CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce Falls

Strategies for Fall Risk Reduction in a Geriatric Behavioral Health Unit

UNMC

The Challenge…

- Patients with delirium, dementia, or psychosis may be agitated and confused, putting them at risk for falls

-AHRQ Fall Prevention Toolkit, 2013

- Rate of falls in geropsych patients may be as high as 17.1 falls/1000 patient days

-Oepen et al, Int Psychogeriatr, 2018

- Odds of falling unassisted were 3.7 times greater for pts with cognitive impairment

-Venema et al, BMC Geriatrics, under revision

- Odds of fall-related injury were 2.8 times greater for pts on geropsych unit

-Fischer et al, Infect Control Hosp Epidemiol, 2005

Managing Falls in a Geriatric Inpatient Psychiatric Unit

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Geriatric Inpatient Psychiatric Facility

- Opened in 2015
- Distinct part unit within CAH
- 10 Beds
- Average LOS 10-12d
- 85% Neurocognitive Disorder
- 55+

Patient Population

- Axis I Diagnosis
  - Major Depressive Disorder, Schizophrenia, Bipolar Disorder
- Exhibiting behaviors related to diagnosis
  - Paranoia, hallucinations, suicidality, hyper sexuality, agitation, *increased aggression*
- Medical Comorbidities
  - Diabetes, Parkinson's, COPD, CHF, PVD

Patient Population (cont.)

- Referrals
  - Nursing Homes, Emergency Departments, Family members
- Reason for referral
  - Acute change in mental status
  - Behaviors have become unmanageable in current setting
  - Patient needs 24 hour supervised treatment
  - Case is of high complexity

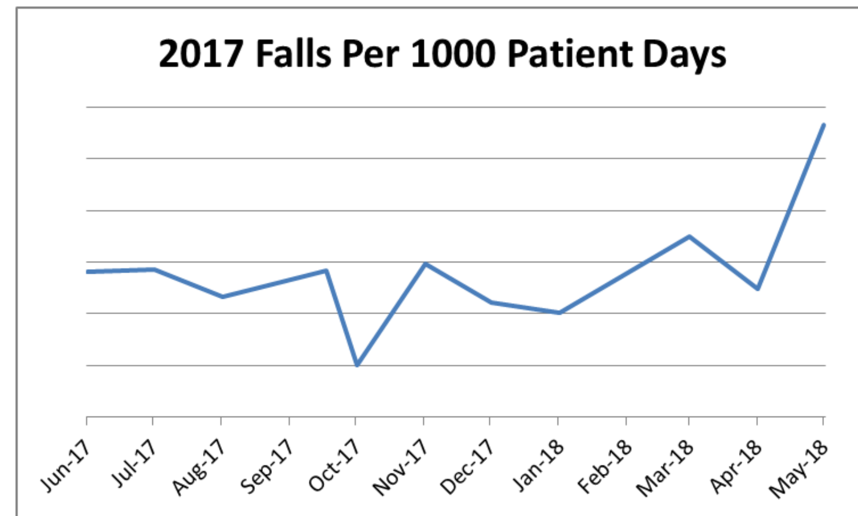
What we do

- Goal:
  - Decrease behaviors
  - Restore previous function
- Nursing Staff
  - 1-2 RN
  - 2-3 LPN, CNA, MHT
- Psychiatrist & APRN

- Methods:
  - ID Triggers
  - De-escalation techniques
  - Establish schedules
  - Medications
    - Antidepressants
    - Mood Stabilizers
    - Stimulants
    - Antipsychotics

