CAPTURE Falls Collaboration and Proactive Teamwork Used to Reduce

Best Practices for Sustainment



What is Sustainment?

Stability of work methods

Maintaining a change

Consistent achievement of goals

What are you trying to sustain?

Structures – the tools that you have

Examples:

Your fall team

Bedside staff

Equipment

EMR

KNOW Falls database

Processes – what you do

Examples:

Staff training

Administer screening tool

Administer interventions

Post fall huddles

Report falls

Outcomes

Examples:

Total fall rates

Unassisted fall rates

Injurious fall rates

Audit results

Why is thinking about sustainment important?

- Changes are subject to degradation as soon as the pressure for change is gone
 - Until behaviors become rooted in social norms and shared values

 Most organizational change is not maintained (up to 70%) if a plan for sustainment is un- or under-developed.



Recommendation from Literature

- Encourage all staff, especially those with "boots on the ground," to express ideas
- Involve staff in decision-making related to a change

- Fall risk reduction team includes bedside staff (grassroots involvement) vs. only management
- Gather nursing input when selecting fall risk screening tool

Recommendation from Literature

- Release time for staff to participate in quality/safety work
- Include quality/safety work in staff job descriptions

- Schedule and hold regular meetings
- Avoid scheduling fall team meetings during critical patient care hours
- Compensate staff for extra time spent in meetings

Recommendation from Literature

- Rotate fall team membership to promote more widespread formal involvement in the change
- Provides gradual influx of fresh ideas and enthusiasm

- Engage new nursing staff on team
- May be difficult due to size of staff, but may happen naturally with staff attrition



Recommendation from Literature

- Continuously share improvements with staff, board
- Share how change has positively impacted patients/staff/the organization
- Celebrate maintenance of improvement

- Bulletin boards, staff newsletters, or staff meetings used to share fall rates, date of last fall, audit results
- "No-fall" huddle; discuss case studies of success
- Patient safety as a line item on every board meeting

Recommendation from Literature

- Avoid declaring victory prematurely
- Doing so can reduce momentum, sense of urgency

- Focus on sustainment of processes, not just outcomes
- Did we simply get lucky to have no falls, even though we weren't doing the right things?

Recommendation from Literature

 Allow for enough time to pass for outcome change to be measurable and meaningful

- Typical initial increase in falls because of an increased emphasis on reporting and more stringent definitions of falls and fall-related injury
- May take 2-3 years to see a meaningful decline in outcomes

Recommendation from Literature

Conduct
 "improvement
 huddles" to
 anticipate problems,
 review performance,
 and support a
 culture of learning
 and improvement

- Post-fall huddles
- No-fall huddles
- Discuss falls in other daily rounds, safety briefings/huddles



Recommendation from Literature

 Implement mechanisms to monitor progress

- Evaluate staff
 education initiatives
- Robust auditing program
- Reporting to KNOW Falls
- Reviewing post-fall huddles

Recommendation from Literature

 Develop sustainable infrastructure for training/staff education

- New employee orientation
- Annual competency training
- Topics: fall program/policies in general, risk assessment tool, safe transfers and mobility, and post-fall huddles

Key References

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