Falls and Fall Prevention Webinar Series

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
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MARCH 3, 2020

GREAT LAKES
PARTNERS FOR PATIENTS

Illinois | Michigan | Wisconsin
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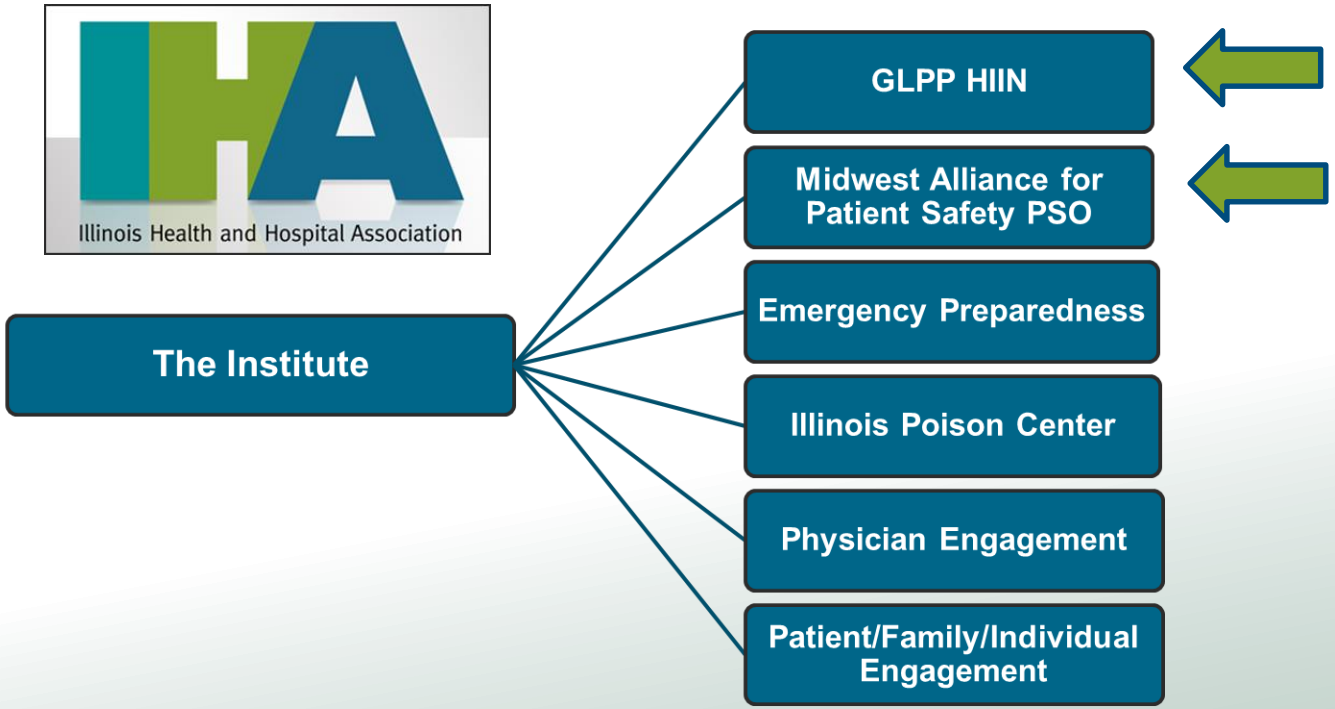
Accelerating Improvement at the Point of Care

Housekeeping Items

- The webinar is being recorded and will be made available along with the PowerPoint following the presentation.
- Feel free to use the chat feature during the presentation.
- Lines will be muted until the Question/Answers portion of presentation.

Institute for Innovations in Care and Quality



HIIN Overview

- Goals:
  1. **20% reduction in all-cause patient harm** (to 97 Hospital-Acquired Conditions [HACs]/1,000 discharges) from 2014 interim baseline (of 121 HACs/1,000 patient discharges); and
  2. **12% reduction in 30-day readmissions** as a population-based measure (readmissions per 1,000 people).

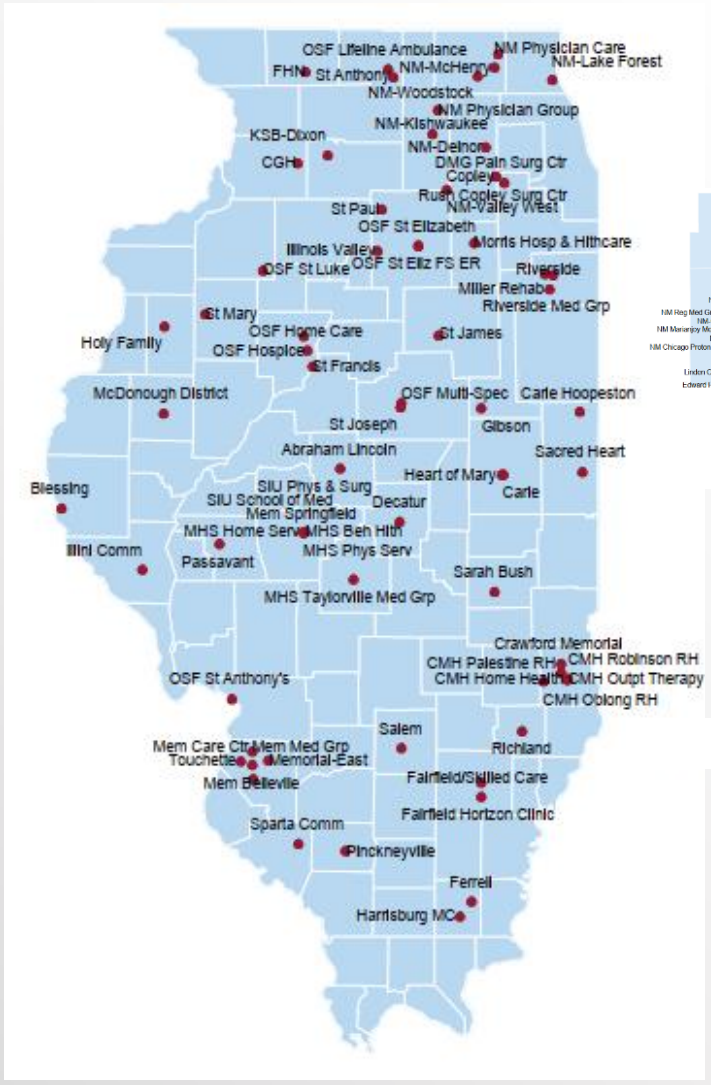
- Interventions may include:
  1. *Learning collaboratives*
  2. *Data sharing networks*
  3. *Peer-to-peer training among hospitals*
  4. *Conference calls, webinars, and site visits*

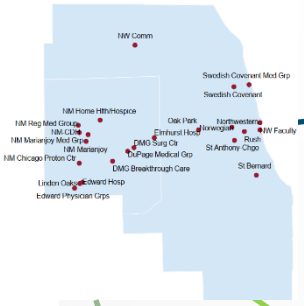
HIIN Overview

1. Adverse drug events (ADE)- opioid safety, anticoagulation safety, and glycemic management
2. Central line-associated blood stream infections (CLABSI)-in all hospital settings, not just Intensive Care Units (ICUs)
3. Catheter-associated urinary tract infections (CAUTI)-in all hospital settings, including avoiding placement of catheters, both in the ER, and in the hospital
4. Clostridioides difficile (C. diff)- including Antibiotic Stewardship
5. Injury from falls and immobility
6. Pressure Ulcers
7. Sepsis and Septic Shock
8. Surgical Site Infections (SSI)-to include measurement and improvement of SSI for multiple classes of surgeries
9. Venous thromboembolism (VTE)-including all surgical settings
10. Ventilator-Associated Events (VAE)-to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC)
11. Readmissions

