AGENDA

- Housekeeping
- From the literature: Factors that influence staff decisions to report fall events
- Sneak peek of potential revisions to the CAPTURE Falls Fall Event Reporting Form and opportunity to provide feedback

Housekeeping

1. Coming soon!! New Roadmap Feature of CAPTURE Falls website
    - Content organized by key activities for your fall risk reduction team
    - Education and tools available for each major activity
    - Expanded resources from other toolkits and reputable resources
    - Contact Vicki victoria.kennel@unmc.edu with:
        - **Feedback and ideas for improvement**
        - **Tools, resources, success stories you would like to share on our website**
        - **If you can no longer find something**
    - https://www.unmc.edu/patient-safety/capturefalls/index.html

Housekeeping

2. Event Reporting
    -   Quarterly data reports (Q3 2020) were sent last week to hospitals that reported at least one fall in the past year to Know Falls.
    -   Reporting of all falls is encouraged—including outpatient, ER, ambulatory care, LTC, etc.
    -   Contact Anne at askinner@unmc.edu with REDCap issues (add users, password resets) and special report requests.

Falls Reported

CAPTURE Falls Collaborative
Reported Total, Unassisted, and Injurious Falls Over Time
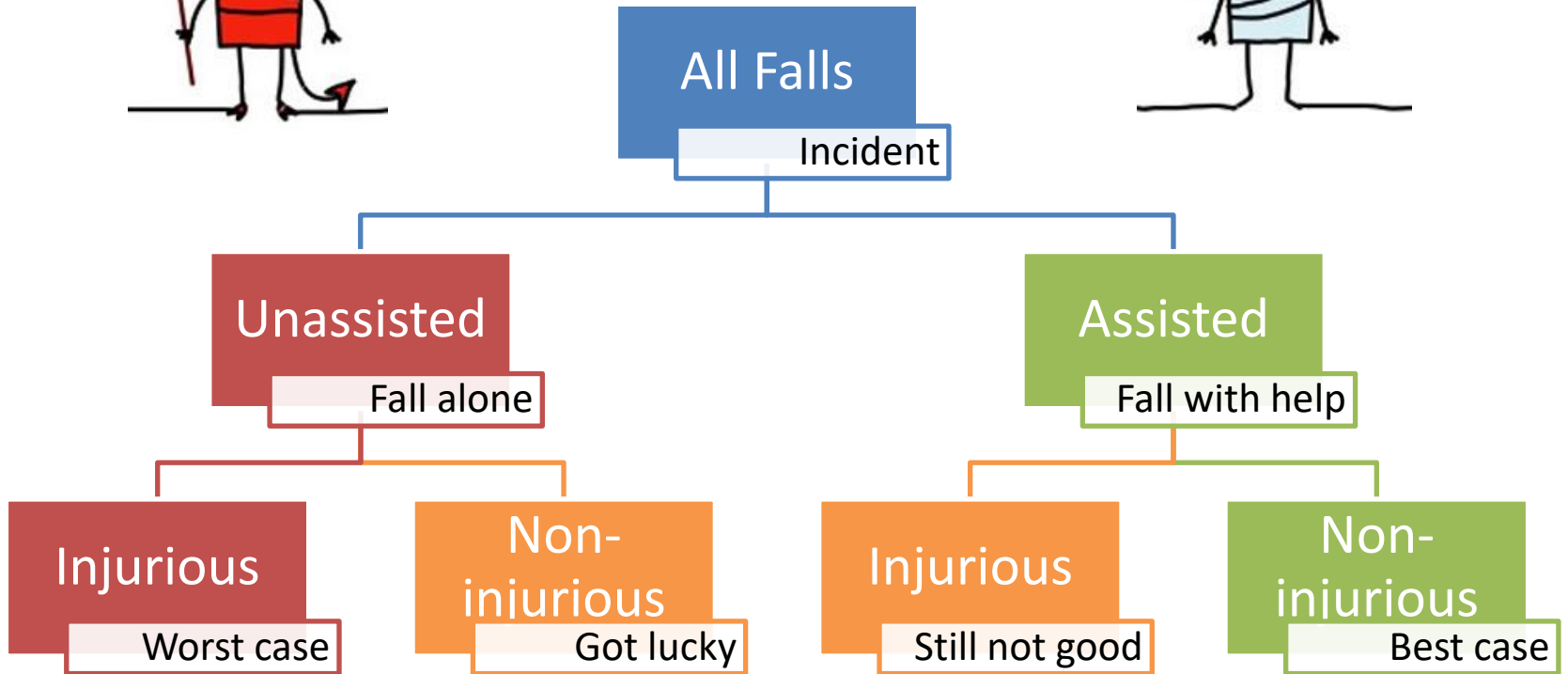Acute, Swing, Observation, Hospice Admissions
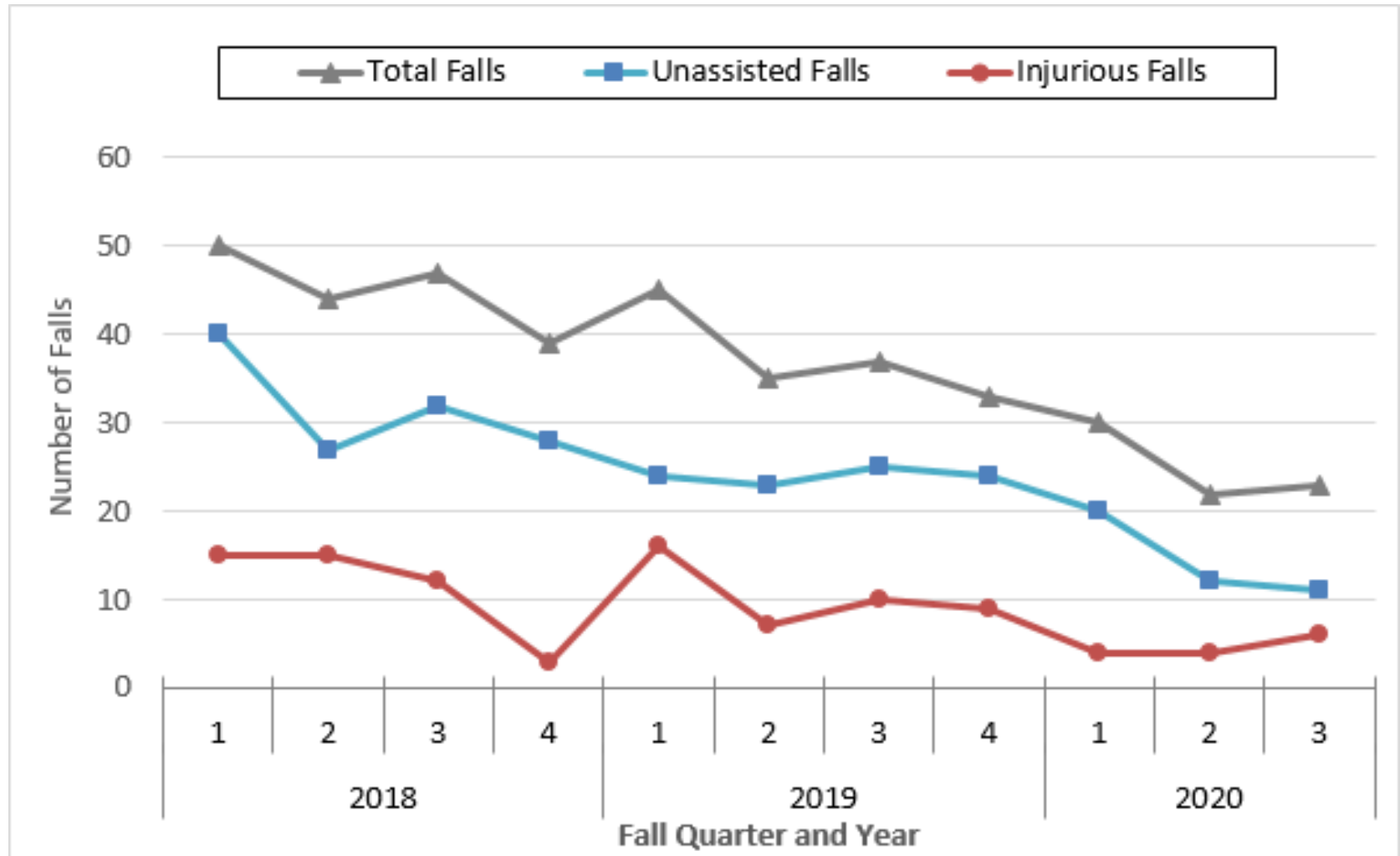
From the Literature…

