

CAPTURE Falls

Best Practices for Auditing Fall Risk Reduction Processes

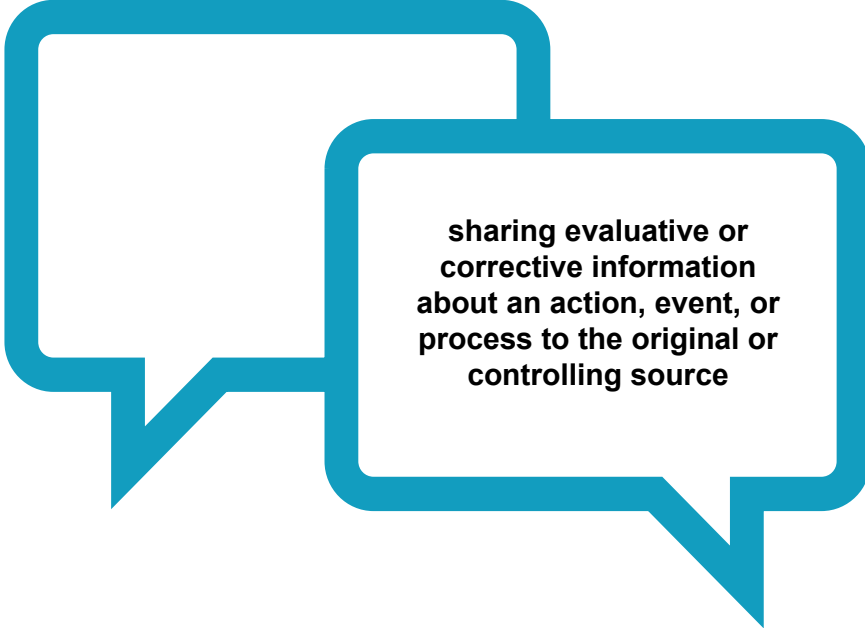


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What is Auditing? What is Feedback?



**systematic process to
obtain evidence in
order to verify that
activity is being
conducted in
compliance with
policies and
procedures**



**sharing evaluative or
corrective information
about an action, event, or
process to the original or
controlling source**

Auditing and Feedback's Relationship with Quality Improvement



A first step to identify potential improvement opportunities



Establish a baseline to use to analyze impact of tests of change



Part of rapid cycle evaluation during iterative testing phases



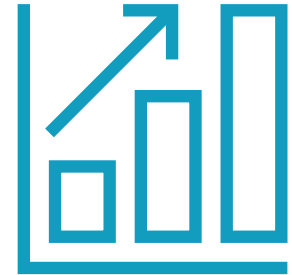
Quality assurance tool to track if improvements are sustained over time



What Does the Evidence Say About Audit and Feedback Interventions?



- Small but potentially important improvements in compliance with desired practice
- Feedback may be more effective when:
 - Baseline performance is low (not performing well to start with)
 - A supervisor or colleague is responsible for the audit and feedback
 - Feedback is provided more than once
 - Feedback is given both verbally and in writing
 - Feedback includes clearly defined target for improvement and an action plan to help get there



What Does the Evidence Say About Audit and Feedback Interventions? ⁽²⁾



- How and why and in what circumstances do audits work?
 - Sense of urgency can trigger engagement with an audit
 - Champions influence perceptions that audits are worth the effort
 - Audits initiated from the 'bottom-up' more likely to result in sustained change
 - Healthcare professionals can use audit data to support requests for change from leaders
 - Audits legitimize the process of providing feedback to colleagues



What Does the Evidence Say About Audit and Feedback Interventions for Fall Risk Reduction?



- Auditing appears to be used often in practice but is not well-documented in the literature
- Overall impact not well-studied
 - Limited detail available about strategies to monitor adherence to care processes
 - Limited data collected about the direct/indirect impact of auditing and feedback

Hempel S, Newberry S, Wang Z, et al. Hospital fall prevention: a systematic review of implementation, components, adherence, and effectiveness. *J Am Geriatr Soc*. 2013;61(4):483-494. doi:10.1111/jgs.12169 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670303/>

Morris ME, Webster K, Jones C, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis. *Age Ageing*. 2022;51(5):afac077. doi:10.1093/ageing/afac077 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9078046/>

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Monitoring Fall Risk Reduction Processes and Practices in Addition to Outcomes



- Fall rates are a critical outcome measure
- Fall risk reduction care processes are the actions taken to reduce fall risk
 - Are the care processes in place as intended?
 - What can we do to change our systems and behavior and increase adherence to fall risk reduction practices?



