CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

Best Practices for Auditing Fall Risk Reduction Processes

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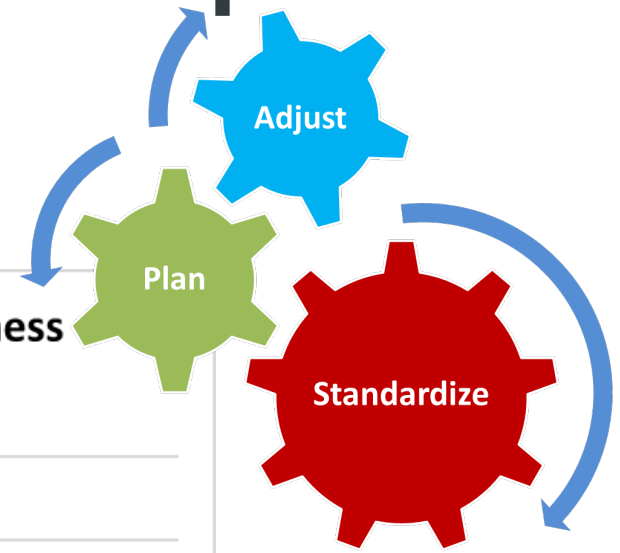
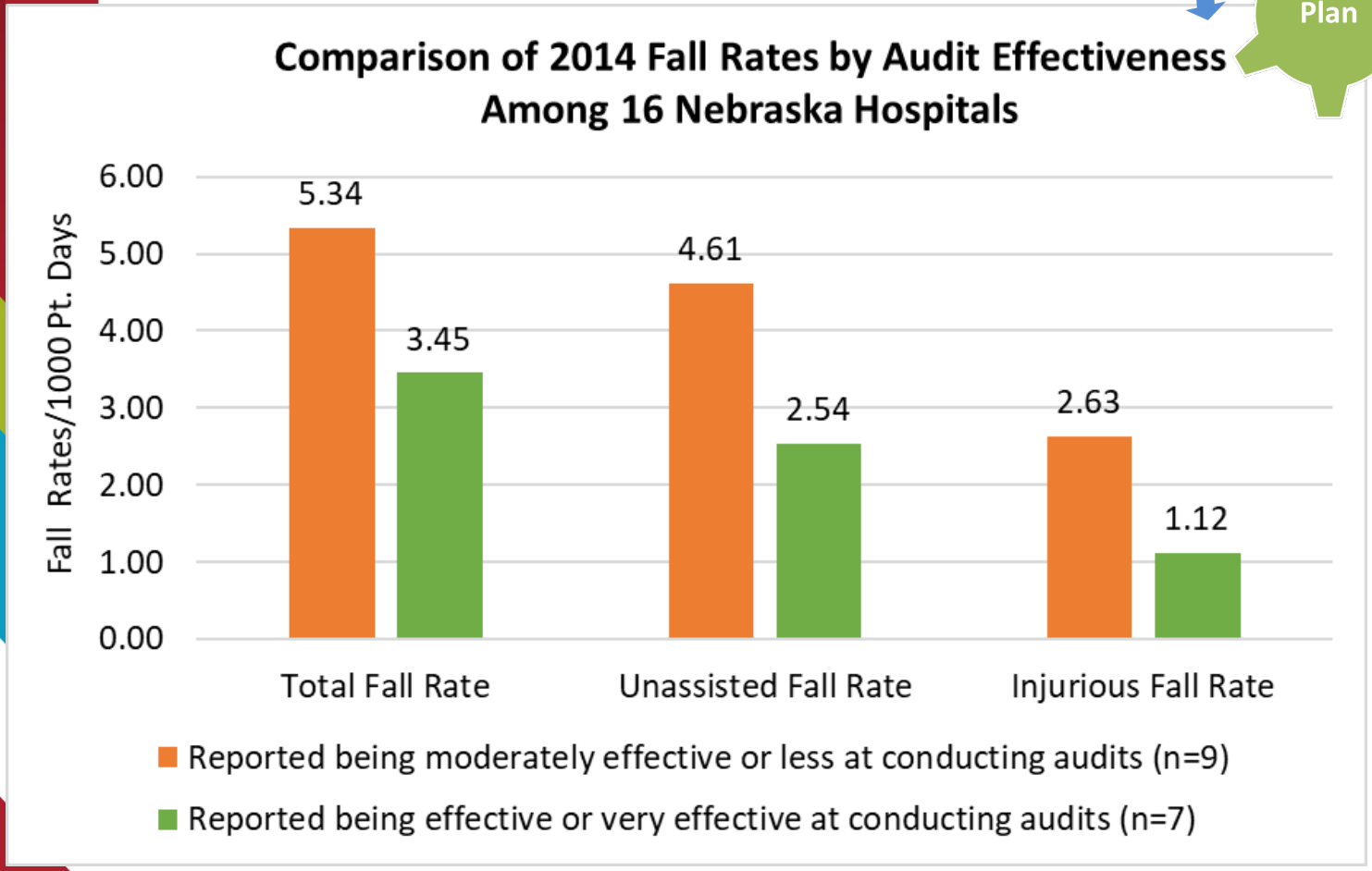
Auditing: key coordination process





Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
What to audit?	- Completion of risk assessment tool - Care processes (e.g. interventions) - Completion of reporting forms	- Equipment safety and function (e.g. w/c parts, call lights) - Environment (e.g. clutter, lighting)	- Individual Environment (e.g. Does equipment/furniture fit patient? Do w/c brakes work? - General Environment (e.g. clutter, lighting, security of grab bars)
Who to conduct audit?	Unit Manager or Unit Champion	Facility Management Staff, Nursing	- Individual: Nurse admitting the patient - General: "Person in charge of the area"
Which patients to audit?/When to audit?	OK to select arbitrary number of percentage of census	Not addressed	- Individual: every patient upon admission - General: At regular intervals (e.g. monthly)

Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
How to audit?	Checklist plus: - Direct observation of care - Medical Record Review - Surveying staff	Use of checklist and direct observation of equipment and environment	Use of checklist and direct observation of equipment and environment
What to do with results?	Reflect on barriers and develop plan to address unfavorable results	Not addressed	Immediately address issues for individual patients

Best practices for auditing fall risk reduction interventions – for more information:

Agency for Healthcare Research and Quality	•https://www.ahrq.gov/sites/default/files/publications/files/fallpxtoolkit_0.pdf •https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original (see link for "Measurement grid word template")
U.S. Department of Veteran's Affairs	• https://www.patientsafety.va.gov/professionals/onthejob/falls.asp (see link for "Falls Policy" and then information re: "Environmental Checklist and Rounds" within that document)
Victorian Quality Council	• https://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/tools.pdf (see section on "Environmental Audits" within this document)

CAPTURE Falls Suggestions

What to audit?	Who to conduct audit?	Which patients to audit/When to audit?	How to audit?	What to do with results
- Completion of fall risk tool per policy - Implementation of interventions to ensure routinization - Patient/Family awareness of limitations and role of interventions - Absences of interventions identified by reflecting on fall events/past audits - Environment and equipment	- Members of fall risk reduction team - Consider using staff that do not provide routine care; patients may be more comfortable responding to those who do not provide routine care	- Select random sample on a regular, recurring basis - Number or percentage of patients depends on your typical census and feasibility	- Use an existing checklist or modify one for your needs - Combine direct observation, medical record review, and patient and staff interviews depending on items being audited	- Immediately address issues for individual patients - Document changes made after audit (e.g. update care plan, patient/family education) - Reflect on reason for gaps and develop plan to address - Share results (positive and negative) with core team staff

Tips for Staff Education

- Describe the auditing program in its entirety
- Emphasize the importance of auditing as a proactive strategy to manage risk
- Provide examples of the types of feedback staff may receive during/after an audit
- Ask for staff feedback on the auditing program
- Engage staff in a ‘practice’ or simulated audit

CAPTURE Falls Hospitals – Two Case Studies of Auditing in Action

St. Francis Memorial Hospital – West Point

Brodstone Memorial Hospital – Superior

Information shared by:
Boone County Health Center
Butler County Health Care Center
Henderson Health Care Services
Memorial Health Care System
Perkins County Health Services

