

CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

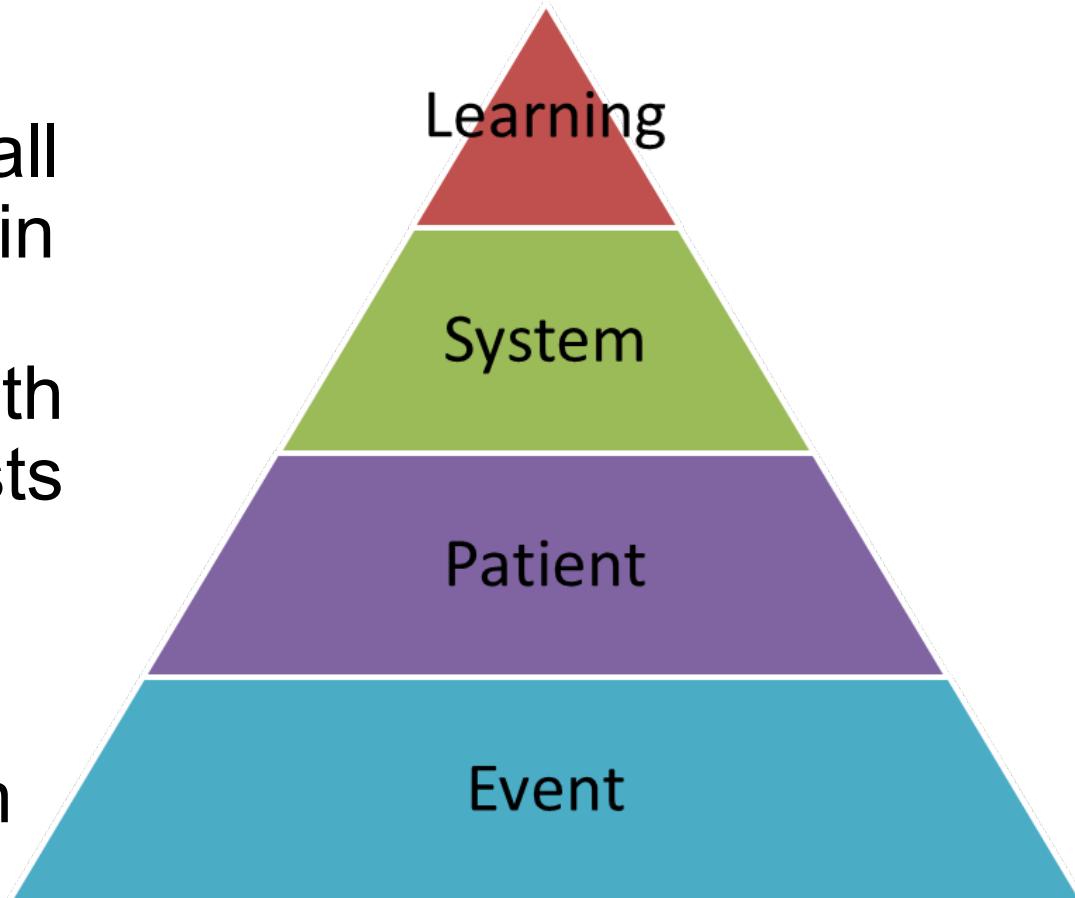
Quarterly Collaborative Call #32

July 23, 2019 2:00 – 2:30 p.m. CST

**Strategies for Fall Risk Reduction in a
Geriatric Behavioral Health Unit**

AGENDA

1. Housekeeping
2. Strategies for Fall Risk Reduction in a Geriatric Behavioral Health Unit – with guests from Fillmore County Hospital Fall Risk Reduction Team



Housekeeping



1. Thinking of colleagues in central NE
2. Thank you for your feedback!
3. CAPTURE Falls moving forward
4. Global Online Summit about hospital immobility July 10-12th; recorded presentations can be found at <https://endpjparalysis.org/>



The Challenge...

