Using TeamSTEPPS Tools to Partner with Patients and Prevent and Learn from Falls

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Objectives

1. Identify key challenges to conducting effective post-fall huddles and how to overcome these barriers to team learning

2. Identify best-practices in conducting post-fall huddles that facilitate immediate learning by front-line workers

3. Classify types of human error that contribute to preventable patient falls

4. Explain why post-event huddles and debriefs facilitate critical thinking, learning, and perceptions of teamwork
Falls: Quality and Safety Problem

- **Prevalence** *(Oliver et al., 2010)*
  - 2% - 3% of hospitalized patients fall each year
  - 30% - 51% of falls result in injury

- **Benchmarks from National Database of Nursing Quality Indicators** *(Staggs et al., 2014)*
  - 3.4 falls/1000 pt. days
  - 0.8 injurious falls/1000 pt. days

- **Outcomes**
  - Cost...$14,000 greater for 2% of fallers with serious injury *(Wong et al., 2011)*
  - 1/11 Hospital Acquired Conditions (HACs) hospitals not reimbursed for
  - Falls contribute to 40% of nursing home admissions *(Tinetti et al., 1988)*
  - Fear of falling limits mobility *(Tinetti et al., 1994)*
As compared to other HACs, little progress made in decreasing falls since CMS ceased paying hospitals for conditions not present on admission.

Why?

(AHRQ Interim Update)
Evidence indicates that teams decrease fall risk...but how?

- **Systematic review**: Etiology of falls is multifactorial (Oliver et al., 2004), thus falls require a multifactorial/interprofessional approach for prevention.

- **Systematic review**: Themes specific to successful implementation of fall risk reduction programs include multidisciplinary implementation and changing attitudes of nihilism (Miake-Lye et al., 2013).

- **Cohort pre-post designs**: Fall risk has been reduced in studies where interprofessional team members were actively engaged in fall risk reduction efforts (Gowdy et al., 2003; von Renteln-Kruse et al., 2007).

- **Theory**: Effective teams are the fundamental structure for managing complexity/learning and implementing change in organizations (Edmondson, 2012; Higgins et al., 2012).
TeamSTEPPS Leadership Tools: Huddles and Debriefs

- **Huddle**: an ad hoc meeting to regain situation awareness, discuss critical issues, and emerging events.

- **Debrief**: a planned meeting to exchange information to recount, document, analyze, and learn from an event to improve teamwork skills and outcomes.

What is a Post-Fall Huddle?

An ad hoc meeting immediately after a fall that includes staff caring for the patient and (ideally) the patient and family.

Useful to multiple stakeholders in multiteam system (MTS):
- Patient and family
- Core team
  - Nursing
  - PT/OT
  - Pharmacy
  - Quality Improvement
  - Providers
- Coordinating Team
- Administration/Management

http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html
Goals of a Post-Fall Huddle

Contingency
Team Goals

1. Discover root cause of the fall through group sensemaking (critical thinking) and learning
2. Decrease the risk of a future fall for the patient who has fallen by changing the plan of care for that particular patient

Overarching
MTS Goals

1. Decrease fall risk for all patients by applying what is learned in the huddle to the system
2. Improve trust among bedside personnel (core team)
3. Improve collaboration and coordination among component teams
Compare and Contrast

http://webmedia.unmc.edu/nursing/heroes/capturefalls/
Key Challenges

Poll Now Open-ended Question:

- Use one to two words to describe what you think was the biggest difference between the two videos.

- Show results in a word cloud
Characteristics of ineffective huddles

1. Poor leadership
2. Blaming and critical comments
3. Unmanaged challenging/negative personality
4. Unreceptive staff
Huddle best practices that facilitate learning and action

Social and technical aspects to consider:

1. Establish the purpose
2. Include the right people
3. Huddle at the right time
4. Huddle in a meaningful location
5. Find the right facilitator to lead the huddle
6. Ensure facilitator effectively leads the huddle
7. Manage and elicit good huddle team member behavior
8. Use a form or guide to assist the process
CAPTURE FALLS:
POST-FALL HUDDLE GUIDE

1. Establish facts... a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient’s plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation
   a. Who attended
   b. Type of fall
   c. Type of error

POST-FALL HUDDLE FACILITATOR TIPS

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the front line to learn about why a patient fell – actively listen and be slow to judge)
2. Ask probing questions (e.g., ask “why?” until root causes are identified)
3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person’s contribution)
4. Give praise and acknowledge good work (e.g., say “thank you” and “nice job” when appropriate)
5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)

Huddle Form


Post-Fall Huddle Facilitation Guide Section 1

**Purpose:** To lead a front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.

**Directions:** Complete after ALL assisting and unassisted patient falls as soon as possible after patient care is provided but prior to leaving the shift.

**Participants:** Designated post-fall huddle facilitators for the shift, healthcare professionals who made care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.

**Remember:** Patients fall because their sense of balance is outside their base of support.

***During the huddle look for specific answers and continue asking “why?” until the root cause is identified!***

1. Establish Facts:
   - 1a. Did we know this patient was at risk? ______ YES ______ NO
   - 1b. Has this patient fallen previously during this stay? ______ YES ______ NO
   - 1c. Is this patient at high risk of injury from a fall? (AHRF) ______ YES ______ NO
   - Age 85+ ______
   - Bone Fracture ______
   - Coagulation ______
   - Surgical Post Op Patient ______

2. Establish what patient and staff were doing and why:
   - ASK: What was the patient doing when he/she fell?
   - ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.