Guidance on Auditing and Feedback in Fall Risk Reduction

Agency for Healthcare Research and Quality

- Preventing Falls in Hospitals Toolkit

U.S. Department of Veteran's Affairs

- VHA National Center for Patient Safety Falls Toolkit

CAPTURE Falls Program

- CAPTURE Falls Roadmap



Key Components of an Auditing and Feedback Program for Fall Risk Reduction



What is your goal/intent for this audit?

What to audit?

What is the sample you will audit?

Who will conduct the audit?

When/how to conduct the audit?

What will you do with the audit results?



Determine the Goal or Intent for this Specific Audit



- Identify initial potential areas for improvement in fall risk reduction practices?
- Gather data on fall risk reduction practices to establish a baseline for which you hope to see improvement over time?
- Targeted focus on a fall risk reduction practice as part of rapid cycle evaluation during tests of change?
- Track if improvements made in fall risk reduction practices are sustained over time?
- Specific concerns about a particular shift, team/unit's performance in fall risk reduction?



What to Include in the Audit



Completion of fall risk assessment tool per policy



Implementation of care processes – interventions (universal, targeted) as intended



Environment and equipment (specific to the patient and generally in the broader environment)



Patient/family education, awareness of limitations and role of interventions



Other – completion of post-fall clinical assessment, conducting post-fall huddles, completing reporting forms, etc.



Clearly Defining the Audit Criteria



Fall Risk Safety Rounds

Date:

Room Number:											
Medical Record Number:											
Reviewed by:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Y
High Fall Risk Marked on whiteboard?											
High Fall bracelet in place?											
High Fall Risk Interventions											
Cluttered Room?											
Call light within reach?											
Side Rails up all the way?											
Tabs alarm in place and on?											
Gripper Socks?											
Gaitbelt used?											
Walker or Assistive device close to patient?											
Left alone in restroom, if high fall risk?											
Patient able to tell you why they are high fall risk?											

Patient Safety – Falls Survey Instruction Sheet

- High Fall Risk Marked on Whiteboard?
 - Is the box checked on the whiteboard next to a shooting star?
- High Fall Bracelet in Place?
 - Is the patient wearing a yellow bracelet?
- High Fall Risk Interventions?
 - Are there obvious interventions in place?
- Cluttered Room?
 - Is the room free of clutter? Are there objects on the floor? Are there chairs which left out in the middle of the room? Is there a clear path to the bathroom or bed for patient if needed?
- Call light within reach?
 - Is the call light placed within reach of the patient?
- Side Rails all the way up?
 - Are the TOP siderails all the way up – not in the halfway up position?
- Tabs Alarm in place and on?
 - Is the alarm under the patient whether they are in bed or in the chair? Is the alarm connected to the control box? Is the alarm on and the green light flashing?
- Gripper socks?
 - Is the patient wearing yellow gripper socks if they have a yellow bracelet? If they have a yellow bracelet do they still have gripper socks on?
- Gaitbelt used?
 - If the patient is being transferred is staff using a gait belt?
- Walker or assistive device close to the patient?
 - If a patient uses an assistive device is the device close to the patient if they are in bed or chair? Or is it stored across the room or behind the door?
- Left alone in restroom if high fall risk?
 - If a patient is in the restroom are they left alone?
- Patient able to tell you why they are high fall risk?
 - Ask the patient if they understand why they are at an increased risk of falls? Do they understand all of the interventions that are in place to increase their safety?

Presence, absence, or not applicable?

Specific numbers?

Open-ended comments?

Other criteria to inform judgment?



Selecting your Audit Sample



Simple or
systematic
random
sample



Judgment
sample

How will you select your sample?



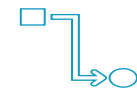
Number or percentage of
patients (sample size)
often influenced by census

Sample size adequate
enough to detect patterns
that may indicate
improvement (or lack of)



Resources (time, staff)
available may inform
feasibility

Knowledge of and
implications of impacts in a
particular area(s) may also
inform decisions



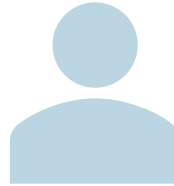
Conducting the Audit – Who Will Help?



