CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

Quarterly Collaborative Call #50

January 23, 2024

2:00 – 2:30 p.m. CT

Topic:

Learning from Falls – A Focus on Fall Event and Rate Reporting

University of Nebraska Medical Center℠

AGENDA

- Housekeeping
- Know Falls updates
- Annual fall rate reporting process
- Safe table process for future collaborative calls

Housekeeping

1. Know Falls Event Reporting
   - 2023 Quarter 4 reports will be sent in February
   - Please have all fall events entered into REDCap by **January 31, 2024 for the purpose of 2023 Quarter 4 reports and annual fall rate calculation process**
   - 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. Know Falls Access – New Log In Step for REDCap “External Users”
   - On December 17, 2023, UNMC implemented a **2-factor authentication** for all UNMC REDCap external users (this includes our CAPTURE Falls REDCap users)
   - Follow these steps to successfully log in to REDCap:
     - ✓ When logging into https://unmcredcap.unmc.edu/redcap/ click the 'External Users' tab, and choose email authentication after regular logging in.
     - ✓ Once you select email authentication, you will receive you a 6-digit code in your email. Enter that code before it expires. If it expires, you are able to get a new code by submitting again.
     - ✓ Once you enter the code and submit, you should see a Success message and receive access to your account.
   - Contact us with any issues and we can coordinate with UNMC REDCap IT to help resolve

Housekeeping

3. CAPTURE Falls Roadmap "Face Lift"
    - UNMC Website rebranding effort
    - CAPTURE Falls webpages will look different, but content will remain the same!

Housekeeping

4. FYI: Nebraska Hospital Association/CAPTURE Falls Fall Intensive Cohort
   - Reminder – we are here to support all hospitals within the CAPTURE Falls Program!

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

Housekeeping

5. 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 evaluate the current state of fall risk management practices (screening, assessment, and intervention) in clinic settings
        - Intend to send out survey to RHC clinic managers in February/March 2024
    - We will still be supporting CAHs for inpatient fall risk reduction!

Know Falls Updates

Rationale for Changes

- ✓ Review of current “Common Formats” for patient safety events recommended by the Agency for Healthcare Research and Quality
- ✓ Deliberation regarding potential redundancy of some items and the usefulness of items to assist in learning from fall events
- ✓ Historical use by hospitals (if rarely used in the past, it was deleted)

- Changes result in a net loss of 45 “fields”
  - Some of these included the deletion of entire questions; some are deletion of answer options (e.g. condensing multiple choice or multiple answer options)
  - Note that there will also be minor wording edits in some places

- **We plan to have changes take effect on Feb 1 (gives you time to get 2023 fall data in before changing the form)**

Summary of Selected Changes

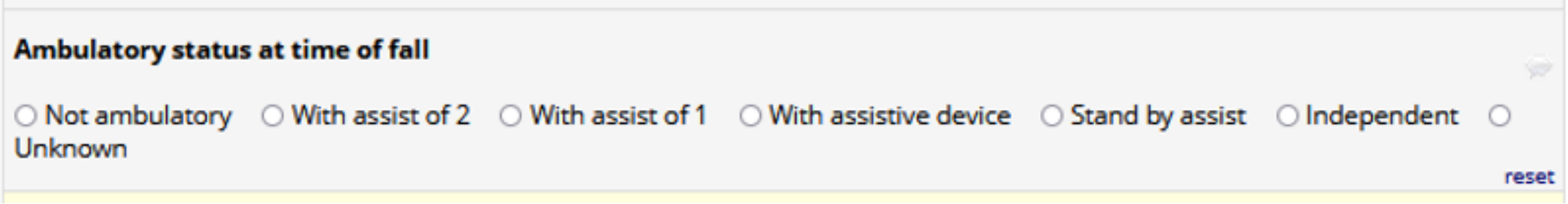
Added **fall definition** to top of form to serve as reminder of what “counts” as a fall event.

Definition of a 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 assisted (e.g., when a patient begins to fall and is assisted to the ground by another person) or unassisted.

