# CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

## Using Data to Reduce Fall Risk

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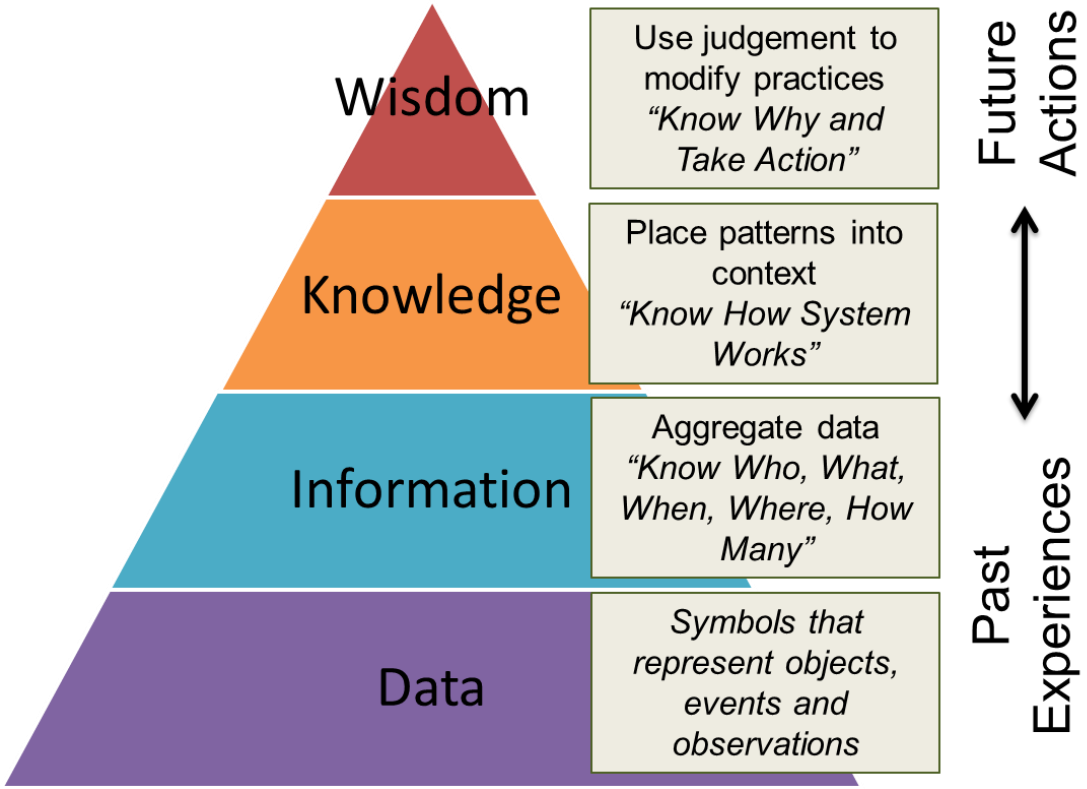
# Collecting, interpreting, and learning from data is the foundation of quality improvement and patient safety.




**Data, Information, Knowledge, Wisdom Hierarchy**

Ackoff, R. (1989). From Data to Wisdom.pdf. Journal of Applied Systems Analysis, 16, 3–9.

# 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."

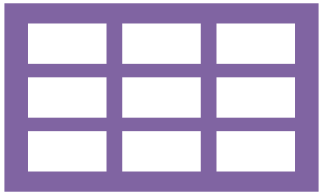
*- CAPTURE Falls Lesson Learned*

# Data/Information Sources

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

# CAPTURE Falls Gap Analysis Scorecard

## Data



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

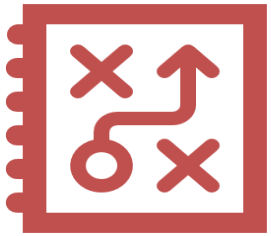
## Information

- 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)

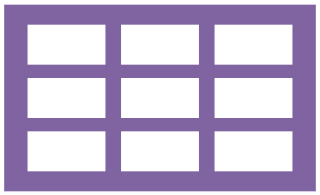
## Wisdom



- Action plan to address fall risk reduction program deficiencies

# Process Audits

## Data



- Data representing observations of fall risk reduction practices

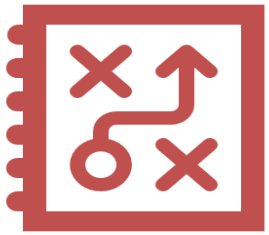
## Information

- 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



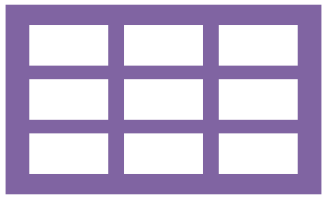
- Action plan to address fall risk reduction program deficiencies
- Actions to improve auditing program through communication/ feedback.

"…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

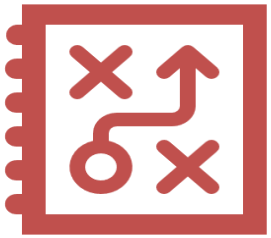
## Information

- 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

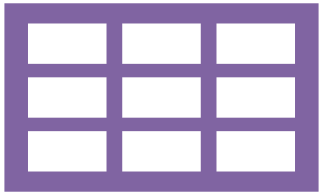
## Wisdom



- Action plan to address fall risk reduction program deficiencies

# Post-fall Huddle and Documentation

## Data



- Documentation of interprofessional team discussion after a fall event

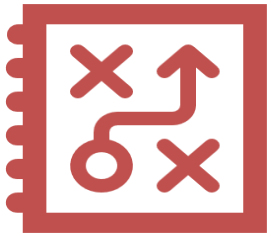
## Information

- 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

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