MAPS Member Benefits

A component patient safety organization of IHA





Protection

- Federal Privileges
- Confidentialities

Education & Resources

- Safe Tables
- Webinars
- Safety Culture Workshop
- Peer-to-Peer Collaboration

Event Collection & Analysis

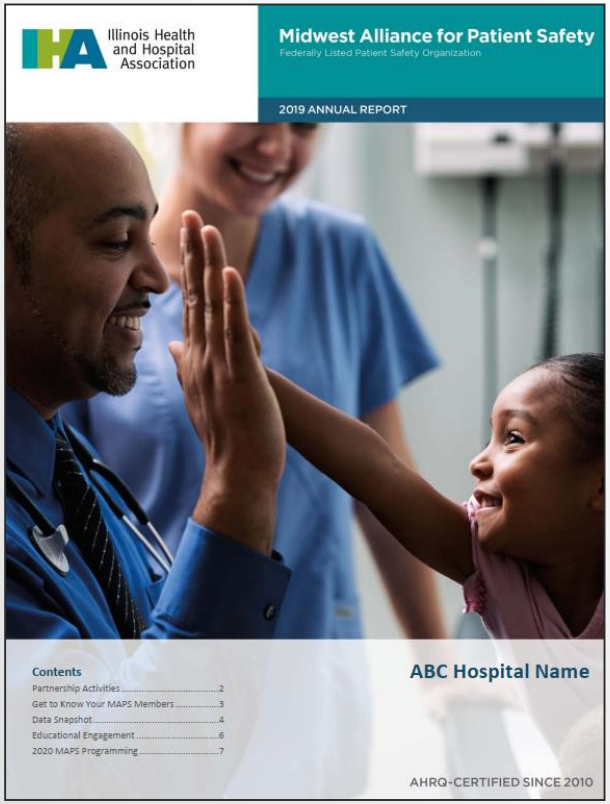
- Event trending & feedback
- Data submission & mapping support

Member Deliverables

- E-newsletter & Alerts
- Top 10 Patient Safety paper
- Annual Reports & Case Discoveries

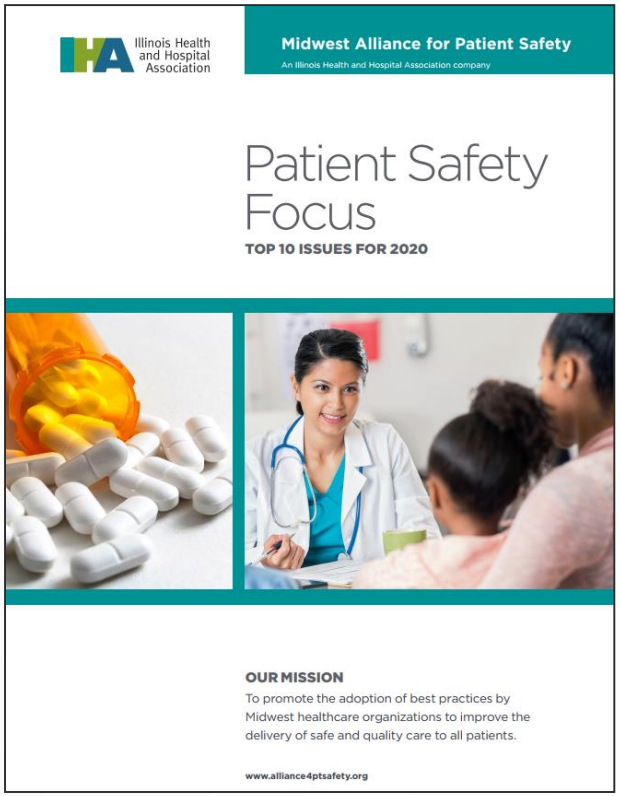
Key Member Deliverables

ANNUAL REPORT



MONTHLY E-NEWS

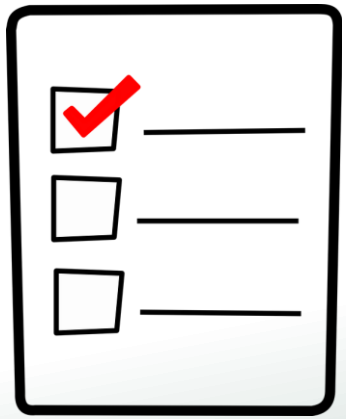
TOP TEN



Visit www.alliance4ptsafety.org

Webinar Series Information

- Tuesdays from 10:00-11:00 CT/ 11:00-12:00 ET
  - March 3rd: Post Fall Management – Getting to Types of Falls and Repeat Fallers
  - March 17th: Innovations in Fall and Fall-Injury Prevention and Reduction Strategies within Hospitals



Post Fall Management: Getting to Types of Falls and Repeat Fallers

March 3, 2020

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Objectives

- Examine post fall practices as key intervention to reduce repeat falls.
- Redesign patient/resident education to fully engage them as full partners in care.
- Construct a program evaluation model to assure fidelity and reliability of the post fall huddle intervention.

My Goals

- Challenge and Inspire you to add precision to your patient safety practices and redesign fall prevention clinical practices to protect patients from Injurious Falls as your organization's Primary Outcome

The Face of “Harm”

Let's Share!

- How do you know your fall prevention program is working?
- Can you affirm that patients who fall more than once are not falling for the same reason?
- How is your post fall program working?
- How do you measure success?

Sept 28, 2015: TJC Sentinel Alert: Preventing Falls and Fall Injuries

- Lead efforts to raise awareness of the need to prevent falls resulting in injury
- Establish an interdisciplinary falls injury prevention team or evaluate the membership of the team in place
- Use a standardized, validated tool to identify risk factors for falls and injury risk factors
- Develop an individualized plan of care based on identified fall and injury risks, and implement interventions specific to a patient, population or setting

Suggestions cont.

- Standardize and apply practices and interventions demonstrated to be effective, including:
  - A standardized hand-off communication process
  - One-to-one education of each patient at the bedside
- Conduct post-fall management, which includes: a post-fall huddle; a system of honest, transparent reporting; trending and analysis of falls which can inform improvement efforts; and reassess the patient
  - **Conduct a post-fall huddle**
  - Report, aggregate and analyze the contributing factors on an ongoing basis to inform improvement efforts.

Post Fall Practices

- Post Fall Huddle
- Post Fall Assessment
- Patient/Resident/Family Education
- Staff Education

Huddles

How Many Huddles Are You Doing?

Understanding Falls

- Many studies point out that a major determinant of a future fall is the **history of previous falls** (Degelau, et al., 2012; Gates, et al., 2008; Oliver, et al., 2004).
- Because older adults continue to fall despite the implementation of evidence-based guidelines to prevent falls, identifying the **causes** of each fall is critical to preventing future falls.

Fast To Act

- Within the inpatient settings, clinicians are able to act when a patient fall occurs, to **quickly determine the event with the patient,** using the post-fall huddle process.
- Once a fall occurs in our care, the etiology and/or cause of the fall and injury must be investigated to prevent future occurrences.

PFH: Purpose

- Post-fall huddles are used in inpatient settings of care to determine the cause of the fall and injury, and intervene appropriately (Ganz, et al, 2012; AHRQ, 2010; Quigley, et al., 2009; Anderson, Mokracek, & Lindy, 2009).
- A huddle is an immediate evaluation of each fall, by a team, preferably interdisciplinary, with the patient in the environment where the patient fell.