Factors that influence staff decisions to report fall events

Fall Incident Types

Not all falls are equal…

All Falls
Incident

Unassisted
Fall alone

Assisted
Fall with help

Injurious
Worst case

Non-injurious
Got lucky

Injurious
Still not good

Non-injurious
Best case

When to Report a Fall?

Lessons learned from the literature on factors that influence whether or not staff may report a fall

Staff believe reporting falls improves safety

Staff believe reporting falls protects from legal liability

If patient was injured during the fall

Staff lack access to, training on, and/or reporting process/system not user friendly

Role models don't report falls

No fall definition

?
If staff witnessed the fall
If staff felt the fall could have been prevented
If staff felt that patient factors caused the fall

OPEN ACCESS ARTICLE:
Haines, T. P., Cornwell, P., Fleming, J., Varghese, P., & Gray, L. (2008). Documentation of in-hospital falls on incident reports: qualitative investigation of an imperfect process. *BMC health services research*, *8*, 254. https://doi.org/10.1186/1472-6963-8-254. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2621198/
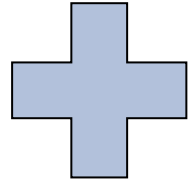
Discussion of Fall Event Reporting and Huddle Process

Opportunity to Provide Feedback

Our Hope…
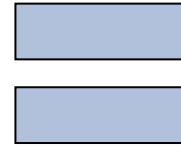
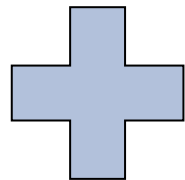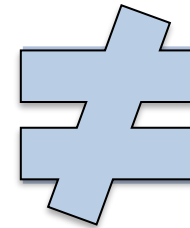Documentation **+** Discussion **=** Learning from Falls and Improvement in your Program

Documentation **+** Discussion **≠** A Data Entry "Chore"

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In an "Ideal World," what we think should happen…

Patient Fall Occurs

Bedside staff initiates fall event report

Huddle commences; completion of fall event report continues; completion of huddle documentation occurs

Fall Team Member enters information into Know Falls (online system to report to CAPTURE Falls)

Fall Risk Reduction Team reviews and discusses falls as needed/during regularly scheduled meetings to promote organizational learning.

Collaborative Member Sharing and Discussion
What Really Happens?

1. What are the steps involved in your fall event reporting process?

2. When are fall event reports completed in relation to conducting a post-fall huddle?

3. What challenges do you observe with fall event reporting?

Proposed Revisions to CAPTURE Falls Reporting Forms

Opportunity to Provide Feedback

Simplifying the CAPTURE Falls Reporting Forms

Broad Overview of Proposed Changes

- Identified and eliminated redundancies
- Created a more logical order to tell the story of the fall
  - Who is the patient?
  - What were the circumstances of the fall?
  - What was the impact of the fall?
  - Why did the patient fall and what could we do differently? (leads into huddle)
- Open ended questions on paper form *(results in fewer lists of checkboxes... and pages)*

Broad Overview of Proposed Changes

Report Date: _____ Completed By: _____ Know Falls Report Number: _____

CAPTURE Falls Event Learning Form

Definition of fall: A fall is a sudden, unintended, descent of a patient's body to the ground or other object (e.g., onto a bed, chair, or bedside mat) that can be unassisted or assisted (e.g. when a patient begins to fall and is assisted to the ground or other object by another person). *AHRQ Common Formats Hospital Version 2.0*

Who is the patient?

