Welcome to the KHC HIIN Falls Sprint

*October 2018 - March 2019*

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

**Mobility**

**PFE**

**Post Fall Huddles**
Sprinters as of 2 p.m., Nov. 29

- Clara Barton Hospital
- Coffey County Hospital
- Ellsworth County Medical Center
- F.W. Huston Medical Center
- Greenwood County Hospital
- Hillsboro Community Hospital
- Hodgeman County Health Center
- Jewell County Hospital
- Lawrence Memorial Hospital
- Mitchell County Hospital Health Systems
- Norton County Hospital
- Osborne County Memorial Hospital
- Phillips County Hospital
- Rush County Memorial Hospital
- Saint John Hospital
- Scott County Hospital
- South Central Kansas Medical Center
- Sumner County Hospital District No. 1
- Washington County Hospital
- Wichita County Health Center
- William Newton Hospital

Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 24</td>
<td>Introduction and kick-off webinar</td>
</tr>
<tr>
<td></td>
<td>Introduction to Falls Discovery Tool, Creating a Culture of Mobility</td>
</tr>
<tr>
<td>November 30</td>
<td>Learnings from using Falls Discovery Tool, Develop AIM, Plan PDSA</td>
</tr>
<tr>
<td>December 13</td>
<td>PDSA Learnings and intro to Teach-back</td>
</tr>
<tr>
<td>January 24</td>
<td>PDSA Learnings and intro to post-fall huddles</td>
</tr>
<tr>
<td>February 28</td>
<td>PDSA Learnings and next steps</td>
</tr>
<tr>
<td>March 22</td>
<td>Wrap up and celebration!</td>
</tr>
</tbody>
</table>

KHC HIIN Falls Sprint
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)*

“Hopes” for the Falls Prevention Sprint

▶ Prevent/reduce falls
▶ We recently formed a multidisciplinary fall prevention process improvement team. The tools and resources offered by this initiative will be very valuable to this team and its success
▶ Prevent falls, education to nursing staff, improved processes.
▶ How to prevent falls in the future with our residents
▶ Hope to discover some interventions that will reduce falls on our senior behavioral health unit.
▶ I hope to, of course, reduce the number of falls in our facility. But, after the webinar, I also hope to reduce the amount of time patient’s are in our facility, and also hope to make it so they can return home, rather than have to go to long term care.
“Hopes” (cont’d)

- Better the process ‘post fall’ to ensure it is reported, additional prevention measures are put in place, etc.
- Learn fall prevention techniques for our assisted living facility.
- Help us update protocols and keep our patients/staff safer.
- We started a falls prevention team earlier this year and have struggled with progress. We are looking for new ideas and strategies to reduce our fall rate.
- Reduce falls in inpatient and swing bed settings.
- Benefit by learning new ways to help prevent falls and improve our overall patient safety and quality of care.

“Hopes” (cont’d)

- We hope to decrease falls, especially in our geriatric psych unit. I know they are a special population, but I hope to gain knowledge that can be used hospital-wide to reduce falls by at least 15%.
- Increasing patient safety through early mobilization. Switch staff focus from preventing falls to encouraging mobilization. Learn ways to implement processes that will decrease injuries to patients through falls.
- My hope is twofold. One, getting staff involved with participating in making changes and implementing changes. Second, add PT to the quality committee.
- Decrease amount of falls and promote safety.
- Our hospital hopes to benefit with this sprint to improve patient and family awareness of the risk of falls. Also hope to improve education of staff with proven ways of preventing falls. For me, I hope to gather information on how to be a better leader for this program and add to our current initiatives.
Hospital Bright Spot

- Hospital-wide approach - nursing, rehab, physicians, pharmacy
- Physician champion engaged
- Patient and family education on admission & ongoing
- Medication review built into EHR
- All departments created fall safety posters during patient safety week
- No pass zone

