KHC HIIN Falls Sprint

A targeted focus among Kansas hospitals on preventing Falls with Injury

Session #4
January 24, 2019
10:00 to 11:00 a.m.

Welcome to the KHC HIIN Falls Sprint

- Our Goals
  - Create a learning community
  - Support ACTION!
    - Testing
    - Innovation
    - Sharing

2

Timeline

October 24	Introduction and kick-off webinar Introduction to Falls Discovery Tool, Creating a Culture of Mobility
November 30	Learnings from using Falls Discovery Tool, Develop AIM, Plan PDSA
December 13	PDSA Learnings and intro to Teach-back
January 24	**PDSA Learnings and intro to post-fall huddles**
February 28	PDSA Learnings and next steps
March 22	Wrap up and celebration!

KHC HIIN Falls Sprint 3

Measuring Success

Outcome:

- HIIN Falls with Injury Measure

Processes:

- Development of a SMART aim statement for preventing falls with injury
- Completion of monthly PDSA cycles
- Share a summary of your experience and learnings
  (Completion of brief summary template)

KHC HIIN Falls Sprint 4

Learnings and Observations

- Observations
  - Bedside handoff
  - Call lights
  - Bedside tripping hazards
  - Bedside delirium prevention
  - Post Fall Huddle
- Surprises?

5

PDSA

Cycle #1

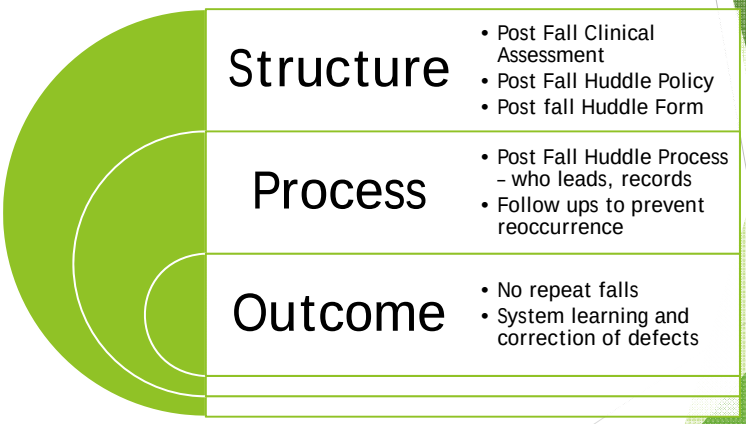
Hospital sharing

6


Intro to Post Fall Huddles
7


The aftermath of a fall
Embarrassment
Fear of Potential Serious Injury
Fear of personal, professional liability
Learning opportunity
Lots of available data
Patient
All staff on unit
Environment
Equipment
How do we learn in these conditions?
8

Post-fall huddle is a structured method to collect data and learn from the fall



9

Post Fall Clinical Assessment

- Assess before mobilizing
- Rapid Response Team
- Protocol for VS, Neuro checks for patients on anti-thrombotics or suspected head injury
- Communicate anti-thrombotics to provider when reporting fall
- Consider escalating unwitnessed falls, or falls with thromotics to admin on duty, supervisor

10

SAFE from FALLS 3.0

Audit Questions	Yes	No
Falls screening & assessment of fall AND injury risk factors		
1a) The organization requires, and has a designated place to document, screening of all patients for fall risk factors within 8 hours of admission for inpatients.	☐	☐
1b) The organization requires, and has a designated place to document, screening of all patients for injury risk factors (i.e., ABCs – Age; Bones; Coagulation; post-Surgical) within 8 hours of admission for inpatients.	☐	☐
Anticoagulants *(Increased injury risk for patients taking anti-coagulants)*		
2a) Inpatients on anticoagulants are identified within 4 hours of admission during the medication reconciliation process.	☐	☐
2b) Nursing falls screening also captures anticoagulant use as part of fall injury risk screening.	☐	☐
2c) Anticoagulation usage is flagged within the electronic medical record to increase awareness across providers and nursing staff.	☐	☐
2d) The care plan is reviewed for patients on anticoagulants to include interventions specific to anti-coagulant risk: • Patient is evaluated for discontinuation of anti-platelets by the provider • Patients are encouraged to wear shoes during ambulation versus slippers • Perform environmental checks to make sure any possible environmental hazards are mitigated (e.g., no sharp corners, reduce equipment/furniture by bed that patient could hit if they do fall, obstacles between bed and bathroom) • Institute "Within Arms Reach" with toileting and ambulation for all patients on anticoagulants • Video-monitored bed (if available) if meets following criteria: on anticoagulants; impulsive or confused; risk of falling • If video-monitoring is not available, evaluate for bed/chair alarms	☐	☐
2e) Patient and family education is provided outlining increased risk for injury for patients on blood thinners along with fall and injury prevention strategies and steps to take if the patient does fall.	☐	☐
Linking interventions to specific risk factors		

