CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

Best Practices in Teamwork to Support Fall Risk Reduction

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AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

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C A P T U R E

Collaboration and Proactive Teamwork Used to Reduce **Falls**

http://unmc.edu/patient-safety/capture_falls.htm

Learning Objectives

- Describe the role of teamwork to support organizational learning about fall risk reduction
- Explain how the multi-team system supports implementation of a fall risk reduction program
- Use TeamSTEPPS tools to support fall risk reduction

Part I: Introduction and Background

Teamwork supports organizational learning about fall risk reduction

Teamwork and Organizational Learning

The knowledge, skills, attitudes, language, and coordinating mechanisms inherent in teamwork[1] create the flexibility team members need to manage complexity[2] and learn from experience.[3-5]

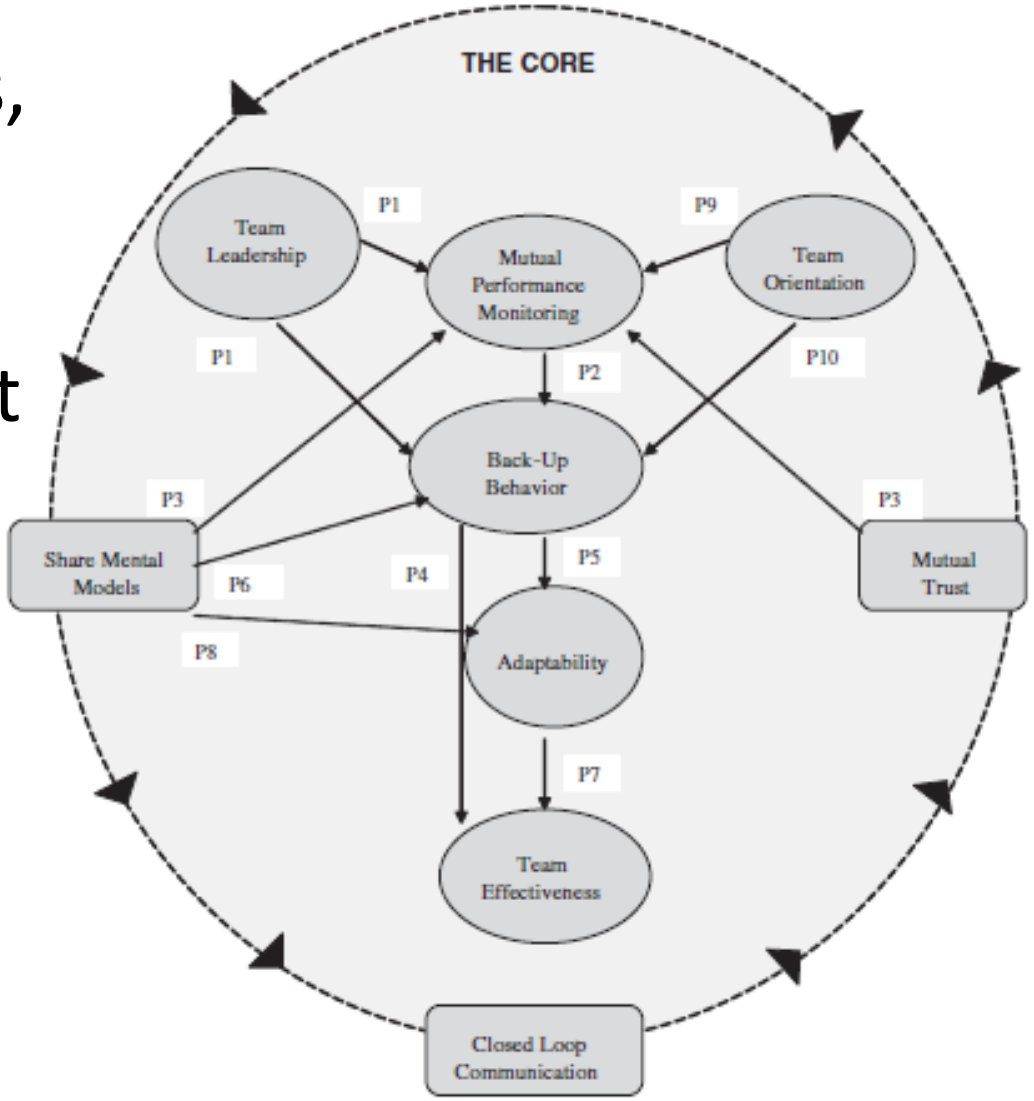
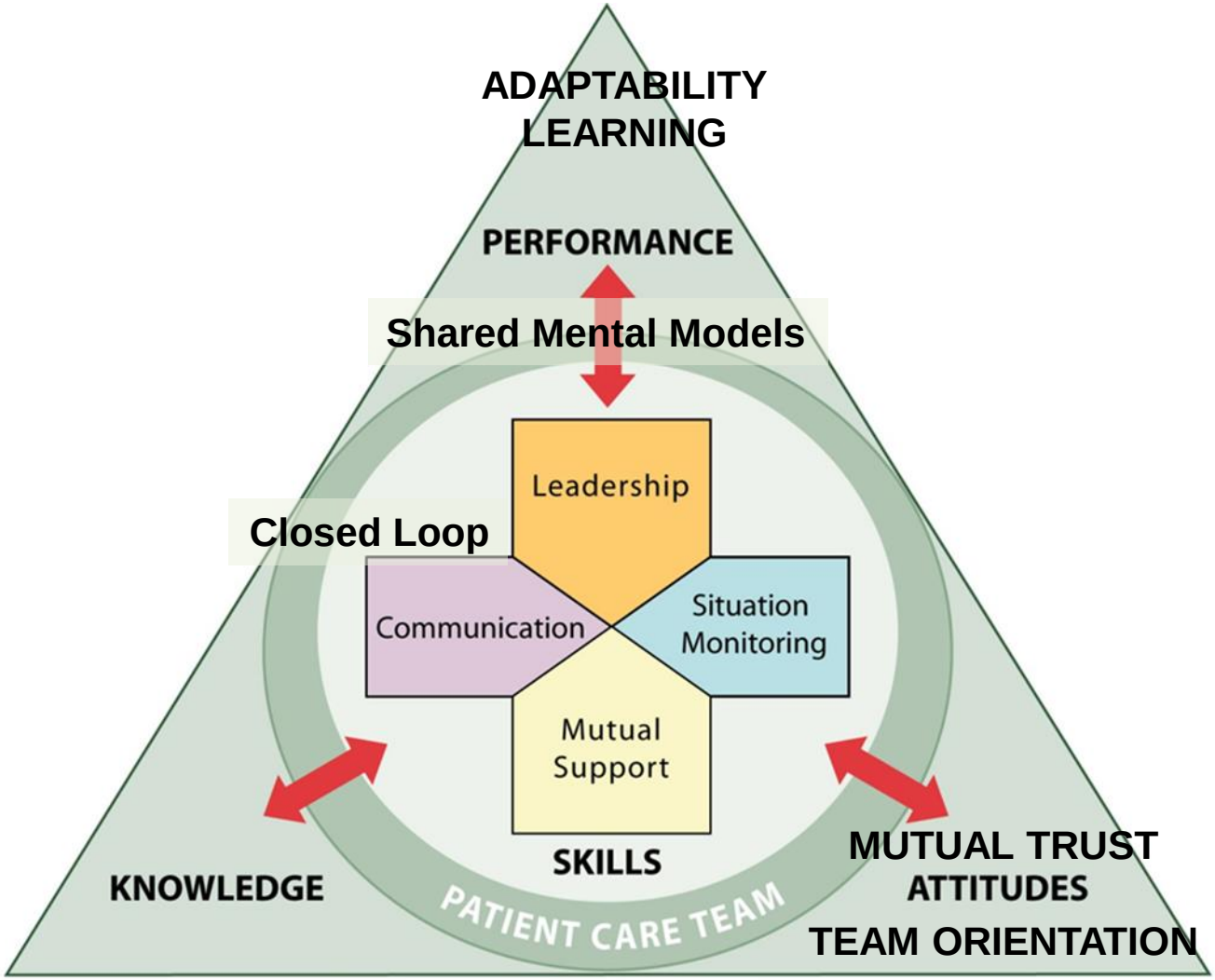