Top 10 Checklist

1. Multidisciplinary team with front lines
2. Engage all in safe environment & no pass zone
3. Multifactorial assessment on vulnerable populations
4. Tailored interventions
5. Communicate risk across the team
6. Round Q 2 H on vulnerable populations
7. Safe mobilization
8. Review medications
9. Engage patients and families, use teach-back
10. Conduct post-fall huddles at bedside with patient
Taking a closer look at home

Moving to Action...
Where are you starting?
Polling Question

Where is your unit / organization on the change continuum for your fall improvement efforts
1. Not thinking about it yet
2. We are evaluating if we need to change
3. We have decided that change is necessary
4. We are currently testing and implementing changes
5. We have made improvements and are sustaining
6. We have made improvements that were not sustained and have relapsed

Falls Process Improvement Discovery Tool

2 Methods - Chart Audit and Observations

- Chart Audit / RCA - Do this first
- Tracer Observations
  - Observe a post fall huddle
  - Observe a bedside handoff
  - Ask staff about toileting practices, observe call light
- Bedside Observations
  - Are delirium prevention strategies in place?
  - Are tripping hazards observed
  - Is toilet room safe?
**KHC Hospital Improvement Innovation Network**  
**Falls Prevention Sprint**  
**Session #2**  
**November 30, 2018**

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### PI DISCOVERY TOOL

**STEP 1**

Tab 1 - Chart audits on falls with injuries to identify gaps or opportunities.

5-10 charts

Opportunities to the right:

1. Elimination / toileting
2. Injury Risk
3. Medications
4. Mobility

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### KHC IIIN Falls Process Improvement Discovery Tool

**Chart 1**

*Injuries:* Do NOT spend more than 20-30 minutes per chart.

**Focus on Falls with Injury as priority:** use falls without injury if injuries are not available in past 12 months.

<table>
<thead>
<tr>
<th>Information about the fall with injury</th>
<th>Instructions: Enter brief characteristics for each chart.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature and severity of injury</td>
<td>discordance description</td>
</tr>
<tr>
<td>Was the fall unexpected?</td>
<td>No</td>
</tr>
<tr>
<td>Disambiguation reason for the fall</td>
<td>Discourage paper based chart, reduced mobility</td>
</tr>
<tr>
<td>Additional remarks</td>
<td>Falls occurring at night</td>
</tr>
</tbody>
</table>

**X = process failure**

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### Individualized Care Planning Processes

1. **Factors contributing to the fall:**
   - Patient fall-related medications that could contribute to deficit? (Dehydrated, hypotensive, anemia, anticoagulants. See Tab 3)
   - Patient did have unmarked sleep? (X)

**Factors that may have contributed to the fall and delirium:**

- X = valium given 1 hr prior to fall
- X = v. & I. given at 1:30 and 3:30 

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### Chart 2 - Fall Tracer Observations

**Chart 2**

- X = Time of fall
- X = Location of fall
- X = Time of the fall
- X = Date of the fall
- X = Location of the fall

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### Chart 3 - Delirium Inducing Drugs

**Chart 3**

- X = Time of fall
- X = Location of fall
- X = Time of the fall
- X = Date of the fall
- X = Location of the fall

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**Note:** Do NOT spend more than 20-30 minutes per chart.
Falls Process Improvement Discovery Tool:
Elements to be observed 3-5 times. Different staff, time of day, day of week.
Instructions: Mark an X in the box where a process failure occurred. You may check more than one box per
Observation #
<table>
<thead>
<tr>
<th>Process Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe a Post fall huddle: Do staff engage the patient in “what was different this time?”</td>
</tr>
<tr>
<td>Observe bedside handoff: Do staff engage the patient in their safe mobility plan for the day?</td>
</tr>
<tr>
<td>Observe bedside handoff: Do staff engage the patient in their safe mobility plan for the day?</td>
</tr>
<tr>
<td>Observe bedside handoff: Do staff engage the patient in their safe mobility plan for the day?</td>
</tr>
<tr>
<td>Failing and call lights: Are staff/nurse prepared for patient supervision in the toilet?</td>
</tr>
<tr>
<td>Tracer Observations are due 12/13</td>
</tr>
</tbody>
</table>

STEP 2
Tab 2 - Tracer Activity
3-5 Observations
1. Bedside handoff
2. Unit observations
3. Unit observations
4. Unit observations

You never know what you’re going to get
Smart Goals

- Specific
- Measurable
- Attainable
- Relevant / Realistic
- Time Framed

We will reduce injuries from falls from 3 a month to 2 or less a month on 3N by Feb 28, 2019.