Medical Record Number: _____   Admission date: _____

Date of Fall: _____   Time of Fall (military time): _____

Age: _____ If older than 90 indicate >90): _____   Gender: ☐ Male ☐ Female

Admission Type at time of fall: ☐Acute ☐Swing ☐Hospice ☐Observation ☐Outpatient ☐ER ☐Other_____

Principal admitting diagnosis:_____

Other comorbidities (including recent surgeries):_____

Ambulatory Status Time of Fall: ☐ Not ambulatory   ☐ With assist of 2   ☐ With assist of 1   ☐ Independent

Prior to this fall, has the patient fallen while hospitalized? CHECK ALL THAT APPLY

☐ Yes, during this admission ☐ Yes, during a previous admission ☐ No

At the time of the fall, was the patient on medication(s) known to increase the risk of fall?   ☐ Yes ☐ No

Which medications? ☐Anticoagulants   ☐Cardiovascular agents   ☐ Analgesics   ☐ Antidiuretic agents
☐ Anticonvulsants   ☐ Anticholinergics
Other_____

Prior to the fall, was the fall risk assessment score documented? ☐ Yes ☐ No   If yes, list score: _____

Was the patient determined to be at risk for a fall? ☐ Yes ☐ No

What happened?

How was the fall discovered? _____
_____

Where did the fall occur? (e.g. bedside, bathroom, radiology, etc.) _____

How did the fall occur? (e.g. What was the patient doing or trying to do?)
_____
_____

Did staff control the patient's descent (hands on assist) during the fall? ☐ Yes   ☐ No

↳ Was a gait belt used? ☐Yes ☐ No

Other relevant details regarding the fall (e.g. Was patient using an using an assistive device? Did equipment/ furniture/environment contribute?) : _____
_____
_____

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Who fell?

What happened?

Broad Overview of Proposed Changes

What interventions were in use?

For each of the fall risk or fall injury risk interventions below, indicate which were in use at the time of the fall, or not in use, but should have been per care plan/policy.

	In use at the time of the fall	Not in use, but should have been per care plan/policy
Assistive device for gait/transfers	☐	☐
Bed Alarm	☐	☐
Bed in low position	☐	☐
Bedside floor mats	☐	☐
Call light/personal belongings in reach	☐	☐
Chair alarm	☐	☐
Commode	☐	☐
Declutter environment	☐	☐
Delirium prevention or mitigation	☐	☐
Documentation of mobility/ADL assistance	☐	☐
Floor clean and dry	☐	☐
Elevated toilet seat	☐	☐
Gait/transfer belt	☐	☐
Handoff to communicate risk	☐	☐
Hearing aids	☐	☐
Hip Protectors	☐	☐
Locked wheels on bed and/or wheelchair	☐	☐
Mechanical transfer device	☐	☐
Medication review by pharmacy	☐	☐
Night lights/supplemental lighting	☐	☐
Non-slip well-fitting footwear	☐	☐
Occupational therapy referral	☐	☐
Orthostatic vital signs monitoring	☐	☐
Pain management	☐	☐
Patient and family education	☐	☐
Patient placed close to nurses' station	☐	☐
Physical therapy referral	☐	☐
Purposeful hourly rounding	☐	☐
Seating assessment	☐	☐
Sitter	☐	☐
Supervised mobility and/or ADLs	☐	☐
Supervised toileting	☐	☐
Top bed rails up	☐	☐
Video Monitoring	☐	☐
Visible identification of risk (signage, wristband)	☐	☐
Vision Correction	☐	☐
Other; Please specify:_____	☐	☐

Further relevant details on interventions listed above:_____

_____

Fall Impact

Was the patient injured as a result of the fall? ☐ Yes ☐ No

If yes, describe injury and any additional assessment, monitoring, and/or treatment provided:

_____

_____

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What interventions did we OR should we have had in place?

What was the impact?