Addressing Falls

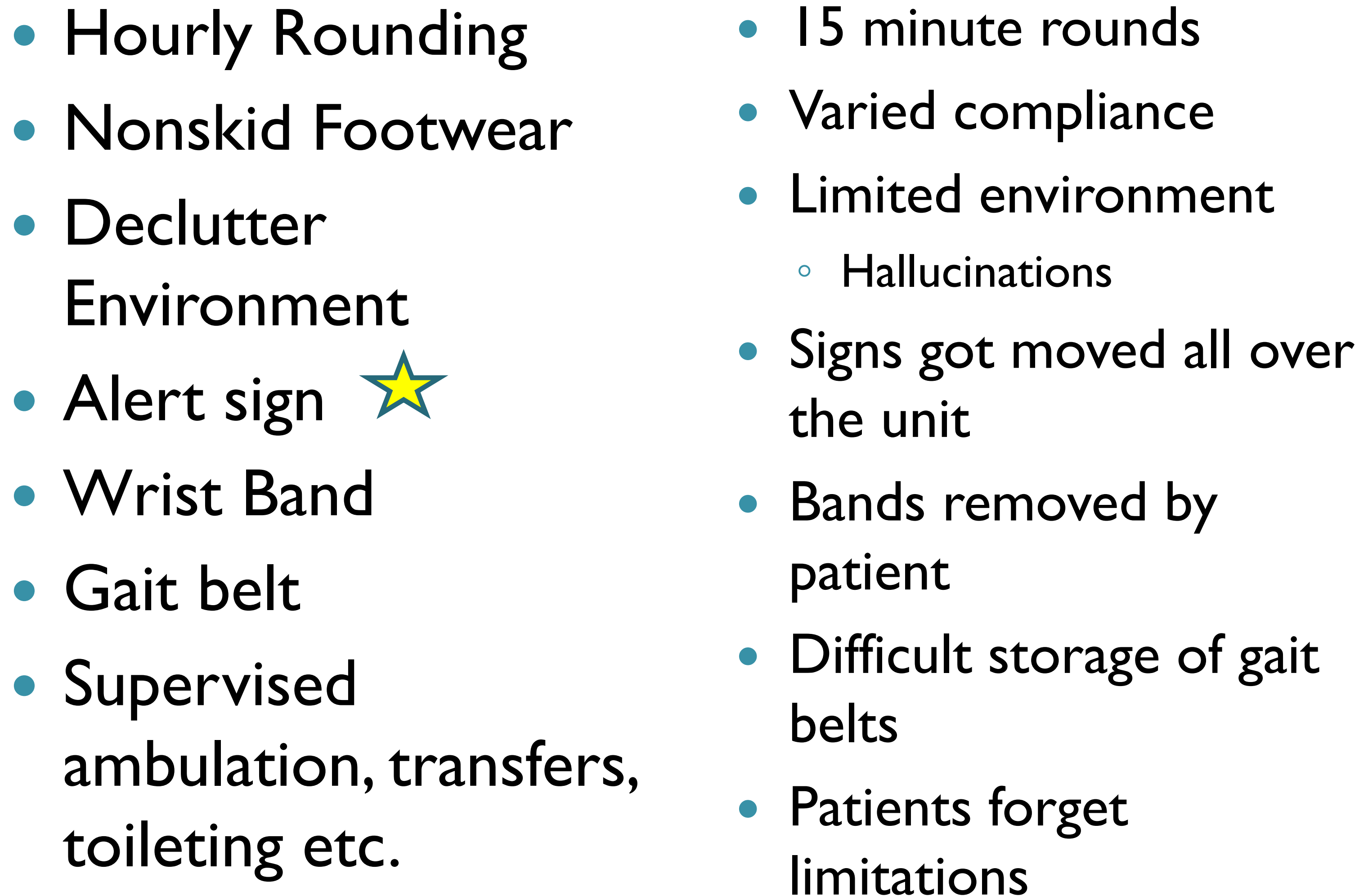
- Motivator-
  - Higher falls rate than desired
- Struggle with benchmarking
  - Acute Care
  - Memory Care/Dementia Unit
  - General Nursing Home



