COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Enhancing Capacity: Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability

Compass, Telligen, IPRO and Alliant

Joint Hospital Quality Improvement Contract (HQIC) Learning and Action Network

June 27, 2023

We will get started shortly!

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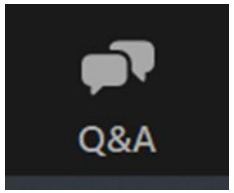
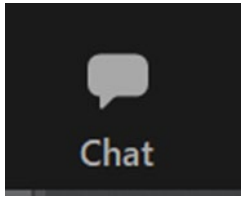
Housekeeping

- Lines have been muted upon entry to reduce background noise
- We encourage you to ask questions for the presenter(s) throughout the event using the Q&A feature



- Please direct technical needs and questions to the Chat Box



- This event is being recorded

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Agenda

- Welcome and Introductions
- Enhancing Capacity: Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability
- Q&A
- Tools and Resources
- Upcoming Events

Presenter

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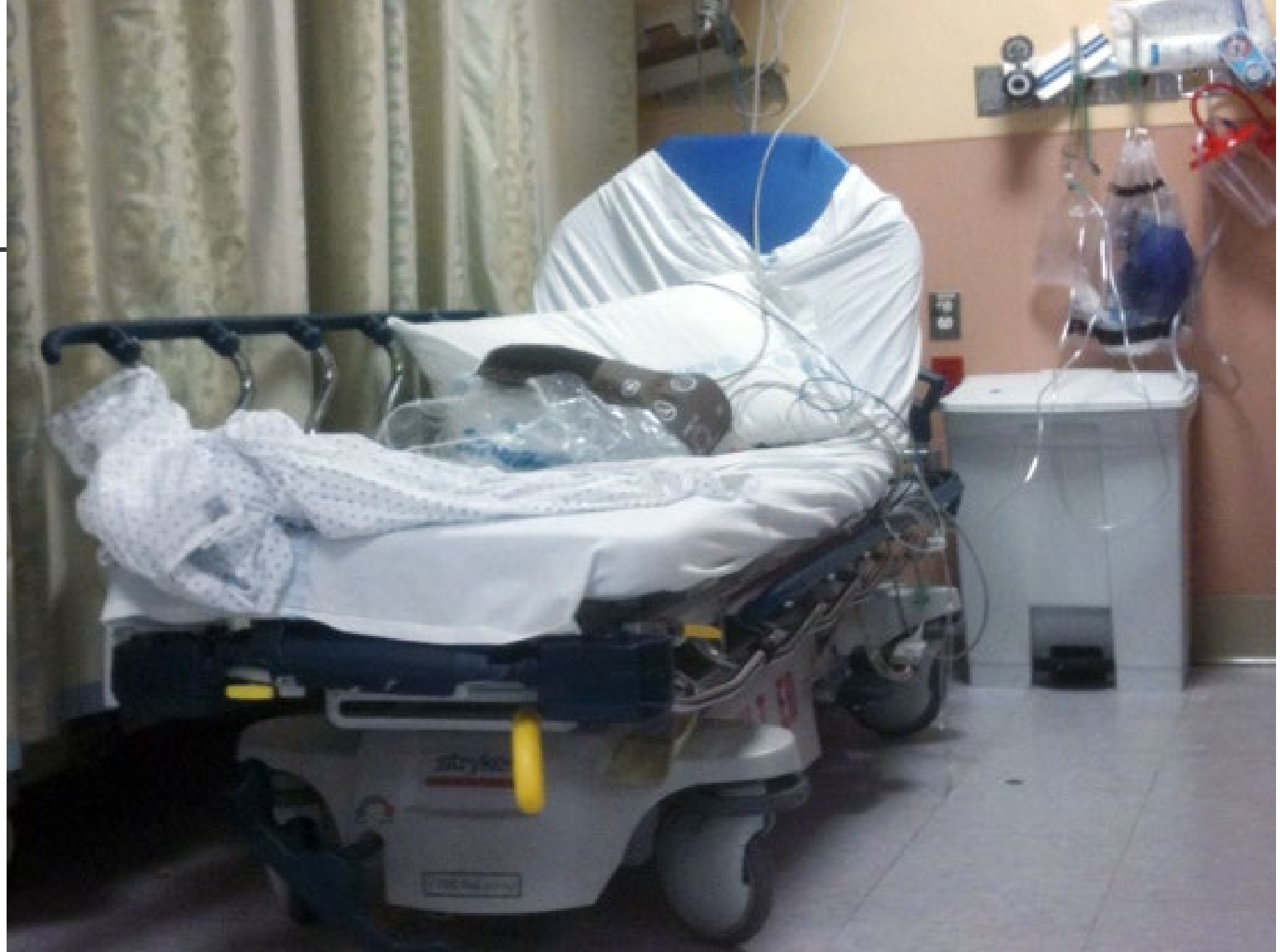
Objectives

- Integrate program evaluation and implementation science
- Discuss essential elements and guidelines for fall and injury prevention programs
- Examine expected fall and fall injury program attributes
- Identify opportunities to enhance fall and fall with injury prevention program infrastructure, capacity and how to sustain improvements



National Guidelines: Shifting

- Reduce Individual Fall and Injury Risk Factors (Individualized Care)
- Integrate Injury Risk /History on Admission
- Implement Universal Injury Reduction Strategies
- Implement Population-Specific Fall Injury Reduction Intervention
- Reduce Harm from Falls

Sept 28, 2015: The Joint Commission (TJC) #55 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, assess fall 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

Program Evaluation Process

- Process by which individuals work together to improve systems and processes with the intention to improve outcomes.*

*Committee on Assessing the System for Protecting Human Research Participants. *Responsible Research: A Systems Approach to Protecting Research Participants.* Washington, D.C.: The National Academies Press: 2002.

