Simplifying the Fall Event Reporting Process at the Bedside
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
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
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
        - **Injurious**
          - Worst case
        - **Non-injurious**
          - Got lucky
    - **Assisted**
      - Fall with help
        - **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:
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”
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

Your needs

Best practices

Meaningful information to learn from falls
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

Who fell?

What happened?

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  □ Antiuretic 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?): ______________________

______________________________
Broad Overview of Proposed Changes

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

What was the impact?
Broad Overview of Proposed Changes

Post-fall Huddle Documentation
### 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
- Inadvertent
- Cognitive factors
- Health issues

#### External factors

- Family/Visitor involvement

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

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<thead>
<tr>
<th>Who</th>
<th>What</th>
<th>When</th>
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| • 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/capturefallsocotober2020
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!

**CAPTURE** Falls

Collaboration and Proactive Teamwork Used to Reduce