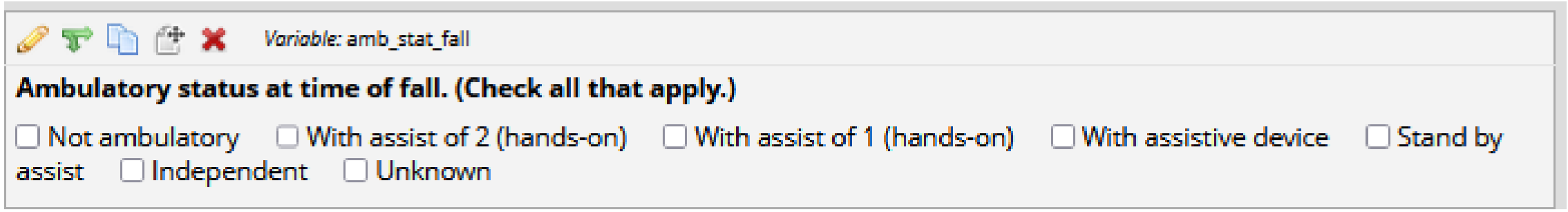
Summary of Selected Changes

Ambulatory status at time of fall

Current/Old: single answer multiple choice



New: multiple answer multiple choice; added “hands-on” to assist of 1 and assist of 2 choices



Summary of Selected Changes

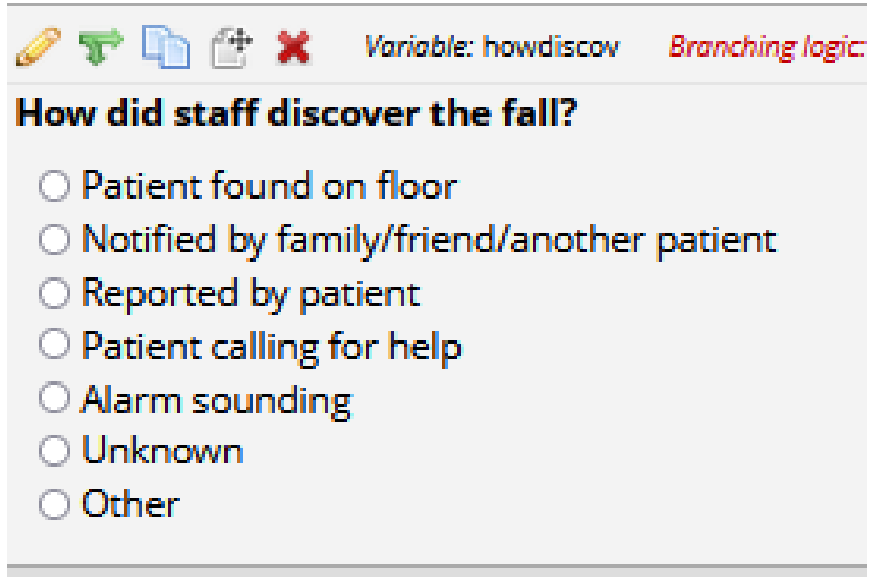
How did staff discover the fall? (applies to unassisted and unobserved falls)

Current/Old:

How did staff discover the fall?

- ○ Patient found on floor
- ○ Notified by family/friend/another patient
- ○ Notified by non-clinical staff
- ○ Notified by ancillary care staff
- ○ Reported by patient
- ○ Patient calling for help
- ○ Alarm sounding
- ○ Patient call light
- ○ Unknown
- ○ Other

New: condensed options



Summary of Selected Changes

What was the patient doing when the fall occurred?

(actions related to toileting are in separate question)

Current/Old:

Please mark the action that most clearly describes what the patient was doing or trying to do when the fall occurred.

- ○ Undergoing a procedure/test
- ○ Ambulating w/assistance
- ○ Ambulating w/o assistance
- ○ Dressing/Undressing
- ○ Dressing/undressing related to showering
- ○ Transferring w/assistance
- ○ Transferring w/o assistance
- ○ Reaching for an item
- ○ Loss of consciousness
- ○ Rolled out / Slipped off of bed
- ○ Showering
- ○ Performing personal hygiene in bathroom (not related to toileting)
- ○ Related to chair/recliner
- ○ Related to geri chair
- ○ Related to wheelchair
- ○ Other

New: condensed options

Variable: pt_attempt *Branching logic:* [toileting] = '0' or [toileting] = '99'

Mark the action that most clearly describes what the patient was doing or trying to do when the fall occurred.

- ○ Undergoing a procedure/test
- ○ Ambulating w/assistance
- ○ Ambulating w/o assistance
- ○ Dressing/Undressing
- ○ Dressing/undressing related to showering
- ○ Transferring w/assistance
- ○ Transferring w/o assistance
- ○ Reaching for an item
- ○ Changing position (e.g., in bed, chair)
- ○ Showering
- ○ Performing personal hygiene in bathroom (not related to toileting)
- ○ Other