It Is Not:

- A comprehensive post fall assessment
- Recorded in the medical record
- An incident report
- Punitive

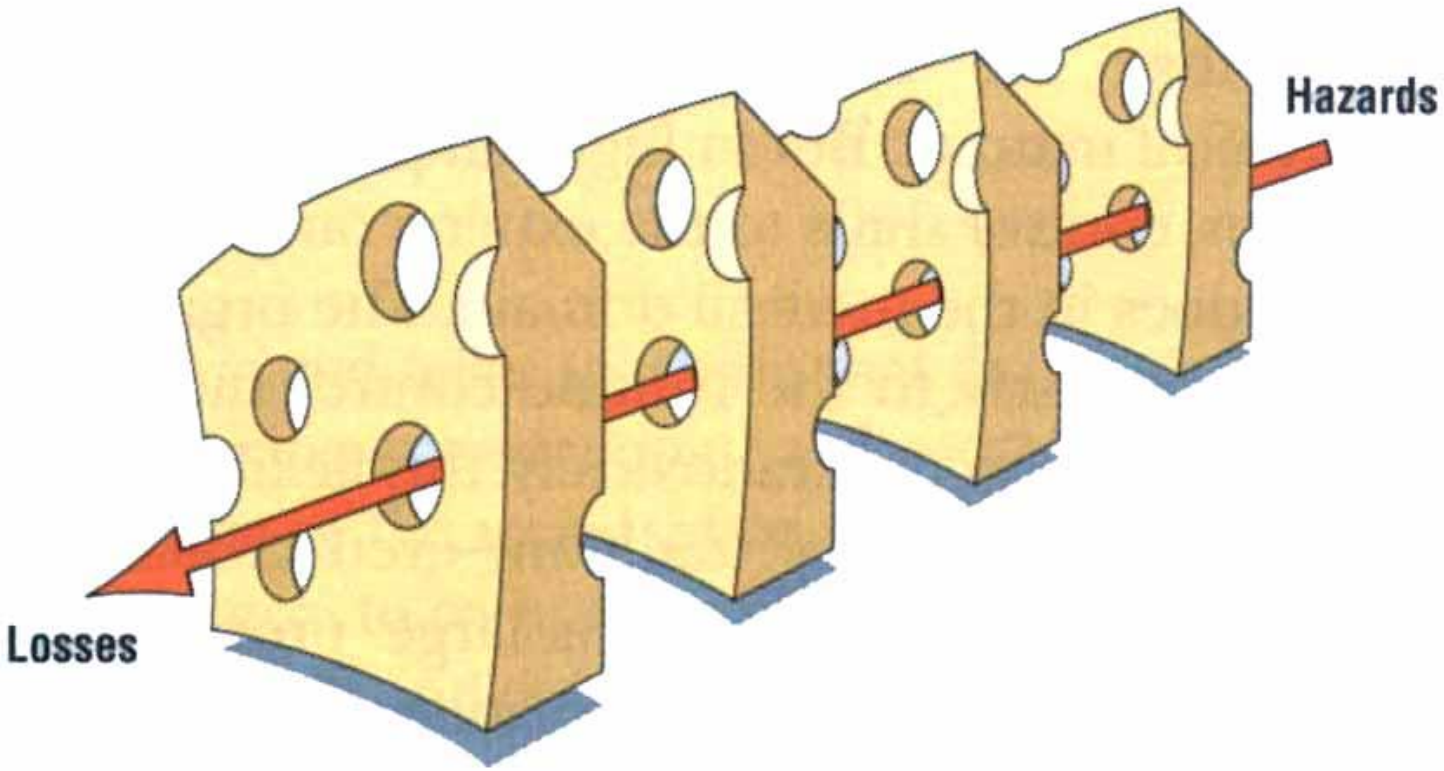
Post Fall Safety Huddles

- Purpose
- Post Fall Analysis
  - What was different this time?
  - When
  - How
  - Why
  - Prevention: Protective Action Steps to Redesign the Plan of Care

Safety Huddles

- **Pre-Shift Huddles**
- **Post Fall Huddles**
- Conducted with the patient/resident where the fall occurred within 15 minutes of the fall
- Post Fall Analysis
  - What was different this time?
  - When
  - How
  - Why
  - Prevention: Protective Action Steps to Redesign the Plan of Care

Accident Theory



Post Fall Huddle (PFH): Essential Components

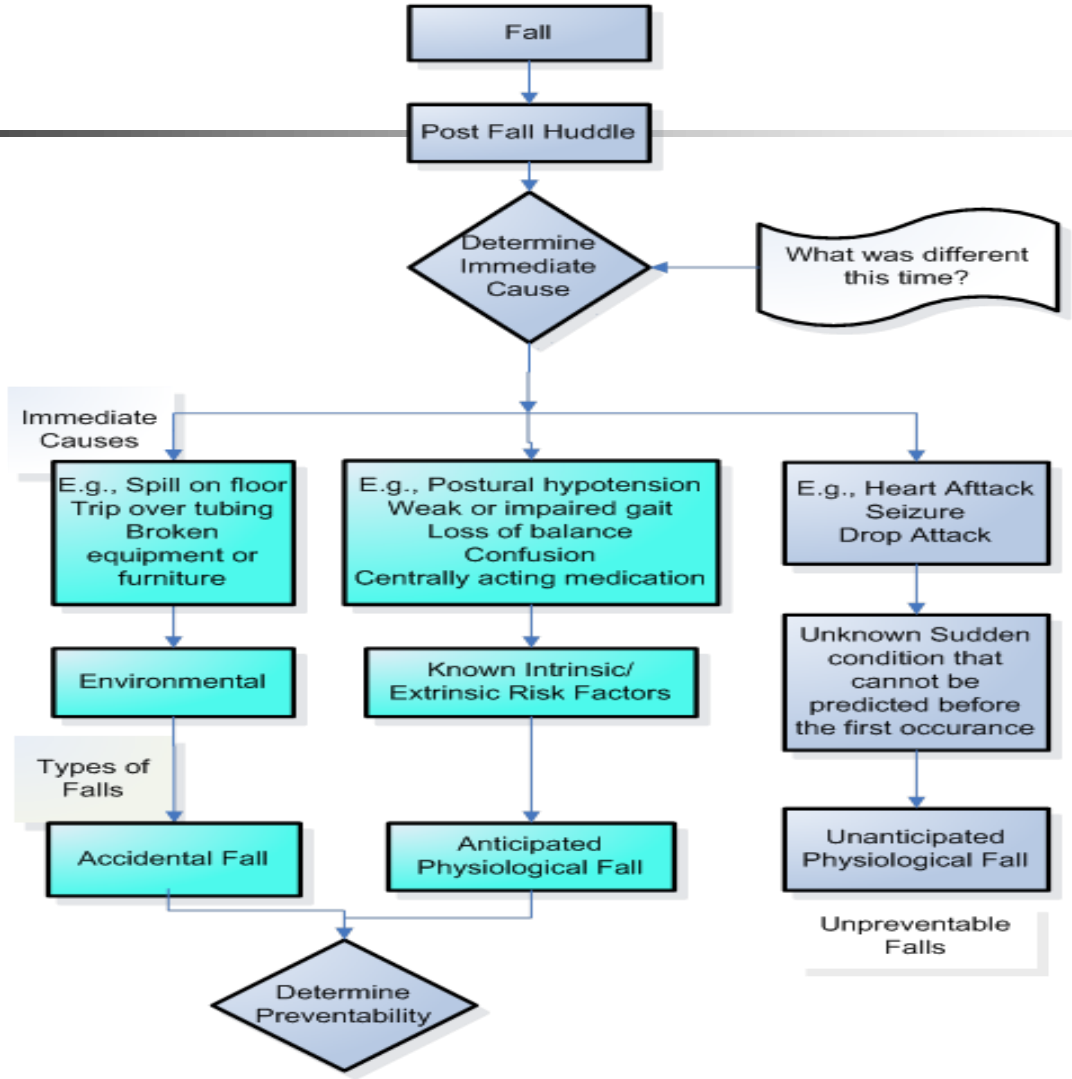
- A brief staff gathering, interdisciplinary when possible, that immediately follows a fall event.
- Convenes within 15 minutes of the fall event
- Clinician(s) responsible for patient/resident during fall event leads the PFH
- Involves the patient/resident whenever possible in the environment where the patient/resident fell
- Requires Group Think to discovery what happened.
- Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient/resident fell.
- Guiding question to ask: **What was different this time you were doing this activity, compared to all the other times you performed the same activity (and did not fall), but this time you fell?**