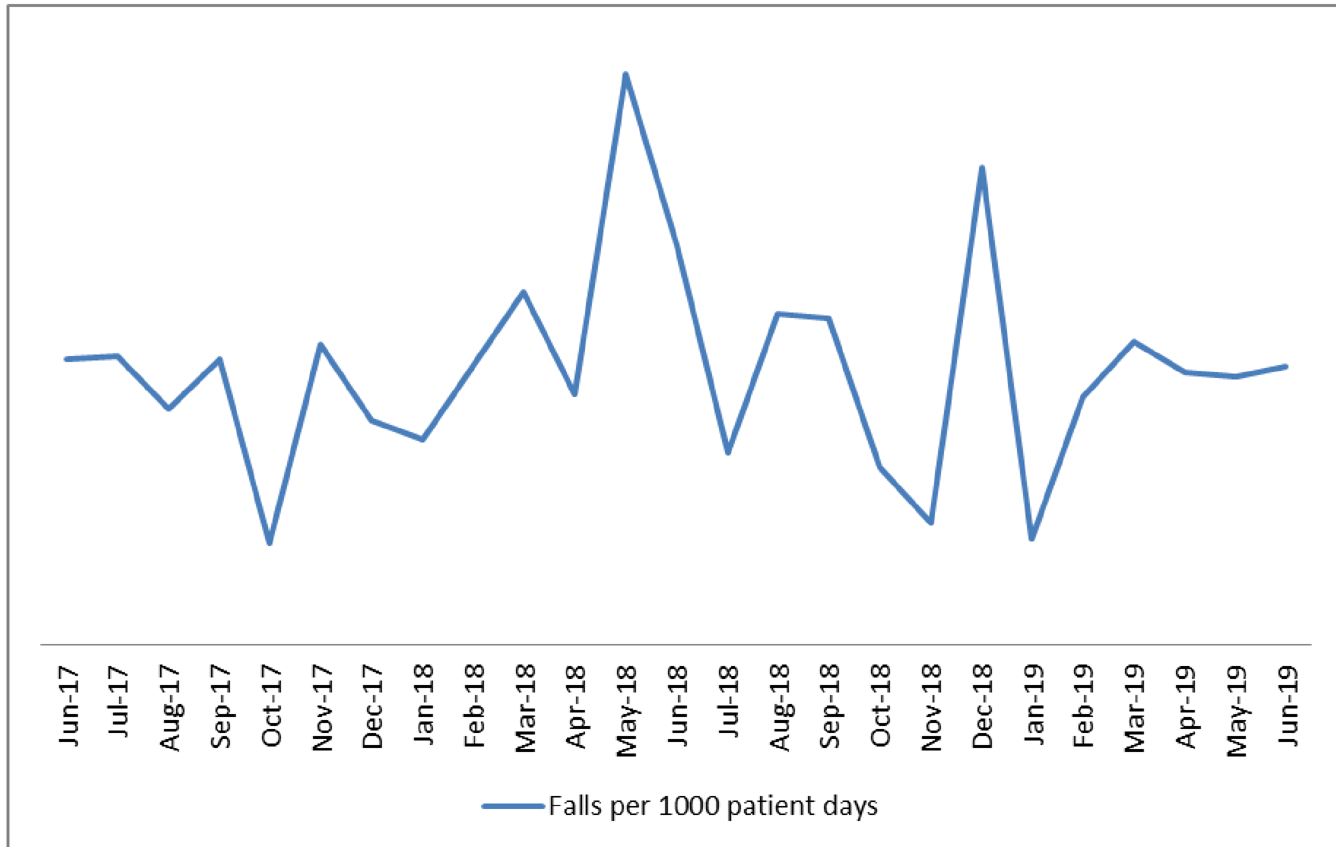
Initial Steps

- Assembled a fall prevention team
  - Nurses
  - CNAs/ Mental Health Techs
  - Pharmacy
  - Physical Therapy
  - DON & Quality
- Started with what we knew*
- Focus on Fall Risk
  - Morse Scale Assessment
    - Average >80
    - History of falls, forgets limitations, weakness
  - Universal Precautions and Targeted interventions
- Post-Fall Huddle

