Collaboration and Proactive Teamwork Used to Reduce (CAPTURE) Falls Part 2: Know Falls: An Online Organizational Tool for Fall Risk Reduction

COMPASS Hospital Improvement Innovation Network
July 18, 2017
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Disclosure

This project is supported by:

- Grants R18HS021429 and R03HS024630 from the Agency for Healthcare Research and Quality
- Nebraska Department of Health and Human Services, Division of Public Health and the Nebraska Office of Rural Hospital Flexibility Program
- University of Nebraska Medical Center College of Medicine Summer Research Scholarships

The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.
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University of Nebraska Medical Center

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Objectives

1. Describe the Data, Information Knowledge, Wisdom (DIKW) framework
2. Recognize the barriers to organizational learning from traditional fall event reports.
3. Explain how the “Know Falls” Learning System uses the DIKW framework to facilitate critical thinking and organizational learning at the patient, unit, and system levels.
Background

Does your fall risk reduction team reflect and learn from data?

*Negative binomial model (Jones et. al, 2015)
Collecting, interpreting, and learning from data is the foundation of quality improvement and patient safety.
CAPTURE Falls

**Generate Ideas**

**Phase 1**

- 2011
- Risk of falls greater in CAHs than non-CAHs
- Lack reporting structure for benchmarking and learning
- Lack team structure to implement org. processes

**Test Ideas**

**Phase 2**

- 2012 – 2015
- Effective interprofessional coordinating teams decrease fall rates
- Standardize
- Plan
- Real-time adjustment

**Spread Ideas**

**Phase 3**

- 2016 – 2018
- Expand, sustain coordinating teams
- Implement online information system to standardize reporting, benchmarking, and learning from falls
- Use coordinating teams to address all quality goals
## Fall Risk Reduction System

### Structure

1. Multi-Team System
   a. Coordinating Team
   b. Core Team
   c. Contingency Team
2. Valid risk assessment tools
3. Reporting/learning system

### Process

1. Reliably implement bedside processes
2. Coordinate processes
3. Conduct Training
   1) Overall Program
   2) Fall Risk Assessment
   3) Safe Transfers/Mobility
   4) Use of Mechanical Lifts
   5) Post-fall Huddles
4. Conduct Post-fall Huddles

### Outcome (Fall Risk)

1. Total Fall Rate
2. Unassisted Fall Rate
3. Injurious Fall Rate
4. Repeat Fall Rate
5. Reporting Fall Outcomes

(Donabedian, 2003)
Core Team—people who provide direct patient care
- Diagnose and treat using evidence-based care plan
- Conduct fall risk assessment
- Implement universal and targeted interventions that address risk factors
- Conduct medication review
- Evaluate mobility and function
- Report and learn from falls—participate in post-fall huddles

http://teamstepps.ahrq.gov/
Structure: Fall Risk Reduction MTS

Contingency Team—members from various teams conduct post-fall huddle

• Meet immediately after a fall to determine what happened, why it happened, what will be done differently…ADJUST

• Goals:
  1. Decrease risk of future falls for an individual patient
  2. Apply what is learned to decrease risk across system
  3. Build trust and share knowledge

(Reiter-Palmon et al., 2015)

Post-Fall Huddle Tools

http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html
Structure: Fall Risk Reduction MTS

Coordinating Team—nurse champion, CNA, pharmacist, PT/OT, QI, senior leader

- Manage resources
- Coordinate fall risk reduction program and interventions
- Hold core team accountable for reliably implementing evidence-based interventions…
- Span location, status/hierarchy, and knowledge boundaries across disciplines (Edmondson, 2012)
Multi-team System for Fall Risk Reduction

Core Team

Contingency Team

Coordinating Team
Knowledge about the System Begins with Reporting

Systems dynamics model for fall risk reduction

1. **Feedback Loop**
   - **Effective Fall Risk Reduction Practices**
   - **Patient Falls**
   - **Report Fall Event**
   - **Aggregate Data and Make Sense of Events**
   - **Implement Changes Based on Analysis**

The feedback loop is positive, indicating an improvement cycle in fall risk reduction.
Fall Event Reporting System

