CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce
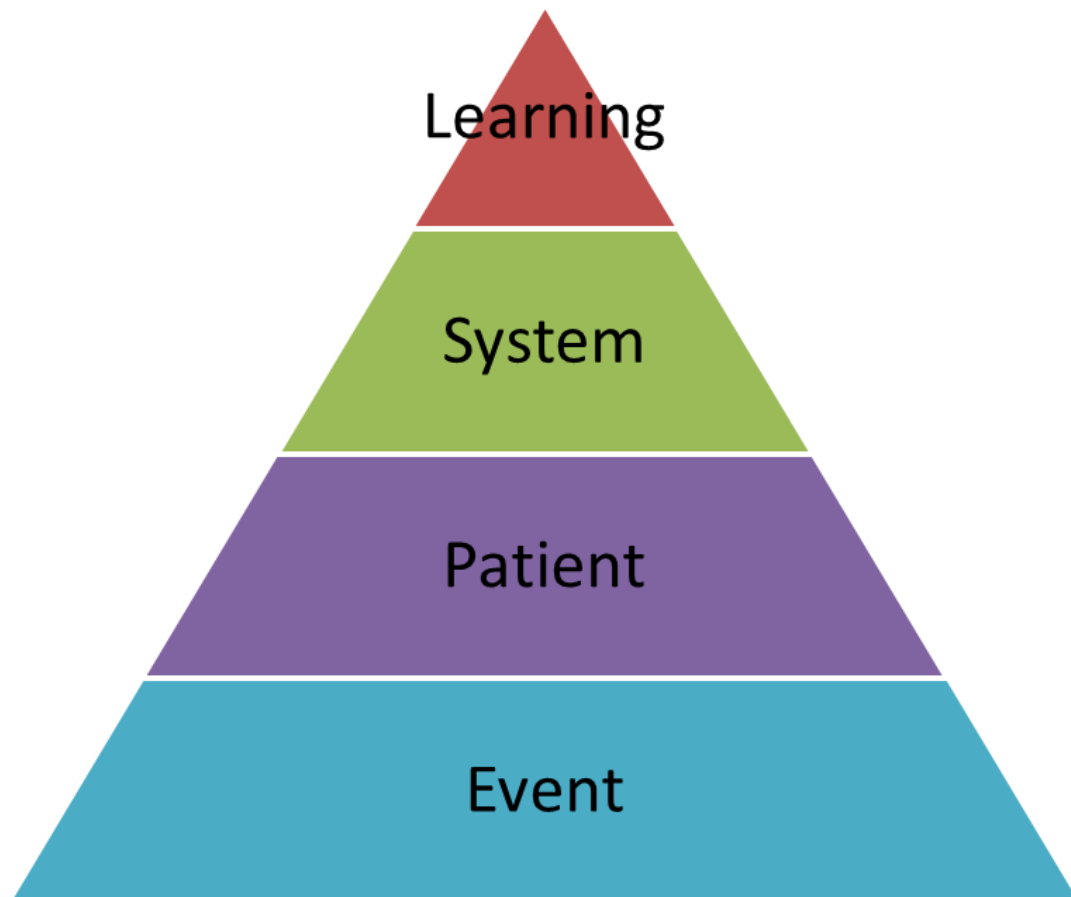
Quarterly Collaborative Call #31
April 23, 2019 2:00 – 2:30 p.m. CST

What's in a Rate?