Fall Prevention Interventions

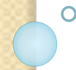


Falls Rate June 2017-June 2019



Year 1 to Year 2 saw average decrease in falls of 2.5 falls/ 1000 patient days

Looking at Falls through a different lens

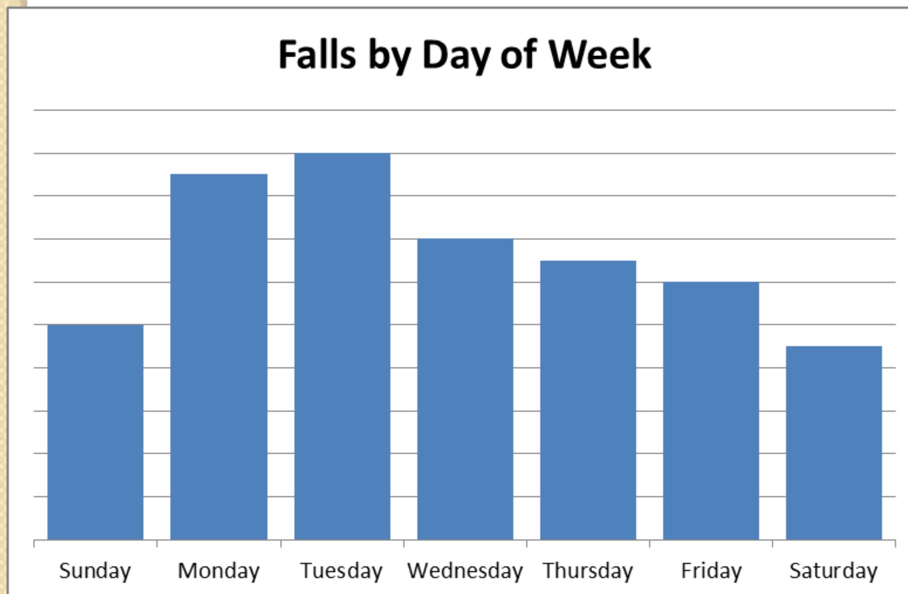


WHERE TO GO FROM HERE

Focus on OUR patients

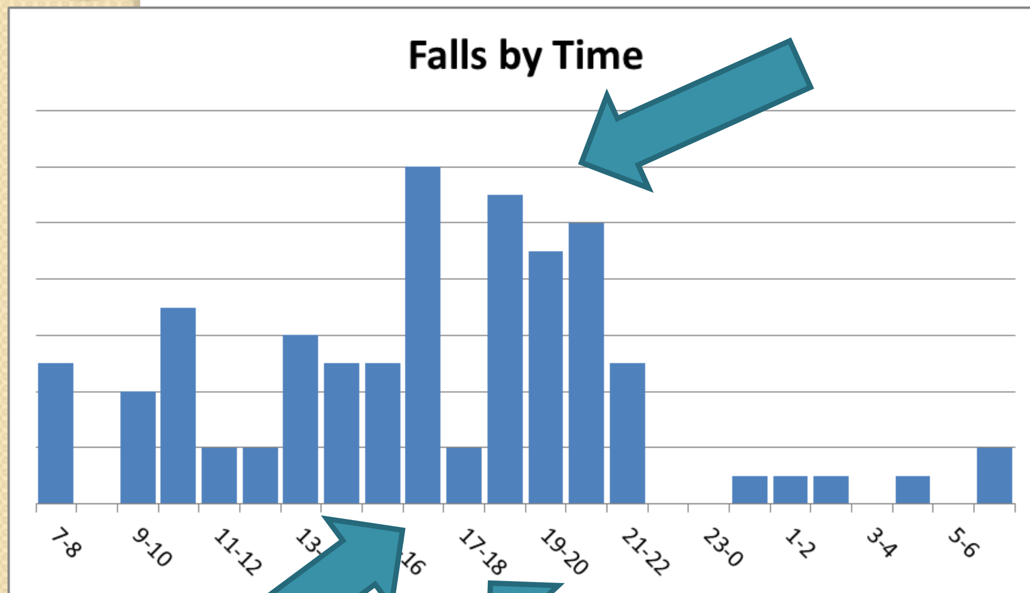
- Looking at data from our patients.
- Recognize our strengths
- Admit our weaknesses and limitations
- Asking for help
- Think outside the box

When are falls happening?