- Patients with delirium, dementia, or psychosis may be agitated and confused, putting them at risk for falls

-AHRQ Fall Prevention Toolkit, 2013

- Rate of falls in geropsych patients may be as high as 17.1 falls/1000 patient days

-Oepen et al, Int Psychogeriatr, 2018

- Odds of falling unassisted were 3.7 times greater for pts with cognitive impairment

-Venema et al, BMC Geriatrics, under revision

- Odds of fall-related injury were 2.8 times greater for pts on geropsych unit

-Fischer et al, Infect Control Hosp Epidemiol, 2005



Managing Falls in a Geriatric Inpatient Psychiatric Unit

Fillmore County Hospital in Geneva, NE

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Geriatric Inpatient Psychiatric Facility

- Opened in 2015
- Distinct part unit within CAH
- 10 Beds
- Average LOS 10-12d
- 85% Neurocognitive Disorder
- 55+



Patient Population

- Axis I Diagnosis
 - Major Depressive Disorder, Schizophrenia, Bipolar Disorder
- Exhibiting behaviors related to diagnosis
 - Paranoia, hallucinations, suicidality, hyper sexuality, agitation, *increased aggression*
- Medical Comorbidities
 - Diabetes, Parkinson's, COPD, CHF, PVD

Patient Population (cont.)

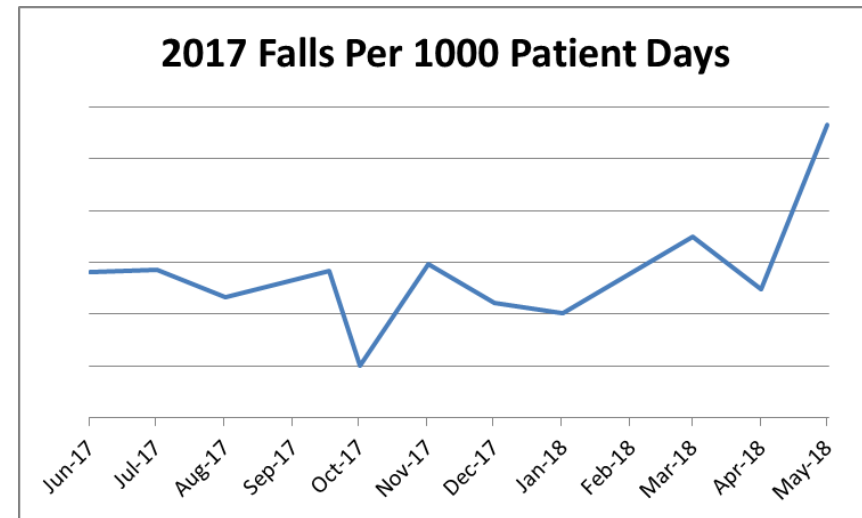
- Referrals
 - Nursing Homes, Emergency Departments, Family members
- Reason for referral
 - Acute change in mental status
 - Behaviors have become unmanageable in current setting
 - Patient needs 24 hour supervised treatment
 - Case is of high complexity

What we do

- Goal:
 - Decrease behaviors
 - Restore previous function
- Nursing Staff
 - 1-2 RN
 - 2-3 LPN, CNA, MHT
- Psychiatrist & APRN
- Methods:
 - ID Triggers
 - De-escalation techniques
 - Establish schedules
 - Medications
 - Antidepressants
 - Mood Stabilizers
 - Stimulants
 - Antipsychotics

Addressing Falls


- Motivator-
 - Higher falls rate than desired
- Struggle with benchmarking
 - Acute Care
 - Memory Care/Dementia Unit
 - General Nursing Home