Figure 1: Graphical Representation of High-Level Relationship Among the Big Five and the Coordinating Mechanisms Including Research Propositions

Salas's Big 5 and TeamSTEPPS



Teaming is Critical When We Must…[6]

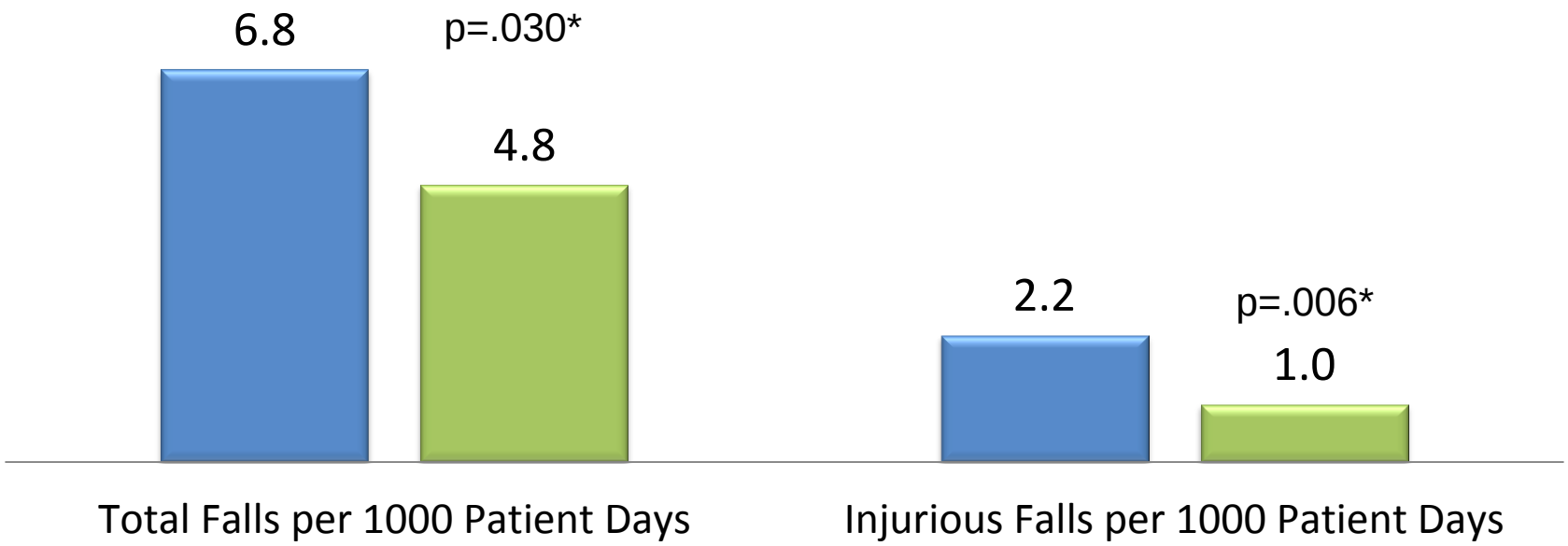
- Balance multiple objectives with minimal oversight
- Quickly transition from one situation to another and maintain communication and coordination (shared mental models)
- Integrate perspectives from multiple disciplines
- Collaborate across multiple locations
- Quickly adapt without a pre-existing plan
- Quickly process complex information

Role of Teams in Fall Risk Reduction

- The etiology of falls is multifactorial, thus fall risk reduction requires an interprofessional approach[7]
- Fall risk has been reduced in studies where interprofessional team members actively engaged in fall risk reduction efforts[8-10]
- An interprofessional team (vs. nursing only) strategy and use of benchmarks have been associated with sustained decreases in fall rates[11-13]

Role of Teams: Integrating Evidence[14]

Does your fall risk reduction team integrate evidence from multiple disciplines to continually improve fall risk reduction efforts?

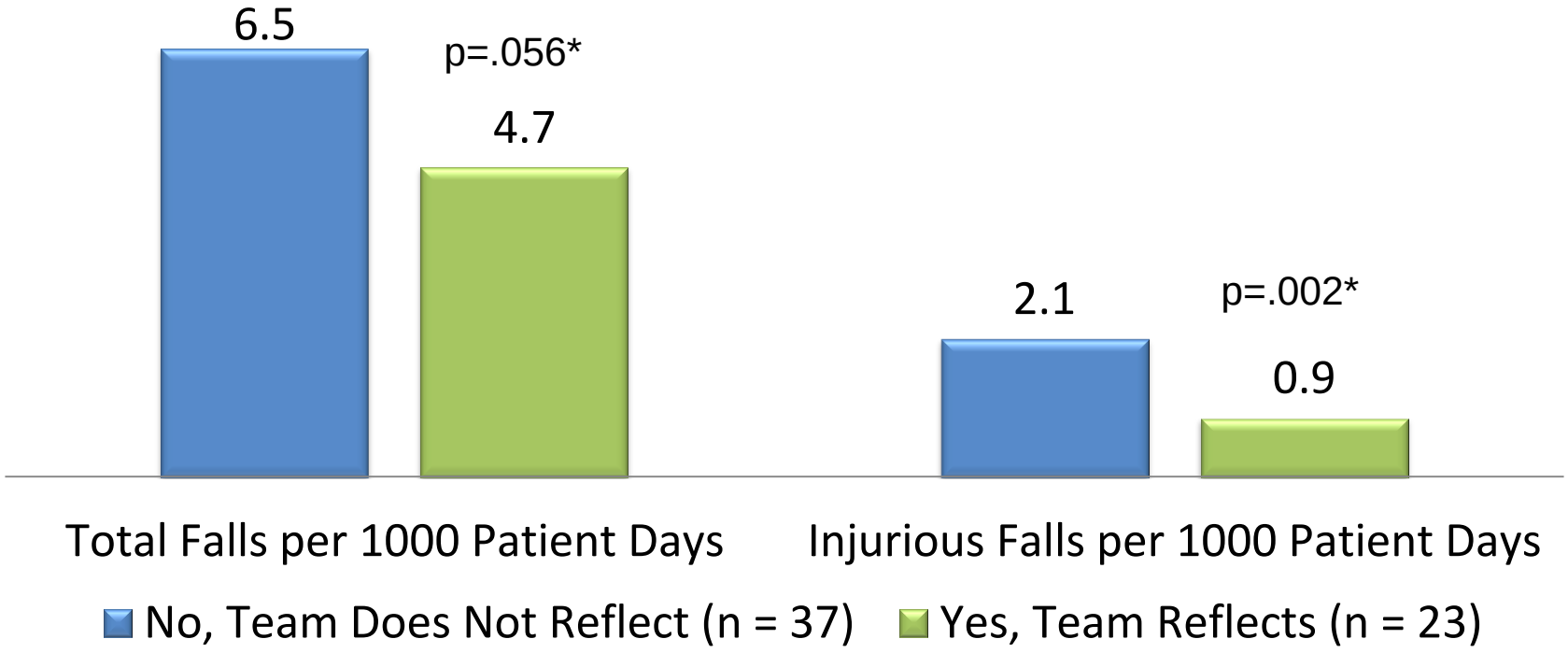


*Negative binomial model

Role of Teams: Team Reflexivity[14]