Not So Smart Goals

- We will eliminate all preventable falls
- Will will achieve zero harm from falls
- We will reduce the fall rate from .06 to .03 / 1000 pt days
- We will show a reduction in our fall rate by 1/31/2019

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - Goal
  - Time Expectation
  - Where

  Outcome measure

*We will reduce our total monthly med surg falls with injury from the FY 2017 average of 6 per month to 3 per month on 6 West by March 31, 2018.*
Look Shallow or Deep?

Developing Change Ideas

<table>
<thead>
<tr>
<th>AIM</th>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
<th>CHANGE IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1b</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>2a</td>
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<td></td>
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<td></td>
<td>2b</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>3a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3b</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Developing Change Ideas

<table>
<thead>
<tr>
<th>AIM</th>
<th>PRIMARY DRIVERS</th>
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<th>CHANGE IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Injuries from Falls by 20% by end of Mar 31, 2018</td>
<td>Address Modifiable Risk Factors</td>
<td>Implement a screening tool that triggers assessment, interdisciplinary input to address risks</td>
<td>Avoid hypnotics/sedatives, anticholinergics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Screen for injury risk</td>
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<tr>
<td></td>
<td>Implement a safe mobility plan</td>
<td></td>
<td>Access mobility upon admission</td>
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<td></td>
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<td></td>
<td>Staff access to mobility equip 24/7</td>
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<td></td>
<td>Maintain a safe environment and path to toilet</td>
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<td></td>
<td></td>
<td></td>
<td>Mobilize patient at their highest level three times a day from day 1</td>
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<td></td>
<td></td>
<td></td>
<td>Communicate mobility plan to the team and the patient</td>
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<td></td>
<td></td>
<td>Document and track mobility activities</td>
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<tr>
<td></td>
<td>Engage the patient and family</td>
<td>Provide structured fall education using teach back</td>
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<tr>
<td></td>
<td></td>
<td>Conduct bedside handoffs with the patient and address mobility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conduct post fall handovers at bedside with the patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protect the patient from injury</td>
<td>Provide optimal post fall care – special care for blood thinners</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Provide appropriate level of supervision in toilet room for high injury risk patients</td>
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<tr>
<td></td>
<td></td>
<td>Implement floor mats for high injury risk patients</td>
<td></td>
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</tbody>
</table>

### 2018 Falls Change Package

- Interventions
  - **Interdisciplinary House-Wide Approach**
    - **Interventions**
      - Screen and assess for modifiable risk factors
      - Implement a screening tool that triggers assessment, interdisciplinary input to address risks
      - Address modifiable risk factors
      - Implement a safe mobility plan
      - Engage the patient and family
      - Protect the patient from injury
    - **Secondary Drivers**
      - Access mobility upon admission
      - Staff access to mobility equipment 24/7
      - Maintain a safe environment and path to toilet
      - Mobilize patient at their highest level three times a day from day 1
      - Communicate mobility plan to the team and the patient
      - Document and track mobility activities
    - **Change Ideas**
      - Reduce injuries from falls by 20% by end of Mar 31, 2018
      - Implement a safe mobility plan
      - Engage the patient and family
      - Protect the patient from injury

- **Learning Loop**
  - Big Gain
  - Post Fall Huddles

- **Identify High Risk, Vulnerable Populations**
  - Screen for history of falls or falls as reason for admission
  - Consider elders high risk
  - Screen for risk for injury using the ABCs

- **Assess and Implement Multifaceted Plan**
  - Multifaceted assessments – cognitive, mobility, urinary continence, frailty risk