Steps to the Post Fall Huddle

1. TL makes announcement
2. Convene within 15 mins **with the pt/resident** in the environment where the patient/resident fell
3. Conduct Analysis: Determine root cause of fall, injury and Type of Fall
4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall and injury are decided by the huddle team.
5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall
7. Communicate updated plan of care in patient/resident hand-off reports.
8. Complete EMR Post Fall Note

Decision Tree for Types of Falls

Tuesday, April 22, 2014



Determine Preventability

Step 1: Conduct the Post Fall Huddle.

Step 2: Determine the Immediate Cause of the Fall.

Step 3: Determine the Type of Fall.

Step 4. If Accidental and Anticipated Physiological Falls, determine Preventability:

Could the care provider (direct care provider) have anticipated this event with the information available at the time?

- *If the Answer is **NO,** the fall is Not preventable.*
- *If the answer is **YES**, the provider must ask another question: Were appropriate precautions taken to prevent this event?*
- *Answer:*
  - *No, Clearly or likely Preventable;*
  - *Yes, Clearly or likely Unpreventable*

Levinson, D. R., (2010, Nov). Adverse events in hospitals: National incidence among Medicare beneficiaries. DHHS. OEI-06-09-00090

Outcomes of Post Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient / Resident (family) involved in learning about the fall occurrence
- Prevent Repeat Fall
- Reduce Repeat Fall Rate

Post Fall Assessment

Different than a Huddle!

Post Fall Assessment

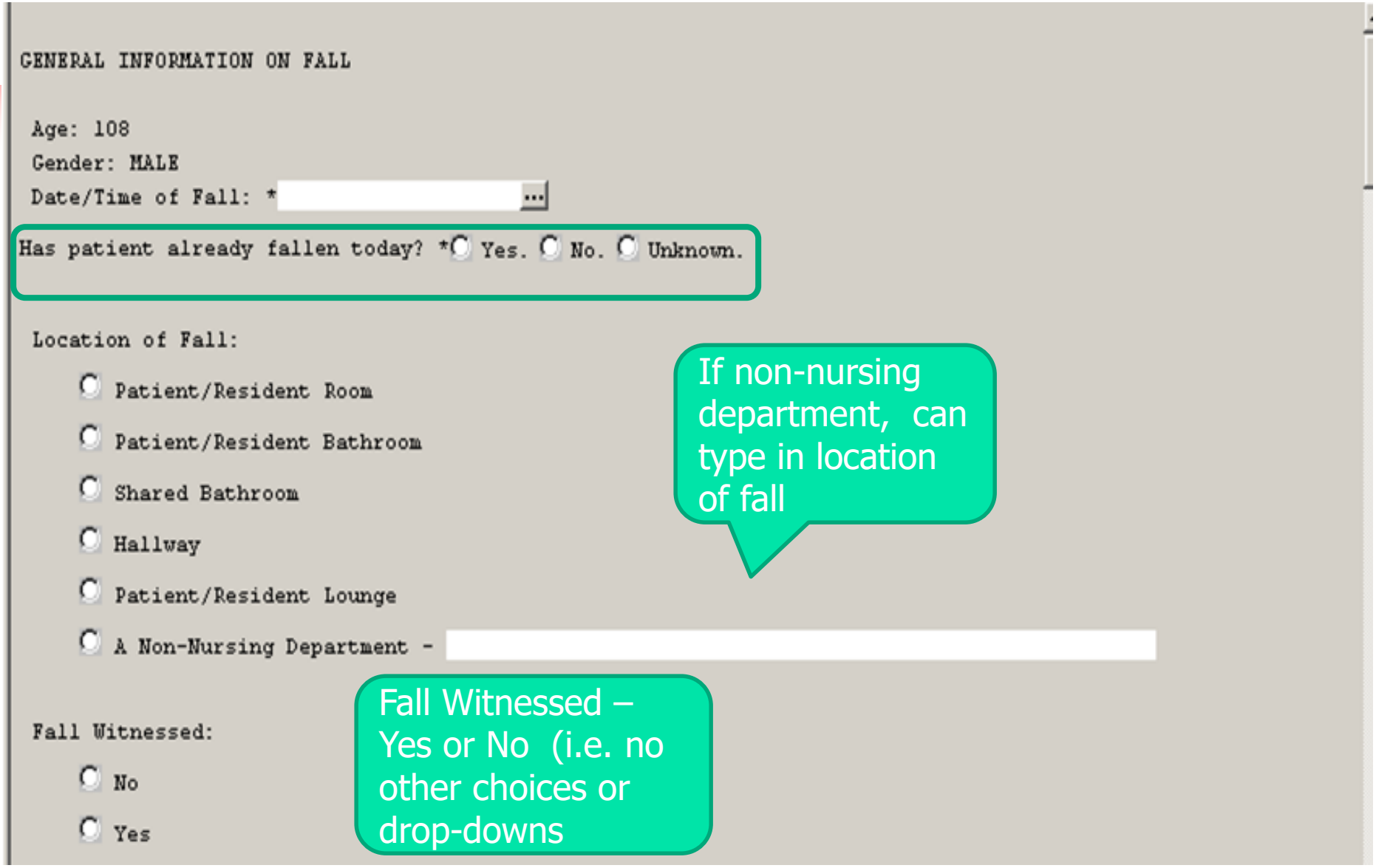
- In-depth Data Gathering
- Circumstances of the Fall
- Patient/Resident Presentation
- Assessment of Patient/Resident Condition