UNMC

AGENDA

1. Housekeeping
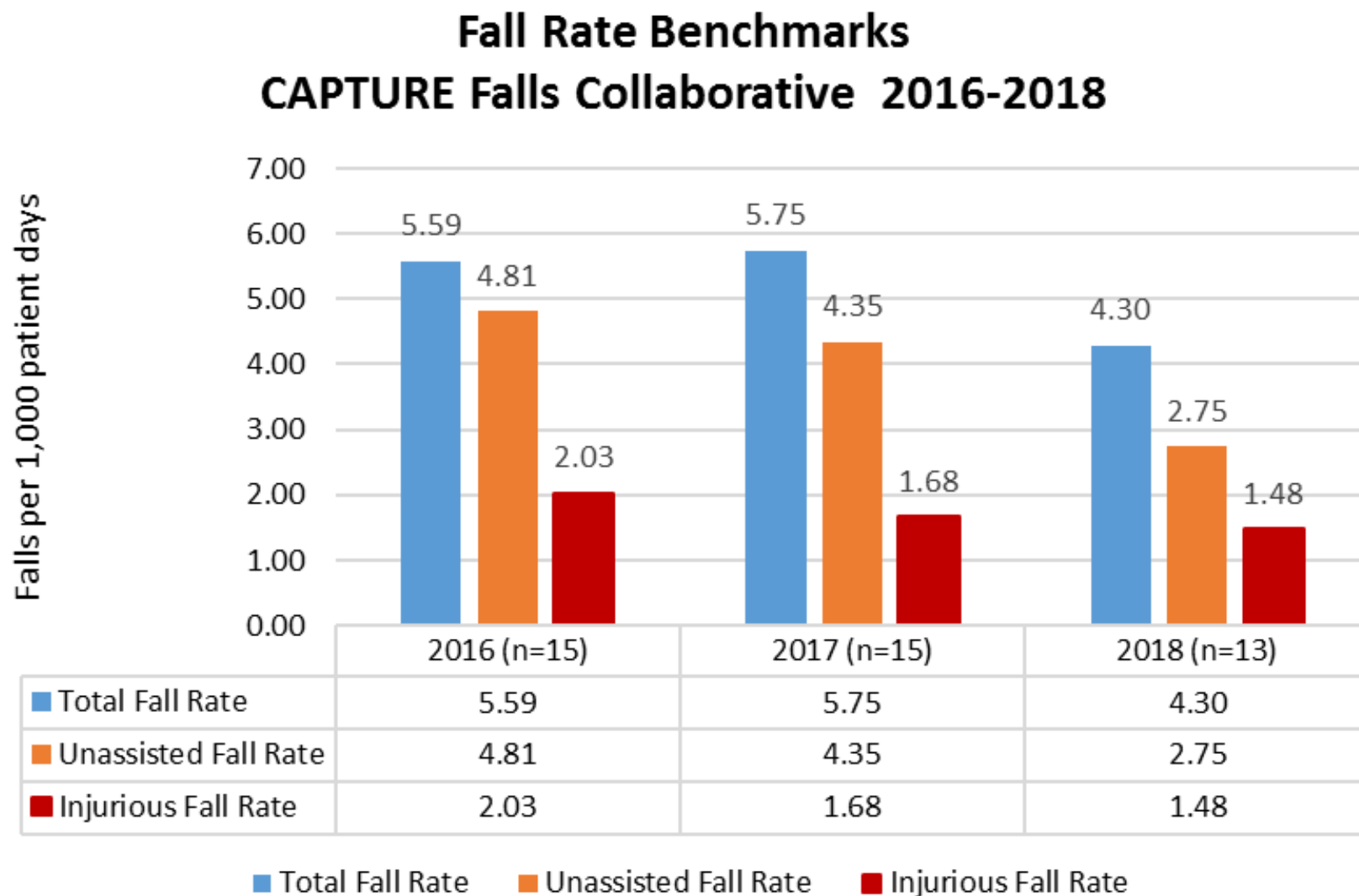2. 2018 Fall Rate Benchmarks
3. Fall Rate Discussion

Housekeeping

1. Nursing and Rehab Therapies Collaboration Survey
2. Final "quarterly" call late Spring 2019
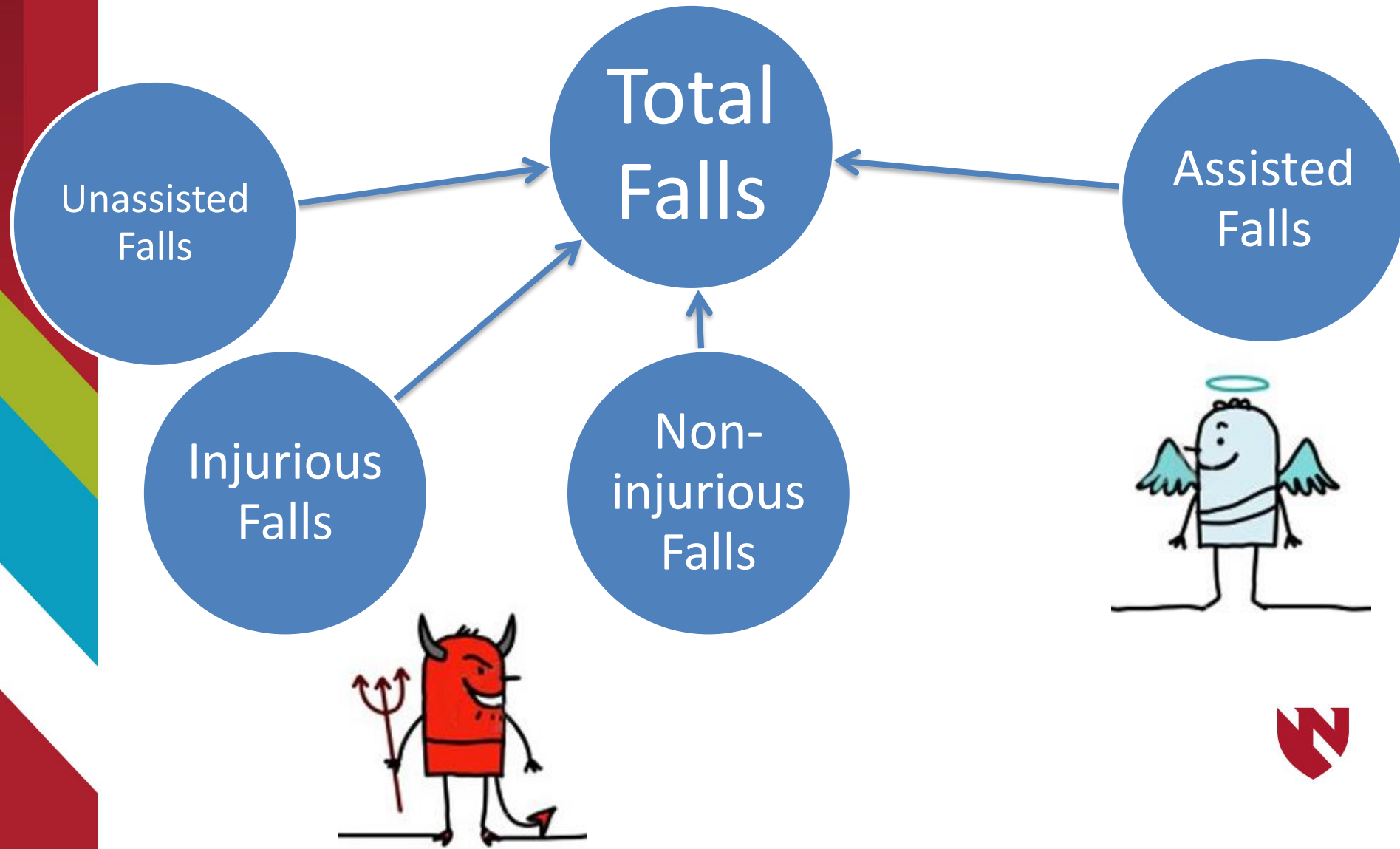3. CAPTURE Falls moving forward

2018 Fall Rate Benchmarks

Fall Rate Benchmarks
CAPTURE Falls Collaborative 2016-2018

Falls per 1,000 patient days

	2016 (n=15)	2017 (n=15)	2018 (n=13)
■ Total Fall Rate	5.59	5.75	4.30
■ Unassisted Fall Rate	4.81	4.35	2.75
■ Injurious Fall Rate	2.03	1.68	1.48

■ Total Fall Rate ■ Unassisted Fall Rate ■ Injurious Fall Rate

What's In a Total Rate? Both Good and Bad…

Predictors of Fall-Related Injury

- Based on 3,962 falls from 8 Midwestern Hospitals from 2001-2003

- The odds of injury for an unassisted fall were 1.83 times that of an assisted fall.