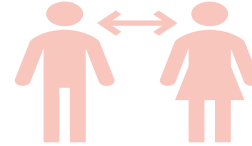
Members of your fall risk reduction team



Well-respected local champions/peers passionate about fall risk reduction



Consider opportunities for representatives from other departments



If talking with patients – patients may be more comfortable responding to staff who do not provide routine care

Team member participation may vary by audit

Timing and frequency

What is audited

Purpose of the audit

Improvement cycle vs. assurance



Conducting the Audit – Sources and Resources



Use an existing checklist or worksheet, or modify or create one to meet your specific goals/needs



May combine direct observation, medical record review, and patient and staff interviews depending on focus of the audit



Consider how the data documented during the audit will be used/transformed into information useful for feedback



Conducting the Audit – Example Audit Tools ⁽¹⁾



CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices – Fall Audit Tools

Fall Audit Tools

Fall Audit Tools

- **Example Process Audit Tools:** The following auditing tools were shared by hospitals who have participated in the CAPTURE Falls program. These tools can be used as is or adapted to fit your own needs.
- Process Audit Tool Example 1 [word document]
- Process Audit Tool Example 2 [word document]
- Process Audit Tool Example 3 [word document]
- Process Audit Tool Example 4 [word document]
- **Assessing Fall Prevention Processes:** Tool 5B Assessing Fall Prevention Care Processes in the AHRQ Fall Prevention Toolkit offers a sample fall prevention intervention auditing protocol.
- **Equipment Safety and Environmental Checklist:** The VA National Center for Patient Safety Falls Toolkit policy document offers an example Equipment Safety Checklist (see attachment 1) and an example Environmental Checklist and Rounds (see attachment 2).

Fall Audit Education



Conducting the Audit – Example Audit Tools (2)



FALL REDUCTION AUDIT TOOL

Auditor's Name:

Date: Room #: Patient Initials:

Documented Morse Score:

Active Risk for Fall Care Plan (circle): Universal Med High

"Call Don't Fall INTERVENTION" identified (circle) in the patient's room:

Universal Med High

"Proceed to the appropriate INTERVENTION level that corresponds to the above question to verify all interventions are active"

UNIVERSAL INTERVENTIONS:

Call light in reach	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a = not applicable due to patient's condition)	YES	NO	n/a

MEDIUM RISK INTERVENTIONS:

(Morse >45, No Fall History, No memory limitations, No cognitive deficit)

Call light in reach	YES	NO	
Yellow "fall risk" light illuminated in hallway	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a = not applicable due to patient condition)	YES	NO	n/a
Bed in low position	YES	NO	
Gait belt in use for transfer/ambulation (n/a = No chance to observe)	YES	NO	n/a

HIGH RISK INTERVENTIONS

(History of fall OR memory limitations OR cognitive limitations)

Call light in reach	YES	NO	
Yellow "fall risk" light illuminated in hallway	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a = not applicable due to patient condition)	YES	NO	n/a
Bed in low position	YES	NO	
Gait belt in use for transfer/ambulation (n/a = No chance to observe)	YES	NO	n/a
Alarm in place (bed and chair may share on for both places)	YES	NO	
Consider room by the nurses station (Room #14-25)	YES	NO	
Consider sitter at bedside	YES	NO	

Changes made after observation:

- ___ Intervention level changed
- ___ Care Plan Updated
- ___ Primary Nurse Updated
- ___ Additional Interventions initiated (LIST: _____)
- ___ Education provided to patient
- ___ Other (LIST: _____)

Comments:



Conducting the Audit – Example Audit Tools ⁽³⁾



Fall Risk Audit Form	Observation # Room		
Reviewer: _____	Date: _____ Time: _____ Fall Risk Score = _____		
Falls History Assessment done on Admission profile.	Yes	No	N/A
At risk for falls documented in chart.			
Falls Prevention Education given to patient and/or family.			
FALL RISK REDUCTION ACTIONS (Tailor to Hospital Policies)	Yes	No	N/A
Falls Risk sign posted near door.			
Yellow armband in place.			
Is patient aware of own fall risk?			
Is sitter or family companion aware of patient's fall risk?			
Is call light within reach?			
Does bed alarm work?			
Is a bed alarm in use?			
Is a chair alarm in use?			
Is the environment free of clutter?			
Is RN documenting "Falls Precautions" in patient chart?			
Is RN documenting Bed and/or Chair alarm use in patient chart?			