Data Analysis

Fall Reports

Patient Falls

DIKW Hierarchy

Wisdom

Knowledge

Information

Data

Change Fall Risk Reduction Practices

Sense Making

Reflect/ make sense “Know Why and Take Action”

Place patterns into context “Know How”

Aggregate data “Know Who, What, When, Where, How Many”

Record observations in database “Know Nothing”

DIKW Hierarchy\(^5\text{-7}\)

- **Data**-Symbols that represent objects, events, and their environment; what we observe
- **Information**-Data that are connected and reduced into patterns to answer questions…who, what, when, where, how many
- **Knowledge**-How a system works; the ability to control a system and give instructions in its use
- **Wisdom**-Answers “WHY?” The ability to use judgment to implement the most appropriate behaviors and systems to prevent problems
Medical Record Number

Date of Fall

Time of Fall

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, and member of your fall risk reduction team as available (e.g., PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

Reminder: Patients fall because their center of mass is outside their base of support. During the huddle look for specific answers and continue asking “why?” until the root cause is identified.

1. Establish facts:
   1a. Did we know this patient was at risk?  YES  NO
   1b. Has this patient fallen previously during this stay?  YES  NO
   1c. Is this patient at high risk of injury from a fall? (ABCS)  Age 95+  brittle bones  Coagulation  Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.
   ASK: What was the patient doing when he/she fell? (Be specific...e.g., transferring sit-stand from the bed to wheelchair). Ask why multiple times.
   ASK: What were staff caring for this patient doing when the patient fall? Ask why multiple times.

3. Determine underlying root causes of the fall.
   ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.

4. Make changes to decrease the risk that this patient will fall or be injured again.
   ASK: How could we have prevented this fall?
   □ Need to consult with physical/occupational therapy about mobility/positioning/seating
   □ Need to consult with pharmacy about medications

   ASK: What changes will we make in this patient’s plan of care to decrease the risk of future falls?
   □ What patient or system problems need to be communicated to other departments, units or disciplines?

Post-Fall Huddle Documentation

By the huddle facilitator, Item 4 should be completed by the fall risk reduction team.

<table>
<thead>
<tr>
<th>Fall Type</th>
<th>Preventability</th>
<th>Actions Taken to Prevent Recurrence for This Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental</td>
<td>Possible</td>
<td>Prevention or intervention were in place</td>
</tr>
<tr>
<td>Anticipated</td>
<td>Possible</td>
<td>Prevention or intervention were in place</td>
</tr>
<tr>
<td>Unanticipated</td>
<td>Unpreventable</td>
<td>Prevention or intervention were in place</td>
</tr>
</tbody>
</table>

Describe actions taken to decrease risk of recurrence at the system level:

Contributing to patient safety and quality of care.

Form to your quality improvement coordinator.

Scan and email via encryption to asiziner@unmc.edu
Puzzle Analogy

• Each piece of information can be thought of as one puzzle piece

• The pieces have to be brought together to create the whole...knowledge
Effective Reporting Systems

Characteristics

1. Nonpunitive
2. Confidential
3. Independent
4. Expert Analysis
5. Timely
6. Systems oriented
7. Responsive
Paper Event Reporting

Barriers

- Security
- Lack of standardization
- Paper management
- Version management
- Individual events
- Data entry needed for aggregate analysis
- System flow
- Time lag
- Static / Checklist oriented…
Know Falls Learning System
Know Falls Learning System

• Secure online standardized fall event data collection tool for front line staff
• Promotes critical thinking through logic based form items
• Supports effective post-fall huddles
• Provides real-time reports to assist interprofessional Fall Risk Reduction Teams in identifying and address system weaknesses
• Builds a shared knowledge-base of fall risks and effective interventions in CAHs
• Facilitates creation of a fall rate benchmark
Know Falls Learning System

Fall Event Learning Form

Post-fall Huddle Form

System Learning Form
Know Falls Learning System

- Research Data Capture tool developed by Vanderbilt University to securely connect researchers and data
- Administered by UNMC Research Information Technology Office
- Password protected user accounts
- Users assigned to Data Access Groups
Know Falls Learning System

Log in

University of Nebraska Medical Center

All UNMC students, faculty, and staff already have access to this system — use your standard UNMC username and password below (but do not include UNMC_DOMAIN before your username).

A username and password can also be assigned by the Research IT Office to non-UNMC personnel.