Does your fall risk reduction team…

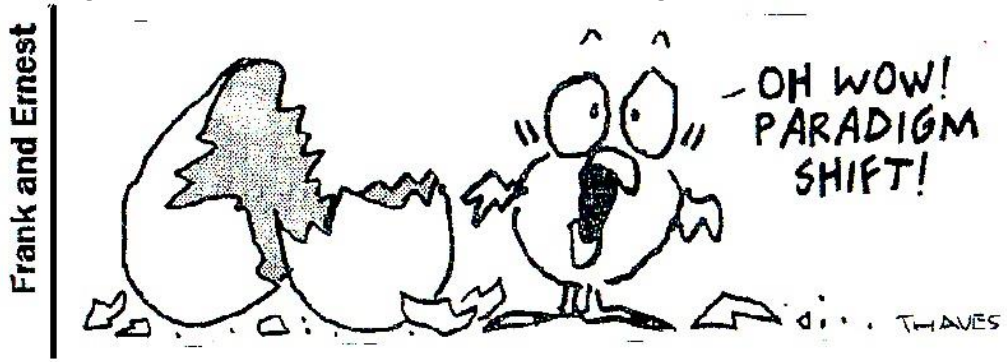
1. **Collect and analyze data regarding fall risk reduction program outcomes?**
2. **Modify fall risk reduction policies and procedures based on outcome data?**
3. **Conduct root cause analyses of injurious falls?**



*Negative binomial model

Team Reflexivity/Learning [15]

Teams are more likely to learn from errors and mistakes and adapt their actions to minimize future risks when they reflect on outcome data, and the policies and procedures that produced those outcomes

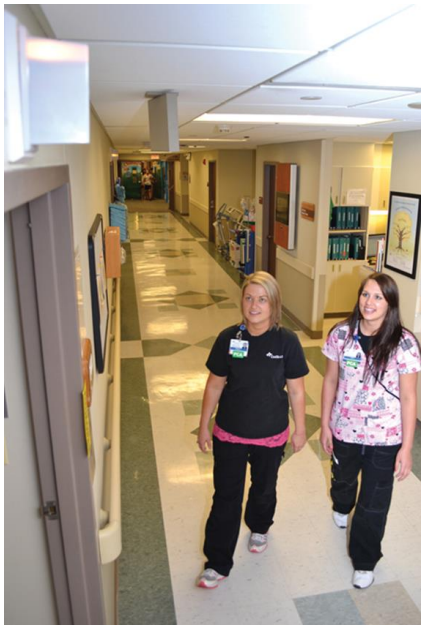


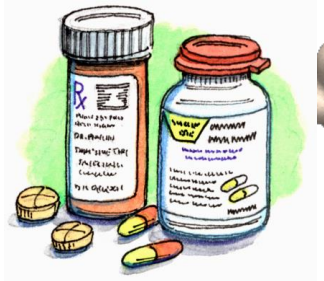
Paradigm shift: Interprofessional fall risk reduction teams should coordinate and facilitate organizational learning and innovation as they implement and evaluate a hospital's fall risk reduction program

Multi-team system supports implementation of fall risk reduction program

What Defines a Team?

Two or more people who interact dynamically, interdependently, and adaptively toward a common and valued goal, have specific roles or functions, and have a time-limited membership

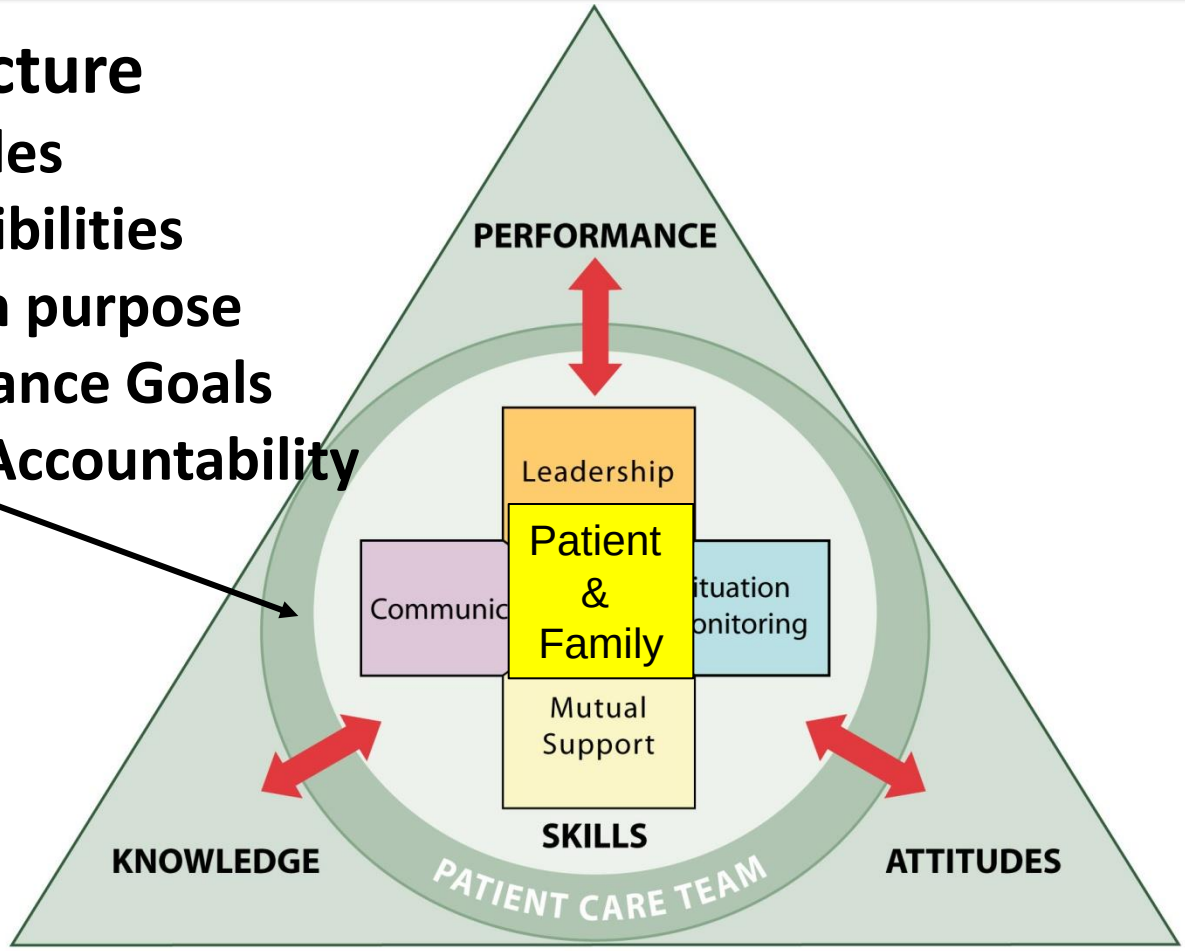




Team Structure

Team Structure

- Clear Roles
- Responsibilities
- Common purpose
- Performance Goals
- Mutual Accountability



Team skills are the result of effective team structure

Fall Risk Reduction Multi-Team System[16]

Ask-Me-3[17]
Fall Risk Reduction
1. Why might I fall?
2. What do I need to do?
3. Why is it important for me to do this?