3. Determine underlying root causes of the fall:
   - ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.

4. Make changes to decrease the risk that this patient will fall or be injured again:
   - ASK: How could we have prevented this fall?

5. What changes will we make in this patient’s plan of care to decrease the risk of future falls?

**Ask:** What patient or system problems need to be communicated to other departments, units or disciplines?

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**Decision Tree for Types of Falls**

Source: http://www.palliativecare.org/professionals/resources/decision-tree

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**To be completed by Fall Risk Reduction Team***

- What type of error(s) occurred? CHECK ALL THAT APPLY
  - Were there task errors? (e.g., planned interventions were not in place as intended)
  - Describe:
  - Were there judgment errors? (e.g., decision had to be made about uncertain processes)
  - Describe:
  - Were there care coordination errors? (e.g., fall risk status not communicated to all parties)
  - Describe:
  - Were there systems interaction errors? (e.g., lack of coordination between multiple people and equipment)
  - Describe:
Best Practices...more than a checklist

Social Behaviors
✓ Leaders engages patient first
✓ Leader sets tone for learning
✓ Leader provides feedback to staff
✓ Leader invites staff participation
✓ Team members have shared mental model of learning goal

Technical/Check List
✓ Establish the facts
✓ Leader uses the guide but lets the story emerge via conversation
Best Practices...more than a checklist

Social Behaviors
- Leader summarizes and invites additional input...specifically from patient
- Members contribute what they know and didn’t know...including the patient
- Members educate patient

Technical/Check List
- Identify root causes as the story emerges
- Identification of root causes leads members to identify solutions at two levels
  1. Patient
  2. System
Best Practices...more than a checklist

**Social Behaviors**
- Members take responsibility for communicating results to their departments/discipline
- Leader educates members
- Leaders summarize key learning points as a narrative and returns to the goals of improving patient and system safety

**Technical/Check List**
- Specifically consider communication across disciplines and departments
- Establishing risk of injury
- Identified changes needed to patient plan of care and system coordination
## Learning Domains

<table>
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<tr>
<th>Process Uncertainty</th>
<th>Actor Interdependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Task Error</td>
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<tr>
<td></td>
<td>High</td>
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<tr>
<td></td>
<td>Coordination Error</td>
</tr>
<tr>
<td>High</td>
<td>Judgment Error</td>
</tr>
<tr>
<td></td>
<td>System Interaction</td>
</tr>
</tbody>
</table>

*(MacPhail & Edmondson, 2011)*

*Completed later by coordinating team*
MTS Definition and Typology

• “Two or more [component] teams that interface directly and interdependently in response to environmental contingencies toward the accomplishment of collective goals.” (Mathieu, Marks, & Zaccaro, 2001, p. 290)
  – Component teams achieve proximal goals
  – MTS achieves overarching/organizational goal

• Characteristics
  – Composition
  – Development
  – Coordination

(Zaccaro, Marks, & DeChurch, 2012)
MTS Components and Linkages

- **IP Contingency Team** (56% Nursing)
- **IP Core Team** (84% Nursing)
- **IP Coordinating Team** (40% Nursing)

**Data**

- **Event Information**
  - Who, What, When, Where
- **Event Sensemaking**
  - How, Why

**Patient Information**

**Patient Sensemaking**

**Patient Action**

**Patient Outcome** (Fall ?)

**System Information**

**System Sensemaking**

**System Action**

**System Outcome** (Fall Rate)

- Conduct Gap Analysis: Integrate Evidence from Mult. Disciplines
- Conduct Annual / New Emp. Training & Assess Competencies
- Develop Policies/Procedures (e.g. Communication of Fall Risk)
- Choose Fall Risk Assessment Tool(s)
- Develop Fall Event Reporting Forms
- Collect, Analyze Fall Event Data
- Provide Feedback about Actions Taken

**Audit Bedside Interventions**

**Conduct Root Cause Analysis**

**Benchmark Rates**
Changing Perceptions of Core Team

- Team Structure*
- Leadership*
- Situation Monitoring
- Mutual Support
- Communication
- Management Support*

*p<.05 calculated using random effects ANOVA and adjusted for nesting by hospital
Post-event Huddles/Debriefs

- Coordinating mechanism for MTS
  - Accountability
  - Predictability
  - Shared mental model
  - Change frame of reference
  (Okhuysen & Bechky, 2009)

- Training in error recovery is cognitively effective
  - Detection
  - Reflection
  - Generation of recovery mechanisms
  - Facilitates learning and future action
  (Dror, 2010)

Cognitive sensitization to error
Summary

• Huddles that facilitate critical thinking and learning balance technical and social aspects

• Huddle leader/facilitator activity is key to managing staff behavior, interaction, and learning

• Accurate error classification guides recovery actions to improve patient, team, and system actions and outcomes

• Post-event huddles and debriefs facilitate critical thinking and learning and affect perceptions of teamwork because they are a mechanism for coordination across the MTS
References


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