AGENDA

1. Housekeeping
   – Who are we?
   – Our focus

2. KNOW Falls Debrief

3. Spotlight on How Unassisted Falls Discovered

4. Choosing a Fall Risk Assessment Tool
# The Collaborative – Who Are We?

<table>
<thead>
<tr>
<th>Phase One 2012-2014 (n=16)</th>
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<tbody>
<tr>
<td>Beatrice Community Hospital</td>
<td>Gordon Memorial Health Services</td>
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<tr>
<td>Box Butte General Hospital</td>
<td>Jefferson Community Health Center</td>
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<tr>
<td>Chadron Community Hospital and Health Services</td>
<td>Jennie M Melham Memorial Medical Center</td>
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<tr>
<td>Chase County Community Hospital</td>
<td>Lexington Regional Health Center</td>
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<tr>
<td>Columbus Community Hospital</td>
<td>Pender Community Hospital</td>
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<tr>
<td>Community Medical Center</td>
<td>Providence Medical Center</td>
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<tr>
<td>Community Memorial Hospital</td>
<td>St. Francis Memorial Hospital</td>
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<tr>
<td>Fillmore County Hospital</td>
<td>West Holt Medical Services</td>
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</tbody>
</table>
# The Collaborative – Who Are We?

<table>
<thead>
<tr>
<th>Phase Two 2016 - 2018 (n=17)</th>
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<tbody>
<tr>
<td><strong>Antelope Memorial Hospital</strong></td>
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<tr>
<td><strong>Crete Area Medical Center</strong></td>
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<tr>
<td><strong>Dundy County Hospital</strong></td>
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<td><strong>Gothenburg Memorial Hospital</strong></td>
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<td><strong>Litzenberg Memorial County Hospital</strong></td>
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<tr>
<td><strong>Osmond General Hospital</strong></td>
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<tr>
<td><strong>Saunders Medical Center</strong></td>
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<td><strong>York General Health Care Services</strong></td>
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Current Focus

• Situation: Focus on collaborating with teams to ensure your fall event data drives your learning

• Background: We know...When an interprofessional team effectively coordinates the fall risk reduction program, the risk of unassisted falls is significantly decreased
  – Create policies/procedures
  – Select fall risk assessment tool
  – Link targeted interventions to risk factors
  – Integrate evidence from multiple disciplines
  – Conduct audits to monitor adherence to policy/procedure
  – Communicate results of audits to staff
  – Educate staff about fall risk reduction program
Association Between Effectiveness of Fall Risk Reduction Coordinating Teams and 2014 Unassisted Fall Rates

Spearman
rho = -.70

Effectiveness Score - Fall Risk Reduction Team Activities
Sum of 16 Activities Scored 0 (Not Done) to 4 (Very Effective)
Current Focus

- Assessment: Learning facilitated by using your own data

- Recommendations:
  1. Educate staff to report all falls (assisted & unassisted)
  2. Enter reported fall event data into KNOW Falls
  3. Commit to participating as a team in individual quarterly calls with UNMC to review your hospital’s fall event data and action plan implementation
  4. Respond to communications from UNMC via email and the KNOW Falls system

- Contract
- Gap Analysis
- Historical Fall Event Data
- Field Comment Log in Know Falls
KNOW Falls Purpose

1. Standardize definitions
   For the purposes of patient safety, a fall is a sudden, unintended, uncontrolled downward displacement of a patient’s body to the ground or other object. This definition includes unassisted falls and assisted falls (i.e., when a patient begins to fall and is assisted to the ground by another person).

2. Standardize data collection for benchmarking

3. Facilitate learning and critical thinking about complex patient and system factors that result in falls and fall-related injury
REDCap Online Reporting

• Research Electronic Data Capture (REDCap) web application
  – HIPAA compliant
  – Online fall event learning system
  – Real-time access to data and reporting functions
KNOW Falls Debrief

• What is going well?
  – Does using system facilitate critical thinking

• What is not going well?