Pa & Fa
Teach back if cognitively able

Contingency Team
= Post Fall Huddle about 1 patient

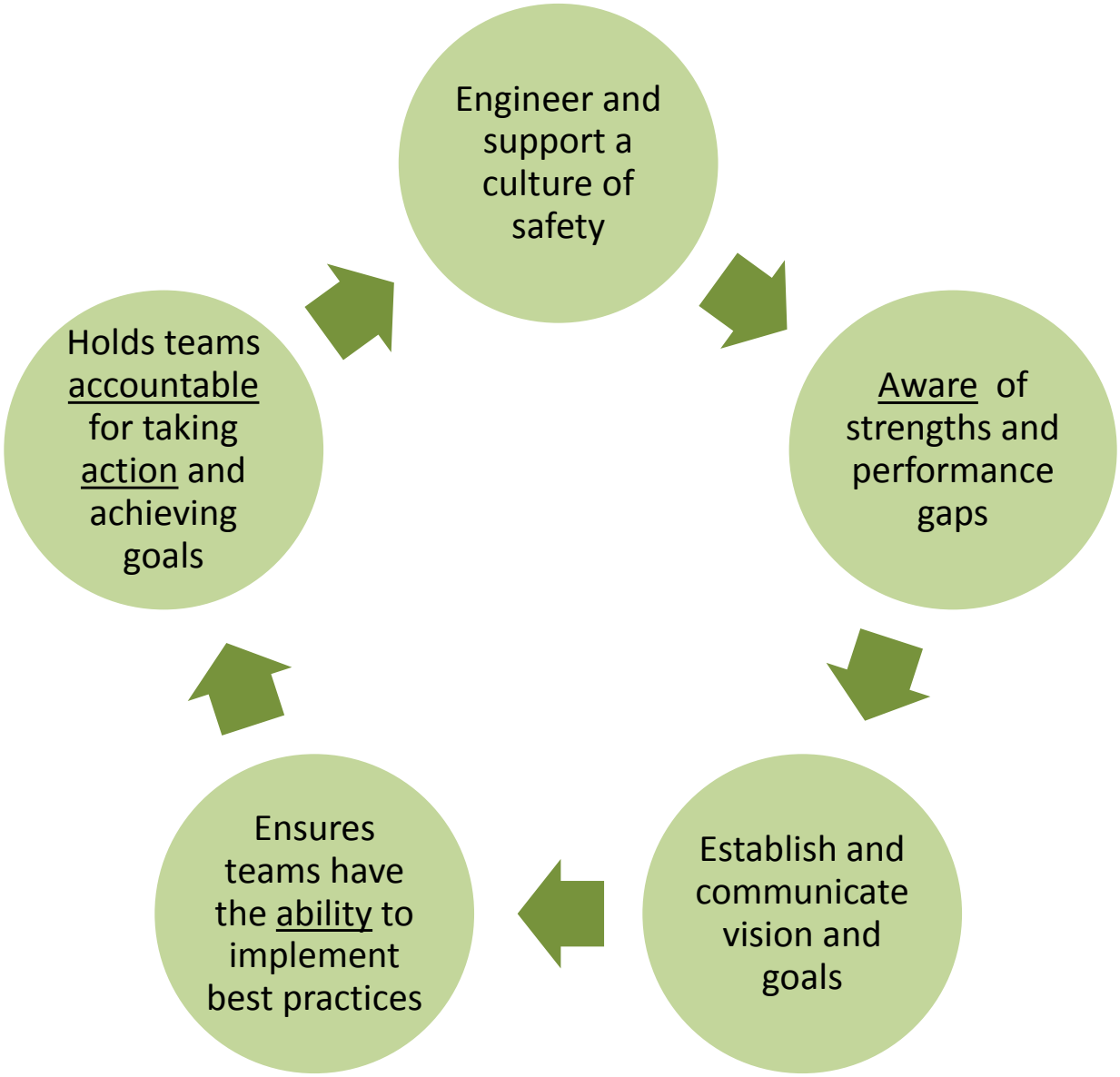
Core Team
Physician
Nursing performs fall risk assessment, implements interventions
PT consults re mobility
Pharmacist reviews medications
All educate patient & family

Coordinating Team = Fall Risk Reduction Team
Accountable for implementation and evaluation of fall risk reduction program; holds core team accountable

Ancillary & Support
Radiology is informed of fall risk during handoff
Housekeeping turns on alarms
Laundry ensures clean gait belt
Env. Services fixes equipment

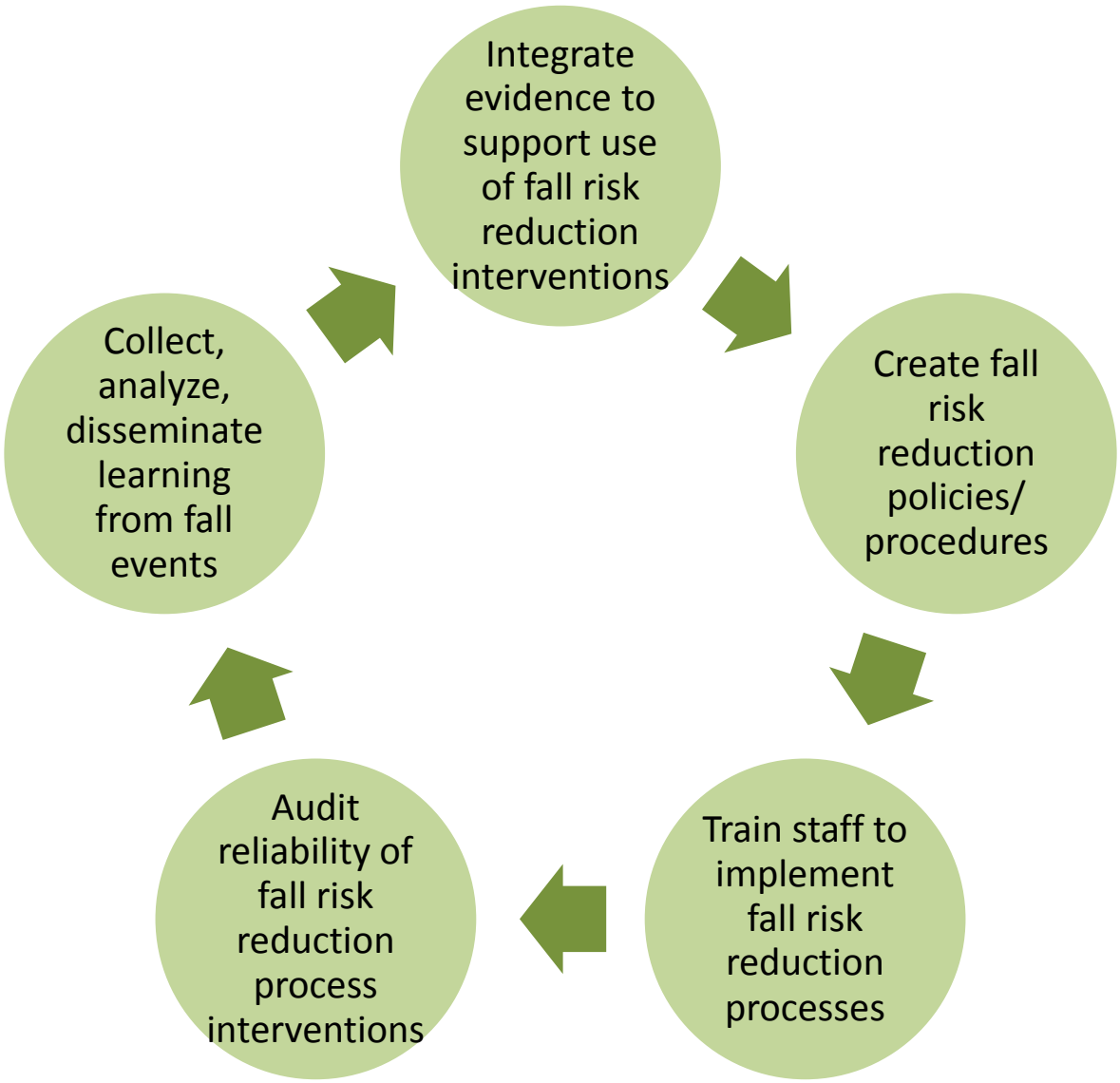
Administration
Holds Fall Risk Reduction Team accountable for implementation and evaluation of fall risk reduction program
Provides resources (time, money, equipment, personnel) for Fall Risk Reduction Team

Role of Administration in MTS[16]