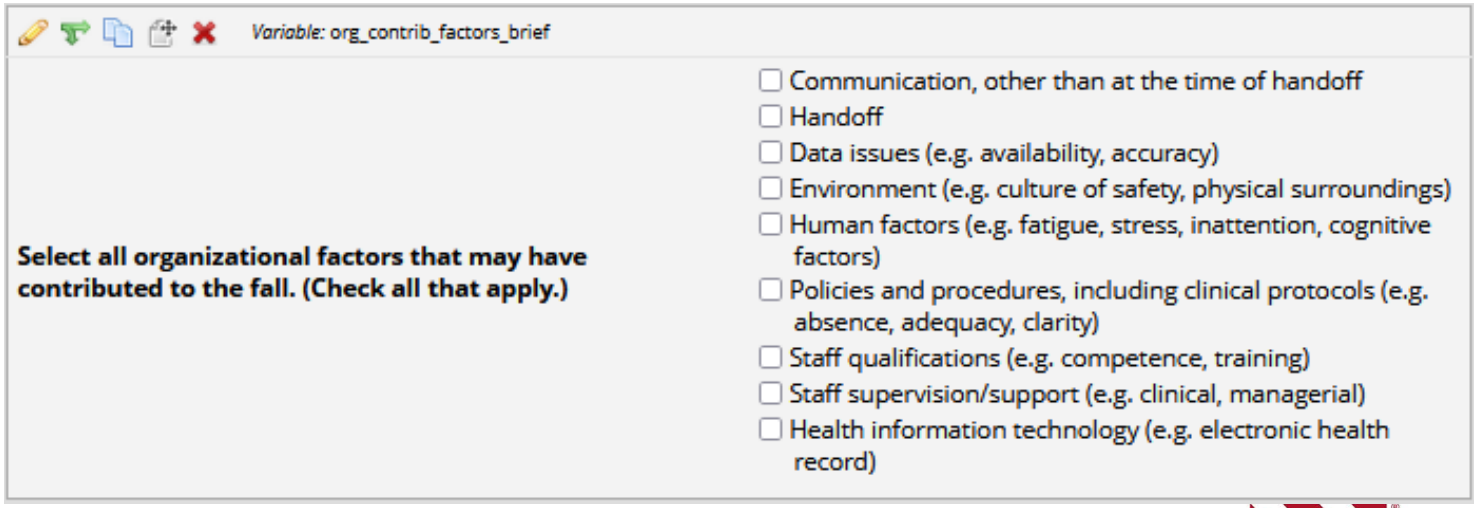
Summary of Selected Changes

Organizational factors that contributed to the fall

Current/Old:

Categories similar to categories listed under “New” on the right, but with multiple sub-items (22 total).

