Updated AHA HRET Falls and Fall Injury Change Package: 2018

Pat Quigley, PhD,MPH,APRN,CRRN,FAAN,FAANP
Nurse Consultant
Retired Associate Director, VISN 8 Patient Safety Center
Retired Associate Chief for Nursing Service/Research
E-Mail: pquigley1@tampabay.rr.com
Jan 4, 2019

Objectives

- Trend the continued and increased burden of hospital falls and injuries over a 5-year period, 2011-2016.
- Identify at least two change ideas to implement related to multifactorial care management, prevention of delirium and functional decline and post fall care, that reduce harm from falls for high risk vulnerable populations
- Gain valuable information and strategies to study data across time to determine effect of improvement efforts

PREVENTING HARM FROM INJURIES FROM FALLS AND IMMOBILITY
Sections

- Adverse Event Area (AEA) Definition and Scope
- Measurement
- Approaching Your AEA
- Conclusion and Action Planning
- Appendices
- References

Accessible: http://www.hret-hiin.org/

Change Package From 2017 to 2018

- New Change Ideas and Improvement Approaches designed to address barriers identified in the literature
- Epidemic of Immobility: Unintended consequence of fall reduction efforts
- Safe Mobilization: Repurposing roles and teams to support safe mobility
- Align Mobility and Delirium Prevention

Other Changes

- Leadership Engagement
- Expanding Team to Include Environmental Services: address slipping and tripping hazards
- Target High-Risk or Vulnerable Populations to test new changes as strategies to avoid intervention fatigue
- Patient Family Engagement (Whiteboards; Post Fall Learning; new patient-focused resources)
Part 1: Adverse Event Area: Definition and Scope

- Falls affect 700,000 and 1,000,000,000 patients each year
- Ranked among the most reported incidents in hospitals and other facilities
- Falls can lead to severe injuries, hip fractures and head trauma
- Significant cause of hospital-acquired injury
  - 3-20% of patients all at least once in hospital stay
  - 6-44% of injuries may lead to death

Progress 2011-2014

- From 2013 - 2014, the Agency for Healthcare Research and Quality (AHRQ) reduced falls with or without injury by 27 percent. This equates to 1,331 harms prevented and a cost savings of $882,453.

Progress 2015-2016

- From 2015 - 2016, the Agency for Healthcare Research and Quality (AHRQ) reduced falls with injury by three percent. This equates to 1,409 harms prevented and a cost savings of $18,265,000.
Progress Reducing Falls and Injuries

- Incredibly Slow!
  - Think of the Burden: Personal, Social, Economic
  - One fall without serious injury costs a hospital an additional $3500
  - Patients with more than two falls without serious injury costs hospital $16,500
  - Falls with serious injury costs hospitals an additional $27,000

Part 2: Measurement: First Set Goals

- Track Your Progress toward Improvement
- Collect Monthly Data Points to Guide Your QI Efforts as part of PDSA
- Study Data Across Time
- Determine effect of improvement strategies on reducing patient harm
- Data allow you to aggregate, analyze and report progress toward goals

Nationally Recognized Process Measure Examples

- % of Pts 65 and older with balance or walking problems, or with a fall in the last 12 months, who were seen by a practitioner in the past 12 months – discussed falls or balance AND received an intervention
- % of Patients 65 and older who were screened at least once within 12 months (for fall risk), or with a history of fall who had a plan of care for falls documented and a risk assessment for falls documented within 12 months

(NOF 0101; National Committee for Quality Assurance; Falls: Screening, Assessment and Care Planning)
Part 3: Approaching Your Area: Investigate Your Problem and Implement Best Practices

Suggested Bundles and Toolkits

- AHA HRET Tools (What to start doing to start improving)
- AHRQ Preventing Falls in Hospitals
- DVA Falls Prevention Toolkit
- HELP (Hospital Elder Life Program) Delirium Assessment, Prevention and Management Tools
- IHI TCAB: Reducing Patient Injuries from Falls
- And more........