- "Even if fall rates remain the same, increasing the proportion of falls that are assisted by a staff member could help decrease injury rates."
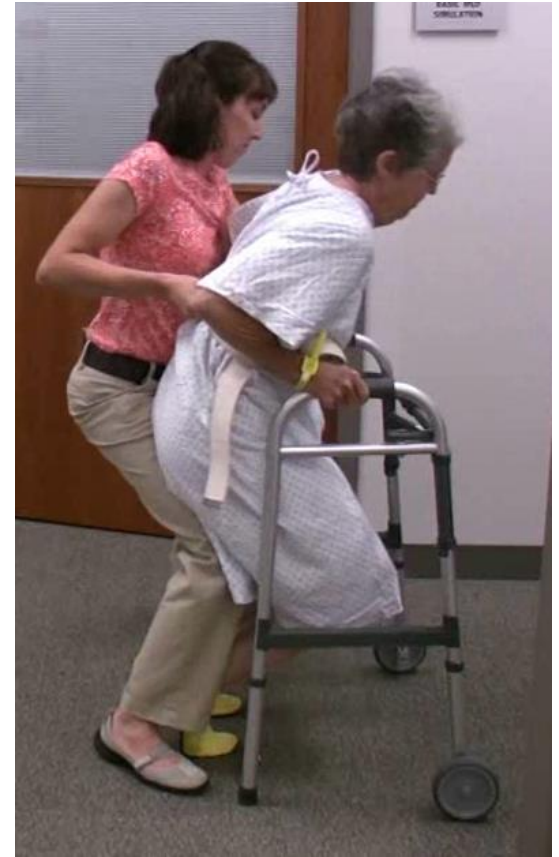
Krauss MJ, Nguyen SL, Dunagan WC, Birge S, Costantinou E, Johnson S, Caleca B, Fraser VJ. Circumstances of patient falls and injuries in 9 hospitals in a midwestern healthcare system. *Infect Control Hosp Epidemiol*. 2007 May;28(5):544-50.

Predictors of Fall-Related Injury

- Based on 154,324 falls reported to the NDNQI in 2011
- The odds of injury for an unassisted fall were 1.59 times that of an assisted fall.

Staggs VS, Mion LD, Shorr RI. Assisted and unassisted falls: different events, different outcomes, different implications for quality of hospital care. *Jt Comm Jrnl*. 2014;40: 358-364

All Falls Are Not Created Equal

Staggs et al, 2014

"When falls tend to occur with assistance, it suggests that staff have identified at-risk patients and are in attendance during mobilization activities...."

"...a more appropriate patient safety goal is reducing unassisted falls, which pose the greatest preventable risk of injury."

"...we would argue that an assisted fall, particularly during mobilization, is not necessarily a failure for the hospital staff and should not be treated as such."

All Falls Are Not Created Equal

Staggs et al, 2015

"Unassisted falls…uniquely reflect quality of care in that they occur when staff members are absent, unaware that the patient needs assistance, or unable to help for some other reason."

"…attempts to prevent all falls could discourage appropriate patient mobilization."

Staggs VS, Davidson J, Dunton N, Crosser B. Challenges in defining and categorizing falls on diverse unit types: lessons from expansion of the NDNQI Falls Indicator. *J Nurs Care Qual*. 2015 Apr-Jun;30(2):106-12.

Predictors of Fall-Related Injury

- Based on 353 falls reported by 17 rural Nebraska hospitals in 2012-2014

- The odds of a fall resulting in injury were:

  - 2.5 times greater for someone ≥ 65 vs. < 65

  - 2.5 times greater if a fall occurred in the bathroom vs. other location

  - 3.7 times greater if an fall was assisted <u>without</u> a gait vs. assisted <u>with</u> a gait belt
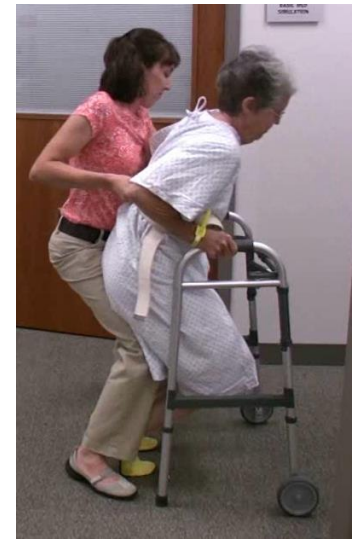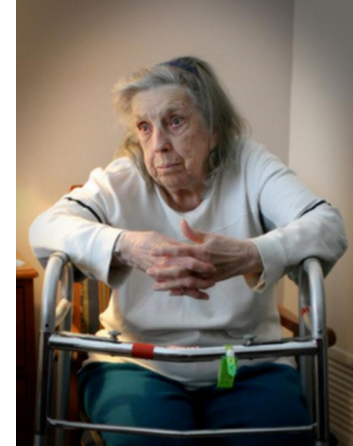
Venema DM, Skinner AM, Nailon R, Conley D, High R, Jones KJ. Patient and system factors associated with unassisted and injurious falls in rural hospitals: An observational study. Submitted to *BMC Geriatrics* (under review).