New: Using primary categories only; no sub-items

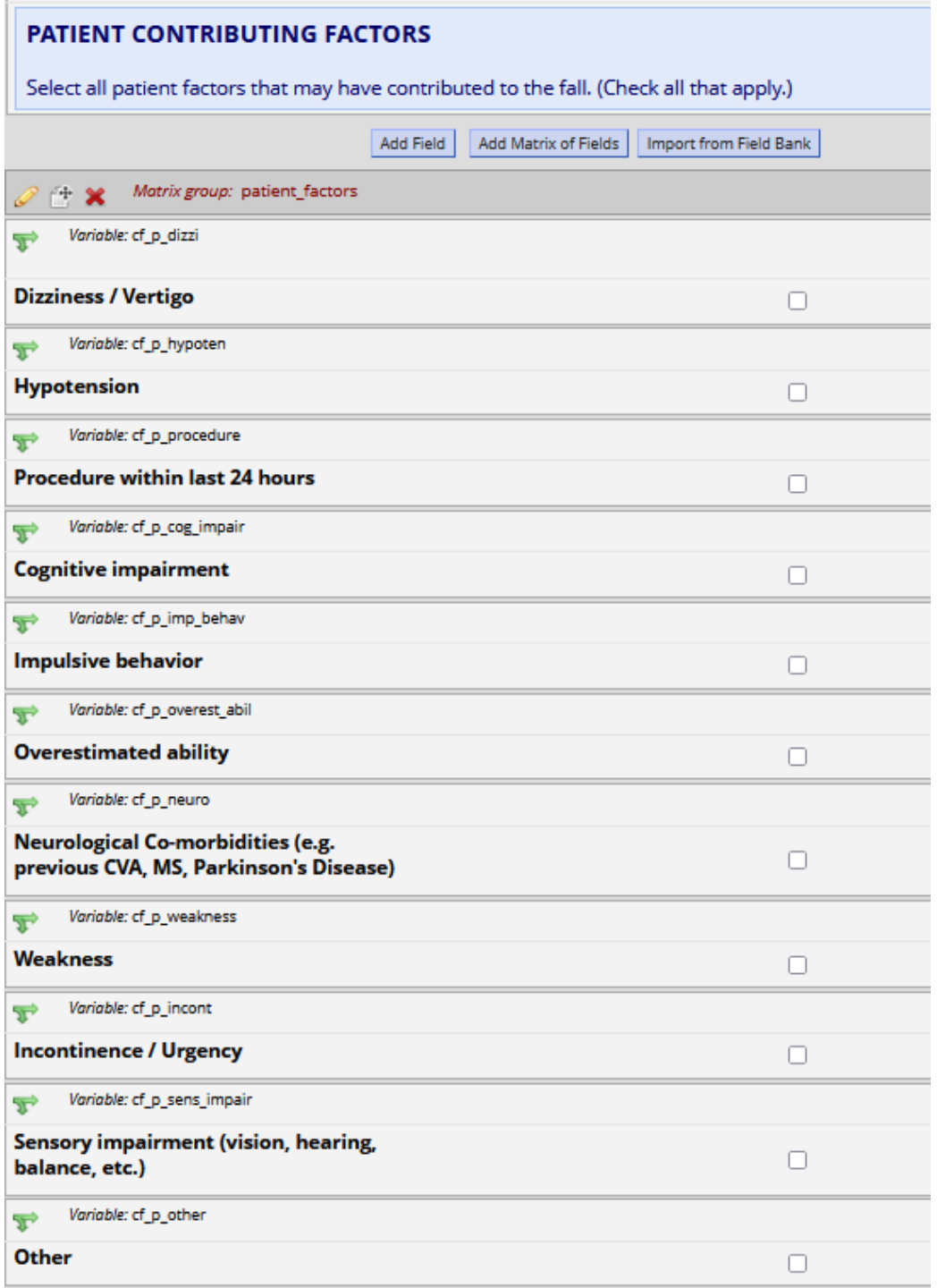


Summary of Selected Changes

Patient contributing factors

Current/Old: 15 possible factors

New: 10 possible factors (see list on right); eliminated factors that were rarely selected



PATIENT CONTRIBUTING FACTORS

Select all patient factors that may have contributed to the fall. (Check all that apply.)

Add Field | Add Matrix of Fields | Import from Field Bank

Matrix group: patient_factors

Variable: cf_p_dizzi
Dizziness / Vertigo ☐

Variable: cf_p_hypoten
Hypotension ☐

Variable: cf_p_procedure
Procedure within last 24 hours ☐

Variable: cf_p_cog_impair
Cognitive impairment ☐

Variable: cf_p_imp_behav
Impulsive behavior ☐

Variable: cf_p_overest_abil
Overestimated ability ☐

Variable: cf_p_neuro
Neurological Co-morbidities (e.g. previous CVA, MS, Parkinson's Disease) ☐

Variable: cf_p_weakness
Weakness ☐

Variable: cf_p_incont
Incontinence / Urgency ☐

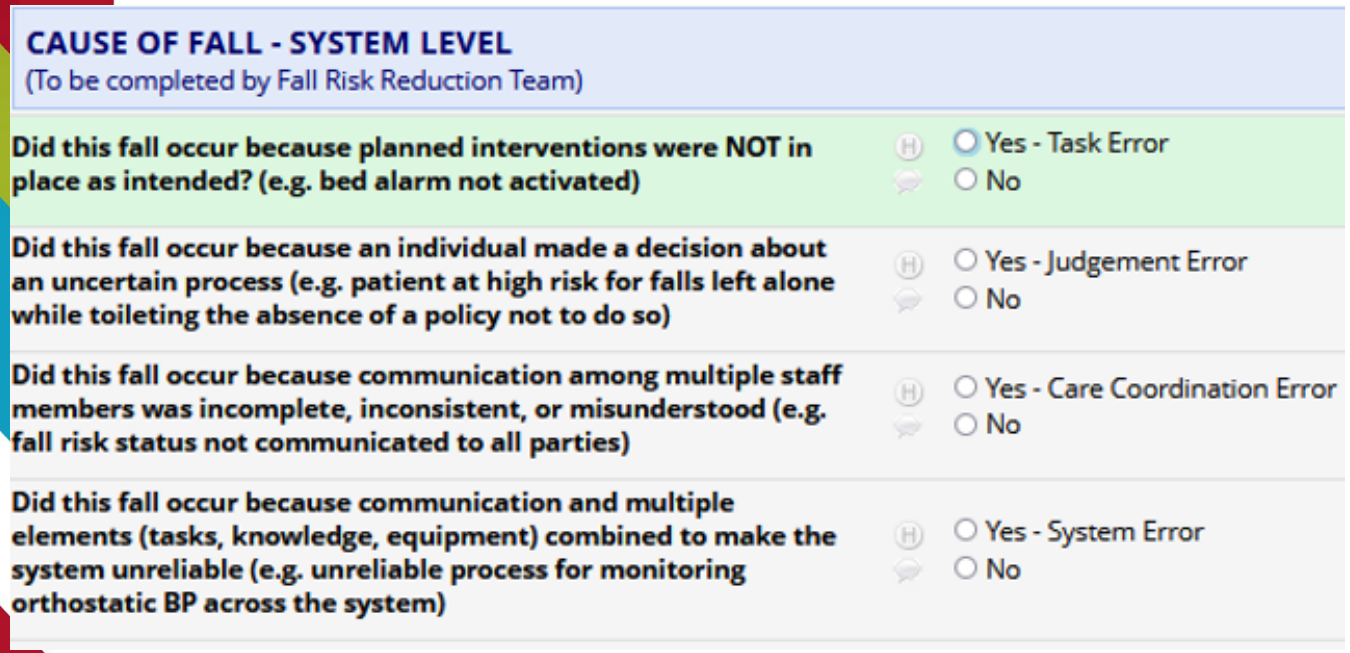
Variable: cf_p_sens_impair
Sensory impairment (vision, hearing, balance, etc.) ☐