Sample Results of Audit

Unit A	Falls History Assessment done on Admission profile			At Risk for Falls on Problem List in chart			Patient Education form indicates Falls Education given to patient and/or family			Falls Risk sign posted near the door.			Yellow armband in place.			Is patient aware of own fall risk?			Is sitter or family companion aware of patient's fall risk?			Is call light within reach?			Does bed alarm work?			Is bed alarm in use?			Is a chair alarm in use?			Is the environment free of clutter?			Is RN documenting Falls Precautions in chart?			Is RN documenting Bed and/or chair alarm use in chart?		
	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a						
November totals	11	1	0	10	2	0	0	3	9	8	4	0	7	4	0	10	2	0	4	0	8	12	0	0	3	0	9	0	0	12	2	0	10	11	0	1	12	0	0	2	0	10
November compliance %	92 %	17 %	0 %	83 %	17 %	0 %	0 %	25 %	75 %	67 %	33 %	0 %	64 %	36 %	0 %	83 %	17 %	0 %	33 %	0 %	67 %	100 %	0 %	0 %	25 %	75 %	0 %	100 %	17 %	0 %	83 %	92 %	0 %	8 %	100 %	0 %	0 %	17 %	0 %	83 %		



What to do with Audit Results?



Immediately address issues for individual patients



Compile and analyze the audit data and summarize results



Document changes made after audit (e.g. update care plan, patient/family education)



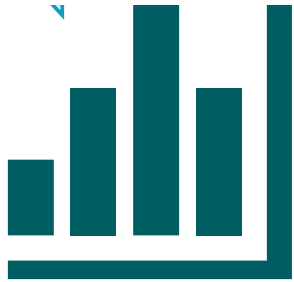
Provide feedback to relevant stakeholders (e.g., individual staff, teams/units, fall risk reduction team)



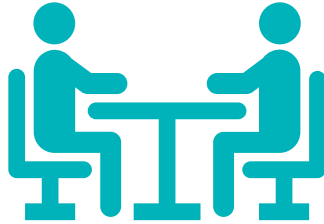
Delivering Post-Audit Feedback to Staff



Feedback about behavior most common behavior change technique reported in studies of audit and feedback



Performance was initially low (not meeting standards)



Supervisor, colleague delivers the feedback



Feedback offered both verbally and in writing



Includes clear targets for improvement and action steps to get there

Crawshaw J, Meyer C, Antonopoulou V, et al. Identifying behaviour change techniques in 287 randomized controlled trials of audit and feedback interventions targeting practice change among healthcare professionals [published correction appears in *Implement Sci.* 2023 Dec 18;18(1):73]. *Implement Sci.* 2023;18(1):63. Published 2023 Nov 21. doi:10.1186/s13012-023-01318-8 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10664600/>

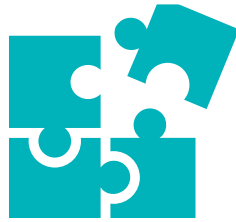
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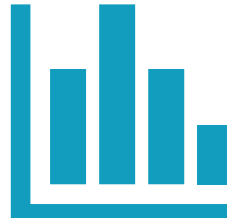
Delivering Post-Audit Results and Feedback to Fall Risk Reduction Team



Review at regularly scheduled meetings



Consider audit data in light of other fall risk reduction program data (e.g., fall event reports, huddle documentation, fall rates, etc.)



Look for patterns and trends that indicate improvement, gaps, and sustainment of fall risk reduction practices



Establish priorities for improvement and action steps to move forward



Recognize and celebrate successes along the way!