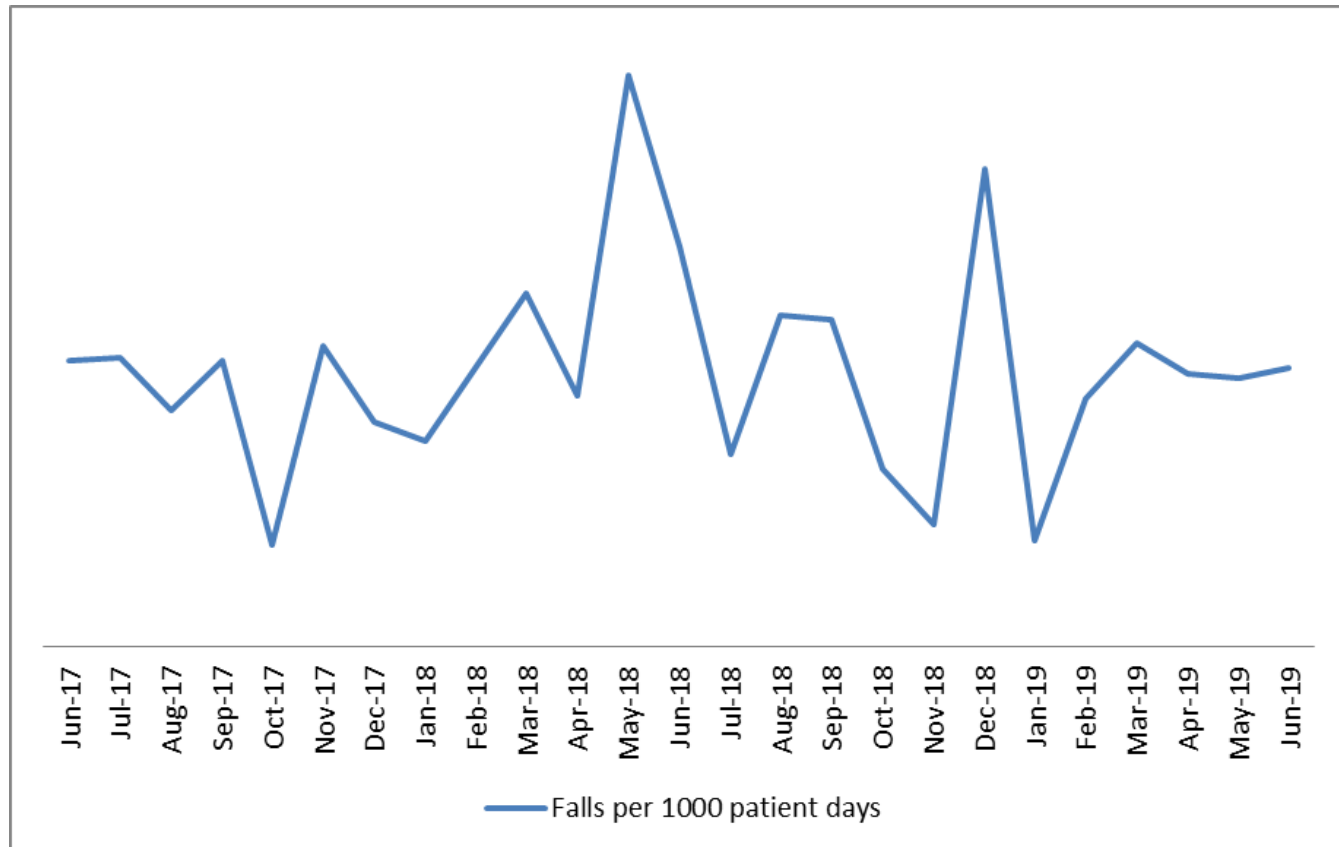
Initial Steps

- Assembled a fall prevention team
 - Nurses
 - CNAs/ Mental Health Techs
 - Pharmacy
 - Physical Therapy
 - DON & Quality
- Started with what we knew*
- Focus on Fall Risk
 - Morse Scale Assessment
 - Average >80
 - History of falls, forgets limitations, weakness
 - Universal Precautions and Targeted interventions
- Post-Fall Huddle

Fall Prevention Interventions

- Hourly Rounding
- Nonskid Footwear
- Declutter Environment
- Alert sign 
- Wrist Band
- Gait belt
- Supervised ambulation, transfers, toileting etc.
- 15 minute rounds
- Varied compliance
- Limited environment
 - Hallucinations
- Signs got moved all over the unit
- Bands removed by patient
- Difficult storage of gait belts
- Patients forget limitations