Drivers in the Change Package

Prevent Harm from Falls
Preventing Harm from Falls

### Primary Driver (PD) 1: Interdisciplinary, House-wide Approach
Organizational support for making falls injury prevention a highly prioritized, well-publicized organizational aim that touches all disciplines and departments: Leadership Engagement

### Secondary Driver (SD) 1: Interdisciplinary Team to Oversee Strategic Plan for Fall Injury Prevention Program

### Actions
- Interdisciplinary discussion of patient falls risk during daily rounds
- Medication review for all patients at risk for injury and/or risk for falls
- Nurse Rounds to include reinforcement of education re: patient-family’s role in falls risk prevention
- Implementation of interdisciplinary post-fall huddle to discuss action plan after patient fall event
Change Ideas: examples......

- Assess effectiveness of current team and change membership and/or leadership to bring fresh ideas
- Reinvent the team if needed. Change focus from "Fall Prevention" to "Safe Mobility" and integrate Safe Mobility into Safe Patient Handling
- Utilize Unit Based Champions for local accountability
- Safe Environment Checks and Opportunity to catch hazards; clutter rounds
And much more........

Ex of Process Measures for Your Test of Changes

- % of Environmental Rounds completed within the organization
- # of Hazards discovered and CORRECTED on environmental Rounds

Secondary Driver (SD) 2: Leadership Ensures that the Environment is Safe

- Engage all levels of staff and disciplines in monitoring the environment for slipping and tripping hazards
- Review your facility design for potential improvements in preventing toileting related falls (refers to Minnesota Hosp Assoc report “Creating a safe environment to prevent toileting related falls”
Change Ideas: Examples

- Create expectations that PTs and Pharmacists discuss their recommendations with the nurse to facilitate timely implementation.
- Institute a "No Pass Zone"
- Use CAPTURE Falls Tools to support interdisciplinary safe mobility activities

Suggested Process Measure

- % of Patients with documentation of interdisciplinary plan of care for fall prevention
- Hardwire the Process: To hardwire the interdisciplinary teamwork and collaboration, it must be embraced by leadership

PD 2: Create Structures for Hospital-wide Learning Loops

Organizational leadership supports systems that promote learning, ongoing evaluation and improvement of falls prevention program including analysis of fall and injuries rates and evaluations of effectiveness of interventions applied to those screened at risk

- Big Data
- Post Fall Huddles
SD1: Use Big Data to inform the organization or unit’s fall improvement strategy

- Analyze data for trends to determine patient, environmental and other factors that are associated with injurious falls to inform improvement activities
- Drill down on circumstances surrounding unwitnessed falls to uncover system failures.
- Do NOT categorize an assisted fall without injury as a care failure as this may impact staff’s willingness to pro-actively mobilize patients

Change Ideas: Exs

- Use trended data to dispel myths or confirm theories about who is falling, when, where and why
- Identify fall characteristics to identify who is falling, environmental and patient factors contributing. Use this data to inform tests of change.
- Drill down on unwitnessed falls as a system failure.
- Share trended data with leadership, staff, pts and visitors.

Suggested Process Measures

- % of nursing units with current falls data analyzed
- % of leadership meetings in which falls data are shared
SD2: Conduct Immediate Post-Fall Huddles at the Patient Bedside

Exs of Change Ideas:
- Use a falls resource team or administrator on call to respond to support post fall huddles
- Conduct huddle immediately at the bedside – treat the environment as a “crime scene” and look for equipment and environmental factors before moving any thing in the room.
- Conduct weekly systems fall reviews to share falls circumstances and learnings across units

Suggested Process Measure
- % of falls that had a post-fall huddle completed with the patient within one hour of the fall
- Hardwire: Leadership supports learning from falls through event review and post fall huddles by allocation of resources to support staff and be being actively engaged in the learning

PD3: Identifying High Risk, Vulnerable Patients and Populations
- Screen for history of falls, or falls as reason for admit
- Consider elders high risk
- Screen for risk of injury using the A, B, C, S
Secondary Drivers and Change Ideas Exs

1. Identify patients admitted for a fall or with a hx of falls and apply special interventions
   - Interview Family to obtain history
   - Record Known Faller on EMR Banner
   - Start small... Conduct Multifactorial Fall Risk Assessment on Pt admitted with injuries from a fall or repeat faller
   Process Measure: % of these patients that receive special interventions

Secondary Drivers and Change Ideas Exs

   - Review aggregated data of injurious falls
   - Evaluate effectiveness of your current fall risk assessment tool and workflow process as impetus to change
   Process Measure: % of high risk or vulnerable pts who undergo multifactorial assessment