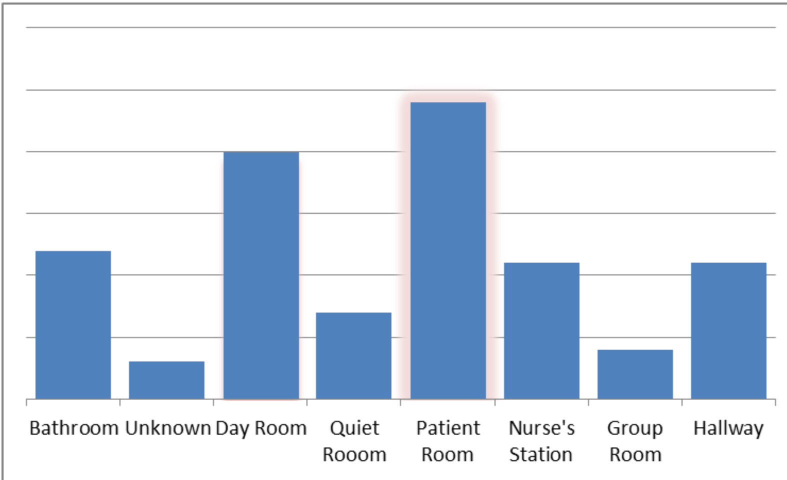
- Thursday & Friday are busy days for admissions and discharges
- Patients experience honeymoon phase for ~72 hours until they cannot maintain current function

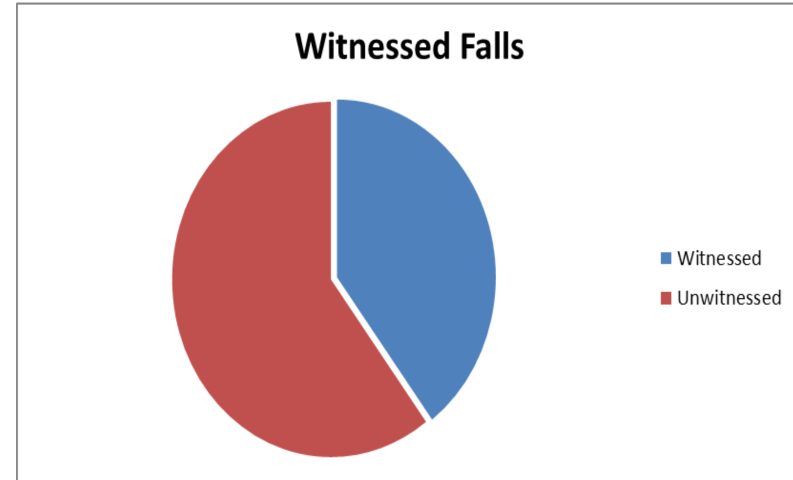
What time do falls occur?