Variable: cf_p_other
Other ☐

Summary of Selected Changes

System Learning Form (intended to be completed with input from your fall team; indicates possible changes that need to be addressed across your whole system)

Current/Old:



CAUSE OF FALL - SYSTEM LEVEL
(To be completed by Fall Risk Reduction Team)

Did this fall occur because planned interventions were NOT in place as intended? (e.g. bed alarm not activated)	Yes - Task Error / No
Did this fall occur because an individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting the absence of a policy not to do so)	Yes - Judgement Error / No
Did this fall occur because communication among multiple staff members was incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)	Yes - Care Coordination Error / No
Did this fall occur because communication and multiple elements (tasks, knowledge, equipment) combined to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)	Yes - System Error / No

Plus additional questions if said “yes” to the above, and questions listed on right

New: 2 questions only:

1) Describe/discuss what your team learned about your fall risk reduction system as a result of this fall.
2) How will your team communicate the knowledge gained from this fall to the rest of your organization?

Let us know if you have any thoughts or questions about these changes before they go “live” on Feb 1.

Annual Fall Rate Reporting: New Process

Annual Fall Rate Reporting Process: Say Goodbye to the Excel form!

Old Process

- ✓ Excel file was shared via encrypted email to Hospital Key Contacts
- ✓ Data known to us (e.g. based on fall events entered into Know Falls) was manually pre-populated into the file by the UNMC CAPTURE Falls team
- ✓ Hospitals with pre-populated data could confirm those data/edit as needed and enter patient days
- ✓ Hospitals without pre-populated data (those not otherwise using Know Falls) entered all requested data.
- ✓ Hospitals emailed the completed excel file back to us

