CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

Quarterly Collaborative Call #49

October 24, 2023

2:00 – 2:30 p.m. CT

Topic:

Reconnecting with Resources – Post-Fall Clinical Assessment, Post-Fall Huddle, and Event Reporting

University of Nebraska Medical Center℠

AGENDA

- Housekeeping
- Reconnecting with Resources
  - Post-Fall Clinical Assessment
  - Post-Fall Huddle
  - Event Reporting

Housekeeping

1. Know Falls Event Reporting
    - 2023 Quarter 3 reports will be sent early November
    - Continue reporting to help facilitate learning from fall events and track your outcomes.
    - Reminder for NCPS members: reporting to Know Falls = reporting to NCPS
    - Contact us with REDCap issues (add users, remove users, etc).

Housekeeping

2. Seeking updates to our contact list for your hospitals
    - Key Contacts received an email from Mary Wood mary.wood@unmc.edu on 10/19
    - Please reply by 10/31; Thank you to those who have already responded!

        - Key contact(s): Usually the lead(s) of your Fall Team; the primary person/people with whom we communicate.
        - Know Falls (REDCap) Access: Those with responsibility for entering or accessing data in that platform.
        - All Others: Regular members of your Fall Team who you would like to receive periodic information from us about falls

Housekeeping

3. Opportunity to share success strategies with the Operational Improvement Team at Nebraska Medicine (UNMC's hospital partner)
    - Nebraska Medicine is in the process of updating their fall program
    - Asked us for recommendations of "Nebraska hospitals that are doing interventions well" to whom they could reach out
    - Let us know if you are willing to have us connect their team to you
    - Anticipate the commitment would be 1-2 Zoom or phone conversations

Housekeeping

4. FYI: Survey of Fall Risk Reduction Practices in Rural Health Clinics (RHCs)
    - CATCH RURAL Falls: Coordinated Action Toward Community Health: RedUce Risk And Limit Falls
    - Began as a 9-month QI pilot for 6 RHCs from 9/22-6/23
    - Next step: Survey all RHCs in NE to determine needs going forward
    - We will still be supporting CAHs for inpatient fall risk reduction!

Reconnecting with Resources: Part 4 of 4!

CAPTURE Falls Roadmap

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

Roadmap

Welcome to the CAPTURE Falls "roadmap." This roadmap provides an organizing framework of activities, educational resources, and tools to help you improve your fall risk reduction program. Different hospitals may want or need to visit different stops along the way (see stops below). Every hospital, however, is ultimately working towards the same destination of keeping their patients safe from falls and fall-related injury.

Jan 2023

- Establish Readiness for Change
- Interprofessional Fall Risk Reduction Team
- Gap Analysis
- Action Plan

Apr 2023

- Fall Risk Reduction Policies and Procedures
- Fall Definition
- Fall Risk Assessment

July 2023

- Fall Risk Reduction Interventions
- Auditing Fall Risk Reduction Practices

Oct 2023

- Post-Fall Clinical Assessment
- Post-Fall Huddle
- Fall Event and Rate Reporting

Reconnecting with Resources

Post-Fall Clinical Assessment

Establish a protocol to guide staff in the assessment of patients for potential injury after a fall occurs.

Learn More

Post-Fall Huddle

Create a safe environment to understand the 'story' behind a fall in order to learn and take action to prevent a future fall.