Comprehensive Post-Fall Assessment

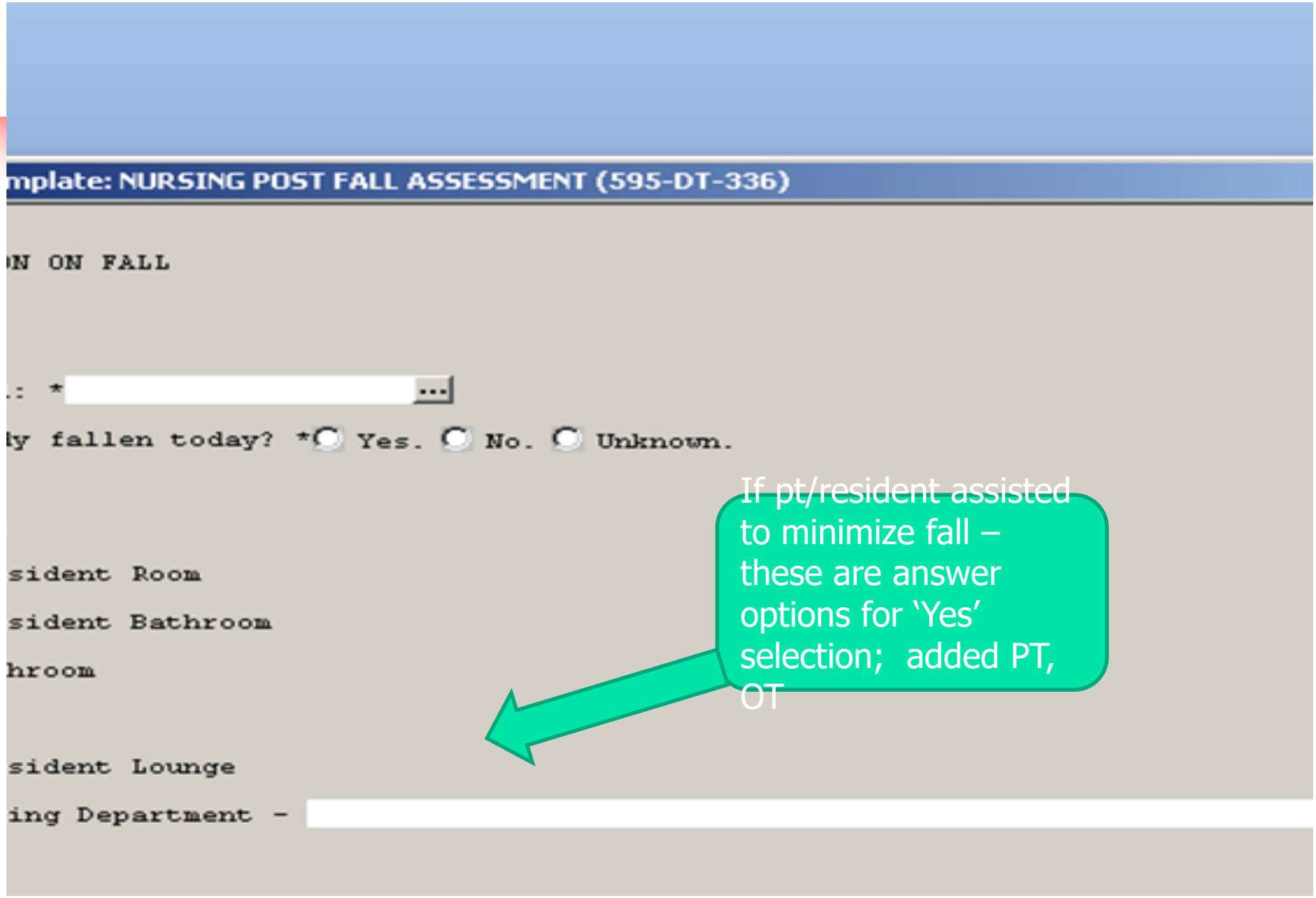
Includes:

- General information about the fall
- Subjective & objective falls documentation
- Patient/Resident Assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based on Fall Risk Scale/ Morse falls scale
- Facility personnel and family notification

Post Fall Note (EMR)



Gen Info


mplate: NURSING POST FALL ASSESSMENT (595-DT-336)
N ON FALL
: *
...
y fallen today? * Yes. No. Unknown.
sident Room
sident Bathroom
hroom
sident Lounge
ing Department -
If pt/resident assisted to minimize fall – these are answer options for 'Yes' selection; added PT, OT

Redesign Patient Education

Change Your Conversation

Methods to Fully Engage Patients

- Teach Back: Tell You Back
- Post Test: Evaluate Learning
- Understand Patient's Perspectives
- Teaching after a Fall

Patient Perceptions about Falls

- Lim, Aug, Teo, et al. (2018) acknowledged that efforts to reduce falls are limited by insufficient understanding of patients' views about falls and preventive initiatives dictated by healthcare providers.

Lim, M. L., Aug, S.G.M., Teo, K.Y., Wee, Y.H.C., Yee, S. P., & Ang, S.Y. (2018). Patients' experience after a fall and their perceptions of fall prevention. JNCQ, 33(1). 46-52

Learning from Fallers

- They studied patients' perspectives toward fall prevention and their experiences about their fall in an acute care hospital in Singapore.
- 100 medically stable and cognitively intact patients were interviewed 1 day after the fall.
- The patients were 64% male, average age of 65.2 years, 94% were alone when they fell, and 58% fell in their room.

6 Themes Emerged

- Apathetic toward falls- falls were not serious and unpreventable
- Self-blame behaviors-described feelings of guilt; admitted to risk-taking behaviors
- Reluctant to impose on busy nurses – did not want to bother the nurses
- Negative feelings toward nurses – frustration with long wait times for nurses to respond
- Overestimated their own ability- to walk independently or manage their activities of daily living
- Poor retention of information – forgot to call and failed to retain fall prevention advice

Consistency in Results

- The findings of this research are consistent with other research findings about patients' perceptions:
- falls are viewed by patients as not serious and unpredictable,
- patients often downplayed the risks of falls, and
- were reluctant to call for help.

Falls Education Resources

Tool Kits (Usually consist of the following media)

- Web sites
- Videos
- Posters
- Brochures
- Tip Sheets
- Assessments

Construct Program Evaluation

AHRQ Falls Toolkit 2013

Quigley Post Fall Huddle

Audit Tool

Program Effectiveness AND Implementation Effectiveness

+ program, - implementation = inconsistent, unsustainable, or poor outcomes

- program, + implementation = poor outcomes

Formative Measures

- Structures:
  - Who attends: Nursing and others – Count them
  - Changed Plan of Care: Add actions to your run-chart: Annotated run chart; Capture interventions
- Processes:
  - Timeliness of Post Fall Huddle (number of minutes)
  - Timeliness of changing plan of care
  - Time to implemented changed plan of care

Summative Outcome

- Prevent Repeat Fall: Same Root Cause and Same Type of Fall
- Reduce costs associated with falls and fall related injuries

Quality Improvement

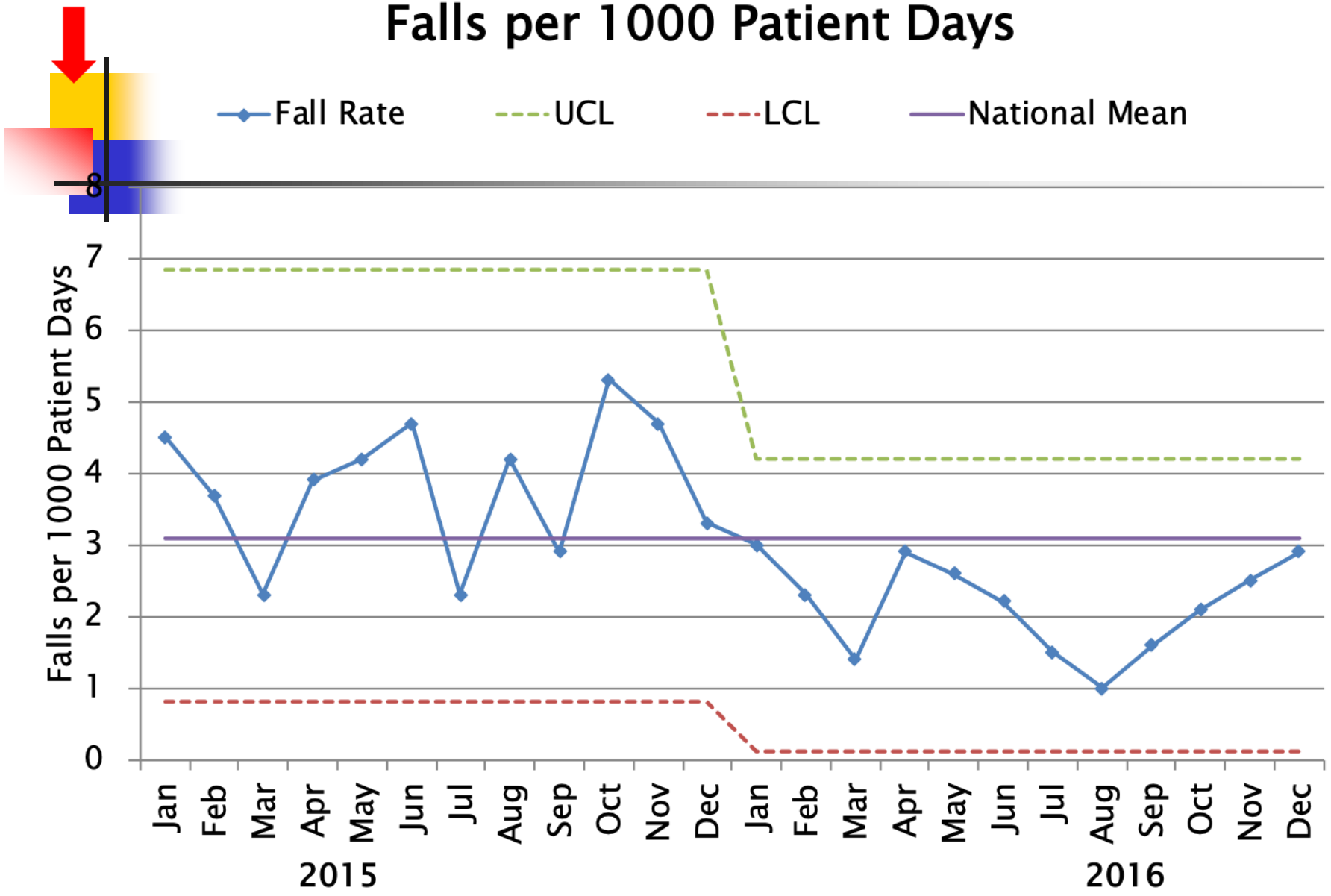
- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient (family) involved in learning about the fall occurrence
- Prevent Repeat Fall