• What should we improve?
  – Access to reports
  – Ease of comparison to similar facilities
Spotlight on How Unassisted Falls Discovered

- 25% (90/353) of reported falls from phase 1 (2012-2014) were assisted
- 14% (32/221) of reported falls from phase 2 were assisted
- Falls more likely to be assisted in phase 2 hospitals if they occur in bathroom or hallway

![Bar chart showing the association between fall location and staff assistance.](chart.png)
How do we discover patients who fall unassisted?...
The majority of the time we find them on the floor.
We have to know when patients are on the move…

Your fall risk assessment should identify factors that alert you to the likelihood that

- A patient will NOT ask for or wait for assistance, age, cognition, urgency/incontinence
- A patient’s balance/gait will be impaired if they do get up with/without assist
  - History of falls, lower extremity weakness, balance deficits, uses an assistive device, sensory impairment, polypharmacy and use of medications on Beers Criteria
## Comparing Fall Risk Assessments

<table>
<thead>
<tr>
<th></th>
<th>FRASS</th>
<th>Johns Hopkins</th>
<th>Marian Joy</th>
<th>Morse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History or Previous Fall</td>
<td>6 m</td>
<td>6 m</td>
<td>3 m</td>
<td>3 m</td>
</tr>
<tr>
<td><strong>Cognition/ Orientation</strong></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Emotional Status/Impulsive</td>
<td>x</td>
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<td></td>
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<tr>
<td>Paresis</td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>Communication Deficit</td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td><strong>Toileting/ Altered B B</strong></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Sensory Impairment</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Assistance Needed for Amb/</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Aid</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>IV/ Heparin Lock</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Equipment that Tethers Pt.</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>Link Interventions to Risk</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factors</td>
<td></td>
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Comparing Fall Risk Assessments

- Marian Joy developed in the rehabilitation setting so considers many risk factors specific to stroke and omits factors relevant to acute care.
- Morse Scale developed in late 1980s before our patients were as old and acutely ill...does not assess age, toileting or medications other than IV.
- FRASS and Johns Hopkins assess all risk factors most likely to affect fall risk; FRASS links risk factors to interventions.
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Suggested Targeted Interventions</th>
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</table>
| Age (65-79) and 80+             | • Hourly rounding  
  • Be aware—potential increased risk for injury due to frailty (skin tears, osteoporosis)                                                                                                                                              |
| History Previous Fall           | • Refer for PT evaluation (automatic standing order if patient admitted due to a fall)  
  • Evaluate any assistive device for appropriateness/fit                                                                                                                                                                                 |
| Impaired Cognition/Orientation   | • Hourly rounding  
  • Bed/chair pressure alarms (Tabs alarms too easily removed)  
  • Toileting schedule  
  • Do not leave alone in bathroom  
  • Low-low bed  
  • Move close to nurse’s station  
  • Educate family members about patient’s specific risk factors  
  • Encourage family members to stay with patient  
  • Family/visitors inform nursing when they leave                                                                                           |
## Linking Risk Factors to Interventions

<table>
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<th>Risk Factor</th>
<th>Suggested Targeted Interventions</th>
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| Altered Elimination                      | • Toileting schedule  
• Commode with drop arm next to bed                                                                                                                                 |
| Sensory Impairment                       | • Unclutter environment  
• Orient patient to environment  
• Ensure adequate lighting  
• Wear glasses, hearing aids as appropriate                                                                                                                   |
| Impaired Activity (i.e. needs assist with gait and transfers) | • Refer for PT and OT evaluation as appropriate  
• Assess for appropriate footwear  
• Keep assistive devices within reach (even if patient is not to get up without assist)  
• Assess patient’s posture when seated in bedside chair (i.e. are they prone to slide out because feet don’t reach floor, is it too difficult to put foot rest down)  
• Document transfer/gait assistance on whiteboard                                                                                                               |
| Medications                              | • Request medication review by pharmacist to determine appropriateness of opioids/sedatives  
• Monitor for orthostatic hypotension as appropriate                                                                                                           |
Assistance is an email away!

- General implementation and best practices (including RCA) …Katherine (kjonesj@unmc.edu)
- KNOW Falls and Online Learning (RedCAP) … Anne (askinner@unmc.edu)
- Interpreting Teamwork Perceptions Questionnaire, Leadership, Team Learning and Functioning … Vicki (victoria.kennel@unmc.edu)
- If in doubt contact all of us!
Quarterly Collaborative Calls:

- Tuesday April 18, 2017 14:00 CST
- Tuesday July 25, 2017 14:00 CST
- Tuesday Oct 24, 2017 14:00 CST

Review the tools created with your assistance

http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html
CAPTURE Falls
Collaboration and Proactive Teamwork Used to Reduce

Enter “capture falls” in google
http://www.unmc.edu/patient-safety/capturefalls/