Research IT Office Announcements

- Please review our REDCap Usage & Fees Policy, which takes effect July 1, 2016.
- Contact us if you need technical information about UNMC’s REDCap deployment for your IRB Application.

Please log in with your user name and password. If you are having trouble logging in, please contact your project administrator. Project Administrators and UNMC faculty and staff may contact the UNMC Research IT Office (RITO) by clicking here.

Username:

Password:

Log in

Forgot your password?
Know Falls Learning System

Add / Edit Records

You may view an existing record/response by selecting it from the drop-down lists below. To create a new record/response, click the button below.

Total records: 394 / In group: 17

Choose an existing Event ID

-- select record --

Add new record

Data Search

Choose a field to search
(excludes multiple choice fields)

All Fields

Search query

Begin typing to search the project data, then click an item in the list to navigate to that record.

NOTICE:

This project is currently in Development status. Real data should NOT be entered until the project has been moved to Production status.
Know Falls Learning System

Fall Event Learning Form

- Event ID 1425-2  2017-07-12 04:35 123000123

If applicable, please attach Event Learning Form and/or any other relevant documentation.

Upload document

- Report Date
  - 07-12-2017

- Completed by
  - AMS

- Date of fall
  - 07-12-2017

- Time of fall
  - 04:35

Military Time
Know Falls: Event Learning Form

Patient Information

Admission Type at Time of Fall
- Acute
- Swing
- LTC
- ICPP LTC
- Hospice
- Observation
- Outpatient
- Visitor
- Other

Patient Medical Record Number
123000123

Patient Admission Date
07-10-2017

Is patient older than 90?
- Yes
- No

Patient Age
76

Patient Gender
- Male
- Female

Reason for hospitalization
Weakness/Anemia

Patient conditions (Select all that apply)
- Anemia
- Cancer
- Cardiovascular
- Connective Tissue
- Cognitive Impairment
- Dementia
- Digestive (Gastrointestinal)
- Drug toxicity
- Electrolyte imbalance
- Endocrine
- Infection
- Influenza
- Mental status change
- Neurological co-morbidity (e.g., previous CVA, MS, Parkinson's Disease)
- OB/Gyn
- Orthopedic
- Pain
- Psychological/Mental Illness
- Renal/Urinary
- Respiratory
- Substance Withdrawal
- Trauma
- Weakness
- Wound
- Other

Please describe any other patient conditions that may have contributed to the fall or risk of injury from the fall.
Know Falls: Event Learning Form

Did the patient recently undergo a surgical procedure?

- Yes
- No
- Unknown

Was the patient taking any of the following medications that are known to increase the risk for falls or injuries as the result of a fall? (Check all that apply)

- Anticoagulants
- Antidiabetic agents (e.g., Insulin, Sulfonylureas, Meglitinides)
- Cardiovascular agents (e.g., Alpha/Beta/Calcium channel blockers, Antiarrhythmics, Antihypertensives, Diuretics)
- Psychotropics (e.g., Benzodiazepines, Hypnotics, Antipsychotics, Sedating Antidepressants)
- Analgesics (e.g., Opioids, Central analgesics, NSAIDs)
- Anticonvulsants
- Anticholinergics (e.g., Sedating Antihistamines, Antispasmodics, Skeletal muscle relaxants)
- Other
- No, the patient was not taking any of the above medications

Please describe any other medications the patient is taking and/or medication related factors that could potentially increase the risk of falls.


Patient’s ambulatory status at time of fall

- Not ambulatory
- With assist of 2
- With assist of 1
- With assistive device
- Stand by assist
- Independent
- Unknown
### Know Falls: Event Learning Form