Effectiveness of Fall Improvement Programs

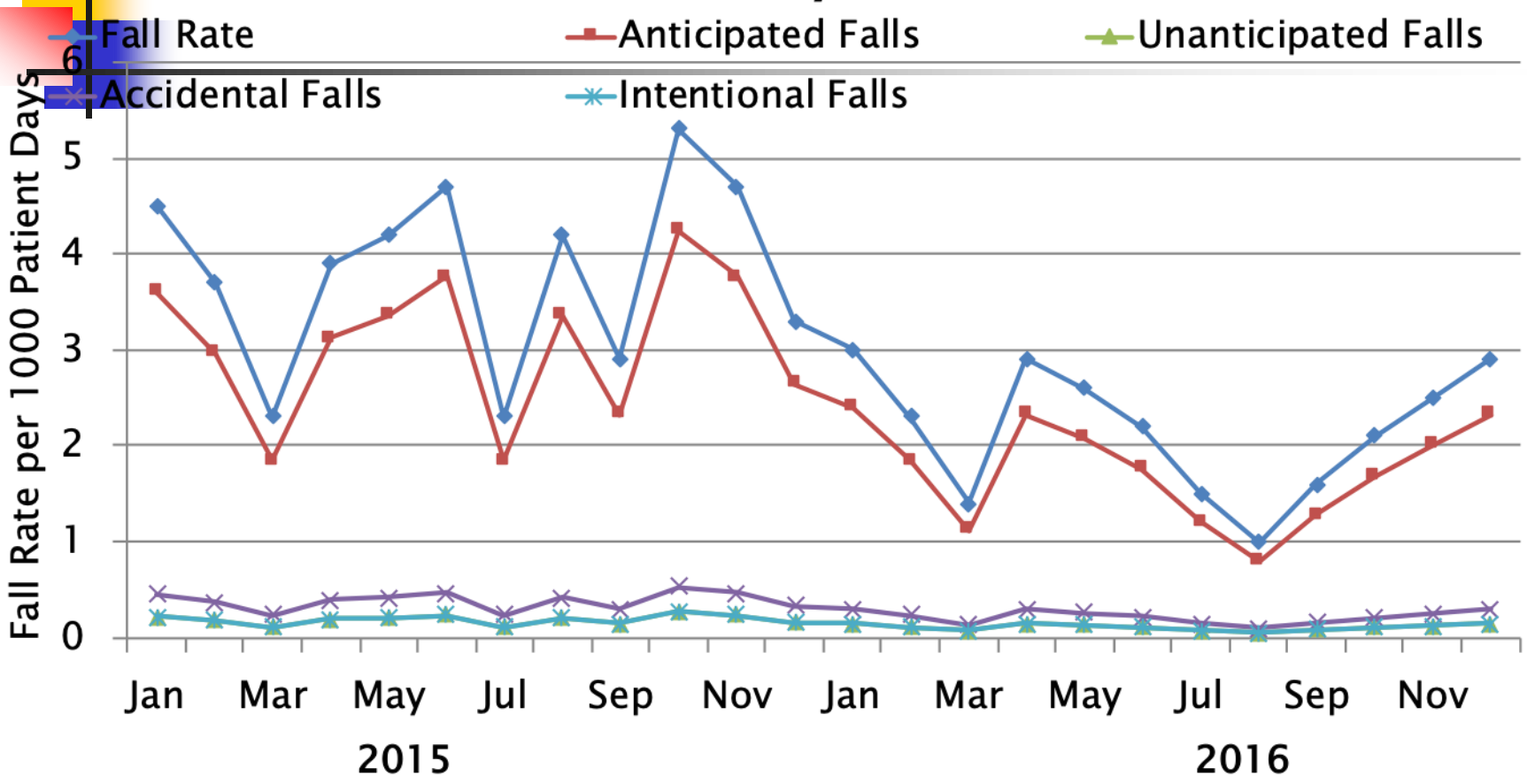
- Interdisciplinary Care Planning
- Post Fall Reviews-100% Compliance
- Integration of Technology