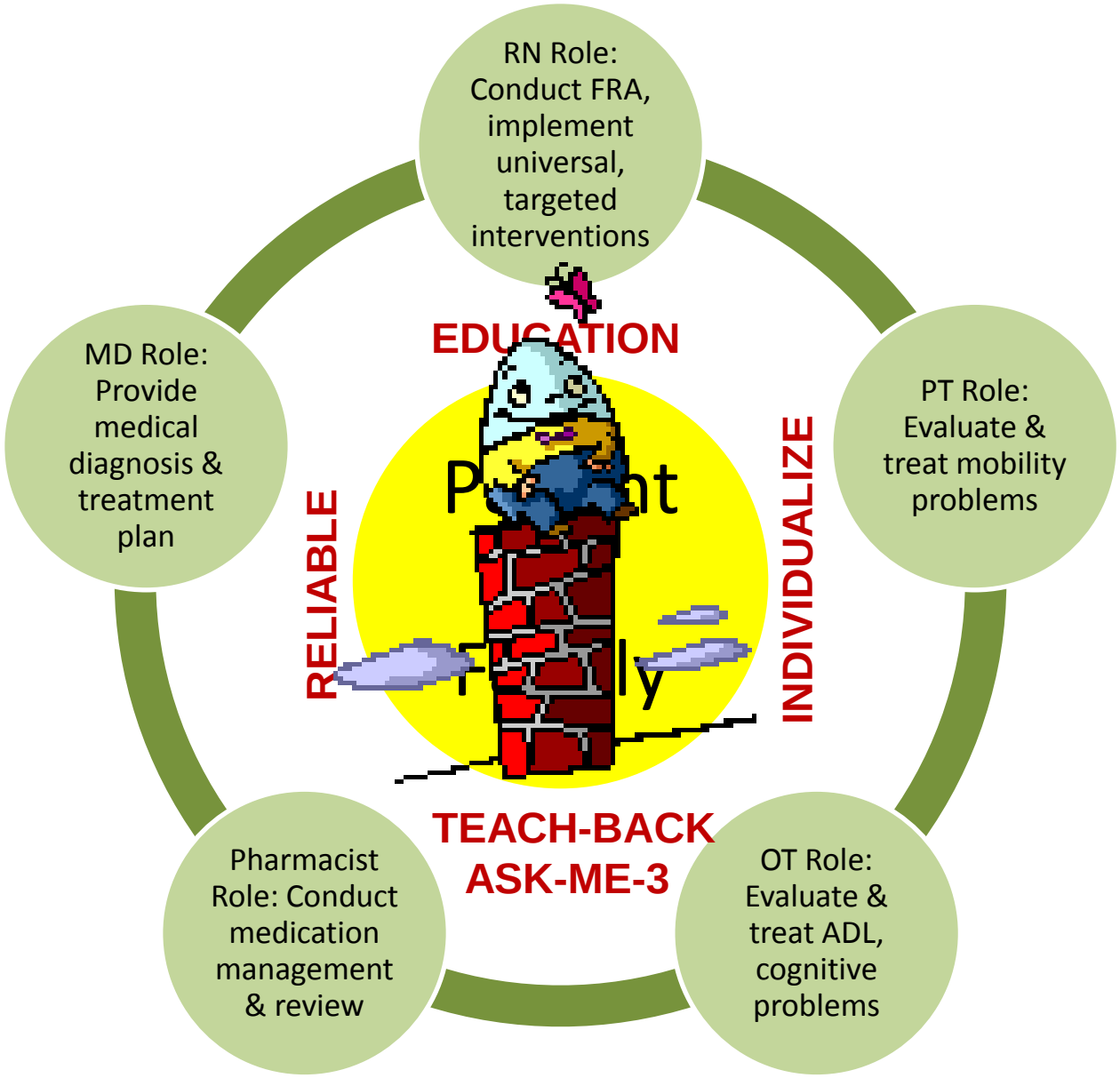
Administration: Includes executive leadership, has 24-hour accountability for the overall function and management of the organization; creates the climate and culture for a teamwork system[16]

Role of Coordinating Team in MTS[16]



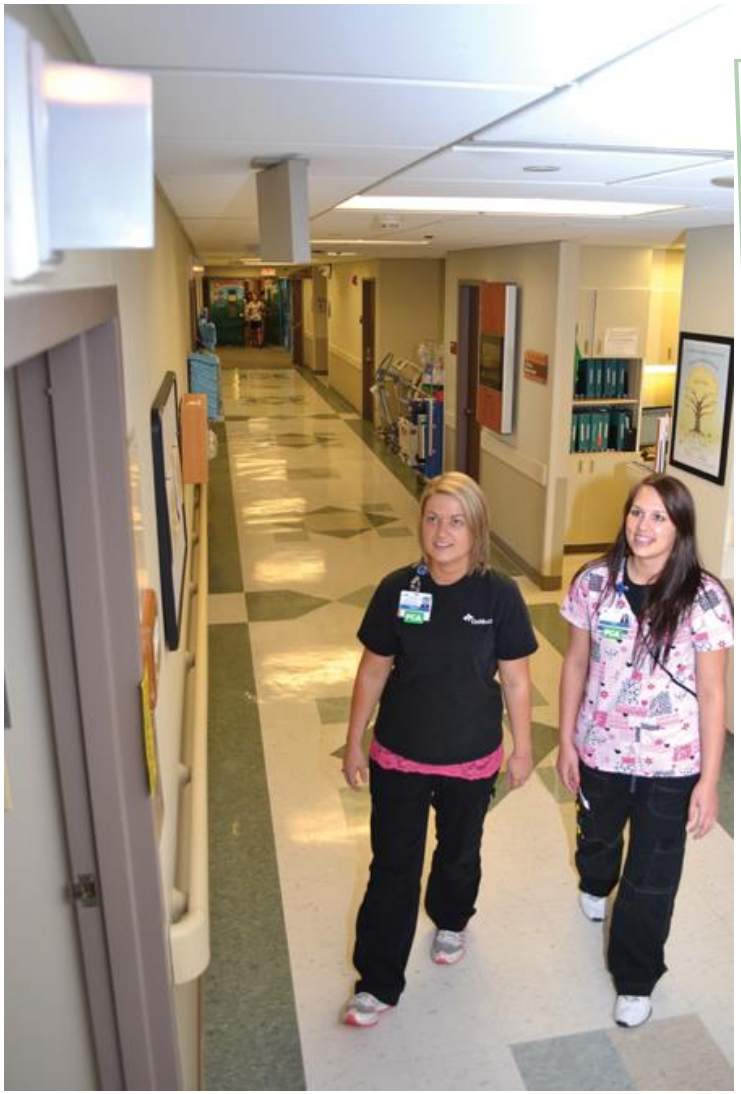
Coordinating Team: Designated leaders who are responsible for managing the operational environment and resources that support the Core Team[16]

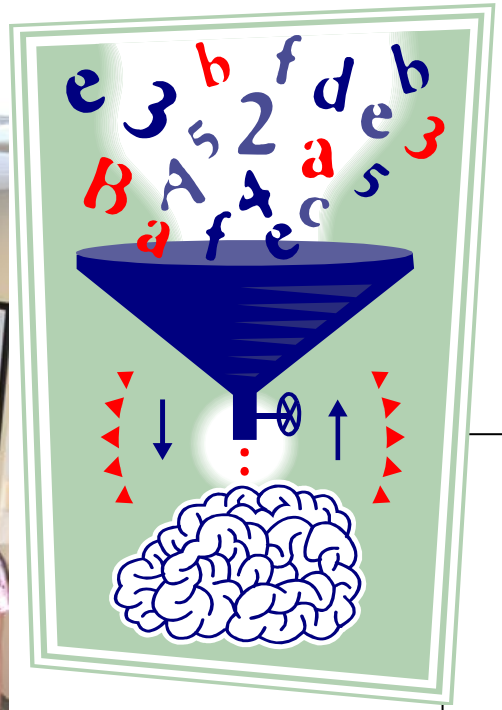
Role of Core Team in MTS[16]

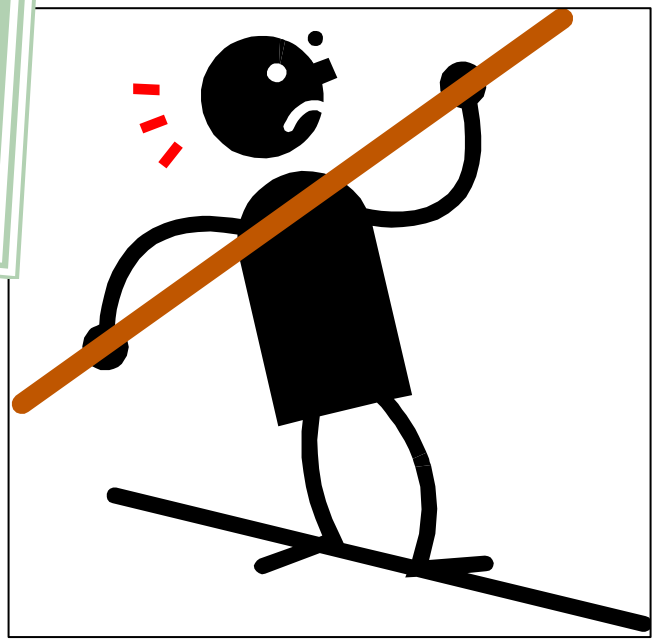


Core Team: Direct care providers who monitor the situation and communicate directly with each other to maintain a shared mental model of the progress toward a patient's goals[16]

Shared Mental Model?