- **Prevent Delirium and Functional Decline**
  - Progressive mobility
  - Avoid hypnotics/sedatives
  - Early recognition of risk to mobilization for unassisted falls
  - Special procedures for patients on blood thinners

- **Provide Optimal Post-Fall Care**
  - Interventions rounding hourly or every two hours
  - Arms length in the bathroom for vulnerable patients
  - 3 L (L) or Codes Surveillance
  - Engage patients and families

- **Engage Patients and Families**
  - At the Design – Public
  - Organizational Design

- **2018 Falls Change Package**
  - Implement floor mats for high injury risk patients
  - Provide appropriate level of supervision in toilet room for high injury risk patients
  - Conduct post fall huddles at bedside with patient

- **Overall**
  - Reduce injuries from falls by 20% by end of Mar 31, 2018
  - Implement a safe mobility plan
  - Engage the patient and family
  - Protect the patient from injury
  - Provide optimal post fall care – special care for blood thinners

Top 10 Checklist

1. Multidisciplinary team with front lines
2. Engage all in safe environment & no pass zone
3. Multifactorial assessment on vulnerable populations
4. Tailored interventions
5. Communicate risk across the team
6. Round Q 2 H on vulnerable populations
7. Safe mobilization
8. Review medications
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Implement mobility plans
- RN Assessment of mobility on admission
- MD orders for activity
- Up in Chair for meals
- Interdisciplinary mobility rounds
- Family training as mobility partners
- Sitters ambulate patients
- Gait belts in pt rooms

Tailored Care
- Test the Fall TIPS tool

Review medications
- Remove culprit medications from order sets
  - ie ambien – just do it
- Target high-risk population for pharmacist med review
- Target a drug class to evaluate ie benzos, sleeping aids

Conduct post-fall huddles
- Conduct immediately at bedside with patient & family
- Engage leadership in responding to fall and leading the huddle
- Include a pharmacist & rehab staff member in the post-fall huddle or case review

Communicate risk across the team
- Early shift huddle to discuss patients that staff are concerned about
- Charge nurse or manager rounding on high-risk patients
Selecting Change Ideas

<table>
<thead>
<tr>
<th>Idea</th>
<th>Can be accomplished in 90 days?</th>
<th>There is WILL to fix this problem?</th>
<th>Is within our control?</th>
<th>Is a sponsor for this work?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idea 1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Idea 2</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Idea 3</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Selecting Change Ideas

Select the Highest Impact / Lowest Effort Idea
Small Tests of Change
Rapid Cycle PDSA

Go Slow to Go Fast
Thinking Small

How can we target a small patient population

- Patients or residents
  - At risk for injury
  - Pts 65 or greater with > 5 medication
  - Pts 85 or older
  - Those who have fallen or admitted for fall

- Other examples: Drug class
  - Benzo’s and sleep aids?
  - Antidepressants or Antipsychotics?
Next Steps

- Write your aim statement
- Finish chart audits using process discovery tool
- Conduct tracer observations:
  - Post fall huddle
  - Bedside handoff
  - Bedside rounds for hazards and delirium prevention
  - Unit call light observation
- Identify ONE SMALL test of change

Resources

Tools to Test:

- HRET HIIN Falls Discovery Tool
- Progressive Mobility Tools
  - [Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool](#)
  - [Timed Get up and Go Test](#)
  - [Get Up and Go Test](#)
  - [Project HELP Mobility Change Package - multiple tools included](#)
  - [Med Surg Mobility Protocol](#)
  - [ICU Mobility Protocol](#)
Resources – future topics

Tools to Test:

• Patient Family Engagement Focused Tools
  • Teach Back Tool for Fall Prevention
  • Fall Tips for Patient and Families Handout

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

Register in advance for our four upcoming Sprint Events

All virtual Sprint events are from 10 to 11 a.m. CT

December 13, 2018

January 24, 2019

February 28, 2019

March 21, 2019
Resources

Collaborative Tools:

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

Jackie Conrad, BSN, MBA
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