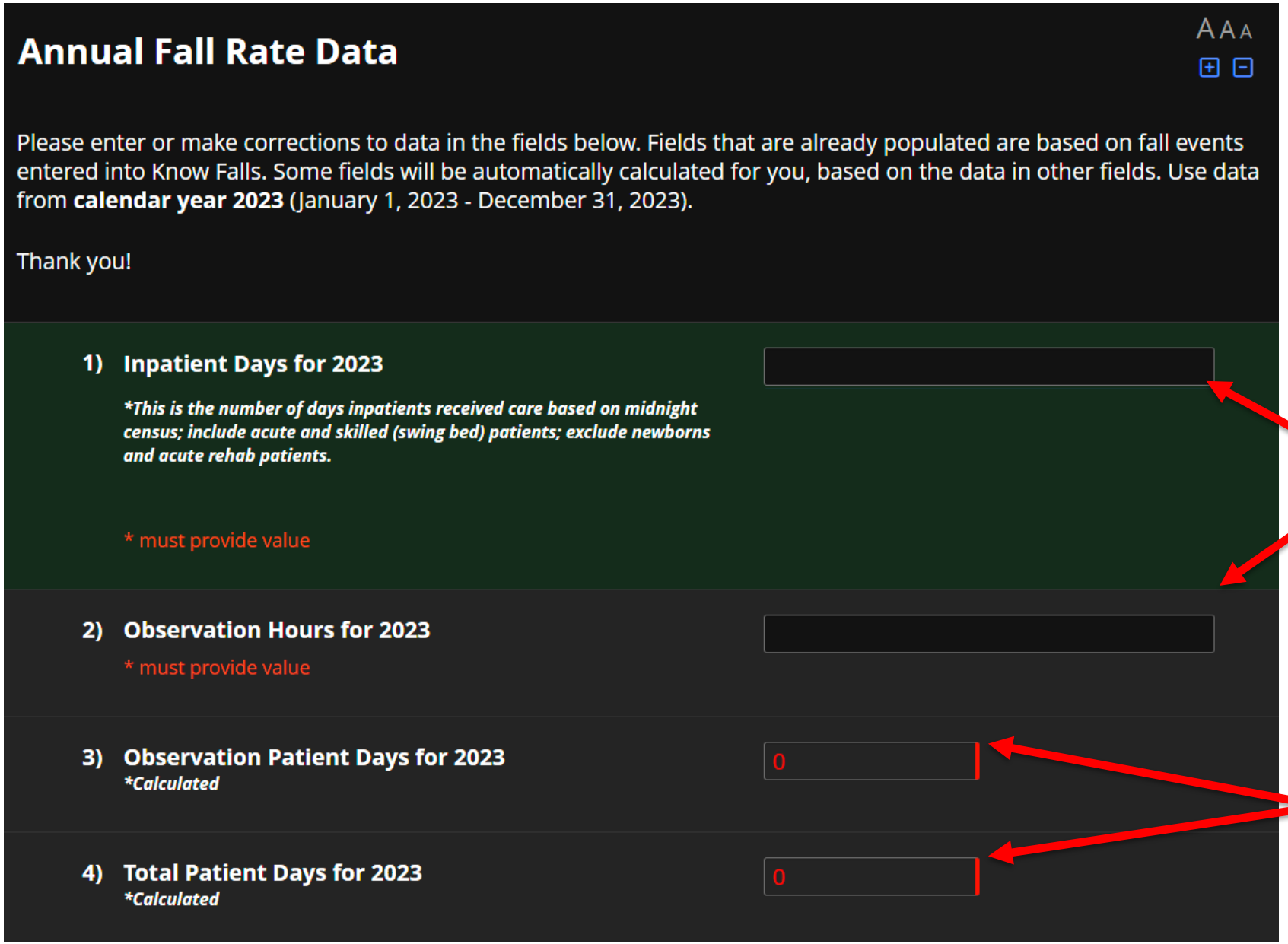
New Process

- ✓ Link to form in REDCap will be sent via encrypted email to Hospital Key Contacts
- ✓ Data known to us (e.g. based on fall events entered into Know Falls) will be automatically pre-populated into the REDCap form
- ✓ Hospitals with pre-populated data can confirm those data/edit as needed and enter patient days
- ✓ Hospitals without pre-populated data (those not otherwise using Know Falls) can enter all requested data.
- ✓ We will automatically receive the information through REDCap – no need to email anything back.

Who will Receive the Email and Link?

- Hospital Key Contacts = Those people who your hospital identified as the leaders of your Fall Risk Reduction Program
- Some hospitals have more than 1 person identified as a Key Contact
  - Each Key Contact will receive the link for your hospital.
  - If one of your other Key Contacts have already completed the form, you will be able to see that the data have already been entered if you click on the link.
  - The form functions as a survey – meaning you don't need an account as an "External User" in REDCap to receive the link.