<table>
<thead>
<tr>
<th>FALL DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where did the fall occur?</td>
</tr>
<tr>
<td>☐ Inpatient care area</td>
</tr>
<tr>
<td>☐ Emergency department</td>
</tr>
<tr>
<td>☐ Therapy area</td>
</tr>
<tr>
<td>☐ Radiology/imaging area, including mobile</td>
</tr>
<tr>
<td>☐ Outside area</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where specifically in the inpatient care area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Bedside</td>
</tr>
<tr>
<td>☐ Chairside</td>
</tr>
<tr>
<td>☐ Bathroom</td>
</tr>
<tr>
<td>☐ Hallway</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did staff assist the patient (hands on) during the fall?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was the fall observed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes by staff</td>
</tr>
<tr>
<td>☐ Yes by visitor, family, other patient</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How did staff discover the fall?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Patient found on floor</td>
</tr>
<tr>
<td>☐ Notified by family/friend/another patient</td>
</tr>
<tr>
<td>☐ Notified by non-clinical staff</td>
</tr>
<tr>
<td>☐ Notified by ancillary care staff</td>
</tr>
<tr>
<td>☐ Reported by patient</td>
</tr>
<tr>
<td>☐ Patient calling for help</td>
</tr>
<tr>
<td>☐ Alarm sounding</td>
</tr>
<tr>
<td>☐ Patient call light</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>
Know Falls: Event Learning Form

Did staff assist the patient (hands on) during the fall?
- Yes
- No
- Unknown

Was a gait belt used during the assist?
- Yes
- No
- Unknown

Was a gait belt available for use?
- Yes
- No
- Unknown

Why was a gait belt not used?
Know Falls: Event Learning Form

Describe the fall

States woke up having a nightmare and needed to use bathroom quickly. Tripped over bedside table while reaching for walker.

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

What was the type of injury? (Check all that apply)
☐ Hematoma / Bruising
☐ Abrasion or Skin tear (not requiring sutures or steri-strips)
☐ Laceration (requiring sutures or steri-strips)
☐ Pain
☐ Dislocation
☐ Fracture
☐ Intracranial injury
☐ Other

Please describe injury and location on patient’s body

Small bruise on Rt elbow.

What was the extent of harm to the patient as a result of the fall?
☐ Minor - application of dressing, ice, cleaning of wound, limb elevation topical medication, bruise or abrasion
☐ Moderate - suturing, application of steri-strips/skin glue, splinting or muscle/joint strain
☐ Major - surgery, casting, traction, consultation for neurological or internal injury or need for blood products
☐ Death
Know Falls: Event Learning Form

Additional clinical treatments and/or monitoring that occurred as a result of the fall

- No additional treatments or monitoring
- Transfer, including transfer to higher level care area within facility, transfer to another facility
- Increased observation
- Additional physiological exams
- Lab tests
- Imaging studies
- Additional medication therapy, including change in pre-incident doses
- Surgical/procedural intervention
- Respiratory support
- Increased length of stay
- Other
Know Falls: Event Learning Form

- Was a fall risk assessment documented for this patient?
  - Yes
  - No

- If no, why not?

- What was the patient’s score on the fall risk assessment?
  - 15 FRASS

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

- Prior to this fall, has the patient fallen while hospitalized?
  - Yes - during this admission
  - Yes - during a previous admission
  - No

- Previous Fall ID number
## Know Falls: Event Learning Form

### FALL RISK REDUCTION INTERVENTIONS

For each of the fall risk interventions below, indicate which were in place and being used to prevent falls for this patient.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>In place</th>
<th>Not in place, but could have potentially prevented fall, and/or reduced harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Device</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Bed Alarm</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Chair Alarm</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Bed in low position</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Call light/personal items within reach</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Gait Belt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip and/or joint protectors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-slip floor mats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-slip footwear</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Not to be left alone while toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthostatic vital signs monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and family education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient placed close to nurses' station</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT/OT includes strengthening: gait, balance, transfer training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purposeful rounding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental or area lighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting regimen</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Video monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visible identification of patient as being at risk for fall (e.g., falling star)</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>
# Know Falls: Event Learning Form