Safe From Falls Roadmap - Anticogualtion

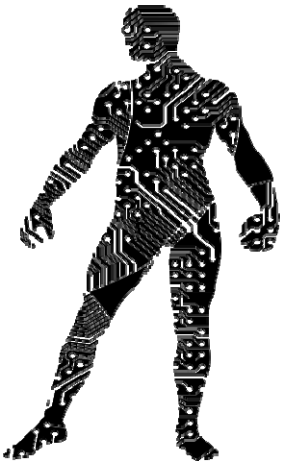
11

Learning from events *(Post-fall huddles)*		
A post-fall policy and process is in place that includes, at minimum: 4a) A fall with suspected injury to the head, or an unwitnessed fall, experienced by a patient taking anticoagulants is included as part of a Rapid Response Team or Rapid Response Process (if a fall was unwitnessed, it is assumed the patient hit their head).	☐	☐
4b) Vital signs and neurological checks are performed immediately post fall at the following intervals, at minimum: • q15 minutes x 2, then • q 30 minutes x2, then • q 1 hour x 4, then • q 4 hours for 24 hours • Re-evaluate the need for frequent monitoring after 24 hours.	☐	☐
4c) Changes in patient's status are reported promptly to the physician, especially if patient is on anticoagulants.	☐	☐
Safe environment *(Rounding; equipment such as video monitoring and alarms; room design)*		
5a) The organization has conducted an assessment of the bathroom, and pathways to the bathroom, identifying opportunities for reducing hazards.	☐	☐
5b) Environmental changes have been instituted in patient rooms and bathrooms to reduce hazards while in the bathroom or on the way to the bathroom.	☐	☐
5c) A process is in place for staff to perform fall prevention checks as part of their rounding process for every patient, which includes ensuring alarms are activated and working properly.	☐	☐

Safe From Falls Roadmap - Anticogualtion

12

Through the eyes of the patient



- Patients over-estimate their abilities and minimize their fall risk
- Patients over-estimate our ability to keep them safe
- Patients want privacy in the bathroom
- Patients respond positively to a nurses authentic caring and concern

13

Post Fall Huddle

- Huddle defined by Team STEPPS: an ad-hoc meeting to regain situational awareness, discuss critical issues and emerging events
- A post fall huddle is a brief meeting immediately after a fall that includes nursing staff caring for the patient and ideally, the patient.
- Useful to patient, family, the care team and administration

14

Purpose of a Post Fall Huddle

- Guide critical thinking
- Identify root cause
- Decrease risk of a recurrent fall
- Revise the plan of care
- Apply what is leaned to other patients and the system
- PLUS:
  - Improves teamwork and trust
  - Improves collaboration and coordination within the interprofessional team

15

Huddle Pitfalls

- Check-the-box approach – task orientation
- Blaming
- Critical Comments
- Unmanaged, challenging behaviors