Preview of Form



Enter data here

These values will be automatically calculated

Preview of Form, continued

Fall Types Breakdown

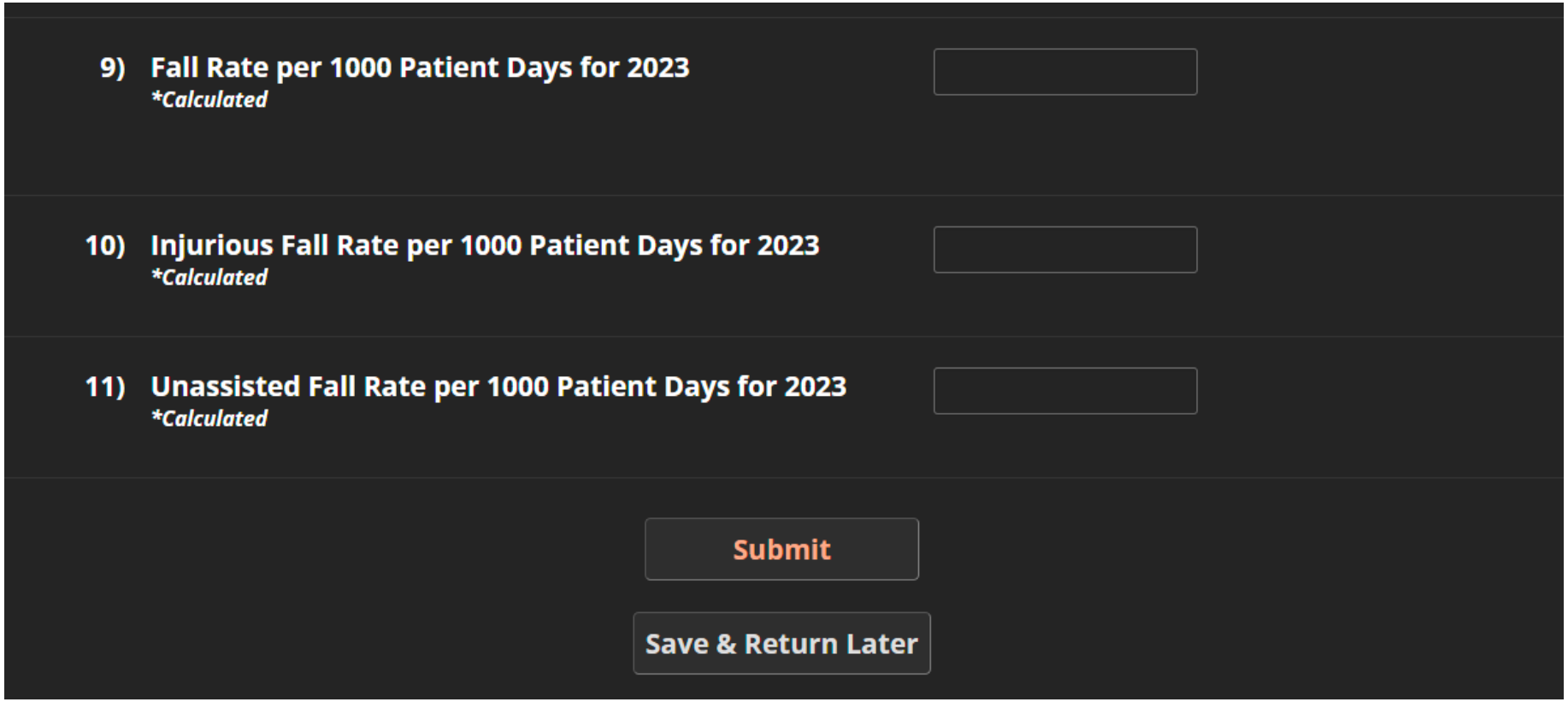
5)	**Number of Total Inpatient Falls for 2023** **Pulled from reported fall events* ***Includes unassisted, assisted, non-injurious, and injurious falls*	16
6)	**Number of Injurious Patient Falls for 2023** **Pulled from reported fall events* ***Includes ALL falls that result in minor harm, moderate harm, major harm, or death*	7
7)	**Number of Assisted Falls for 2023** **Pulled from reported fall events*	5
8)	**Number of Unassisted Falls for 2023** **Pulled from reported fall events*	11

The values on this page will be pulled from reports already entered into Know Falls.

Edit if needed.

If your hospital does not report into Know Falls, you will need to enter data here.

Preview of Form, continued



The values on this page will be automatically calculated based on data in the prior sections.

Proposed Timeline:

Jan 31: Hospitals have all 2023 fall event data entered into Know Falls

Early Feb: UNMC CAPTURE Falls team reviews falls, clarifies fall event data with hospitals as needed

Mid-Feb: UNMC CAPTURE Falls team sends out Q4 2023 Quarterly Reports. Also sends link requesting data for 2023 Fall Rate Calculations to Key Contacts

Early March: Fall rate data request will be due, exact date TBD; UNMC CAPTURE Falls team then shares 2023 Fall Rate Benchmarks with hospitals

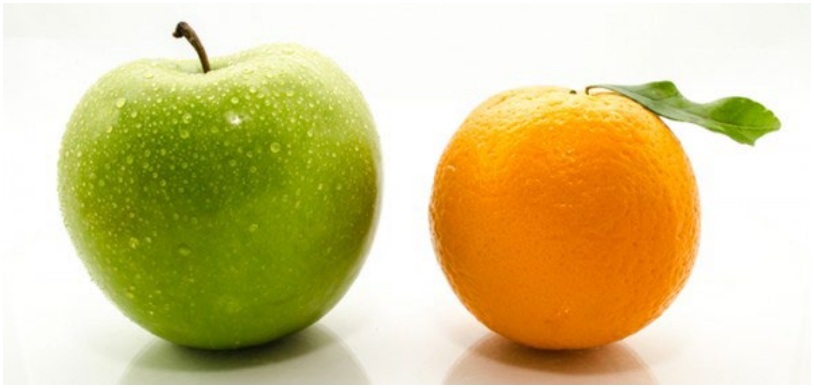
Fall Event and Rate Reporting

Even if you don't actively report fall event data into Know Falls, we hope that you will contribute to the 2023 Fall Rate Benchmarks!

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!