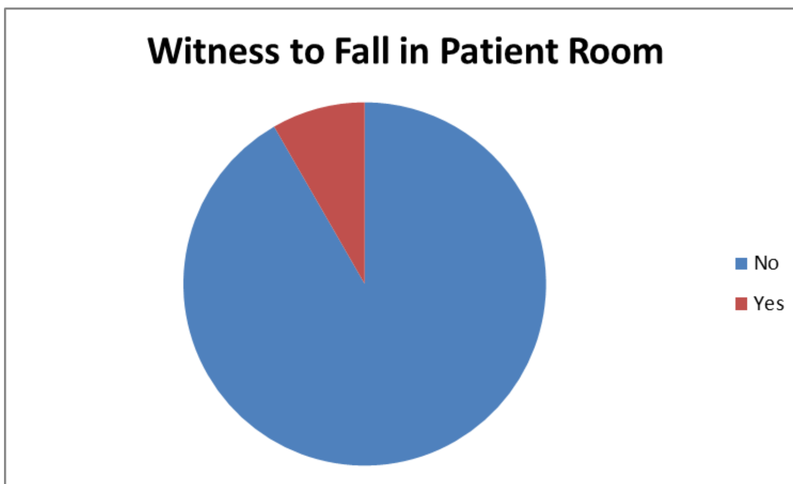


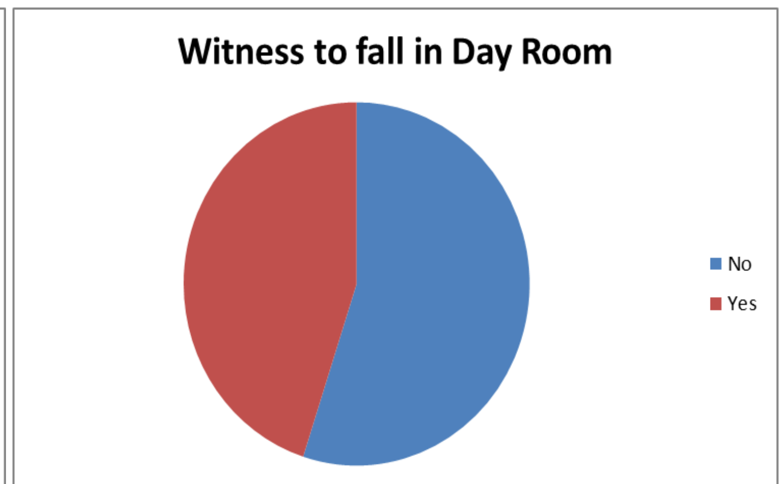
- Not surprising
- What is going on at these times?
  - Sundowning
  - Fatigue
  - Dinner
  - Admissions
  - Shift change
- Changes
  - Implemented an extra staff member

Where falls occur

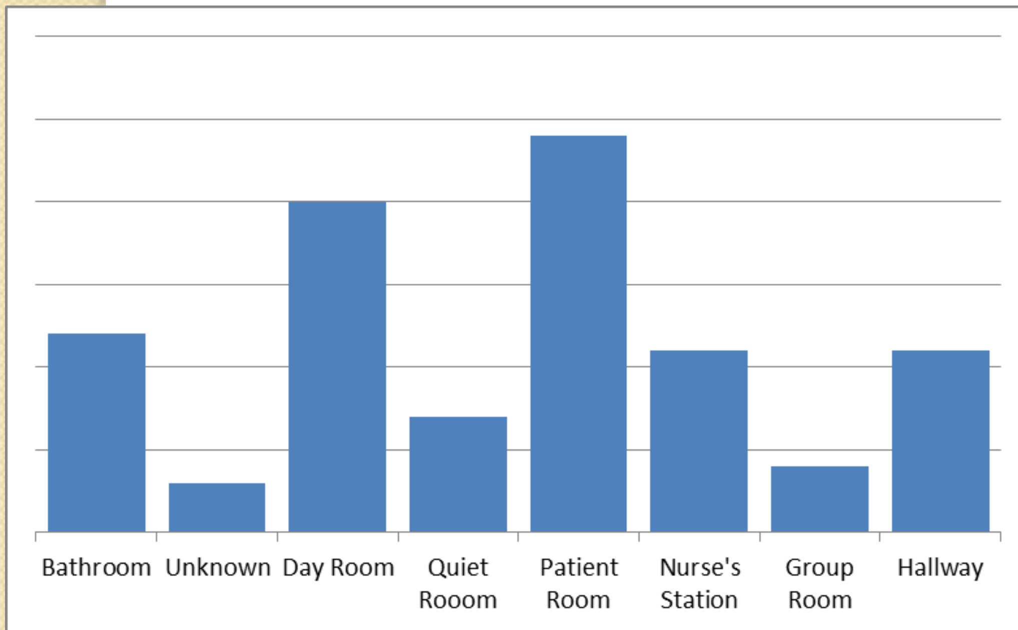








Goal: Restore Previous Function



- Keep patients mobile
  - Sedation and restraints are things we try to avoid

Recent exploration:

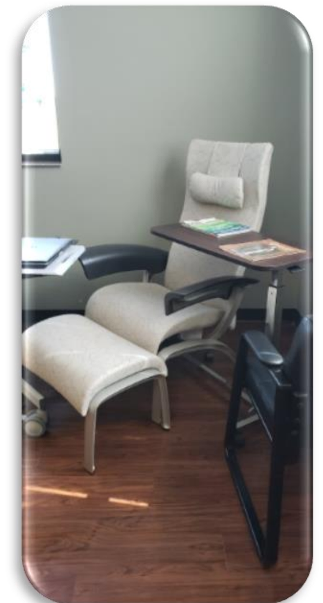
- Video monitoring
  - Falls after bed exit
    - Ocuvera- not available
  - Many patients intentionally sit on the floor, but without a witness, it counts as a fall
    - AvaSure- $$$

Adjacent to nurse's station, used for patients with increased monitoring

Chairs

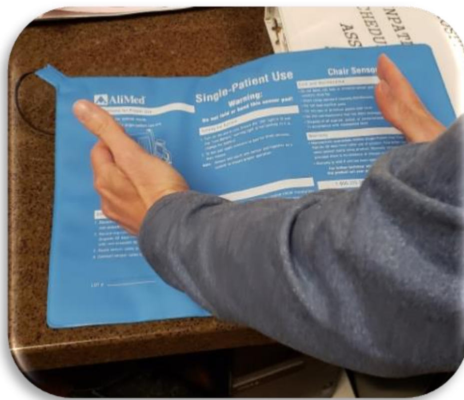
- How is fatigue affecting our patients?
- Are seating options causing trunk fatigue?

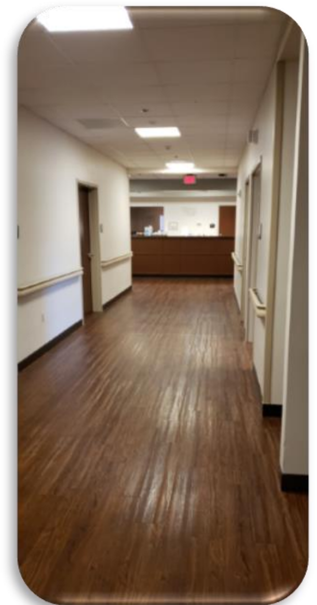
- 2 Broda chairs are almost always in use



Alarms- helpful, but…

- TABS
  - Patients take them off
- Chair
  - Have ~ 2 second delay with patients <120 lbs





Beds

- Bed Alarms
  - Often do not set them off until they are completely out of bed
  - Announce that an exit has happened rather than imminent
- In General…
  - Many of our patients have not slept in an actual bed in years.
  - Utilizing recliner prior to admission

Suggestions from AHRQ and the VA: Focus on Reduction of Injury Risk

Focus on Injury Risk Reduction	Equipment/Environmental Considerations
• Eliminate sharp edges • Reduce/eliminate restraints • Hip protectors • Floor mats • Low beds	• Eliminate sharp edges • Reduce/eliminate restraints • Stable seating/furniture • Self-locking wheelchairs • Reduce clutter • Lighting

- https://www.patientsafety.va.gov/professionals/onthejob/falls.asp
- https://www.patientsafety.va.gov/docs/fallstoolkit14/falls_implementation_%20guide%20_02_2015.pdf
- https://www.patientsafety.va.gov/docs/fallstoolkit14/floor_mat_guide_042114v2.pdf

Additional Suggestions: from AHRQ and the VA

Prevent and/or Assess for Delirium	Other
• Hospital Elder Life Program (HELP) for Prevention of Delirium • AHRQ Delirium Evaluation Bundle (Tool 3J)	• Communication strategies • Diversional activities • Monitoring activities • Anticipate needs (Purposeful rounding) • Medication review specific to agitation

- https://help.agscocare.org/
- https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3j.html
- https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk3.html#note9
- https://www.patientsafety.va.gov/A_Toolkit_Patients_At_Risk_for_Wandering.asp

The content in this document was originally shared as part of a CAPTURE Falls Collaborative Support Call on July 23, 2019

University of Nebraska Medical Center