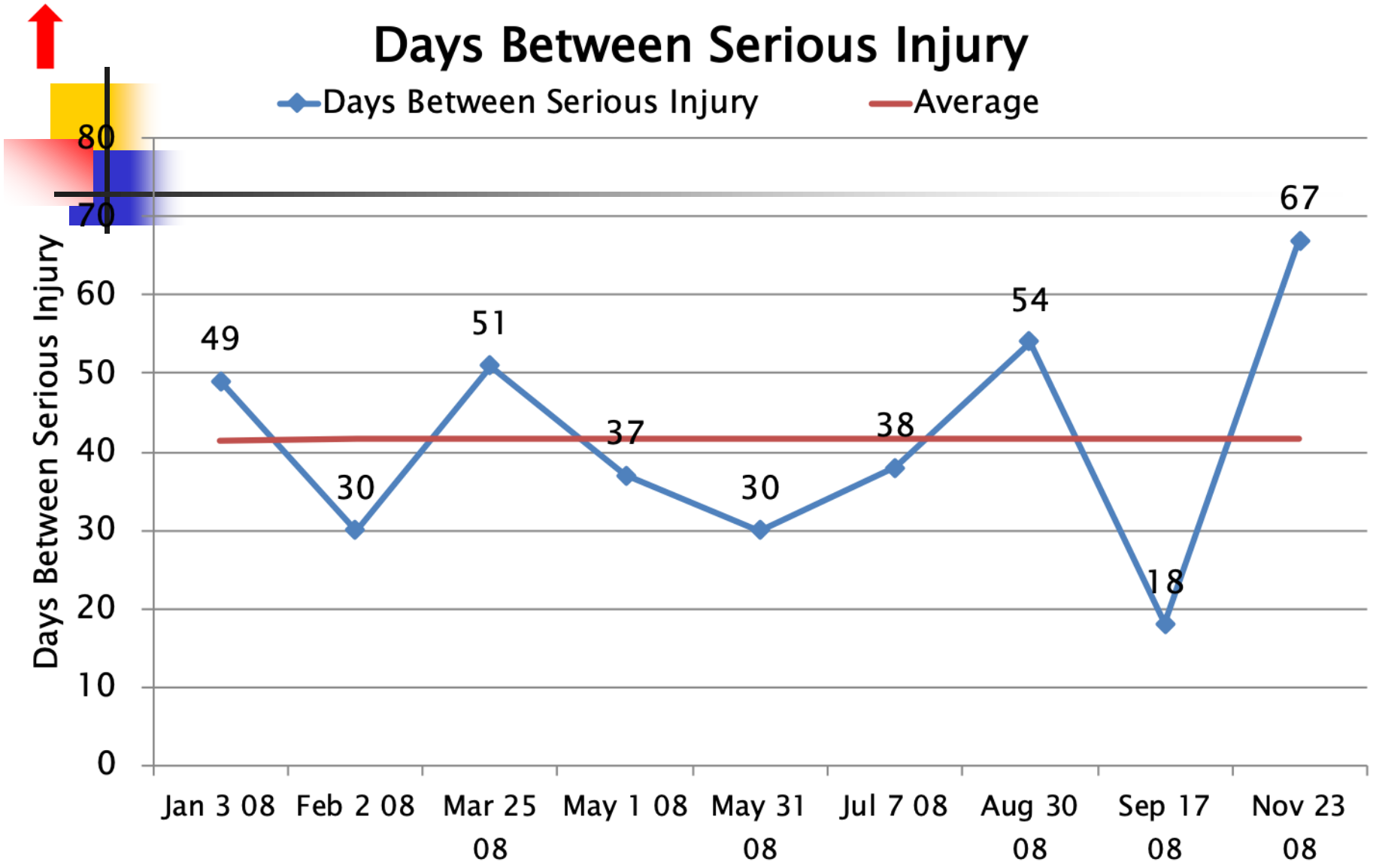
Displaying Data/ Tell Your Safety Story

- Run Charts: Falls by Types of Falls
- Control Charts: Drill Down Your Preventable Falls
- Annotation: Show your Interventions

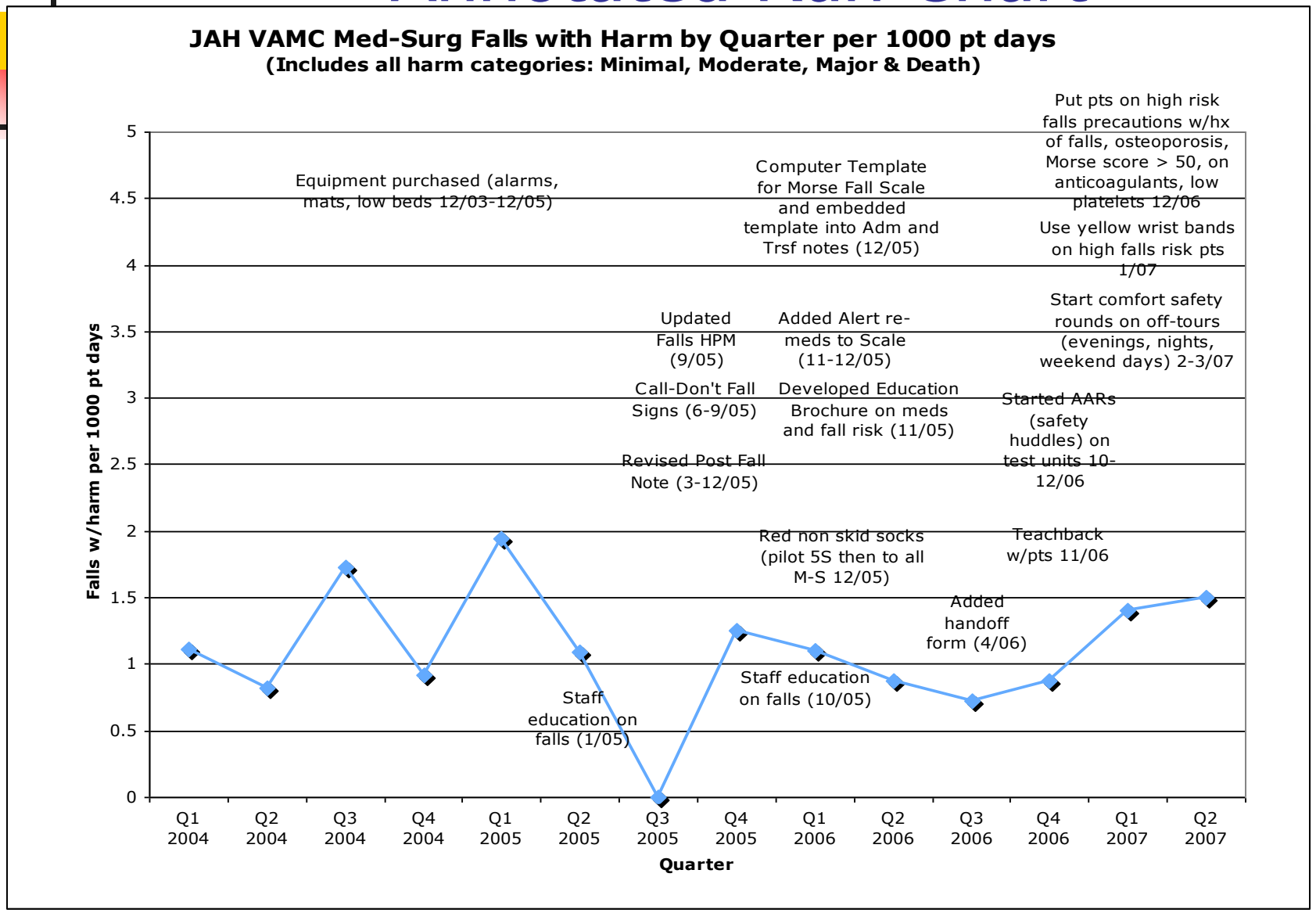

Falls per 1000 Patient Days
Fall Rate
UCL
LCL
National Mean
Falls per 1000 Patient Days
0
1
2
3
4
5
6
7
8
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2015
2016