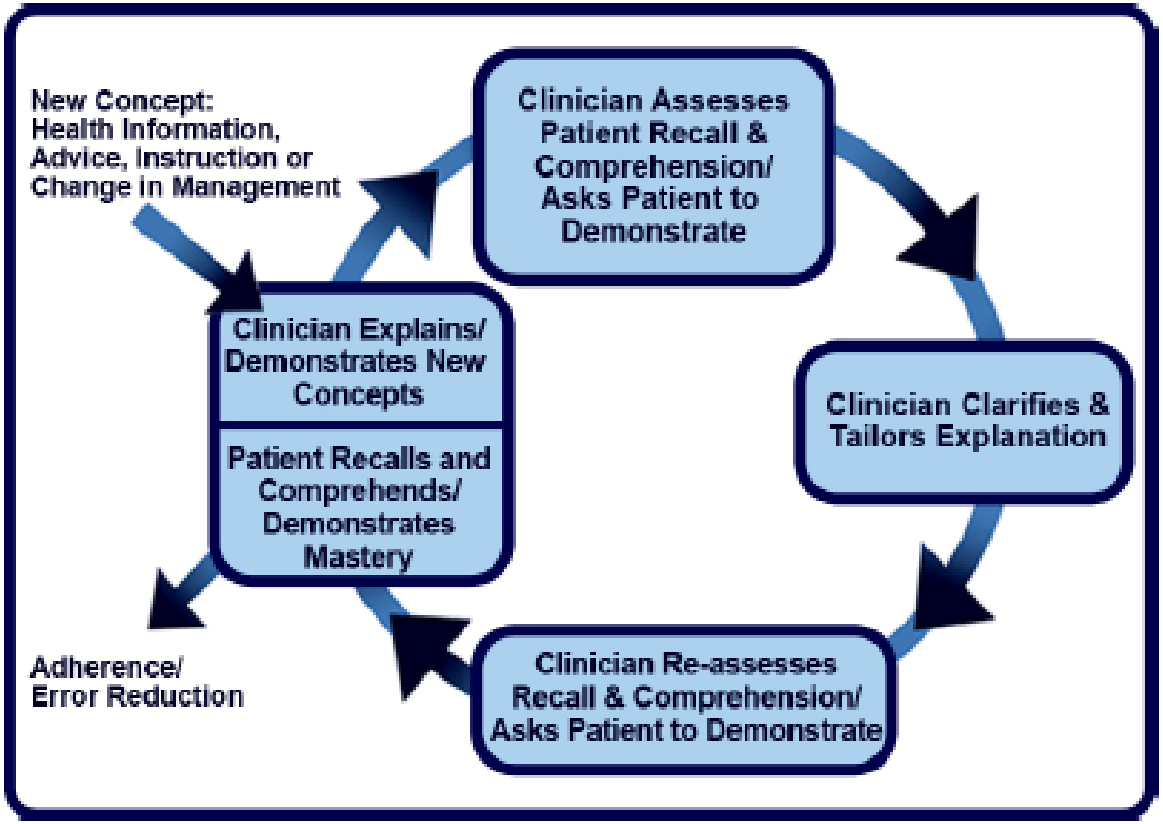
Role of Patient in MTS

Ask Me 3 Fall[17]
Risk Reduction

1. Why might I fall?
2. What do I need to do?
3. Why is it important for me to do this?

Teach-Back / Show-Me Method

Confirming Your Message is Understood



The content for this material was excerpted from Schillinger, D.—*Case and Commentary: Lethal Cap. Morbidity & Mortality Rounds on the Web, Agency for Healthcare Research and Quality*. Available at: http://webmm.ahrq.gov/case.aspx?caseID=53#figure1

Role of Contingency Team[16]

Referred for home health on discharge (safety assessment & PT)

Patient with cognitive impairment falls in bathroom

Conduct post-fall huddle; obtain bed-side commode and discontinue sedative

Discuss fall event in fall risk reduction team meeting

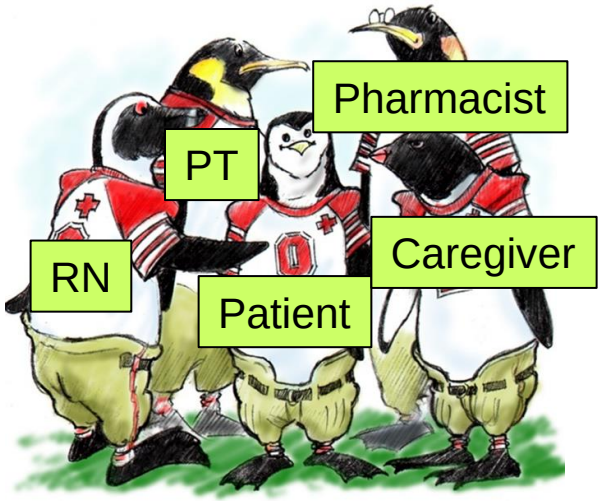
Identify need for standard assessment of cognition linked to levels of supervision

Implement Mini-Cog and tiered levels of supervision: alarms, family, video monitor, sitters

X

Learning and Action

Contingency Team: A time-limited team formed for emergent or specific events and composed of members from various teams[16]



Huddles Facilitate Learning & Action[19]

- Organizational learning--activities that create shared understanding of causes of errors and what can be done to prevent similar errors in the future
- Huddles solve a problem for 1 patient (share solutions informally)
- Coordinating team sees patterns, solves systematic problems brought to their attention by reported events
- Different types of work create different patterns for error, learning and ACTION

Knowledge of Learning Domains Informs Action[19]

		Interdependence of Individuals	
		Low	**High**
Process Uncertainty	**Low**	**Task Execution**: Individuals perform well understood, routine tasks **Task Error Examples:** Forget to turn on bed alarm; housekeeping forgets to stock a room with clean gait belt	**Coordination:** High levels of knowledge high within groups; low between groups **Coordination Error Example:** Information about previous fall not handed off across shifts/depts
	High	**Judgment**: Individuals perform unfamiliar processes that require decision making **Judgment Error Examples:** Leave patient with cognitive impairment alone in bathroom; transfer/ambulate a patient without understanding mobility impairments	**System Interaction:** Multiple people involved in new activity **System Error Examples:** No policy/ procedure to regularly replace batteries in newly acquired chair alarms; no policy/procedure to clarify level of assist for transfers upon pt. admission

Role of Ancillary & Support Services Team[16]

Every member of the team has a defined role in fall risk reduction

Ancillary services—direct, task-specific, time-limited care (e.g. dietary, lab, radiology)

Support services—indirect, task-specific management of environment (e.g. IT, housekeeping, laundry, maintenance)