Learn More

Fall Event and Rate Reporting

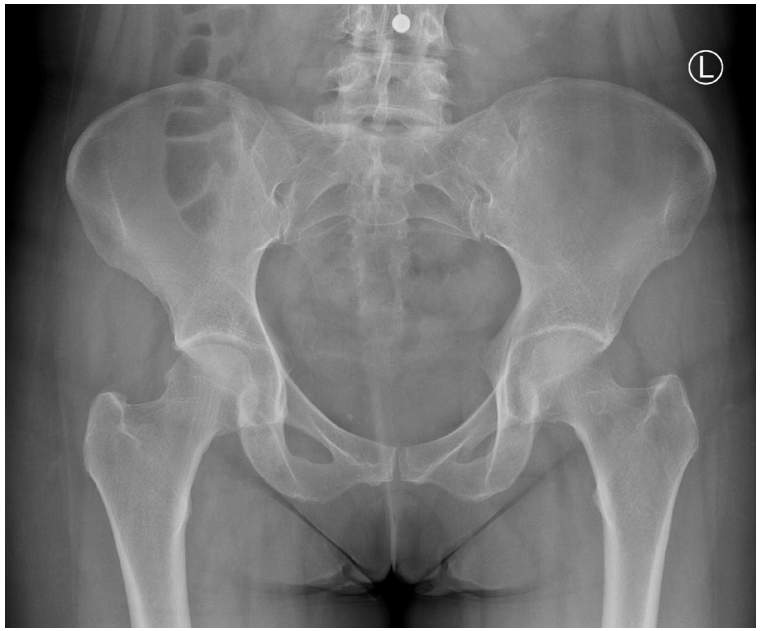
Report and monitor falls and fall rates to track progress within your organization and allow for external benchmarking.

Learn More

Post-Fall Clinical Assessment

CAPTURE Falls Roadmap Post-Fall Clinical Assessment: https://www.unmc.edu/patient-safety/capturefalls/roadmap/post-fall-assessment/index.html

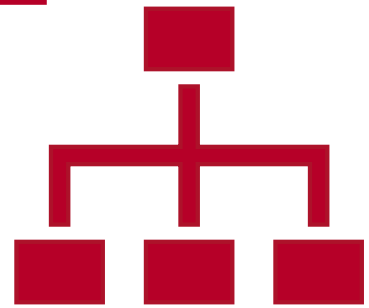
- After a fall, staff should assess the patient for injury and attend to the patient's medical needs.
- Assessment should occur immediately.
- Depending on the patient's risk factors, assessment may need to continue for several hours.



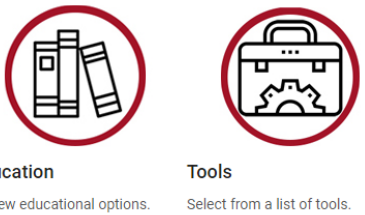
Post-Fall Clinical Assessment

CAPTURE Falls Roadmap Post-Fall Clinical Assessment: https://www.unmc.edu/patient-safety/capturefalls/roadmap/post-fall-assessment/index.html

- Various checklists and decision trees exist
- Common components
  - Check vital signs
  - Clean/dress any wounds
  - Assess for signs/symptoms of fracture or spinal injury
  - Assess for signs/symptoms of head injury if known to hit head or if fall was unwitnessed
  - Notify physician/PA/APRN and family
  - Provide analgesia as needed
  - Consider imaging



Resources: Post-Fall Clinical Assessment



Post Fall Assessment Tools:

- ✓ Agency for Healthcare Research and Quality Post-Fall Assessment Clinical Review: Tool 3N Post-Fall Assessment Clinical Review
- ✓ US Department of Veterans Affairs: VA National Center for Patient Safety Falls Toolkit policy document *(see Section VII and Attachment 3)*
- ✓ Western Australia Department of Health: 2023 Post-Fall Multidisciplinary Management Guidelines
- ✓ Clinical Excellence Commission of New South Wales Ministry of Health: Post-Fall Assessment and Management Guide

Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle: https://www.unmc.edu/patient-safety/capturefalls/roadmap/post-fall-huddle/index.html

A team who convenes after a patient fall to:

- discuss and gather information about the patient fall
- identify changes to reduce the risk of another fall for that patient

Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle: https://www.unmc.edu/patient-safety/capturefalls/roadmap/post-fall-huddle/index.html

The ideal

Who? *All relevant parties*	When? *As soon as possible*	Where? *Location where the fall occurred*
• Staff providing direct care for the patient at the bedside • Other members of interprofessional team involved in the patient's care • Patient • Family/Caregiver(s)	• Preserve adequate recall of important details relevant to the fall	• Similar environment may trigger better recall of the circumstances of the fall • Allows for adequate assessment of environmental factors that may have contributed to the fall

The reality

Who? *Whomever is available*	When? *It depends*	Where? *Physical/virtual space*
• Time of day and workload level often limits who participates in the huddle • Patient ability • Family/caregiver(s) availability (in-person, and/or with technology) • Consider creative ways to engage members of the interprofessional team	• After post-fall clinical assessment is completed • Consider creative ways to engage members of the interprofessional team	• A space similar to where the fall occurred or space for the team to openly discuss the event • Consider patient ability to engage/be involved • Consider use of technology to engage other team members and/or family

Resources: Post-Fall Huddle

Education

Review educational options.

