CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

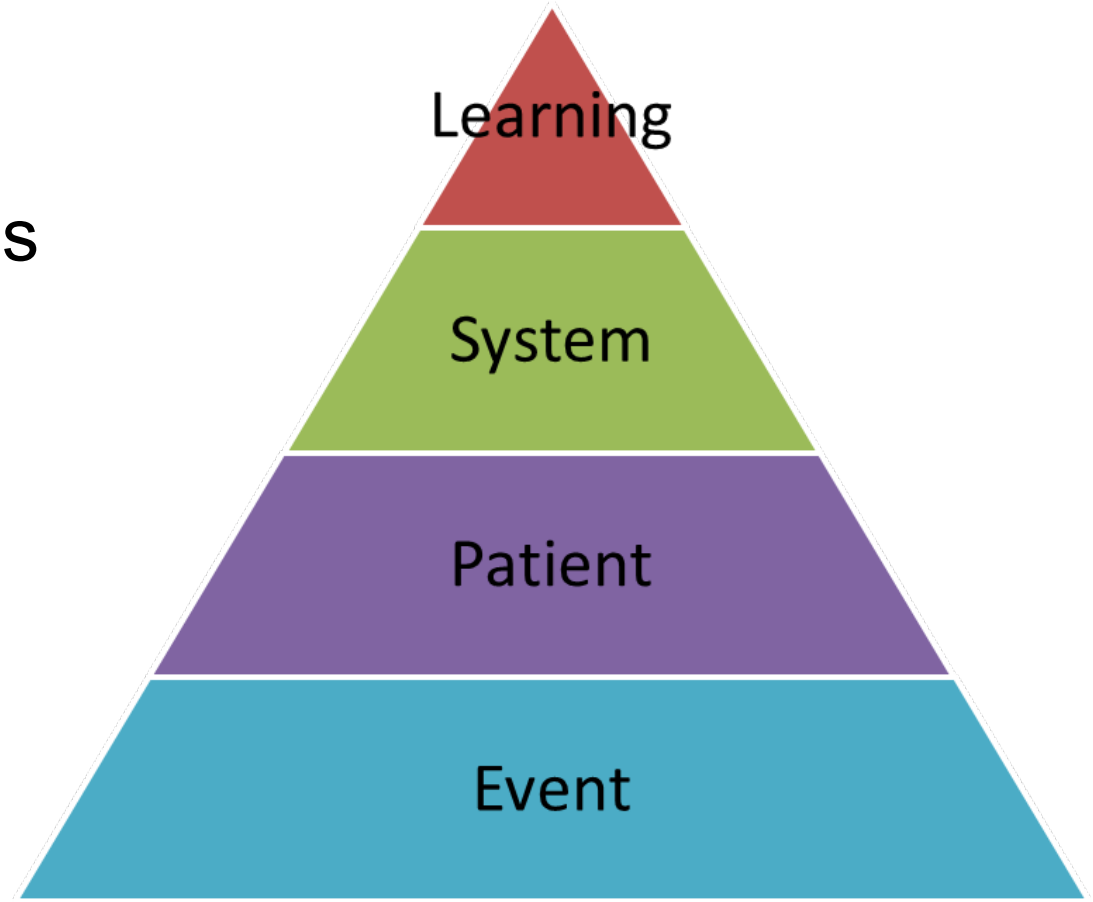
Quarterly Collaborative Call #30
January 22, 2019 2:00 – 2:30 p.m. CST

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

UNMC

AGENDA

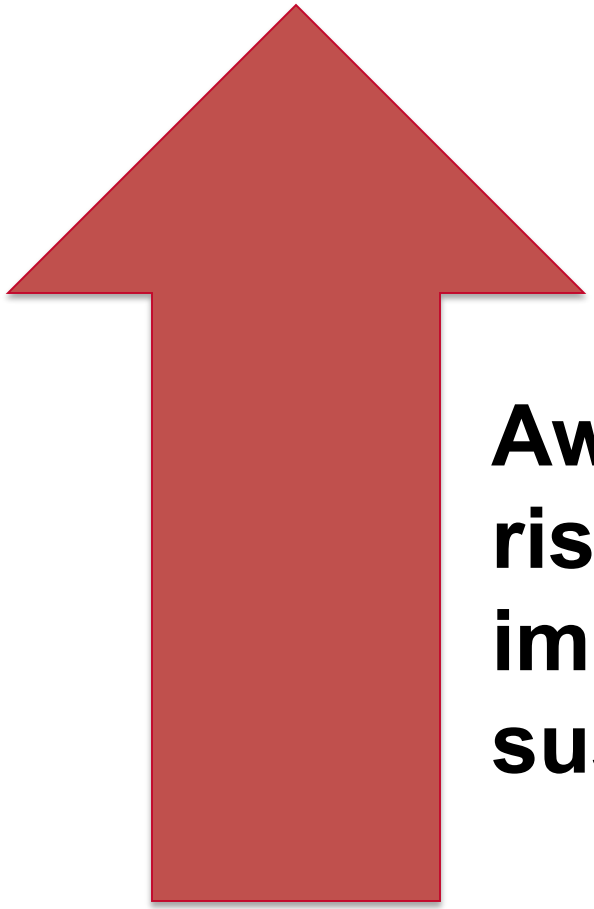
1. Housekeeping
2. Team Rounds/Huddles
3. No-Fall Huddle



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??

How to promote sustainment

Recommendation from Literature	CAPTURE Falls Example
• Conduct "improvement huddles" to anticipate problems, review performance, and support a culture of improvement	• 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

	No-Fall Huddle (Prospective)
F – facts	Establish facts: a) is this patient at risk? b) a previous fall? c) ABCs?
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

	No-Fall Huddle (Retrospective)
F – facts	Review the facts: a) was this patient at risk? b) a previous fall? c) ABCs?
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

REMINDERS

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