Program Effectiveness: Fall Prevention

- Organizational Level: expert interdisciplinary all team, population-specific fall prevention, leadership, environmental safety, safe patient equipment, post fall huddles
- Unit Level: education, communication-handoff, universal and population-based fall-prevention approaches
- Patient Level: exercise, medication modification, orthostasis management, assistive mobility aides

Program Effectiveness: Protection from Serious Injury

- Organizational Level: available helmets, hip protectors, floor mats, height adjustable beds; elimination of sharp edges
- Staff Level: education, adherence, communication-handoff includes risk for injury
- Patient Level: adherence with hip protector use, helmet use, etc.

Evaluations Methods

- Prevalence Studies
- Formative and Summative Evaluation Methods
  - Type of Falls
  - Severity of Injury
    - How are you assessing for injury? Duration? Extent of Injury?
  - Repeat Falls
  - Survival Analysis
  - Annotated Run Charts

Reconsider Overall Falls as Outcome

- If focus on falls, measure preventable falls
- Otherwise, measure effectiveness of interventions to mitigate or eliminate fall risk factors (remember Oliver article, recommendation 2 and 3): Number (and type) of modifiable fall risk factors modified or eliminated upon discharge.

Nationally Adopted Interventions to Reduce Preventable Falls and Fall-related Injuries

- Identify and address each patient's specific fall and injury risk factors (Lelaurin & Shorr, 2019)
- Integrate new systems and devices (webcams, video telesitter technology) that better predict and prevent falls than bed alarms (Lelaurin, et al; Quigley, et al, 2019)
- System-based interventions work: Toileting (i.e. wake em, take em; timed toileting; assist in and out of bed) (Resnick & Boltz, 2019)

Nationally Adopted Interventions to Reduce Preventable Falls and Fall-related Injuries

- Interventions to increase physical activity (motivate and engage patients in activity) increase function and mobility (Resnick & Boltz, 2019)
- Function-focused care – increases physical activity (Resnick & Boltz)
- Frequent medical review minimizes the effects of treatments (ACE units; Acute Care for Elders) (Resnick & Boltz)

So… let's get STARTED!

The Evidence supports Opportunities to enhance fall and fall with injury prevention program infrastructure

- What will you do to ***Change Practice***?

That's Implementation Science

- Focus on Risk Factors
- Focus on Preventing Injury
- Learn from Falls
- Partner with Patients and Family Members

Focus on Identifying Risk Factors and Activating Interventions to Address Each Risk Factor

- Medication Review
- Urinary catheter or IV discontinuation ASAP
- Mobility aids and assistance with walking
- Scheduled toileting
- Appropriate footwear
- More frequent rounding
- Patient engagement in identifying risks, consequences of a fall and needed safety interventions

Focus on Identifying Risk Factors and Activating Interventions to Address Each Risk Factor

- Identify high risk or vulnerable populations to conduct a multifactorial assessment
  - Patients admitted for a fall
  - High risk for injury – A,B,C,S
  - Known faller
- Complete 65 and older, pre-mobility admission mobility assessment
- Capture known faller status to EMR banner

Focus on Preventing Injuries from Falls

- Use A,B,C,S to screen for populations at injury risk
- Use floor mats, hip protectors, helmets
- Assess and mitigate unsafe environmental hazards: thresholds, sharp edges, hard surfaces, water on floors

Focus on Learning From and Preventing UNASSISTED Falls

- Establish criteria for toileting supervision: arms length, foot in the door, help staff stay on task
- Provide more frequent, purposeful rounding for patients high risk for fall or injury
- Schedule toileting for patients needing assistance ambulating to the toilet. Toilet before pain meds, at bedtime. “I have the time”

Partner with Family Members in the Safety of their Loved One

- Assure family attendance in bedside handoffs
- Structure family education with teach back
- Use teach back for fall safety
- Provide structured education by a designated staff

Opportunities to enhance fall and fall with injury prevention program infrastructure and capacity

- Select a Model
- Set Goals
- Conduct Baseline Assessment
- Identify Gap between what is expected and what exists in practice
- Prioritize opportunities for improvement
- Develop a Strategic Plan
- Develop Implementation Plan
- Determine Feasibility: Continue or Terminate
- To continue, develop strategies for sustainability and enculturation
- Celebrate Success

Let’s Look at Opportunities

- See the Organizational Assessment Tool
- Find 3 Opportunities

Set Goals

- Reduce Preventable Falls by 50% in 1 year
  - Accidental
  - Anticipated Physiological Falls
- Reduce Fall Related Injuries by 60% in 1 year
- 100% completion of post fall huddles in 4 months

Align Interventions to Goals

- Reduce Preventable Falls
  - Accidental Falls
  - Anticipated Physiological Falls
- Reduce Injurious Falls

Preparation Phase

- Assess effectiveness of current team and change membership and/or leadership to bring fresh ideas
- Reinvent the team if needed.
- Select Unit Based Champions for local accountability
- Safe Environment Checks and Opportunity to catch hazards; clutter rounds
- Determine Data to be collected and data collection and analysis tools

And much more……

Data is Essential

- 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.
- Share trended data with leadership, staff, pts and visitors.