Tools

Select from a list of tools.

Education Resources:

- ✓ Webinar on Effective Huddles and Debriefs
- ✓ "Good" Post-Fall Huddle and "Bad" Post-Fall Huddle Videos
- ✓ Human Behavior and Fall Risk Reduction Handout

Example Huddle Tools:

- ✓ Post-Fall Huddle Guide and Documentation Form
- ✓ Post-Fall Huddle Pocket Guide
- ✓ Post-Falls Huddle Guide and Post-Fall Huddle/After Action Review

Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting: https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-reporting/index.html

What?

- Fall event data = facts and circumstances of a fall
- Fall rates = fall counts normalized to hospital census

Why?

- Learn from fall events
- Track progress of fall program
- Benchmark your hospital against others

How?

- Internal and external
- Use standard definitions for falls and levels of harm
- Know Falls Learning System and/or other systems

Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting: https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-reporting/index.html

Definition of Terms used in CAPTURE Falls:

"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 assisted or unassisted."

Agency for Healthcare Research and Quality Common Formats Version 2.0

Unassisted	Assisted
• Fall occurs without hands-on assist from another person • May or may not be observed	• When a patient begins to fall and is assisted to the ground or other object by another person • Ideally occurs with a gait belt to allow the caregiver to control the patient's descent

Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting: https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-reporting/index.html

Definition of Terms used in CAPTURE Falls

Non-Injurious

- Patient is not harmed by the fall

Injurious

- Patient is harmed by the fall
- Harm ranges from minor injury to death

Minor
- Fall resulted in application of dressing, ice, cleaning of wound, limb elevation, topical medication, bruise or abrasion

Moderate
- Fall resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain

Major
- Fall resulted in surgery, casting, traction, consultation for neurological (e.g. skull fracture, subdural hematoma) or internal injury (e.g. rib fracture, liver laceration) or need for blood products

Death
- Patient died as a result of injuries sustained from the fall

Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting: https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-reporting/index.html

Standardized definitions allow for valid comparisons with peer hospitals

Normalized rates (x falls/1000 patient days) allow for valid comparisons:
- With hospitals of varying size and/or census
- Over time within hospitals when census varies

vs.

Note that the CAPTURE Falls Collaborative is the only CAH-specific benchmark of which we are aware!

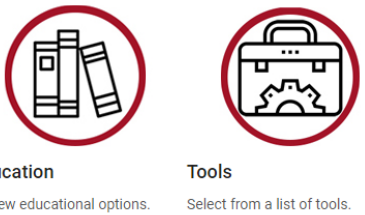
Fall Event and Rate Reporting

CAPTURE Falls Roadmap Fall Event and Rate Reporting: https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-reporting/index.html

Falls more likely to be recorded in incident reports	Falls less likely to be recorded in incident reports
• Staff belief that reporting improves patient safety • Staff belief that reporting protects against legal responsibility	• Poor access to computerized reporting • Non-reporting by role models • Absence of training on reporting • Absence of a fall definition • Self-perceived responsibility for a fall • Perceived blame from others

Haines, T.P., Cornwell, P., Fleming, J. *et al.* Documentation of in-hospital falls on incident reports: Qualitative investigation of an imperfect process. *BMC Health Serv Res* **8**, 254 (2008). https://doi.org/10.1186/1472-6963-8-254

Resources: Fall Event and Rate Reporting



Education Resources:

- ✓ Agency for Healthcare Research and Quality Fall Prevention Toolkit Section 5.1 How do you measure fall and fall related injury rates?
- ✓ Fall Definition and Types Handout
- ✓ Research study describing factors that influence fall event reporting

Tools:

- ✓ CAPTURE Falls Event Learning Form (pdf version; online Know Falls Learning System)
- ✓ Fall Rate Calculator

Resources: Consultations with the UNMC CAPTURE Falls Team

We are here to support YOU!