TeamSTEPPS tools support fall risk reduction—An event-based approach

(adapted from an event reported to the Nebraska Coalition for Patient Safety

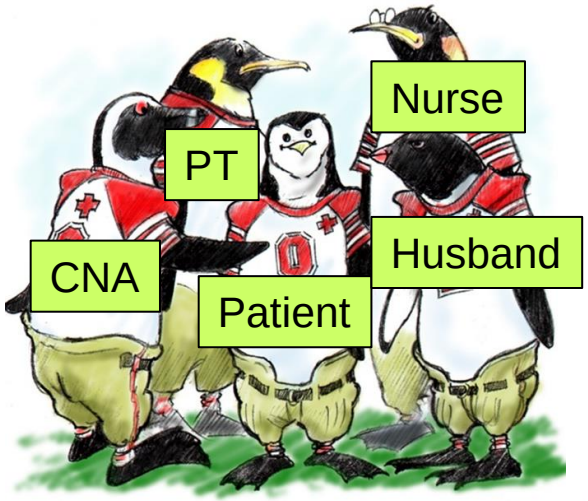
http://www.nepatientsafety.org/)

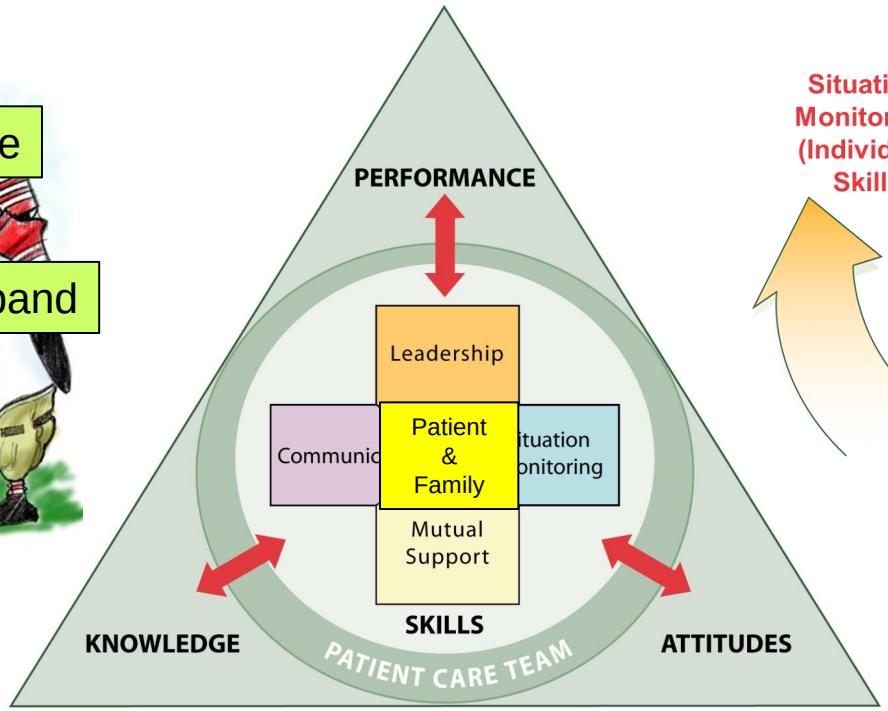
Fall Event

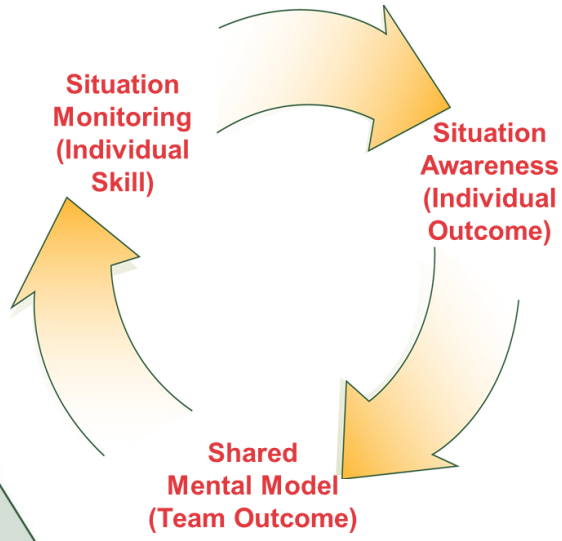
65 y/o female with diagnosis of L4-5 laminectomy assisted to bathroom on evening of surgery by CNA who instructed pt. to hold onto the IV pole for support. Patient's knees buckled and she fell to the floor sustaining minor harm (abrasion to knee). Gait belt and walker were in the room but not used. Husband not initially notified of the fall.

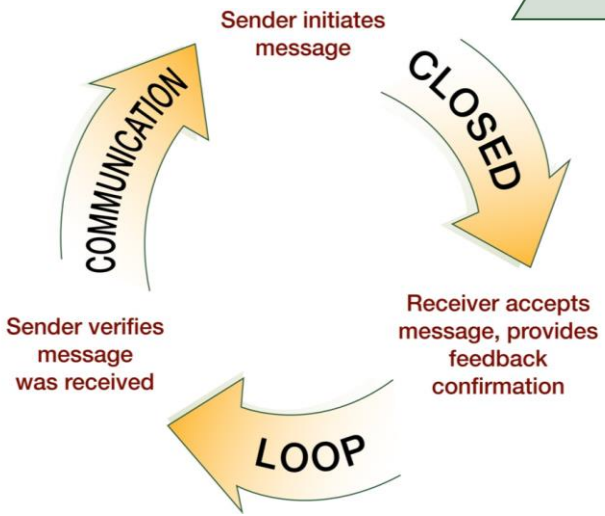
During the post-fall huddle, CNA stated that she was unfamiliar with the patient, did not know her transfer requirements, and transfer information was not posted on the patient's communication board.

Using TeamSTEPPS Tools



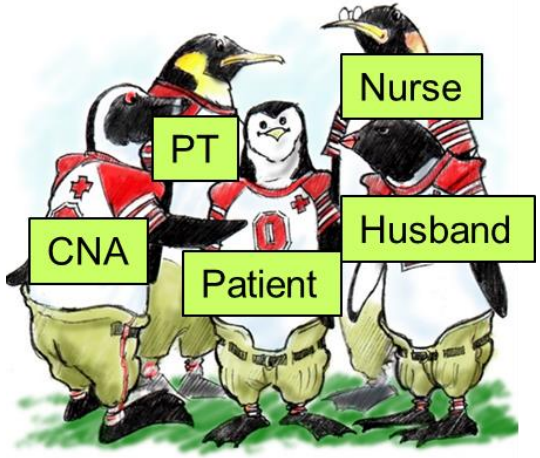






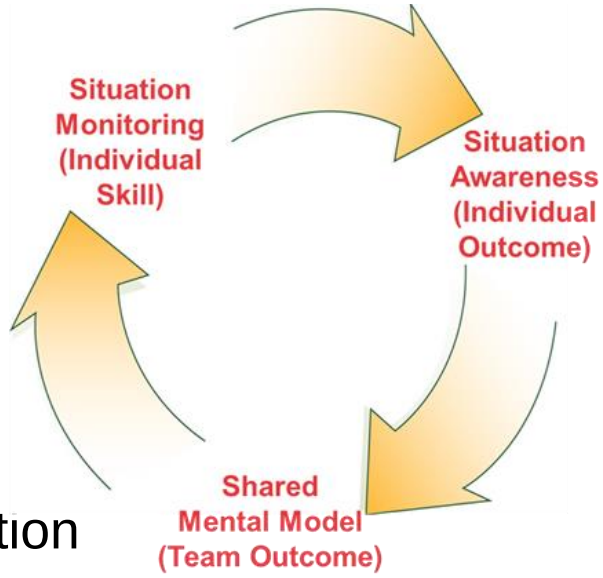
Team Structure & Leadership

- Team Structure
  - Lack of clear roles and tasks
  - Are nurses and CNAs organized as teams?
  - Are physical therapists conducting ongoing training to establish competencies in transfers and gait training?