<table>
<thead>
<tr>
<th>ORGANIZATIONAL CONTRIBUTING FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please click the checkbox next to all factors that increased the patient’s risk of falling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENTAL FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical surroundings cluttered</td>
</tr>
<tr>
<td>Physical surroundings not customized to accommodate pt's mobility limitations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFORMATION ABOUT FALL RISK STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall risk status not available</td>
</tr>
<tr>
<td>Fall risk status not accurate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF QUALIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of competence (qualifications, experience)</td>
</tr>
<tr>
<td>Lack of training (use of gait belt, transfers, lifts)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of communication from supervisor to staff</td>
</tr>
<tr>
<td>Lack of communication among staff or team members</td>
</tr>
<tr>
<td>Lack of communication from staff to patient (or family)</td>
</tr>
<tr>
<td>Fall associated with a handoff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPERVISION/SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clinical supervision</td>
</tr>
<tr>
<td>Lack of managerial supervision</td>
</tr>
<tr>
<td>Poor teamwork</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HUMAN FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff fatigue</td>
</tr>
<tr>
<td>Staff stress</td>
</tr>
<tr>
<td>Staff inattention</td>
</tr>
<tr>
<td>Staff cognitive factors</td>
</tr>
<tr>
<td>Staff health issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POLICIES AND PROCEDURES (includes clinical protocols)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of policies</td>
</tr>
<tr>
<td>Poor clarity of policies</td>
</tr>
<tr>
<td>Lack of compliance with policies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXTERNAL FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Visitor involvement</td>
</tr>
</tbody>
</table>
### Know Falls: Event Learning Form

<table>
<thead>
<tr>
<th>PATIENT CONTRIBUTING FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please click the checkbox next to all factors that increased the patient's risk of falling.</td>
</tr>
</tbody>
</table>

- Dizziness / Vertigo
- Hypotension
- Procedure within last 24 hours
- Constipation
- Cognitive impairment
- Impulsive behavior
- Overestimated ability
- Neurological Co-morbidities (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
Know Falls: Event Learning Form

**IMMEDIATE STEPS TAKEN**

Describe immediate steps taken to reduce the reoccurrence of a fall for this patient.

Decluttered area around bed. Placed urinal within easy reach. Placed bed alarm as reminder to patient. Re-educated to call staff for assist.

**Do you plan to conduct a post-fall huddle for this fall?**

- [ ] Yes
- [x] No

Please refer to the CAPTURE Falls post-fall huddle facilitation guide.

Attachment: [CAPTURE Post Fall Huddle Guide 5.3.pdf](#) (0.1 MB)

Click the **Save and Go to Next Form** button below to complete the post-fall huddle documentation for this fall.

Click the **Save & Exit Form** button below to continue at a later time.

**Form Status**

Complete?

- [ ] Incomplete

---

[Save & Exit Form] [Save & Go To Next Form] [-- Cancel --]
**Know Falls: Post-fall Huddle**

### Postfall Huddle Form

<table>
<thead>
<tr>
<th>Event ID</th>
<th>1425-2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Event ID</strong></td>
<td><strong>[fall_id]</strong></td>
</tr>
<tr>
<td><strong>Fall Summary (Event ID: [fall_id])</strong></td>
<td></td>
</tr>
<tr>
<td>76 year old Female</td>
<td></td>
</tr>
<tr>
<td>Admission type: Acute</td>
<td></td>
</tr>
<tr>
<td>Admit Date: 07-10-2017</td>
<td></td>
</tr>
<tr>
<td>Reason for hospitalization: Weakness/Anemia</td>
<td></td>
</tr>
<tr>
<td>Other comorbidities</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Weakness</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Fall Huddle</strong></td>
<td></td>
</tr>
<tr>
<td>Did a Post-Fall Huddle take place for this fall?</td>
<td></td>
</tr>
<tr>
<td>* must provide value</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Who was included in the huddle? (Please check all that apply)</strong></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>✔</td>
</tr>
<tr>
<td>Family/Caregiver</td>
<td>✔</td>
</tr>
<tr>
<td>Charge Nurse</td>
<td></td>
</tr>
<tr>
<td>CNA</td>
<td></td>
</tr>
<tr>
<td>Primary Nurse</td>
<td>✔</td>
</tr>
<tr>
<td>OT/OTA</td>
<td>✔</td>
</tr>
<tr>
<td>PT/PTA</td>
<td></td>
</tr>
<tr>
<td>Pharmacist / Pharm Tech</td>
<td>✔</td>
</tr>
<tr>
<td>QI Coordinator</td>
<td>✔</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td><strong>Huddle Date</strong></td>
<td>07-12-2017</td>
</tr>
<tr>
<td><strong>Huddle Time</strong></td>
<td>15:00</td>
</tr>
<tr>
<td><strong>Huddle Facilitator Initials</strong></td>
<td>AMS</td>
</tr>
</tbody>
</table>
### Know Falls: Post-fall Huddle