16

Moving the Post Fall Huddles to the Bedside

Good Example of Post-Fall Huddle

Bad Example of Post-Fall Huddle

CAPTURE FALLS TOOLKIT

- Training videos and power point
- Forms
- Pocket Card
- CAPTURE Falls Website

17

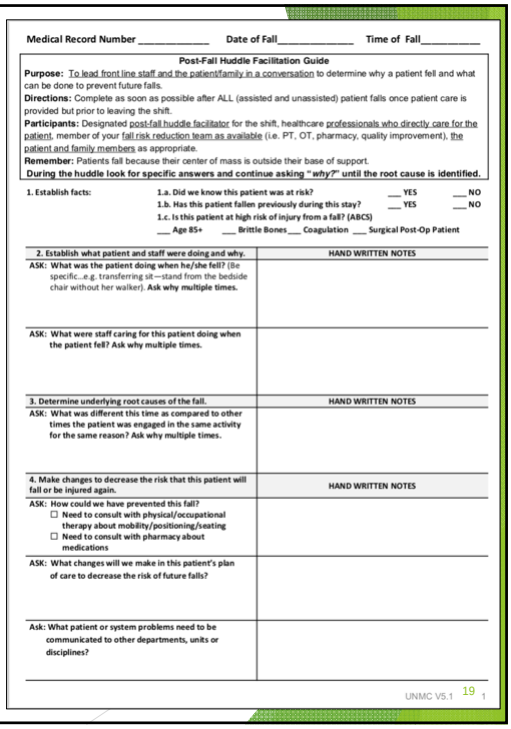
Post Fall Huddle How-To's

- Who leads: RN assigned to patient, charge RN, MD, Fall Team Member, Supervisor, Admin on Call
- Conduct ASAP by end of shift the latest
- Who must attend:
  - staff assigned to the patient
  - Ideally the patient unless this would overwhelm
- Other attendees
  - Everyone on the unit at the time
  - Rehab, Pharmacy, Physician
- Of care team members are not in house at the time of the fall conduct an interdisciplinary review within 24 hours

18

Post Fall Huddle Facilitation Guide

- What went right?
- What went wrong?
  - What was different this time?
- What almost went wrong?
- How do we do better next time?



Medical Record Number _____ Date of Fall_____ Time of Fall_____

Post-Fall Huddle Facilitation Guide

Purpose: To lead 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 as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.

Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly 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 center of mass 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:

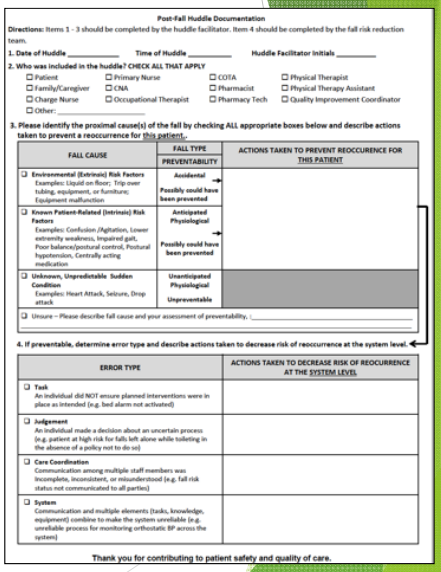
1.a. Did we know this patient was at risk? ___ YES ___ NO
1.b. Has this patient fallen previously during this stay? ___ YES ___ NO
1.c. Is this patient at high risk of injury from a fall? (ABCS)
___ Age 85+ ___ Brittle Bones ___ Coagulation ___ Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.	HAND WRITTEN NOTES
ASK: What was the patient doing when he/she fell? (Be specific...e.g. transferring sit→stand from the bedside chair without her walker). Ask why multiple times.	
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.	**HAND WRITTEN NOTES**
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.	**HAND WRITTEN NOTES**
ASK: How could we have prevented this fall? ☐ Need to consult with physical/occupational therapy about mobility/positioning/seating ☐ Need to consult with pharmacy about medications	
ASK: 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?	

UNMC V5.1 19

Determine Immediate Cause

- Environmental / Accidental
  - Trip over tubing, cord, threshold
  - Liquid on floor
- Anticipated Physiological
  - Confusion / agitation
  - Impaired gait
  - Poor balance
  - Postural hypotension
  - CNS medication
- Unanticipated Physiological
  - LOC



Post-Fall Huddle Documentation

Directions: Items 1 - 3 should be completed by the huddle facilitator. Item 4 should be completed by the fall risk reduction team.