Falls Rate June 2017-June 2019



Year 1 to Year 2 saw average
decrease in falls of 2.5 falls/ 1000
patient days

Looking at Falls through a different lens



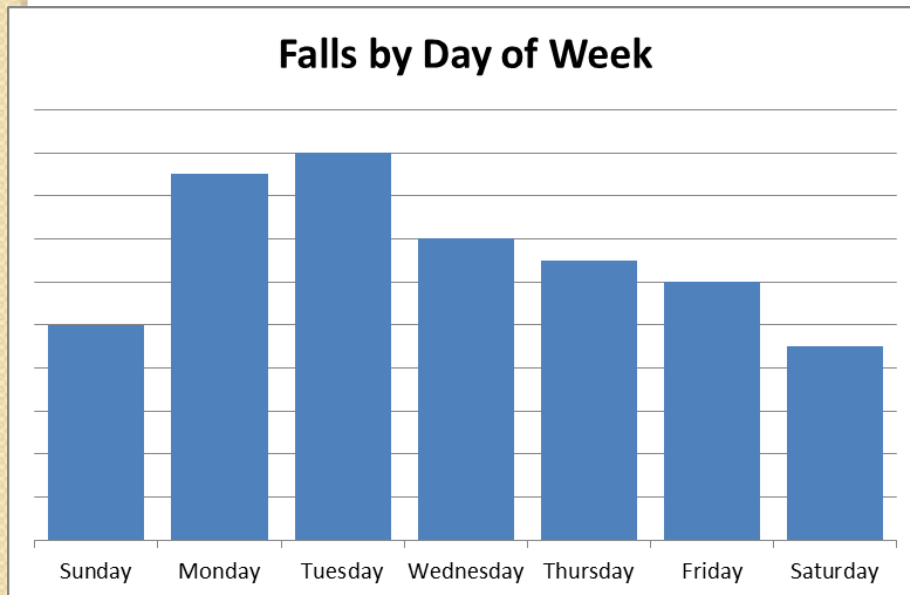
WHERE TO GO FROM HERE

Focus on OUR patients

- Looking at data from our patients.
- Recognize our strengths
- Admit our weaknesses and limitations
- Asking for help
- Think outside the box

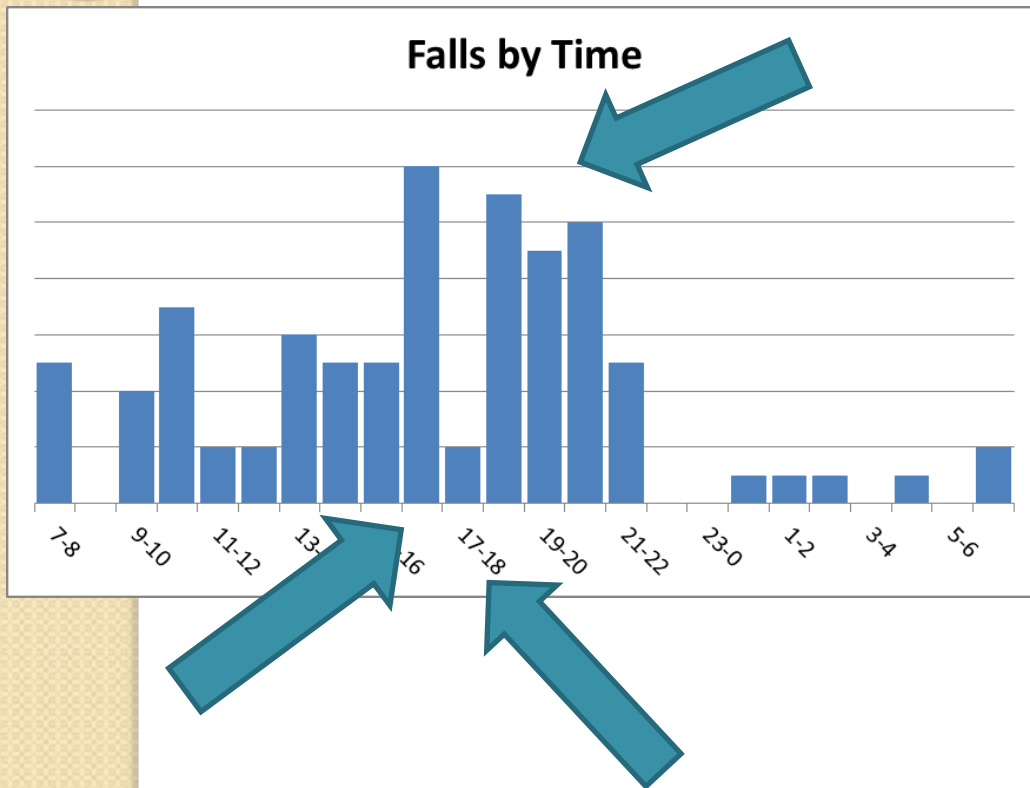


When are falls happening?



