</td>
</tr>
<tr>
<td><strong>How could have fall been prevented?</strong></td>
<td>• Remember to set chair alarm. PT forgot to do so despite communication white board indicating alarms were in use for this patient.</td>
</tr>
<tr>
<td><strong>Actions to prevent recurrence for this patient</strong></td>
<td>• Re-educate PT regarding alarm policy, re-educate patient to call for assistance.</td>
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# Case Study 1 continued: System Learning

| System Learning Form Completion | Fall event and post-fall huddle notes reviewed at next CAPTURE Falls Coordinating Team meeting  
|                               | System learning form completed as a team |
| Cause of fall (system level):   | Task error...fall occurred because planned interventions were not in place as intended (PT forgot to set chair alarm |
| Actions needed at SYSTEM LEVEL to decrease risk of this task error: | Random audits of fall risk interventions including alarm use are already being done. Continue to monitor these processes through random audits. Monitor future falls for similar task error as that may indicate need for additional staff education. |
| What did team learn about the system as a result of this fall? | Human error can still occur despite safeguards (communication board) in place. |
| How will team communicate knowledge gained to rest of the organization? | Nothing at this time. Will monitor to see if errors persist and address then if needed. |
Case Study 2: Fall Event

Patient

• 87 y/o female
• Admitted for fall at home, dehydration
• FRASS score: 18 (+15 = Very High Risk for falls)

Comorbidities and Meds

• OA, HTN, Type II DM, mild cognitive impairment
• Glipizide (DM), Lisinopril (HTN), Celecoxib (OA)

Functional Status

• Ambulates and transfers with wheeled walker, assist of one

Fall Interventions in Place

• Bed/chair alarm, gait belt, hourly rounding, personal items within reach, non-slip footwear, patient education, PT, assistive device, fall risk bracelet and signage, use of communication board

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<td>Pt was unassisted in bathroom because alarm didn’t alert staff. Pt was getting up on own.</td>
</tr>
<tr>
<td>How could have fall been prevented?</td>
<td>Set chair alarm. PT was unaware that chair alarm was part of care plan. Had not looked specifically in the EMR for fall risk reduction interventions in place for this patient. No visual reminders were present in the room to facilitate alarm use.</td>
</tr>
<tr>
<td>Actions to prevent recurrence for this patient</td>
<td>Education of PT regarding alarm usage for this patient and where to locate this information in the EMR, re-educate patient to call for assistance, discuss fall risk interventions during patient hand-offs.</td>
</tr>
</tbody>
</table>
Case Study 2 continued: System Learning

- Fall event and post-fall huddle notes reviewed at next CAPTURE Falls Coordinating Team meeting
- System learning form completed as a team

- Care coordination error...fall occurred because communication among staff was incomplete. PT was unaware that alarm was to be used for this patient.

- Develop visual communication strategy within patient rooms to inform all staff about fall risk reduction interventions to be in place (signage, white board, etc.)

- Need to make communication efficient among the many staff that are in/out of our patient rooms

- Once strategy is developed, will communicate to all departments via internal newsletter, email to staff, and visit to departmental meetings by member of the CAPTURE Falls Coordinating Team.
Key Takeaway Points

• Value in learning from and taking action to prevent falls at the bedside and at the system level
  – Fall risk reduction team owns the system level learning process
  – What are the system level issues we need to address?

• Is system action required immediately? Or do we need to audit processes and monitor for patterns before taking action?
Discussion

Assistance is an email away!

• Contact us for more information about:
  – Fall risk reduction best practices: Dawn (dvenema@unmc.edu)
  – KNOW Falls and Online Learning (RedCAP): Anne (askinner@unmc.edu)
  – Team performance, implementation challenges: Vicki (victoria.kennel@unmc.edu)
  – General questions or not sure?: CAPTURE.Falls@unmc.edu

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

• Tuesday Oct. 23, 2018 14:00 CST
• Topic TBD….let us know if there is something you’d like to discuss!

Review the tools created with your assistance

http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html