Safe Table Process for Future Collaborative Calls

Partnership with Nebraska Coalition for Patient Safety (NCPS)

- UNMC CAPTURE Falls is an analytical subcontractor for NCPS, a federally-listed Patient Safety Organization (PSO)
- Affords privacy and confidentiality protections to our work via the Patient Safety and Quality Improvement Act of 2005.
- Mutual benefits of this partnership
  - Reduce fall event reporting burden for hospitals
  - Improve patient safety and learning without fear of discovery *(part of this process is the conduct of Safe Tables)*

Relevant Definitions

Patient Safety Work Product (PSWP) means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) which could improve patient safety, health care quality, or health care outcomes, including information:

- Which is assembled or developed by a provider for reporting to a PSO and are reported to a PSO,
- Which is documented as within a patient safety evaluation system for reporting to a PSO, or
- Are developed by a PSO for the conduct of patient safety activities, or
- Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

Examples: fall event reports, fall risk reduction policies. Can include both written and oral statements.

Relevant Definitions

Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

Example: Know Falls (REDCap) fall event reporting system

Relevant Definitions

A **Safe Table** is a forum where healthcare providers review and discuss issues related to quality and patient safety improvement in a confidential and privileged space to facilitate group problem solving.

Information discussed during a Safe Table that we host will be considered Patient Safety Work Product within the UNMC CAPTURE Falls/NCPS PSO Patient Safety Evaluation System as defined by the federal Patient Safety and Quality Improvement Act of 2005.

When will we use Safe Tables?

Examples:

- When sharing case studies of fall events
  - UNMC CAPTURE Falls will not share identifying information about the patients, staff, and hospitals involved in these case studies
- During collaborative discussion among hospitals about fall events or fall policies/procedures used at their hospital

Process for Safe Tables

As the Safe Table host, UNMC CAPTURE Falls is required to ensure the confidentiality and privilege protection of information shared during the Safe Table.

- In advance of a Collaborative Call using a Safe Table format, we will send out a document highlighting the “ground rules” of a Safe Table for your review
- Key points of this document will be re-read during the Collaborative Call
- We will not record the Safe Table portion of the Collaborative Call. Other content, such as housekeeping items, or general education will be recorded and shared afterwards like usual.
- Handouts shared before or after the Collaborative Call will not contain Patient Safety Work Product (e.g. details about a fall event, even if non-identifiable). Other slide content will be shared like usual.

Questions about any content covered today?

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
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Sustainment

- Monitor progress towards goals on action plan
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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 April 23, 2024, 2:00-2:30pm CT
    - Tuesday August 20, 2024, 2:00-2:30pm CT (*note the August date, not our typical July)
    - 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

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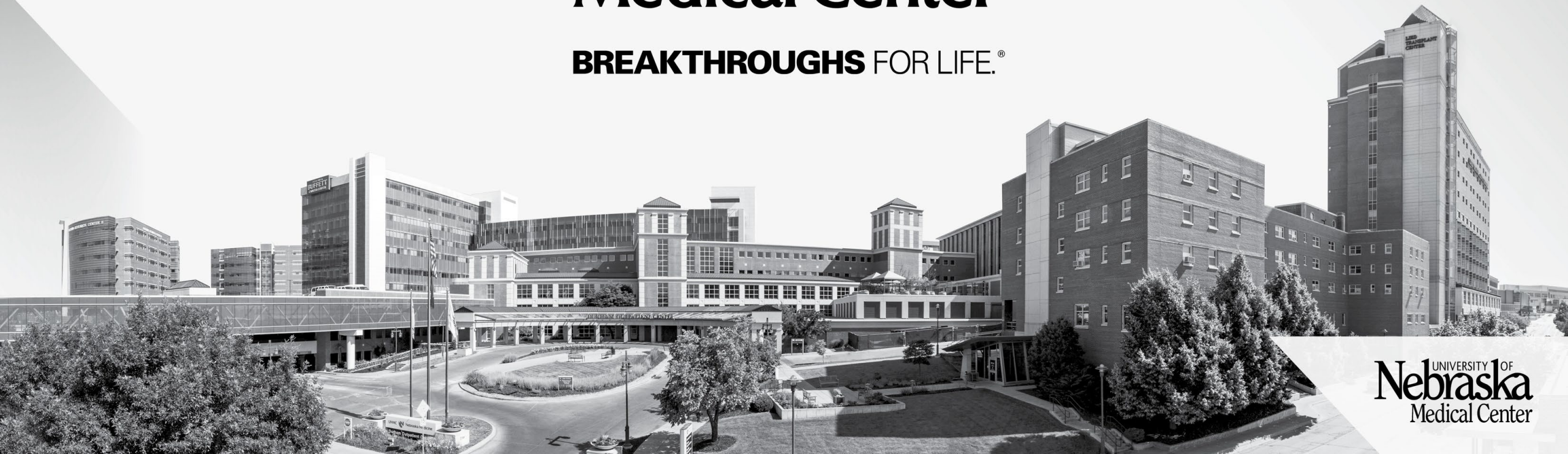

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