Quarterly Collaborative Call #30
January 22, 2019 2:00 – 2:30 p.m. CST

Maintaining Awareness of Falls through Team Rounds and No-Fall Huddles
AGENDA

1. Housekeeping
2. Team Rounds/Huddles
3. No-Fall Huddle
Housekeeping

1. Fall Rate Benchmarking
2. Nursing and Rehab Therapies study
3. Final “quarterly” call late Spring 2019
Sustainment Challenge: Maintaining Awareness

Awareness of patient fall risk and inpatient falls has improved – but how do we sustain this??
### Recommendation from Literature

- Conduct "improvement huddles" to anticipate problems, review performance, and support a culture of improvement

### CAPTURE Falls Example

- Post-fall huddles
- *Daily rounds/huddles*
- *No-fall huddles*
Potential Solution: Daily Rounds/Huddles

• Create opportunities for members of the interprofessional team to discuss falls and fall risk reduction on a regular basis
Potential Solution: Daily Rounds/Huddles

- Crete Area Medical Center’s approach
  - In person safety huddles were poorly attended
  - Designated 1-2 team members from each department to participate in an online team
  - Created a space online using a Skype group for real-time event reporting and learning
    - Falls included in this
  - Enables team to respond more quickly to events
Potential Solution: Daily Rounds/Huddles

- Other approaches described on individual hospital quarterly calls
  - Use daily multidisciplinary rounds to discuss recent falls and get input from professions unable to attend post-fall huddles (i.e. second stage of “hybrid” post-fall huddle)
  - EMR helps drive a “systematic” conversation during daily multidisciplinary rounds about patients’ plans of care, discharge goals, and fall risk reduction needs
Potential Solution: ‘No-Fall’ Huddles

| What                           | Team huddles intended to:                                                                 |
|                               | • Proactively address fall risk reduction for patients at high risk for falls               |
|                               | • Retrospectively reflect on successes in fall prevention for patients at high risk for falls |
| Who                           | Members of the patient care team                                                          |
|                               | Patient and/or family                                                                     |
|                               | Members of the fall risk reduction team, if available                                      |
| When*                         | Proactive – upon admission, during daily rounds                                            |
|                               | Retrospective – during daily rounds, at/after discharge                                    |
| Where                         | Patient bedside or another space that facilitates team discussion                          |
| Why                           | Maintain awareness of fall risk reduction practices                                        |
|                               | Learn from successes and near misses/risky behavior                                         |
| How                           | No-Fall Huddle Guide                                                                      |
## Prospective ‘No-Fall’ Huddle Tool

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<thead>
<tr>
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<th>No-Fall Huddle (Prospective)</th>
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<tbody>
<tr>
<td><strong>F</strong> – facts</td>
<td>Establish facts: a) is this patient at risk? b) a previous fall? c) ABCs?</td>
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| **A** - actions | Establish what the patient and staff need to do to prevent a fall, and why.  
*Determine the key interventions and behaviors that need to be in place to keep this high-risk patient safe from a fall.*  
*What does the patient need to do to help minimize their risk of falling? Why?*  
*What do staff caring for this patient need to do to help minimize the patient’s risk of falling? Why?* |
| **LL** – likely or lingering issues and lessons learned | What circumstances might increase the patient’s risk of falling?  
*Given this patient’s risk factors, what is the most likely scenario in which he/she will fall?*  
*What might we overlook that would increase this patient’s risk of a fall?*  
How will we prevent this fall? |
| **S** – steps forward | What patient or system information needs to be communicated to other departments, units or disciplines?  
Ensure patient’s plan of care reflects appropriate interventions. |
# Retrospective ‘No-Fall’ Huddle Tool

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<thead>
<tr>
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<th>No-Fall Huddle (Retrospective)</th>
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<tbody>
<tr>
<td><strong>F – facts</strong></td>
<td>Review the facts: a) was this patient at risk? b) a previous fall? c) ABCs?</td>
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| **A - actions** | Establish how patient and staff actions kept this high-risk patient safe from falling, and why.  
*Determine the key interventions and behaviors that kept this high-risk patient safe from a fall.*  
*What did the patient do to decrease their risk of falling? Why?*  
*What did staff do to decrease patient’s risk of falling? Why?* |
| **LL – likely or lingering issues and lessons learned** | Did staff engage in any at-risk behaviors that could have led to a fall?  
*What ‘near-misses’ did we catch that could have contributed to a fall?*  
*What ‘at-risk’ behaviors did we overlook?*  
*What was different this time as compared to other times when similar high-risk patients have fallen?*  
How can we prevent future falls for similar types of patients? |
| **S – steps forward** | What patient or system successes and problems need to be communicated to other departments, units or disciplines?  
Disseminate success story to share lessons learned with all staff. |
Help us develop and validate the ‘No-Fall’ team huddle tool and process

- Feedback on the first version of our no-fall huddle guiding questions
- Interested in pilot testing this process in your hospital

Contact Vicki at victoria.kennel@unmc.edu
Discussion:

• Your thoughts on what you have heard?
• Strategies that have worked or not worked for you?
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
Quarterly Collaborative Calls:

- Tuesday April 23, 2019 14:00 CST
- Topic: TBA
- Tuesday July 23, 2019 14:00 CST

Review the tools created with your assistance

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