Using Data to Reduce Fall Risk
Collecting, interpreting, and learning from data is the foundation of quality improvement and patient safety.

Data, Information, Knowledge, Wisdom Hierarchy

Data Sources

- What sources of data does your team use for information and knowledge about your fall risk reduction program?

- Does your team continuously transform data and information from fall-related events and audits into an action plan to decrease the risk of falls?

“It’s more than just the numbers of falls.”
- CAPTURE Falls Lesson Learned
## Data/Information Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Purpose</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPTURE Falls Gap Analysis Score Card</td>
<td>Identify gap between your current structures and processes and best evidence to develop an action plan</td>
<td>Fall Risk Reduction Team (FRRT)</td>
<td>Annually</td>
</tr>
<tr>
<td>Fall Event Report</td>
<td>Data Collection</td>
<td>Member of Bedside Team</td>
<td>After each fall</td>
</tr>
<tr>
<td>Post-Fall Huddle</td>
<td>Immediate learning and action planning</td>
<td>Bedside Team (Interprofessional if possible)</td>
<td>After each fall</td>
</tr>
<tr>
<td>Process Audits</td>
<td>Determine reliability of interventions</td>
<td>FRRT</td>
<td>Regularly</td>
</tr>
</tbody>
</table>
CAPTURE Falls Gap Analysis Scorecard

Data
- Data representing structures, process assessment, and outcomes of fall risk reduction program

Information
- Gaps between current structures and processes and best evidence
- Perceived effectiveness and reliability of processes
- Measurement of hospital fall risk (total, unassisted, and injurious fall rates)

Knowledge
- Understanding of areas which have the greatest need for improvement.
- Understanding of relationship between structures, processes, and outcomes of fall risk reduction system
- Awareness of hospital fall risk and ability to compare with similar hospitals (i.e. benchmarking)

Wisdom
- Action plan to address fall risk reduction program deficiencies
Process Audits

Data
- Data representing observations of fall risk reduction practices

Information
- Number of times fall risk reduction practices (e.g. gait belt available in room) are observed per policy compared to total observations
- Adherence to policy over time

Knowledge
- Understanding of reliability of fall risk reduction practices
- Awareness of potential improvement areas

Wisdom
- Action plan to address fall risk reduction program deficiencies
- Actions to improve auditing program through communication/feedback.

“...Our processes cannot just be reacting to a fall. It has to begin with data from audits so we know if we are creating an environment that decreases errors, reports assisted falls and decreases injury.”

- CAPTURE Falls Lesson Learned
Fall Event Reports

**Data**
- Data representing:
  - Demographics, health conditions, and fall risk factors of patients that experienced a fall
  - Descriptive observation of event
  - Impact of event on patient
  - Context of event (e.g. activity at time of fall, interventions in place)
  - Perceived cause of event including contributing factors

**Information**
- Aggregate data for identifying and/or visualizing trends within fall risk reduction system
- Analysis to identify relationships between patients, harm, interventions, and contributing factors.
- Total, unassisted, and injurious fall counts to calculate hospital fall rates

**Knowledge**
- Awareness of fall patterns (e.g. time, location)
- Understanding of the reliability and effectiveness of fall risk reduction interventions
- Awareness of hospital fall rates and ability to benchmark with similar hospitals

**Wisdom**
- Action plan to address fall risk reduction program deficiencies
Post-fall Huddle and Documentation

Data
- Documentation of interprofessional team discussion after a fall event

Information
- Number of falls followed by post-fall huddles
- Factors that may have precipitated or contributed to the fall
- Interventions that may have prevented the fall and/or reduced the risk of injury

Knowledge
- Shared understanding of how fall occurred through the lens of different health professions
- Awareness of the reliability and effectiveness of system to reduce fall risk
- Lessons learned from fall event to build upon knowledge-base

Wisdom
- Immediate actions to take to reduce the risk of a repeat fall
- Action plan to explore changes needed to address system issues