Auditing Fall Risk Reduction Practices



Lessons learned
and anecdotes from
our work



Patients and family members can provide a lot of valuable information

- Must be able to communicate and have adequate cognition
- Monitor for the socially desirable response



Engage multiple departments if able

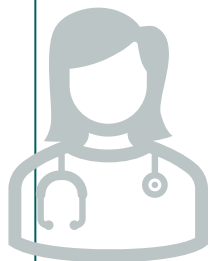
- Multidisciplinary input and different perspectives
- Promote hospital-wide involvement in fall risk reduction
- Facilitate cross-departmental communication



Developing an auditing program benefits from its own tests of change

- Revising auditing criteria, tool, process, etc.
- Impacts may be seen in fall rates, but also in day-to-day practice change

Staff Education about Auditing and Feedback



- Describe the auditing program in its entirety
- Emphasize the importance of auditing as a proactive strategy to manage risk - this is not a form of competency assessment, performance appraisal, or a disciplinary process
- Provide examples of the types of feedback staff may receive during/after an audit
- Ask for staff feedback on the auditing program



New employee orientation



Annual education



Fall Prevention Awareness Week (September)



Patient Safety Awareness Week (March)



Resources: Auditing Fall Risk Reduction Practices



Education Resources

- ✓ Auditing Fall Risk Reduction Interventions
- ✓ Human Behavior and Fall Risk Reduction

Example Auditing Tools:

- ✓ Process Audit Tools from CAPTURE Falls Hospitals
- ✓ Equipment Safety and Environmental Checklist (see pages 16-19 of linked document)



Summary

1

Research for auditing and feedback interventions specific to fall risk reduction is lacking, but we can learn from and apply lessons learned from the broader evidence base around auditing and feedback interventions to inform our work in fall risk reduction

2

Auditing can help us monitor compliance/adherence to fall risk reduction care practices, and inform process measures for our fall risk reduction programs

3

Auditing AND feedback is key – must close-the-loop with care teams/units and the fall risk reduction team about performance successes and areas for improvement

4

For staff education, ensure staff understand the purpose of the audit, the process used to conduct the audit, and how they will receive feedback



References and Resources ⁽¹⁾

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3. CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices. Available at <https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-audit/index.html> Accessed May 13, 2024.
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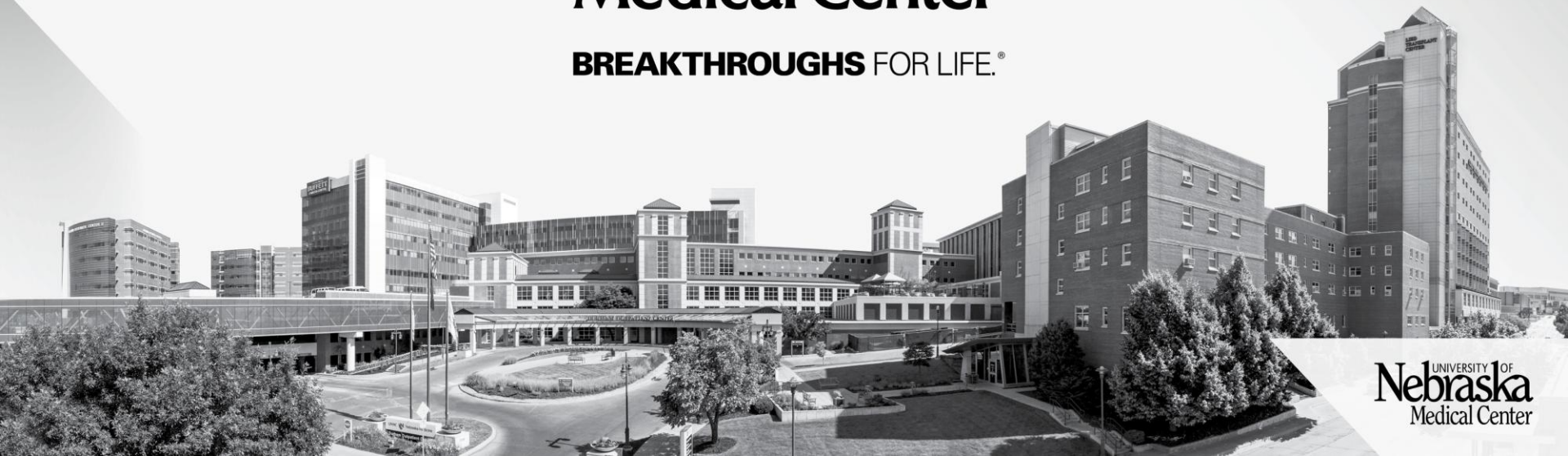


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