- Leadership
  - Brief between nurse and CNA regarding care plan?
  - Post-fall huddle to learn and take action

Situation Monitoring



STEP

Status of the Patient

Day of surgery for laminectomy, previously used walker during ambulation

Team Members

CNA, Primary Nurse, Patient, Husband, Physical Therapist

Environment

Walker, gait belt in room; no transfer information on whiteboard

Progress Toward Goal

Keep pt. free from injury

Mutual Support

- Seek and offer task assistance

- Advocate and assert for the patient
  - CNA to Nurse: “I’m concerned about transferring Mrs. Smith because she just had surgery today and there is no information about how she transfers on the whiteboard.”

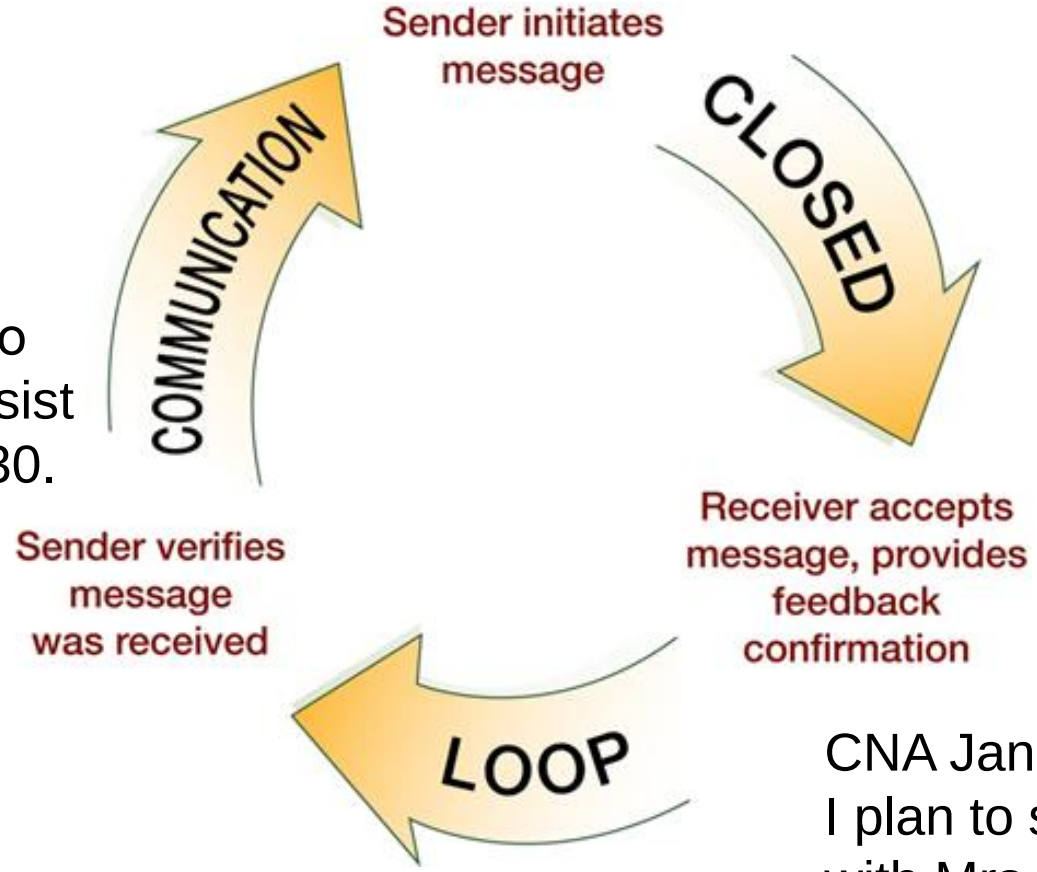
Communication

- SBAR at shift change
  - S: Let me know when you are ready to get Mrs. Smith up to the bathroom.
  - B: She used a walker for ambulation before her surgery because her legs were weak. PT already brought a walker up to the room and a clean gait belt is in the server.
  - A: She is at high risk for a fall because of her surgery and pre-existing lower extremity weakness.
  - R: Since PT has not had a chance to see her, we should use the mobilization testing approach so we know what to expect the first time we get her up.

Close the Loop…Check Back

SBAR Message from Nurse Linda at Shift Change

Jane, I'll plan to be ready to assist you around 7:30.



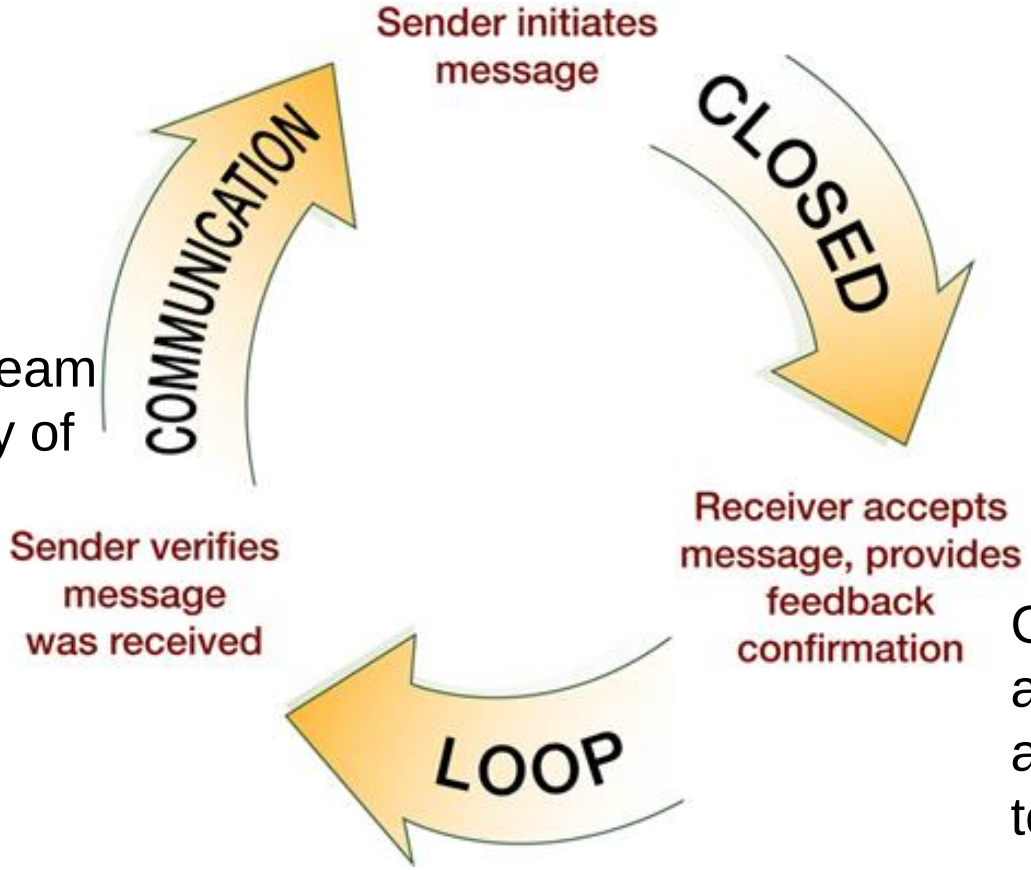
CNA Jane: Thanks, Linda. I plan to start my rounds with Mrs. Smith about 7:30.

Summary

- Integrate the science of teamwork into fall risk reduction
- The complexity of systems and patients requires proactive teamwork and collaboration across professions to decrease risk of falls
- Core teams learn from each fall by conducting post-fall huddles
- Fall risk reduction teams support organizational learning from all falls by identifying trends, ensuring structures and processes are evidence-based, and holding core team accountable

Close the Loop at All Levels

Fall is Reported



Coordinating Team audits reliability of Core Team processes

Coordinating Team analyzes and aggregates events to look for trends

Root causes of events and changes in policy/procedure are communicated to the front line core teams

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https://www.research.net/s/capturefalls-eval6

We value your input!

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