Initial Steps

- Begin engagement or re-engagement with UNMC team on a rolling basis
- Form your team
- Complete gap analysis
- Form action plan

Resources Available

- At least one consultative meeting with UNMC team to review gap analysis and action plan
- Use of CAPTURE Falls online roadmap
- **Additional consultation with UNMC team "on-demand"**
- Quarterly collaborative calls for education and program updates
- Know Falls database for reporting and learning from falls

Sustainment

- Monitor progress towards goals on action plan
- Monitor fall rates; compare with benchmarks
- Update gap analysis when appropriate

Can also "jump in" anywhere in your fall risk reduction process for focused topic-specific support

Reminders

1. Future Collaborative Calls/Educational Opportunities: Let us know if there is a topic or series of interest!
    - Tuesday January 23, 2024, 2:00-2:30pm CT
    - Tuesday April 23, 2024, 2:00-2:30pm CT
    - Tuesday August 20, 2024, 2:00-2:30pm CT
    - Tuesday October 22, 2024, 2:00-2:30pm CT
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!

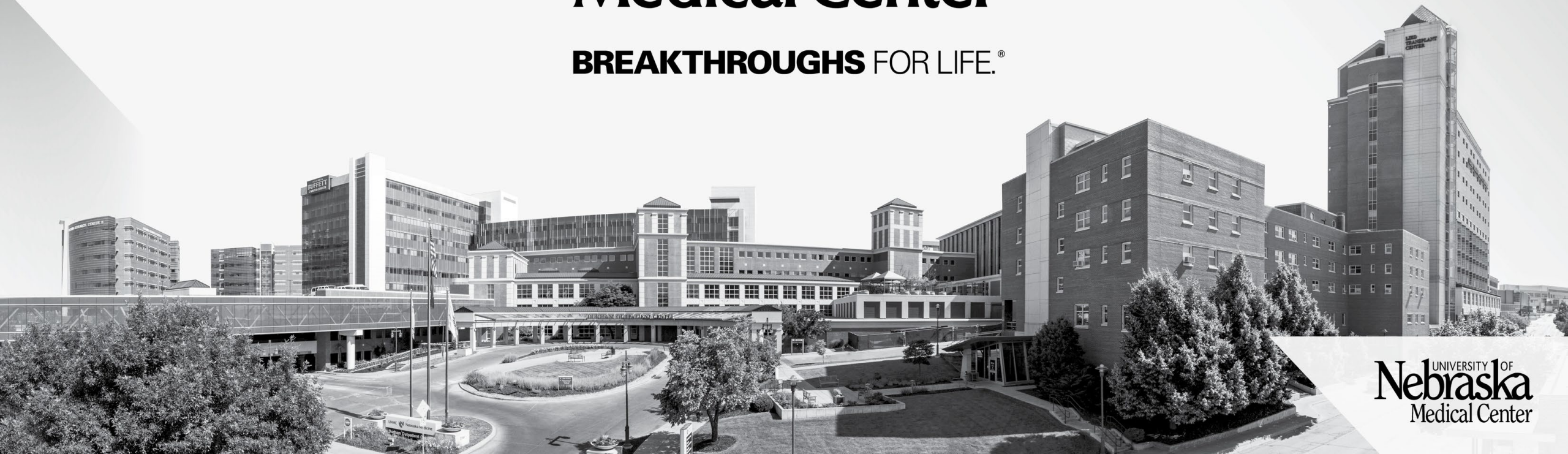
Assistance is an email away!

Contact us for more information about:

- Fall risk reduction best practices: Dawn (dvenema@unmc.edu)
- Team performance, quality improvement and implementation challenges: Vicki (victoria.kennel@unmc.edu)
- Know Falls and Online Learning (REDCap): Dawn (dvenema@unmc.edu) and/or Matt (matthew.mcmanigal@unmc.edu)
- General questions or not sure?: CAPTURE.Falls@unmc.edu

University of Nebraska Medical Center℠

BREAKTHROUGHS FOR LIFE.®



University of Nebraska Medical Center