Accidental Falls Due to Falls from Low Beds

- Structure Goal: Develop a Safe Bed Program (Height Adjustable Beds, Safe Exit Side, Concave Mattresses)
- Outcome Goal: Reduce Bed-related Patient Falls by 70 % on rehab unit within 1 year
- Set up your Task Force/Work Group

Anticipated Physiological Falls due to Postural Hypotension

- Structural Goal: Implement a Postural Hypotension Program (P&P, EMR Templates; pt assessment and care management) by 5 months
- Outcome Goal: Reduce falls due to OH by 80% in 1 year
- Set up your Task Force/Work Group

Reduce Injurious Falls from Bed

- Structure Goal: Implement a Floor Mat Program (product selection, pilot test, P&P Development, EMR Template, Staff Education, Patient Education) by 6 months
- Outcome Goal: Within 1 year, 90% of patients who fall from beds will fall on a floor mat
- Set up your Task Force/Work Group

Implement the Post Fall Huddle

- Structure Goal: PFH Processes implemented in P&P, education program, and QI
- Outcome Goal: Within 4 months, 100% of patients who fall from beds will fall on a floor mat
- Set up your Task Force

Create action plan while sharing with peers on how to overcome barriers and achieve successes.

- Develop 3 Opportunities for Your Action

Falls Strategic Plan: Integration Timeline

Last Updated Aug 2021	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20
Pre-Design Phase (~ 1 month)										
Task Force Co-Chairs meet, develop initial plans										
Create integrated Charter, measures, & communications										
Design Phase (~ 2 months)										
Assess interventions, resources, & requirements										
Falls Collaborative Kickoff 2-10-2022 2pm EST										
Implementation Phase (~ 4 months)										
Monthly integrated Collaborative meetings										
TF Co-Chairs begin to implement selected interventions										
Sustain & Improve										
Transition active work, ready for next implementation cycle										

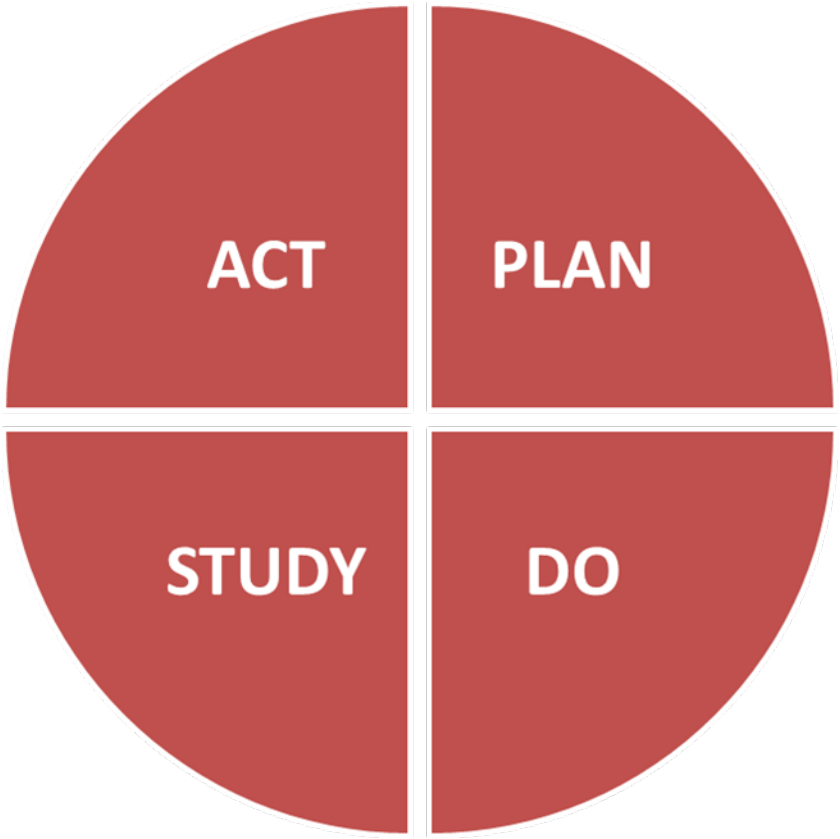
Measuring the Change

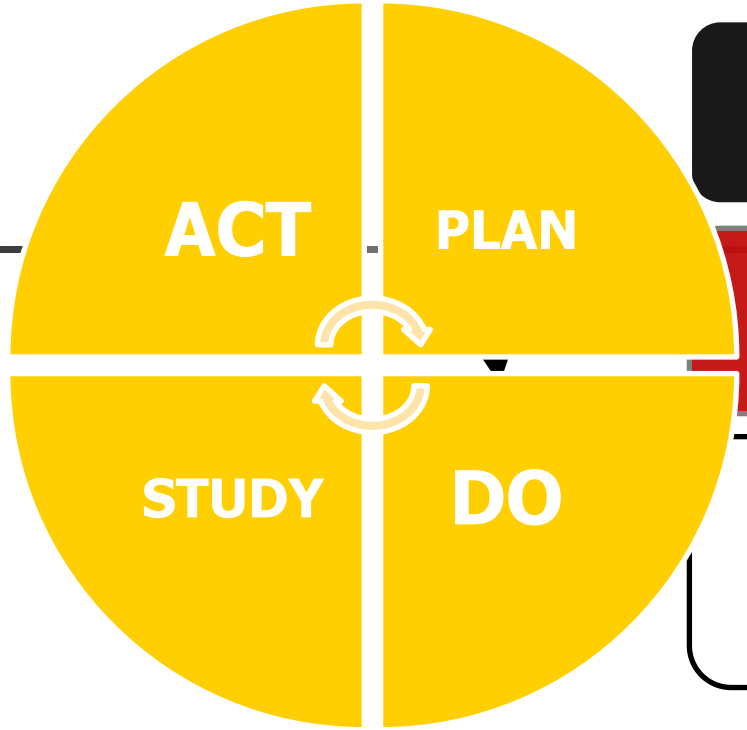
- Patient focus?
- Aim?
- Find a measure that captures that change?
  - How to measure process changes?
  - How to measure outcomes?
  - Chart review, Medical tests, interviews, behavioral change, questionnaire, phone calls.