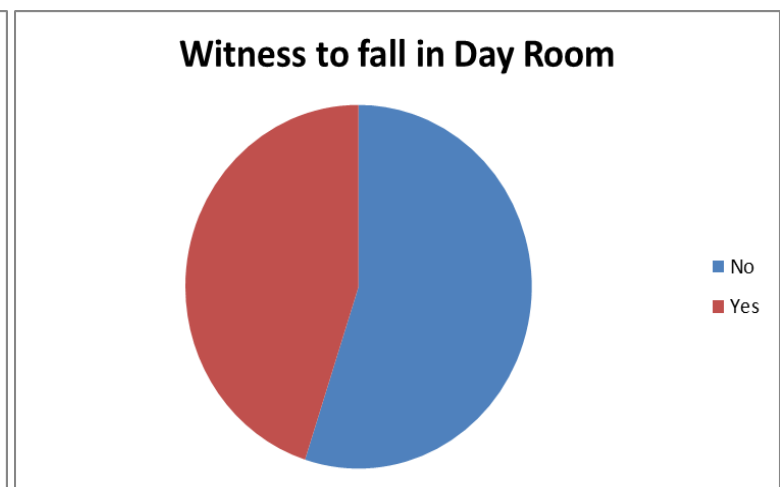
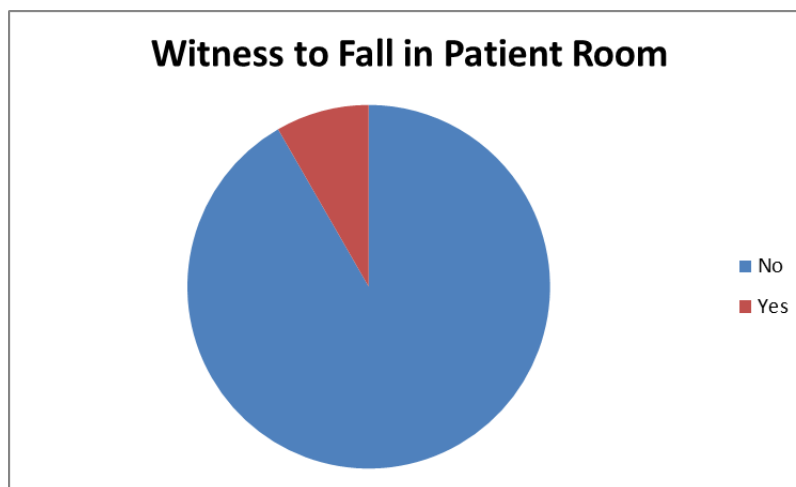
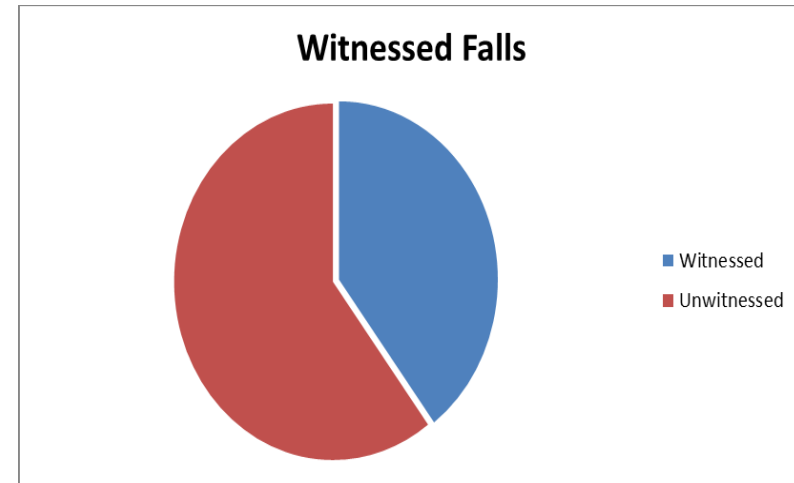
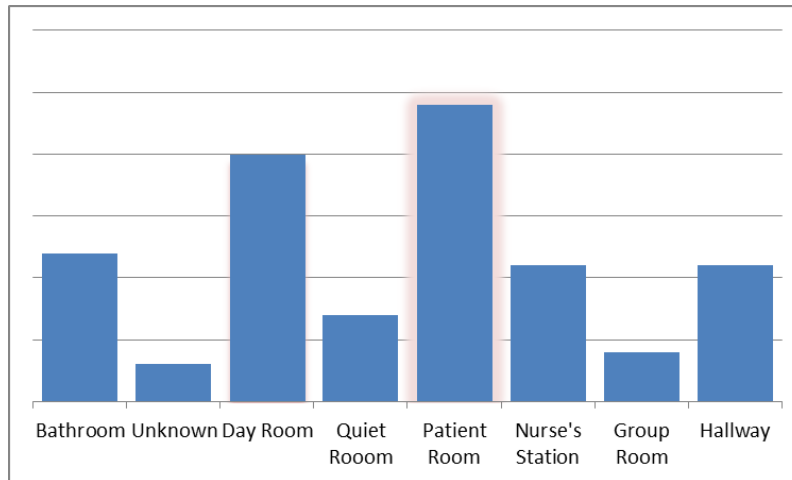
- Thursday & Friday are busy days for admissions and discharges
- Patients experience honeymoon phase for ~72 hours until they cannot maintain current function