CAPTURE Falls Collaborative Call Audit tool, process and outcomes

Franciscan Care Services

Audit Tool

CAPTURE Falls Audit 2018	Jan	Jan	Jan	Feb
Account number				
Date	1/30/18	1/30/18	1/30/18	2/9/18
Fall Hx obtained on admission	Y, response was none, incorrect	Y	Y, response was one fall but that was incorrect	Y, response was one fall
Hx falls last 6 months	N	Y	N	Y
1 fall last 6 months	N	Y	N	Y
2 or more falls last 6 months	Y	N	N	N
Patient "alert" marked appropriately	N, changed by this nurse	N, changed by this nurse	N, marked + fall, changed by this nurse	N, added recent fall
Risk for injury care plan present	Y	Y	Y	Y
Risk and assist signage on doorways	M, 1	M, Indep	M, 1	U, I
Signage determined by last assessment	M, 1	U, Indep	M, 1	U, I
Fall prevention handout given to pt	Y	Y	Y	Y
Pt able to do teach back gait belt, signage, slippers, alarms	Y,N,Y,N	Y, Y, Y,Y	Y,Y,Y,Y	Y,Y,Y,Y
Call light within reach	Y	Y	Y	Y
Bed alarm in use	Y	NA, Indep	NA	NA
Chair alarm in use	Y	NA, Indep	No, pt in chair	NA
Gait belt in use	Y	NA, Indep	Y	NA
AD with in reach	Y	Y	Y	Y
Patient suggestions or comments	none	pleased with fast call light response time	"excellent service"	none
Reviewed results with team leader	Y	Y	Y	Y, signage was just changed to Independent based on therapy assessment
Comments	Emailed admission nurse regarding falls hx being incorrect, asked for correction	Updated magnets to reflect U falls risk	asked TL to update admission assessment to no falls in last 6 mo.	Emailed adm nurse to initiate the Pt Alert for recent fall

Process

- Audit conducted monthly on 3-5 patients
  - Try to audit patients with family members present
  - Audit patients who are able to speak and are cognitively intact
- Results are reviewed in “real time” with team leader/staff for recognition or correction.
- Results are emailed monthly to the Fall prevention team and reviewed at their meeting.

Outcomes

- Nearly 100% of patients audited can perform a teach back regarding the gait belt, gripper slippers and chair/bed alarms.
- About 75% can perform teach back related to signage.
  - We believe our patients are learning this through experience and repetition.
- Nursing assistants ask the Team Leader which signage needs to be posted.
  - Also reviews signage and fall prevention program with the patients and their families.

Fall Survey Audit Tool

Superior care close to home.

Brodstone
MEMORIAL HOSPITAL

Fall Survey Audit Tool

- Increased awareness of patients at risk for falls
- Increased ways for staff to help prevent falls
- Increased hospital-wide awareness of patients at risk
- Involvement of several departments
  - Nursing,
  - Business office,
  - Diagnostic imaging,
  - Patient education
  - Therapy

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MEMORIAL HOSPITAL

The audit tool

Date:

Fall Risk Safety Rounds

Room Number:																				
Medical Record Number:																				
Reviewed by:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
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?																				
Gait belt 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?																				

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Fine Tuning:
Falls survey instruction Sheet

Patient Safety – Falls Survey Instruction Sheet

1) High Fall Risk Marked on Whiteboard?
    a. Is the box checked on the whiteboard next to a shooting star?
2) High Fall Bracelet in Place?
    a. Is the patient wearing a yellow bracelet?
3) High Fall Risk Interventions?
    a. Are their obvious interventions in place?
4) Cluttered Room?
    a. Is the room free of clutter? Are their objects on the floor? Are there folding chairs which were left out in the middle of the room? Is there a clear path to the bathroom or bed for the patient if needed?
5) Call light within reach?
    a. Is the call light placed within reach of the patient?
6) Side Rails all the way up?
    a. Are the TOP siderails all the way up – not in the halfway up position?
7) Tabs Alarm in place and on?
    a. 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?
8) Gripper socks?
    a. Is the patient wearing yellow gripper socks if they have a yellow bracelet? If they don't have a yellow bracelet do they still have gripper socks on?
9) Gaitbelt used?
    a. If the patient is being transferred is staff using a gait belt?
10) Walker or assistive device close to the patient?
    a. If a patient uses an assistive device is the device close to the patient if they are in the bed or chair? Or is it stored across the room or behind the door?
11) Left alone in restroom if high fall risk?
    a. If a patient is in the restroom are they left alone?
12) Patient able to tell you why they are high fall risk?
    a. 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?

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Small changes at a time

- Involved different departments outside of nursing
- Provided an audit tool
- Gathered auditors to seek more feedback
- Updated audit tool
- Provided instructions for clarification

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Leads to large improvements

- Hospital wide involvement in preventing falls
  - Involved different departments
  - Daily huddle number of falls
  - CEO encouragement/involvement
- Improved communication between nurses and departments surveying
  - Engaged and involved staff trying to prevent falls as a team
  - Bringing possible problems to the nurses station immediately
- Discovery of how high fall policy is implemented
  - Physical therapy Pharmacy Nursing
- Improvements to overall process

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WOW moment

- Diagnostic Imaging, a department involved in audits
  - Prevented a fall
  - Not while they were doing audits
  - Because they utilized what they learned doing rounds

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The content in this document was originally shared as part of a CAPTURE Falls Collaborative Support Call on April 24, 2018.

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