Align Interventions to Goals

- Reduce Preventable Falls
  - Accidental Falls
  - Anticipated Physiological Falls
- Reduce Injurious Falls

PDSA CYCLE





What are we trying to accomplish?

How will we know that a change is an improvement?

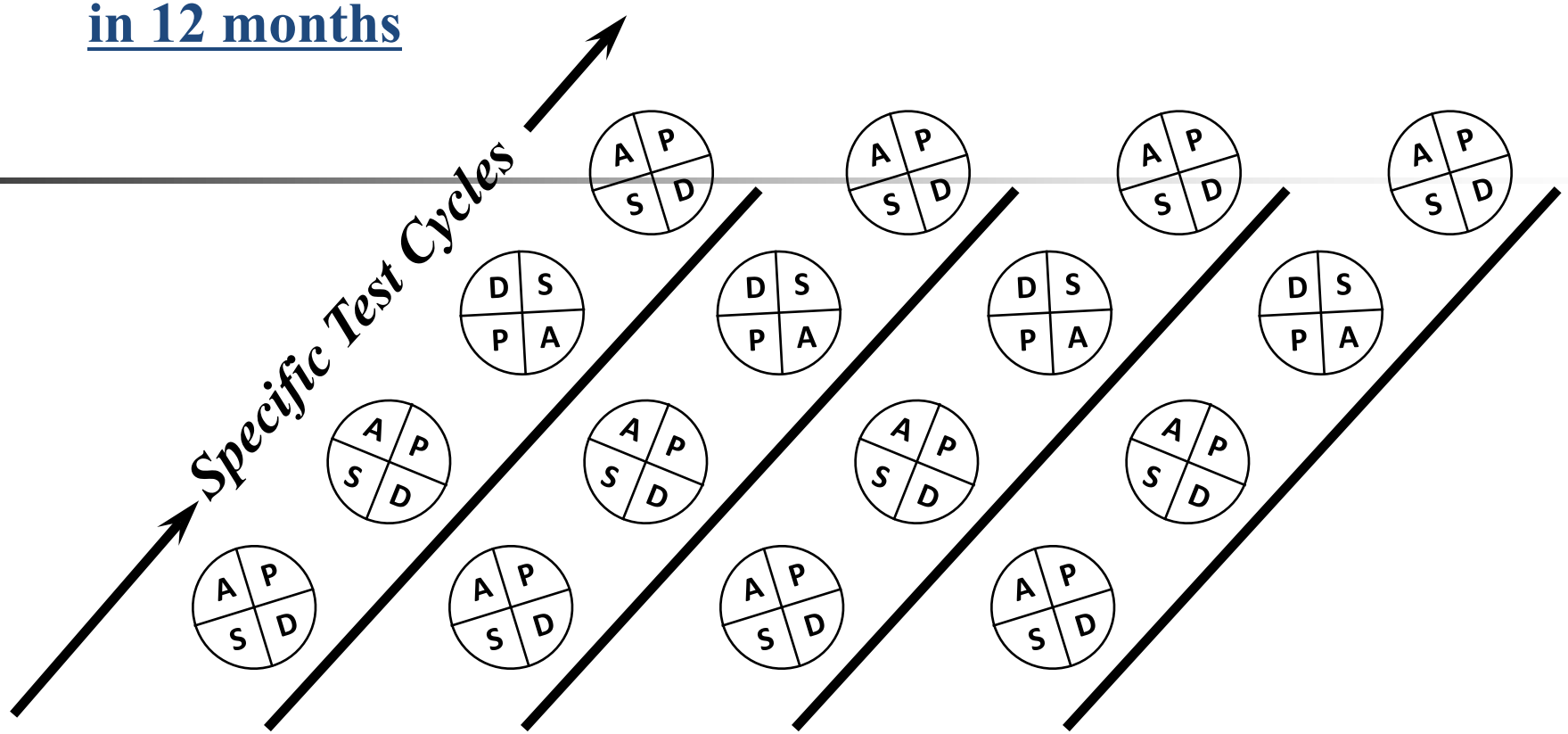
What change can we make that will result in improvement?

A Model for Improvement

Testing on a Small Scale

- Have others that have some knowledge about the change review and comment on its feasibility.
- Test the change on the members of the team that helped developed it before introducing the change to others.
- Conduct the test in one facility or office in the organization, or with one patient.
- Conduct the test over a short time period.
- Test the change on a small group of volunteers.

Overall Aim: Decrease Preventable Falls Rate by 50% in 12 months



Develop assess. protocol

Develop Knowledge of falls

Develop Envron.-mental Assess.