Broad Overview of Proposed Changes

Medical Record Number _____ Date of Fall_____ Time of Fall_____ Know Falls Report #: _____

Post-Fall Huddle

1. Date of Huddle _____ Time of Huddle _____ Huddle Facilitator Initials _____

2. Who was included in the huddle? CHECK ALL THAT APPLY
   - ☐ Patient
   - ☐ Primary Nurse
   - ☐ COTA
   - ☐ Physical Therapist
   - ☐ Family/Caregiver
   - ☐ CNA
   - ☐ Pharmacist
   - ☐ Physical Therapy Assistant
   - ☐ Charge Nurse
   - ☐ Occupational Therapist
   - ☐ Pharmacy Tech
   - ☐ Quality Improvement Coordinator
   - ☐ Other: _____

Considering all patient and organizational factors, what could have caused this patient to fall?	What changes, if any, were/will be immediately implemented for this patient as a result of the fall?

Post-fall Huddle Documentation

Broad Overview of Proposed Changes

Post-Fall Huddle Parking Lot

Could any of these **patient factors** contributed to the event? CHECK ALL THAT APPLY

- ☐ Dizziness/Vertigo
- ☐ Hypotension
- ☐ Procedure within last 24 hours
- ☐ Constipation
- ☐ Cognitive impairment
- ☐ Impulsive behavior
- ☐ Overestimated ability
- ☐ Neurological Comorbidities (e.g. previous CVA, MS, Parkinson's Disease)

- ☐ Weakness
- ☐ Anticoagulant / bleeding disorder
- ☐ Bowel Prep in Progress
- ☐ Incontinence/urgency
- ☐ Symptomatic depression
- ☐ Sensory Impairment (vision, hearing, balance, etc.)
- ☐ Morbid obesity
- ☐ Other: PLEASE SPECIFY _____

Could any of these **organizational factors** contributed to the event? CHECK ALL THAT APPLY

Environment
- ☐ Culture of safety, management of staff
- ☐ Physical surroundings cluttered
- ☐ Physical surroundings not customized to accommodate pt's mobility limitations

Staff Qualifications
- ☐ Lack of competence (qualifications, experience)
- ☐ Lack of training (use of gait belt, transfers, lifts)

Supervision/support
- ☐ Lack of clinical supervision
- ☐ Lack of managerial supervision
- ☐ Poor teamwork

Policies and procedures, includes clinical protocols
- ☐ Absence of policies
- ☐ Poor clarity of policies
- ☐ Lack of compliance with policies

Information About Fall Risk Status
- ☐ Not Available
- ☐ Not Accurate
- ☐ Not Legible

Communication
- ☐ Supervisor to staff
- ☐ Among staff or team members
- ☐ Staff to patient (or family)
- ☐ Fall associated with a handoff

Human factors (Staff)
- ☐ Fatigue
- ☐ Stress
- ☐ Inattention
- ☐ Cognitive factors
- ☐ Health issues

External factors
- ☐ Family/Visitor involvement

Please visit the CAPTURE Falls toolkit at https://www.unmc.edu/patient-safety/capturefalls/ for more information.

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Collaborative Member Sharing and Discussion

We need your input on the revised forms!

1. What do you like?
2. What don't you like?
3. What changes would you like to see?

Fall Event Reporting End-User Group – invitation

Who	What	When
• 2-3 CAPTURE Falls hospitals • Passionate about improving fall event reporting documentation	• Review our draft fall event reporting and post-fall huddle documentation form • Join us for a virtual meeting to discuss possible changes/revisions	• A mutually convenient date and time

Please share feedback on your fall event reporting process by completing this short survey:

https://is.gd/capturefallsoctober2020

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:
   - January 26, 2021; 2:00-2:30pm CT
   - Topic – TBA
     - ***What would you like to discuss?***

2. Looking for fall risk reduction resources?
   Click here: https://www.unmc.edu/patient-safety/capturefalls/index.html
   Still can't find what you are looking for? Let us know what we are missing!

C A P T U R E

Collaboration and Proactive Teamwork Used to Reduce

Falls