#### Cause of Fall - Patient Level

1. **Did an unknown, unpredictable sudden condition such as a Heart Attack, Seizure or Drop Attack cause the fall?**
   - Yes - Unanticipated Fall
   - No

2. **Did any environmental (extrinsic) factors such as liquid on floor, trip over tubing, equipment, or furniture, or equipment malfunction contribute to the fall?**
   - Yes - Accidental Fall
   - No

3. **Did any known patient-related (intrinsic) risk factors such as confusion/agitation, lower extremity weakness, impaired gait, poor balance/postural control, postural hypotension, or centrally acting medication contribute to the fall?**
   - Yes - Anticipated Physiological Fall
   - No

**This fall could have possibly been prevented.**

Establish what patient and staff were doing and why.

<table>
<thead>
<tr>
<th>What was patient doing when he/she fell?</th>
<th>Woke up with nightmare and needed to go to bathroom. Was reaching for his walker and tripped over bedside table.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was staff doing when patient fell?</td>
<td>At nursing desk.</td>
</tr>
<tr>
<td>Determine underlying root causes of the fall.</td>
<td>Had a nightmare--first one during this hospitalization. Had been going to bathroom by himself with walker without any problem.</td>
</tr>
<tr>
<td>What was different this time as compared to other times the patient was engaged in the same activity for the same reason?</td>
<td></td>
</tr>
</tbody>
</table>
**Know Falls: Post-fall Huddle**

<table>
<thead>
<tr>
<th>Make changes to decrease the risk that this patient will fall or be injured again.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walker within reach. Urinal within reach. Room less cluttered.</td>
</tr>
</tbody>
</table>

**How could we have prevented this fall?**

**Do we need to consult with other interprofessional team members regarding the fall risk for this patient?**

- No - Additional consults are not needed at this time
- Yes - with PT/OT about mobility/positioning /seating
- Yes - with Pharmacy about medications
- Yes - with Other (describe below)

**Describe concerns to discuss with pharmacy.**

**Describe actions taken to prevent recurrence for THIS PATIENT.**

- Bed alarm placed as reminder to call nurse even if just for standby assist. Patient thought about calling nurse to assist but didn’t because he wanted to be independent and return to assisted

**What patient or system problems need to be communicated to other departments, units or disciplines?**

- Night shift to keep patient items accessible at night. Check with patient about night light
Know Falls: System Learning

System Learning Form

<table>
<thead>
<tr>
<th>Event ID</th>
<th>1425-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Fall Huddle Summary</td>
<td></td>
</tr>
<tr>
<td>Date: 07-12-2017 Time: 15:00 Facilitator Initials: AMS</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>Family/Caregiver</td>
<td></td>
</tr>
<tr>
<td>Primary Nurse</td>
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<td>Pharmacist / Pharm Tech</td>
<td></td>
</tr>
<tr>
<td>QI Coordinator</td>
<td></td>
</tr>
<tr>
<td>CAUSE OF FALL - PATIENT LEVEL</td>
<td></td>
</tr>
<tr>
<td>Accidental fall - Environmental (extrinsic) factors such as liquid on floor, trip over tubing, equipment, or furniture, or equipment malfunction contributed to the fall</td>
<td></td>
</tr>
<tr>
<td>Anticipated Physiological fall - Known patient-related (intrinsic) risk factors such as confusion/agitation, lower extremity weakness, impaired gait, poor balance/postural control, postural hypotension, or centrally acting medication contributed to the fall</td>
<td></td>
</tr>
<tr>
<td>This fall possibly could have been prevented, please describe actions taken to prevent recurrence for THIS PATIENT:</td>
<td></td>
</tr>
</tbody>
</table>

*Bed alarm placed as reminder to call nurse even if just for standby assist. Patient thought about calling nurse to assist but didn’t because he wanted to be independent and return to assisted living.*
## CAUSE OF FALL - SYSTEM LEVEL
(To be completed by Fall Risk Reduction Team)