Develop specific interventions for fallers

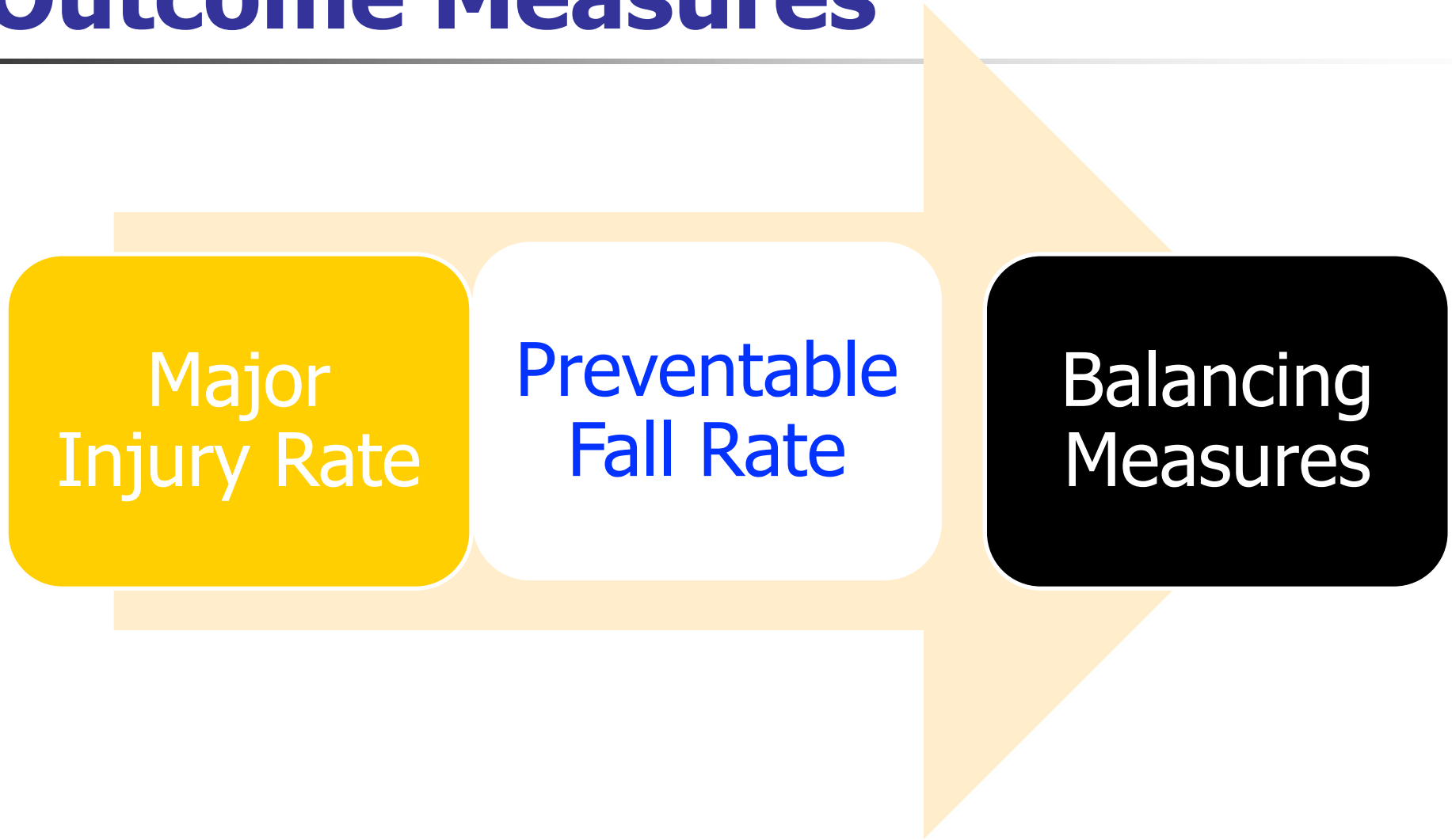
Staff and Patient Education

Examples of Process Measures

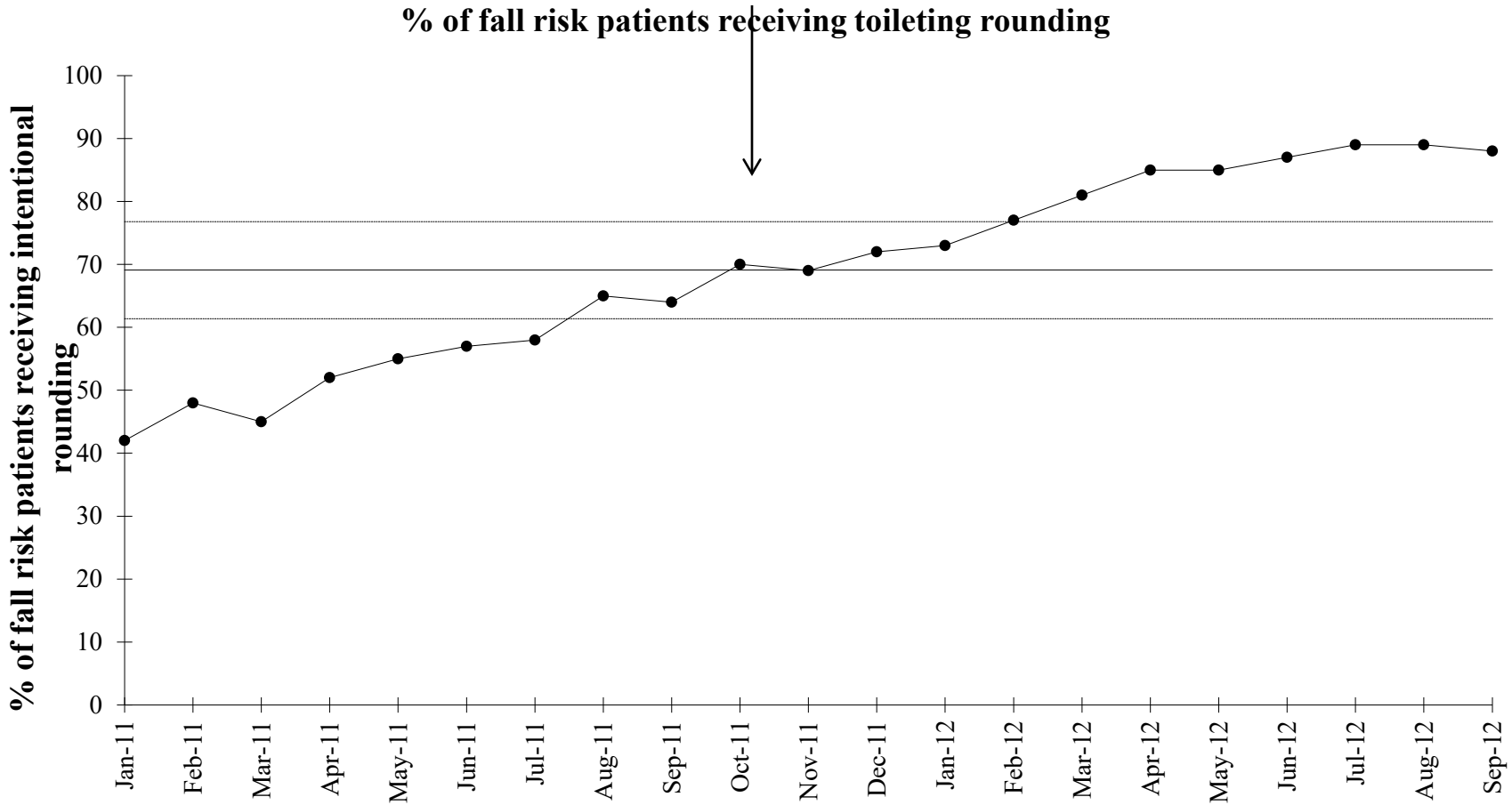
Percentage of:

- Patients at risk for falls and fall related injuries with interventions in place
- Patients ≥65 with orthostatic hypotension (OH) assessed before ambulation
- Observation, chart review

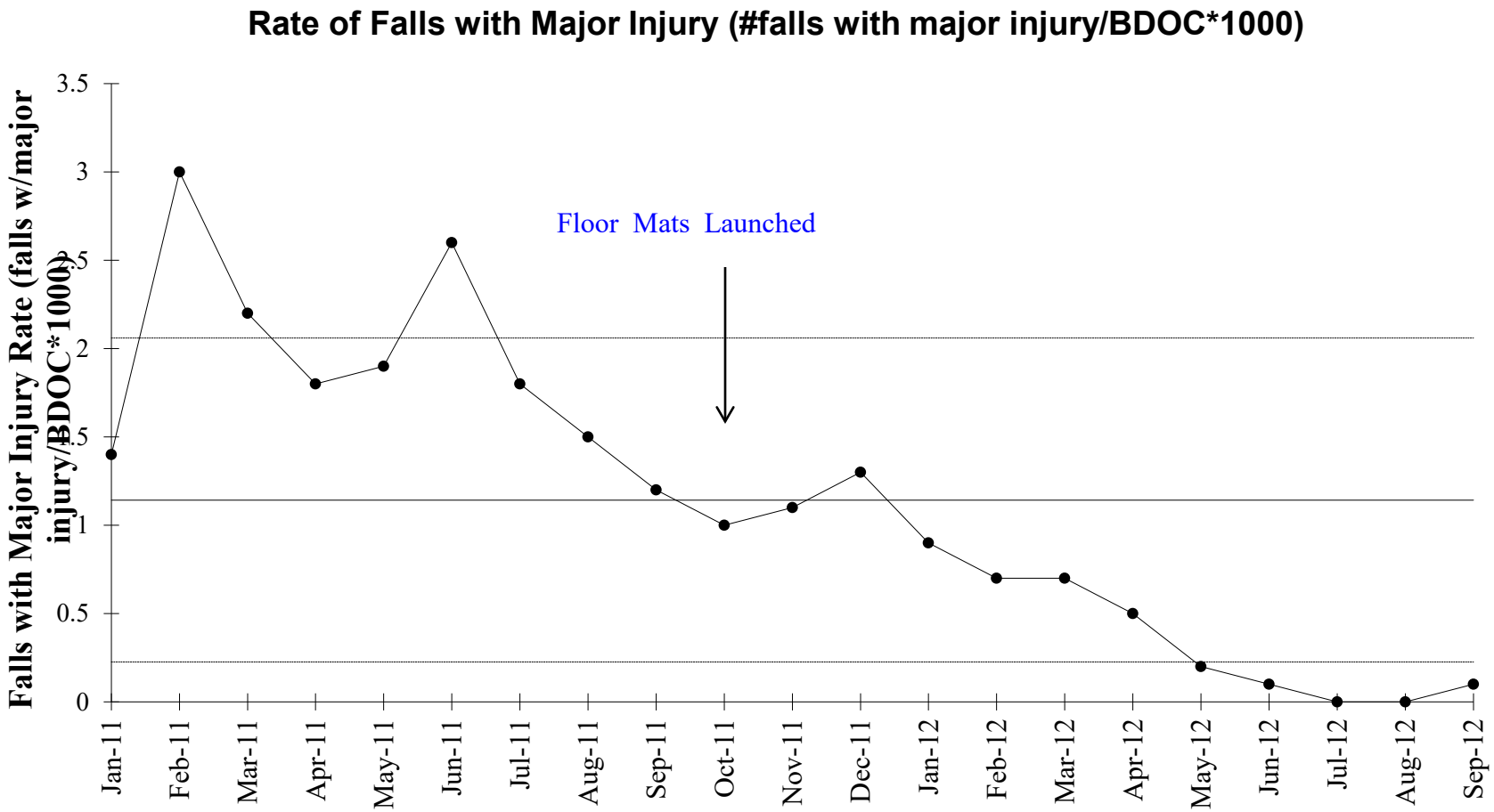
Outcome Measures



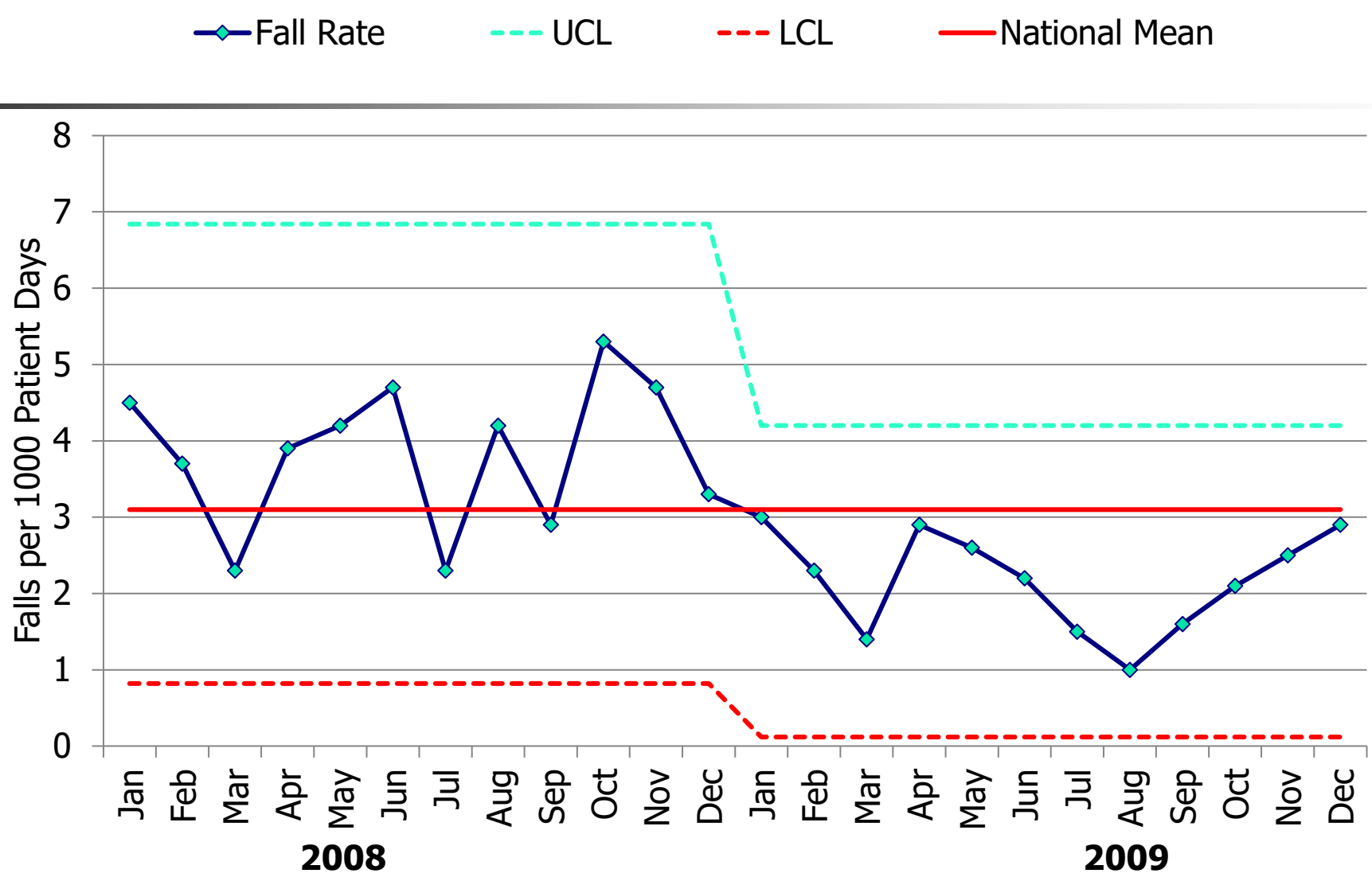
Example of **Process** run chart