Fall Rate by Type of Fall per 1000 Patient Days

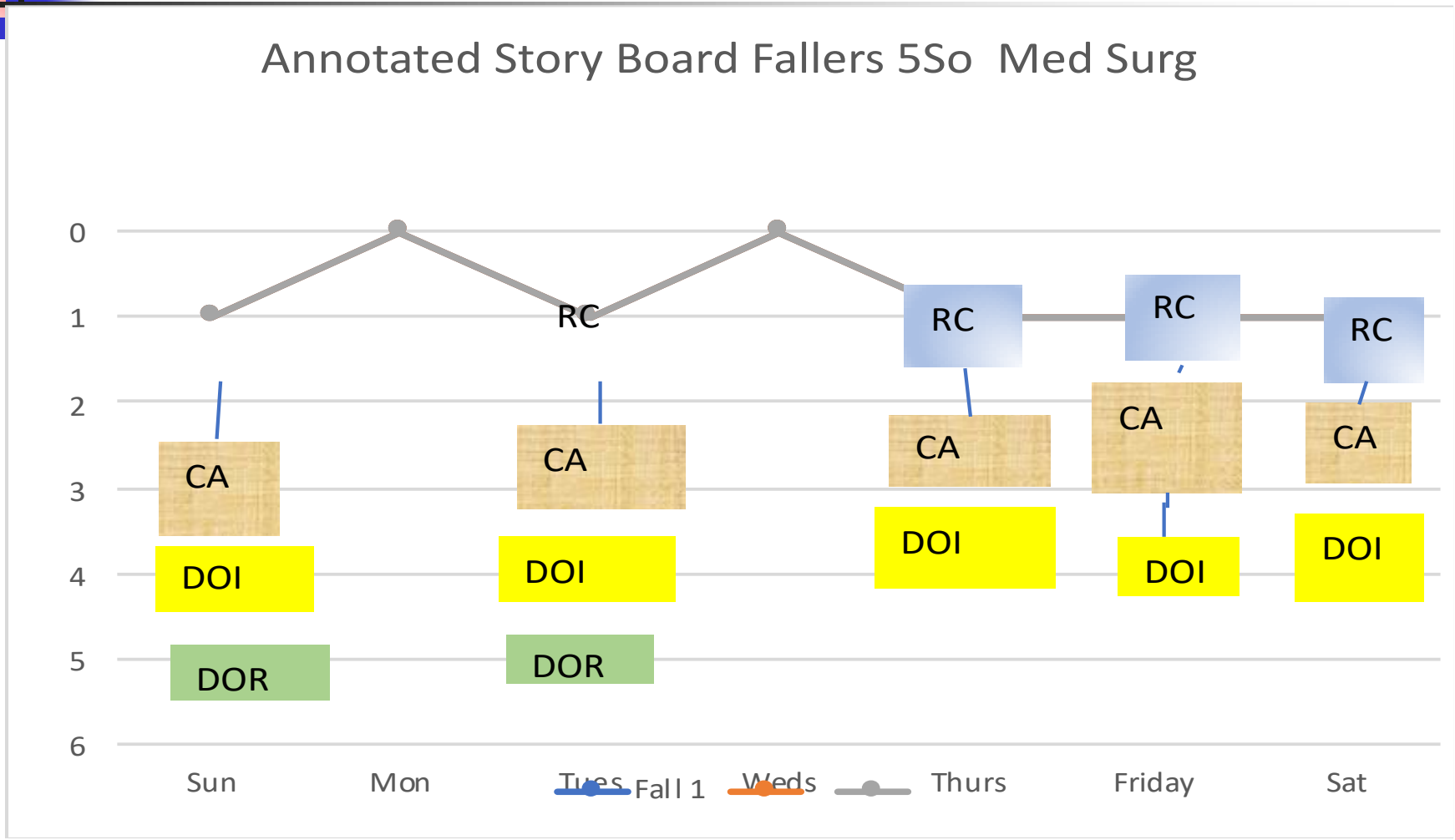



Days Between Serious Injury
Days Between Serious Injury
Average
Days Between Serious Injury
80
70
60
50
40
30
20
10
0
49
30
51
37
30
38
54
18
67
Jan 3 08
Feb 2 08
Mar 25 08
May 1 08
May 31 08
Jul 7 08
Aug 30 08
Sep 17 08
Nov 23 08

Annotated Run Chart



My Storyboard



Learn from Falls: Change Your Conversation

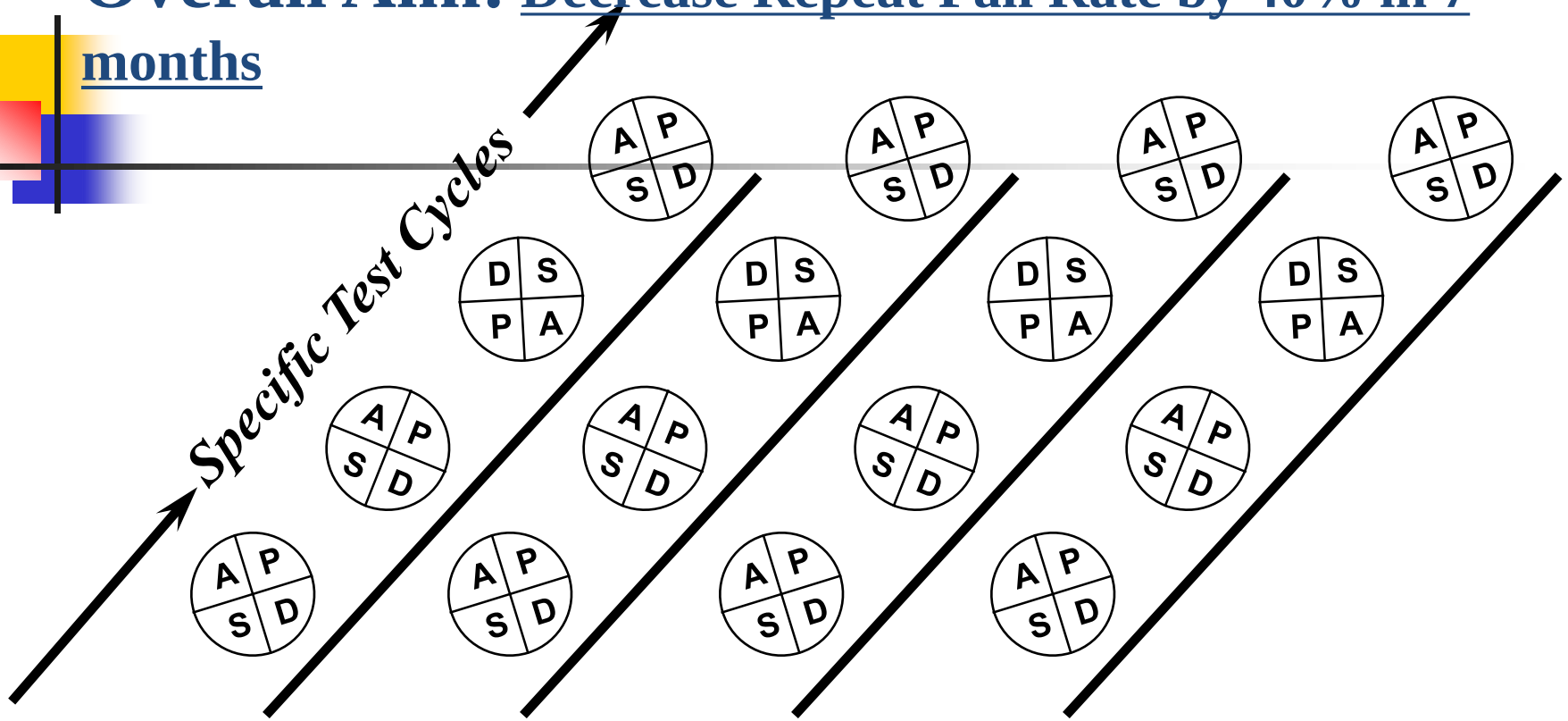
Talk About and Trend Root Causes

- Monitor Interventions for Mitigation/Elimination of Root Causes
- Align Interventions to Type of Falls

Precision In Program Evaluation: Reduction

- Accidental Falls
- Anticipated Physiological Falls
- UnAnticipated Physiological Falls

Overall Aim: Decrease Repeat Fall Rate by 40% in 7 months



Develop PFH protocol	Develop Knowledge of PFH – Nurse Managers then Staff	Case Studies Simulation.	Pilot Test PFH – One Unit – Decrease Barriers	Spread PFH

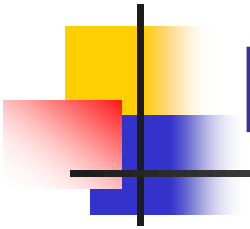
To Change Practice is Not for the Faint of Heart

It takes a lot of work: Patience, Perseverance, Champions, Positive Approach, and Data

Remember the Other Side of the Fall Rate Equation

Find Ways to Celebrate Success

Questions?



Discussion

- I hope this helps!
- Questions and Comments

You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com

Thank you!

If you have team members that would like to participate in future webinars they can **click here to register!**

If you have any questions please reach out to your IHA HIIN Team!