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this fall occur because planned interventions were NOT in place as intended? (e.g. bed alarm not activated)</td>
<td>Yes - Task Error</td>
<td>No</td>
</tr>
<tr>
<td>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)</td>
<td>Yes - Judgement Error</td>
<td>No</td>
</tr>
<tr>
<td>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)</td>
<td>Yes - Care Coordination Error</td>
<td>No</td>
</tr>
<tr>
<td>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)</td>
<td>Yes - System Error</td>
<td>No</td>
</tr>
</tbody>
</table>

### Describe the system error

Added by UNMC: New policy to use the FRASS fall risk assessment tool and link targeted interventions to risk factors is in place but staff have not been educated about the linkage. For example, this patient was known to be weak, impulsive, and have urinary urgency. Therefore, appropriate interventions especially at night would be bed alarm so staff know when patient is up so they can assist as needed due to weakness, toileting schedule and urinal/bedside commode for urgency.

### Describe actions that are needed at the SYSTEM LEVEL to decrease risk of this type of system error.

Added by UNMC: Staff education regarding the linkage of targeted interventions to risk factors identified in the FRASS followed by audits to ensure consistency.
Know Falls: System Learning

Please describe/discuss what your team learned about your fall risk reduction system as a result of this fall.

Different accommodations need to be made at night for patient safety—reduction of tripping hazards, where items that patient needs are placed according to patient wishes, rounding includes asking about toileting and is this being done.

Added by UNMC: When polices/procedures are changed there must be a period of education, audit, and feedback to ensure the new policy/procedure becomes routine in the workflow.

How will your team communicate the knowledge gained from this fall to the rest of your organization?

As this huddle was held when family was in attendance, information was shared with night shift so they could ensure safety needs are addressed at night (may not be same as daytime needs).

Added by UNMC: Determine how to educate staff and conduct audits and provide feedback.
Know Falls: System Learning

Please describe/discuss what your team learned about your fall risk reduction system as a result of this fall.

ORGANIZATIONAL LEARNING

How will your team communicate the knowledge gained from this fall to the rest of your organization?

FEEDBACK LOOP

OR

Critical Thinking

 pense

methods

problems

judgment
Paper Event Reporting

Barriers:

- Security
- Lack of standardization
- Paper management
- Version management
- Individual events
- Data entry needed for aggregate analysis
- System
- Time
- Static / Checklist oriented…

Know Falls
Help us Improve KNOW Falls

• Recruiting 5 hospitals outside Nebraska as additional beta test sites

• What’s in it for you? At NO cost…
  – Full use of KNOW Falls to collect data, reflect on information, know system vulnerabilities, and develop the wisdom to improve fall risk reduction system
  – Access to reports built from aggregate data to facilitate reflection and learning about your fall risk reduction system

• What do you need to do?
  – Email Anne Skinner (askinner@unmc.edu)
The Future!

Anticipate that KNOW Falls will be available on a subscription basis Sept. 2018

- Wisdom
- Knowledge
- Information
- Data
Contact Information

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Katherine Jones, PT, PhD kjonesj@unmc.edu
Victoria Kennel, PhD victoria.kennel@unmc.edu

Toolkit available at:

http://www.unmc.edu/patient-safety/capturefalls/
References


2. UNMC. College of Medicine. Patient Safety. CAPTURE Falls Tool Inventory. Available at: http://www.unmc.edu/patient-safety/cf_tool_inventory.htm


5. Rowley J. Where is the wisdom that we have lost in knowledge? Journal of Documentation. 2006;62:251-270.


CAPTURE Falls Research Team

University of Nebraska Medical Center

– Katherine Jones, PT, PhD
– Victoria Kennel, PhD  (I/O psychologist)
– Dawn Venema, PT, PhD
– Anne Skinner, RHIA, MS
– Mary Wood

University of Nebraska at Omaha Center for Collaboration Science

– John Crowe, MS (I/O psychology graduate student)
Polling Question

HOW ARE WE DOING

Tell Us!
Community of Practice Upcoming Events

August Fall Prevention CoP

Tuesday, August 15\textsuperscript{th} at 11 AM
Part 3: Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls
Falls Prevention Awareness Day

September 22, 2017

10th annual Falls Prevention Awareness Day (FPAD)
Sept. 22, 2017—the first day of fall
In honor of this notable milestone, the theme of the event will be

10 Years Standing Together to Prevent Falls

Contact

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Iowa Healthcare Collaborative
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