Secondary Drivers and Change Ideas Exs

3. Screen for Risk for Injury using the A, B, C, S Criteria
   - During Shift Huddle, review which pts are at high risk for injury from a fall so all staff are aware of these highest-risk pts
   - Use A, B, C, S at beginning of each shift to identify those patients at highest risk for injury from a fall
   - Assess for treatment of osteoporosis and vit D deficiency and provide supplemental Vit D
   Process Measure: % of Pts with risk for injury assessment completed within 24 hrs of admission
Secondary Drivers and Change Ideas Exs

4. Communicate Risk Across the Care Team and Across Disciplines (Communication failure is a common contributing factor to fall-related sentinel events)
   - Standardized visual cues for high fall and injury risk to all care team members
   - Standardized handoff communication tools
   - Incorporate alerts in EMR

Process Measure: % of handoff communications with discussion of pts’ fall risk as observed or documented

PD4: Implement Multifactorial Interventions to Reduce Risk of Falling or Injury

SD1: Universal fall precautions aim to prevent environmental and/or accidental falls (includes Teach Back)
SD2: Implement Multifactorial Interventions to Reduce Risk of Fall or Injury (refers to AGS guidelines: meds, tailored exercise, manage postural hypotension, manage heart rate and rhythm abnormalities; does not cite or recognize bundles for A,B,C,S)

Change Ideas exs:

- Determine criteria for and process for completion of multifactorial assessment and plan.
- Develop multifactorial fall risk assessment and care planning documentation tool to guide clinicians in decision making and documentation.
- Engage physicians in collecting assessment data to determine risk factors that can be minimized.
PD5: Prevent Delirium and Functional Decline in Vulnerable Populations

- SD1: Provide Progressive Mobility
  - Appoint unit mobility champion
  - Educate all nursing staff on safe mobilization; integrate with safe patient handling education
  - Promote "Up on heels for meals"; Day or street clothes
  - Review mobility in interdisciplinary rounds
  - Train sitters to safely ambulate patients to promote mobility and prevent delirium
  - Provide gait belts at bedside of every pt requiring assistance
  - Provide appropriate footwear (not slipper socks)

SD2: Avoid Meds that Affect CNS

Follow 2015 Beers Criteria for sedatives and hypnotics
Change Idea Exs:
Flag vulnerable patients for review of their medications by Pharmacist.
Remove high risk meds from standing orders
Ask pharmacist to recommend alternative ton meds that may increase fall risk.

PD6: Provide Optimal Post-Fall Care to Minimize Injury

- SD1: Assess for Injury Prior to Mobilizing the Pt after an unwitnessed fall
  - Protocols for vs and neurochecks for pts on anti-thrombotics or with suspected head injury
  - Communicate pt's injury risk factors to all members of the team
- SD2: Provide Special post-Fall Care on Patients on Blood Thinners
PD7: Provide Appropriate Level of Surveillance/Observation

Nurses should use their clinical judgment to determine the level of monitoring required to maintain patient safety and monitor for changes in condition.

- **SD1.** Intentional Rounding Hourly or Every Two Hours
- **SD2.** Keep Vulnerable Patients at Arms length when on toilet
- **SD3.** Increase Intensity and Frequency of Observation 1:1 or video surveillance w/ monitor tech that can speak to the patient and alert staff to assist a pt quickly

PD8: Engage Patients and Families in Design and Implementation of Fall Injury Prevention Activities

- **SD1:** Engage patient family advisors in designing strategies to reduce injurious falls
- **SD2:** Engage patients and caregivers in fall safety at the bedside
  - Fall Safety Tips
  - Hand-off
  - Teach Back
- **SD3:** Organizational Design

Your Turn: What Will You Do Next?

Identify at least two change ideas to implement related to:

- multifactorial care management,
- prevention of delirium and functional decline and post fall care
- To reduce harm from falls for high risk vulnerable populations
Resources

- So Many!
- Facing the Facts about Falls in Hospitals
- What to Stop to Start Improving
- Myth Busters
- Me! pquigley1@tampabay.rr.com

VA’s Contributions

Moving Away from Fall Risk Score
Adding Injury Risk to Care Management
Protection from Injurious Falls
Focus on Vulnerable Populations (A, B, C, S) and the bundled interventions by population
Patient Engagement
Implementation Science (PDSA)
Quality Improvement and Program Evaluation

Together We Accomplish More we accomplish more!