What time do falls occur?



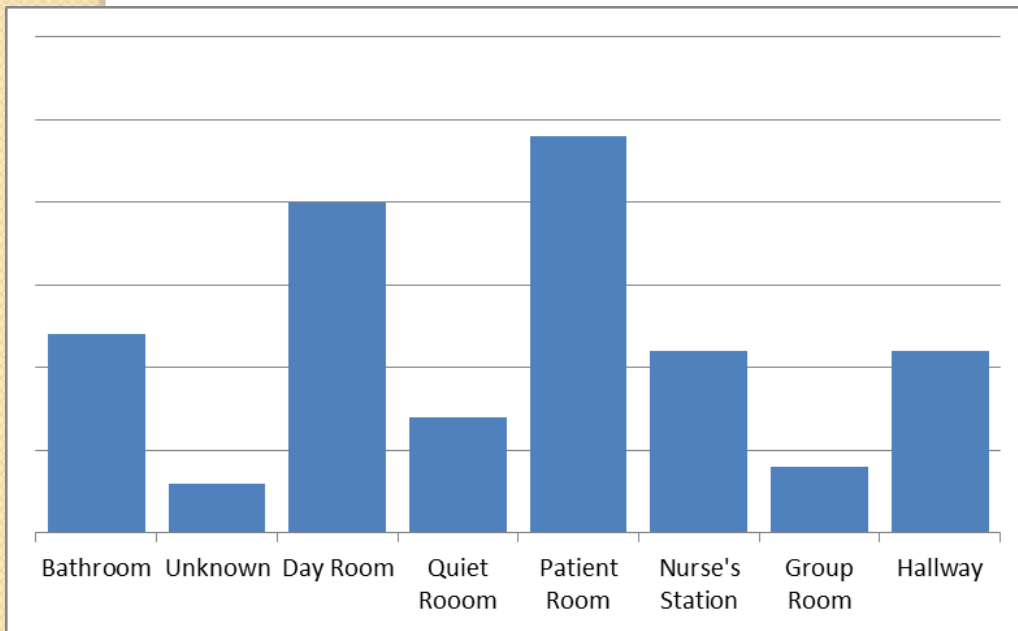
- Not surprising
- What is going on at these times?
 - Sundowning
 - Fatigue
 - Dinner
 - Admissions
 - Shift change
- Changes
 - Implemented an extra staff member

Where falls occur



Goal: Restore Previous Function

- Keep patients mobile
 - Sedation and restraints are things we try to avoid



Recent exploration:

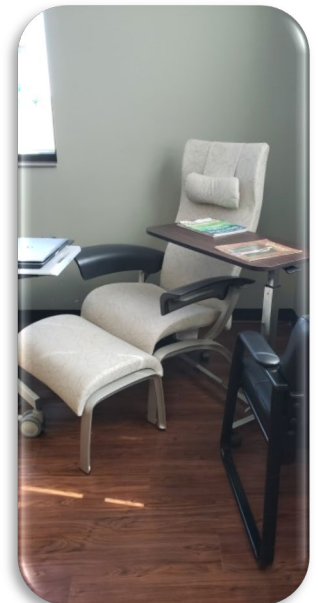
- Video monitoring
 - Falls after bed exit
 - Ocuvera- not available
 - Many patients intentionally sit on the floor, but without a witness, it counts as a fall
 - AvaSure- \$\$\$

Adjacent to nurse's station, used for patients with increased monitoring



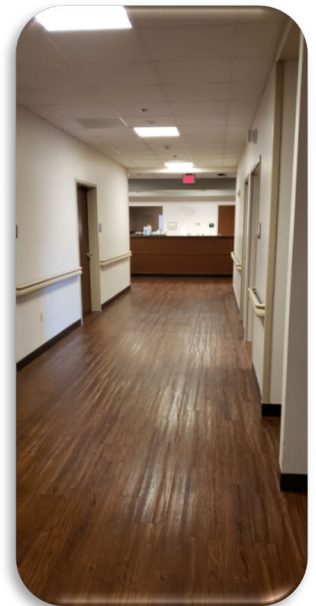
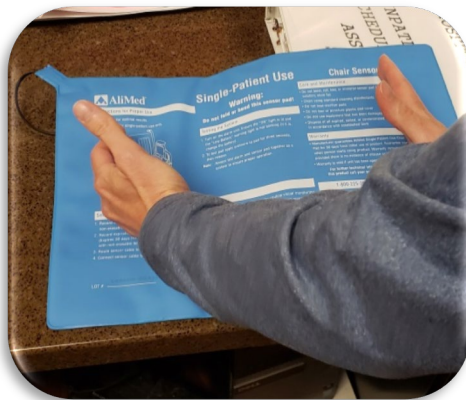
Chairs

- How is fatigue affecting our patients?
- Are seating options causing trunk fatigue?
- 2 Broda chairs are almost always in use



Alarms- helpful, but...

- TABS
 - Patients take them off
- Chair
 - Have ~ 2 second delay with patients <120 lbs



Beds



- Bed Alarms
 - Often do not set them off until they are completely out of bed
 - Announce that an exit has happened rather than immanent
- In General...
 - Many of our patients have not slept in an actual bed in years.
 - Utilizing recliner prior to admission

Looking for your input...

- What alarms have you been happy with?
 - Broda chairs or alternatives you have been happy with using?
 - Thoughts and ideas
-
- Thank you!

Additional Suggestions: from AHRQ and the VA

Focus on Injury Risk Reduction

- Eliminate sharp edges
- Reduce/eliminate restraints
- Hip protectors
- Floor mats
- Low beds

Equipment/Environmental Considerations

- Eliminate sharp edges
- Reduce/eliminate restraints
- Stable seating/furniture
- Self-locking wheelchairs
- Reduce clutter
- Lighting

- <https://www.patientsafety.va.gov/professionals/onthejob/falls.asp>
- https://www.patientsafety.va.gov/docs/fallstoolkit14/falls_implementation_%20guide%20_02_2015.pdf
- https://www.patientsafety.va.gov/docs/fallstoolkit14/floor_mat_guide_042114v2.pdf

Additional Suggestions: from AHRQ and the VA

Prevent and/or Assess for Delirium

- Hospital Elder Life Program (HELP) for Prevention of Delirium
- AHRQ Delirium Evaluation Bundle (Tool 3J)

Other

- Communication strategies
- Diversional activities
- Monitoring activities
- Anticipate needs (Purposeful rounding)
- Medication review specific to agitation

- <https://www.hospitalelderlifeprogram.org/>
- <https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3j.html>
- <https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk3.html#note9>
- https://www.patientsafety.va.gov/A_Toolkit_Patients_At_Risk_for_Wandering.asp

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

1) Future Collaborative Calls/Educational Opportunities:

- Dates TBD
- Topics TBD...What would you like to hear about?
What would you like to tell others about?

2) Review and use the website created with your assistance

<https://www.unmc.edu/patient-safety/capturefalls/index.html>

C A P T U R E

Collaboration and Proactive Teamwork Used to Reduce

Falls