Predictors of Falling Unassisted

- Based on 353 falls reported by 17 rural Nebraska hospitals in 2012-2014
- The odds of a fall being unassisted were:
  - 2.5 times greater for someone ≥ 65 vs. < 65
  - 3.7 times greater for someone with cognitive impairment vs. without
  - 7 times greater if a gait belt was not identified as an intervention in the care plan for that patient vs if it was identified as an intervention.

Venema DM, Skinner AM, Nailon R, Conley D, High R, Jones KJ. Patient and system factors associated with unassisted and injurious falls in rural hospitals: An observational study. Submitted to *BMC Geriatrics* (under review).
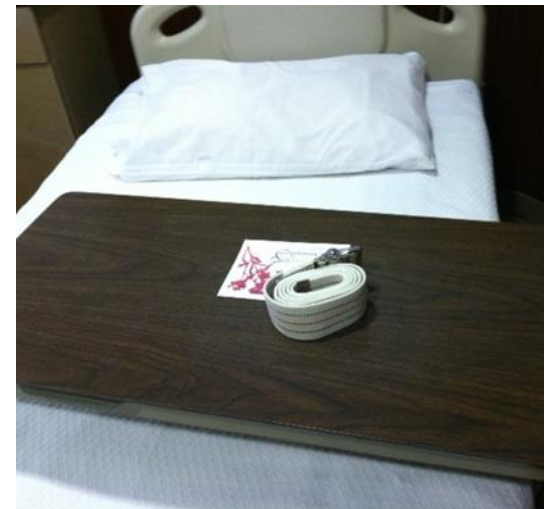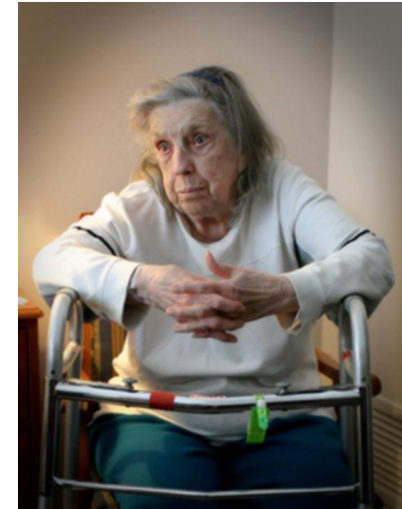
How do you measure up?

- Compare Your Total, Unassisted, and Injurious Rates to the Benchmark
  - Pay particular attention to the unassisted and injurious rates!

How do you measure up?

- Recognize that with small numbers, results may be skewed
- Element of luck?
  - Do things wrong and a patient doesn't fall
  - Do things right and a patient still falls
- Recommend use of process measures to also track your success (audits)

Two Assisted Falls…Two Different Outcomes…Both Opportunities to Learn

- 84 y/o male patient
- Dx: pneumonia, deconditioning
- Transfer and ambulation status: assist of 1 with wheeled walker and gait belt
- Patient was being weighed; knees began to buckle as he was stepping backwards to get off scale
- Staff was assisting pt from behind; Was able to lean pt against them and slowly lower to floor
- Result: No injury; Staff commended for properly assisting patient; Identification that safe transfer and mobility training program was having intended outcomes

Two Assisted Falls…Two Different Outcomes…Both Opportunities to Learn

- 74 y/o male patient
- Dx: CHF, DM
- Transfer and ambulation status: transfers with assist of 2 with gait belt; Pt not able to ambulate any appreciable distance
- 2 staff assisted pt to commode; 1 left to answer another call light. 2nd staff member remained behind the pt.
- Pt began to fall forward from commode. Staff attempted to slow descent by grabbing for shoulders, but was unsuccessful
- Result: Laceration to forehead requiring steri-strips; Identified need for additional reinforcement of safe transfers and mobility concepts for staff.

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 July 23, 2019 14:00 CST
- Topic TBD…What would you like to hear about?

Review the tools created with your assistance

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

C A P T U R E

Collaboration and Proactive Teamwork Used to Reduce

Falls