1. Date of Huddle _____ Time of Huddle _____ Huddle Facilitator Initials _____

2. Who was included in the huddle? CHECK ALL THAT APPLY

☐ Patient ☐ Primary Nurse ☐ COTA ☐ Physical Therapist
☐ Family/Caregiver ☐ CNA ☐ Pharmacist ☐ Physical Therapy Assistant
☐ Charge Nurse ☐ Occupational Therapist ☐ Pharmacy Tech ☐ Quality Improvement Coordinator
☐ Other: _____

3. Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this patient.

FALL CAUSE	FALL TYPE PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
☐ Environmental (Extrinsic) Risk Factors Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	Accidental → Possibly could have been prevented	
☐ Known Patient-Related (Intrinsic) Risk Factors Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	Anticipated Physiological → Possibly could have been prevented	
☐ Unknown, Unpredictable Sudden Condition Examples: Heart Attack, Seizure, Drop attack	Unanticipated Physiological Unpreventable	
☐ Unsure – Please describe fall cause and your assessment of preventability.		

4. If preventable, determine error type and describe actions taken to decrease risk of reoccurrence at the system level.

ERROR TYPE	ACTIONS TAKEN TO DECREASE RISK OF REOCCURRENCE AT THE SYSTEM LEVEL
☐ Task An individual did NOT ensure planned interventions were in place as intended (e.g. bed alarm not activated)	
☐ Judgement An individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)	
☐ Care Coordination Communication among multiple staff members was incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)	
☐ System Communication and multiple elements (tasks, knowledge, equipment) combine to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)	

Thank you for contributing to patient safety and quality of care.

20

After the Huddle

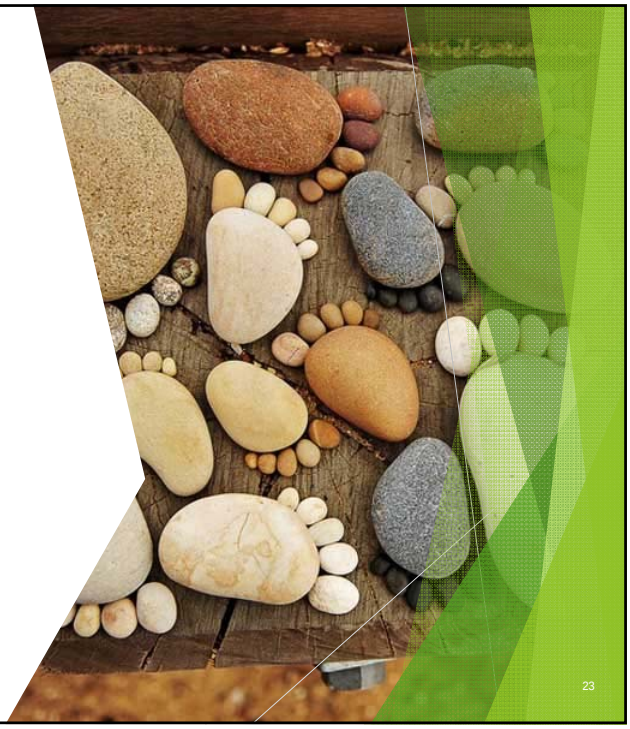
- Revise the plan of care
- Communicate revised plan of care
- Disseminate information about the fall and root cause
- Round on the patient to assess understanding of new plan of care
- Interdisciplinary huddle within 24 hours
  - Rehab
  - Pharmacy
  - Physician

21

Remember, Go Slow to Go Fast

22

Next Steps



- Submit your Next PDSA Cycle to Michele
- Observe a Post Fall Huddle
- Present your PDSA learnings at session February 28, 2019

23

Resources – future topics

Tools to Test:

- Post-fall huddle
  - CAPTURE Falls mobility training videos, mobility tools – includes Post Fall Huddle training videos and documentation tools

KHC HIIN Falls Sprint

24

Resources

Collaborative Tools:

- Monthly Virtual Learning Sessions
- List-serv
- Subject Matter Expert – Coach Jackie

Jackie Conrad, BSN, MBA
Improvement Advisor
Cynosure Health, Inc.
jconrad@cynosurehealth.org

KHC HIIN Falls Sprint

25