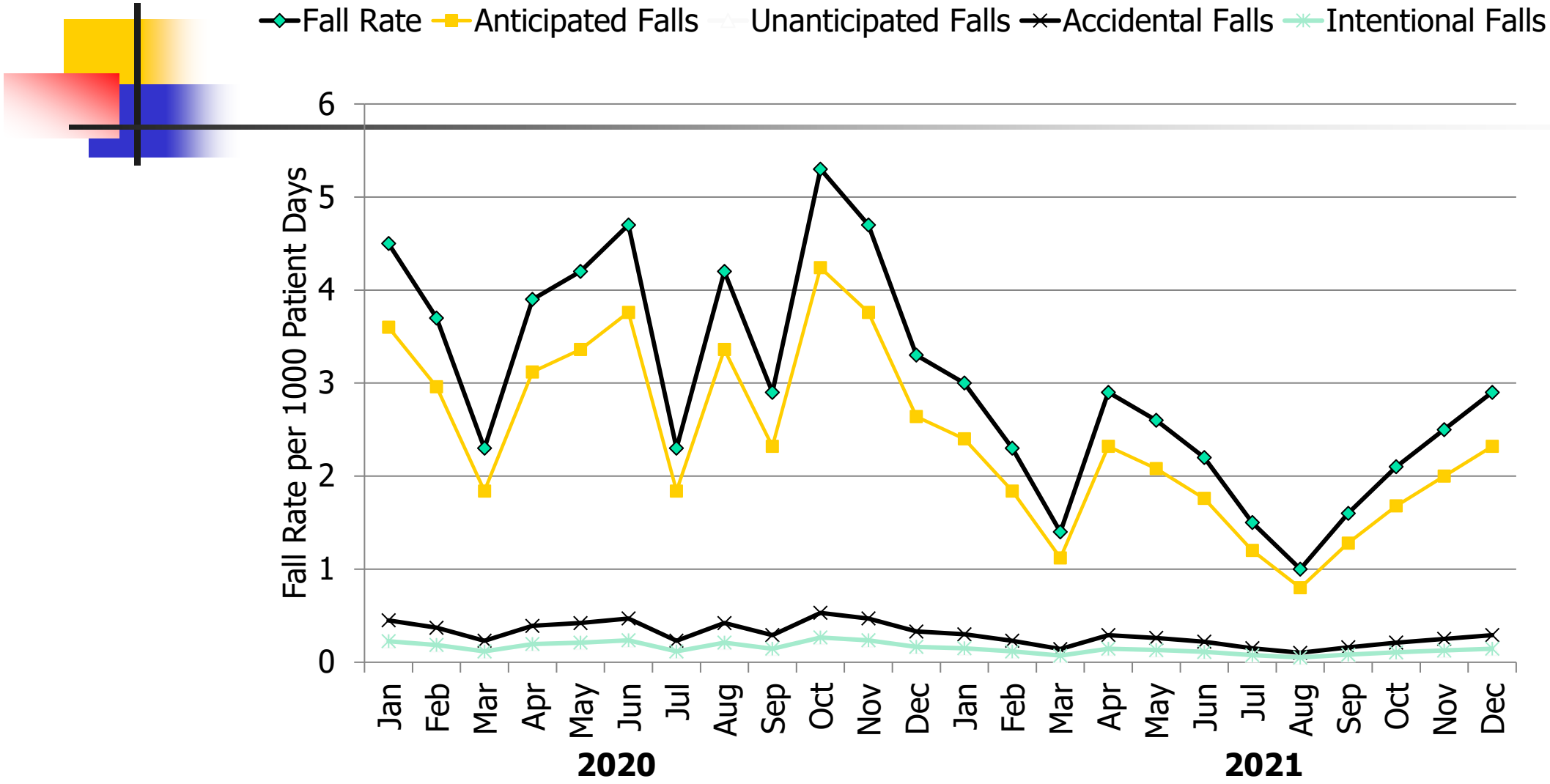
Example of a **Outcome** Run Chart



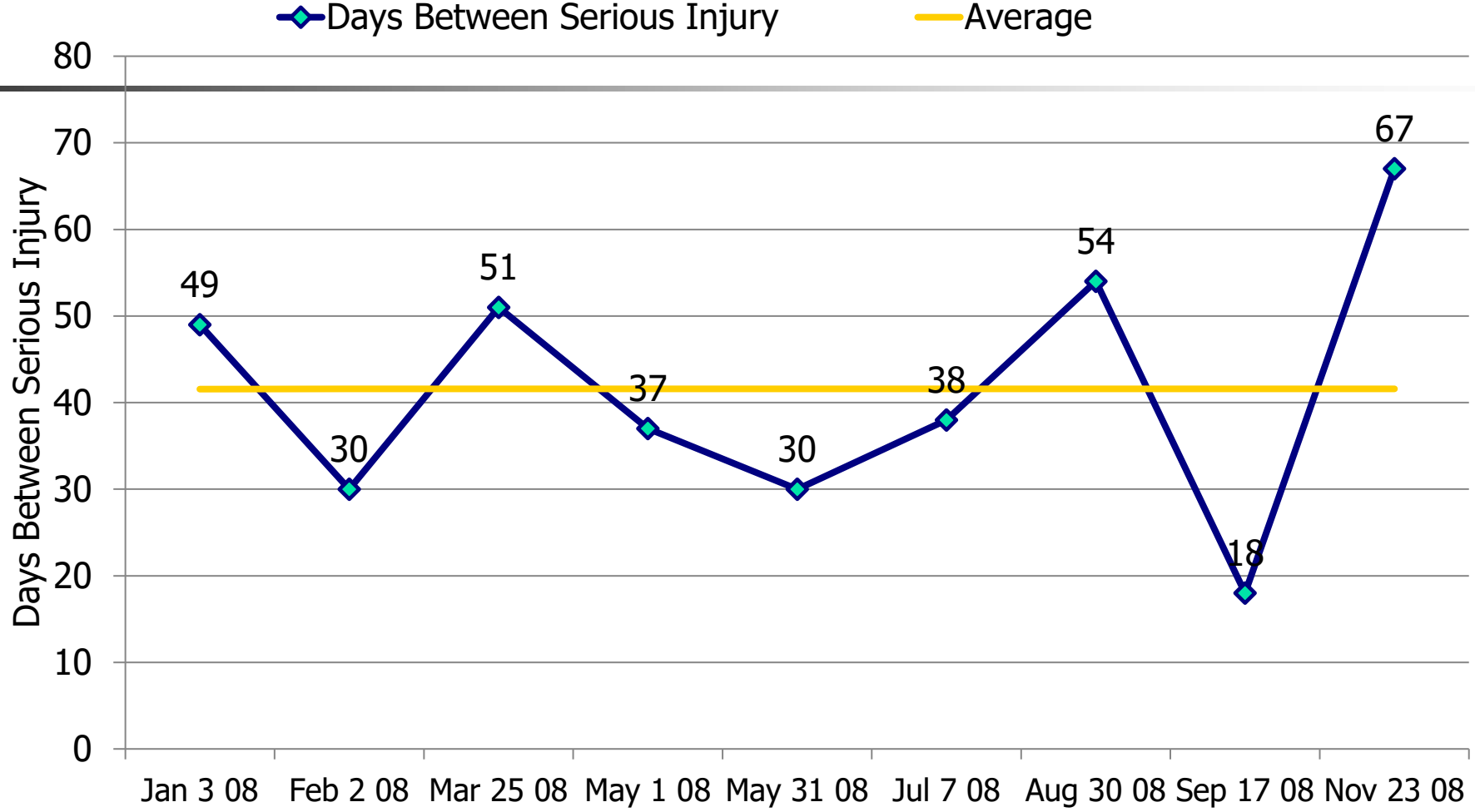
Falls per 1000 Patient Days



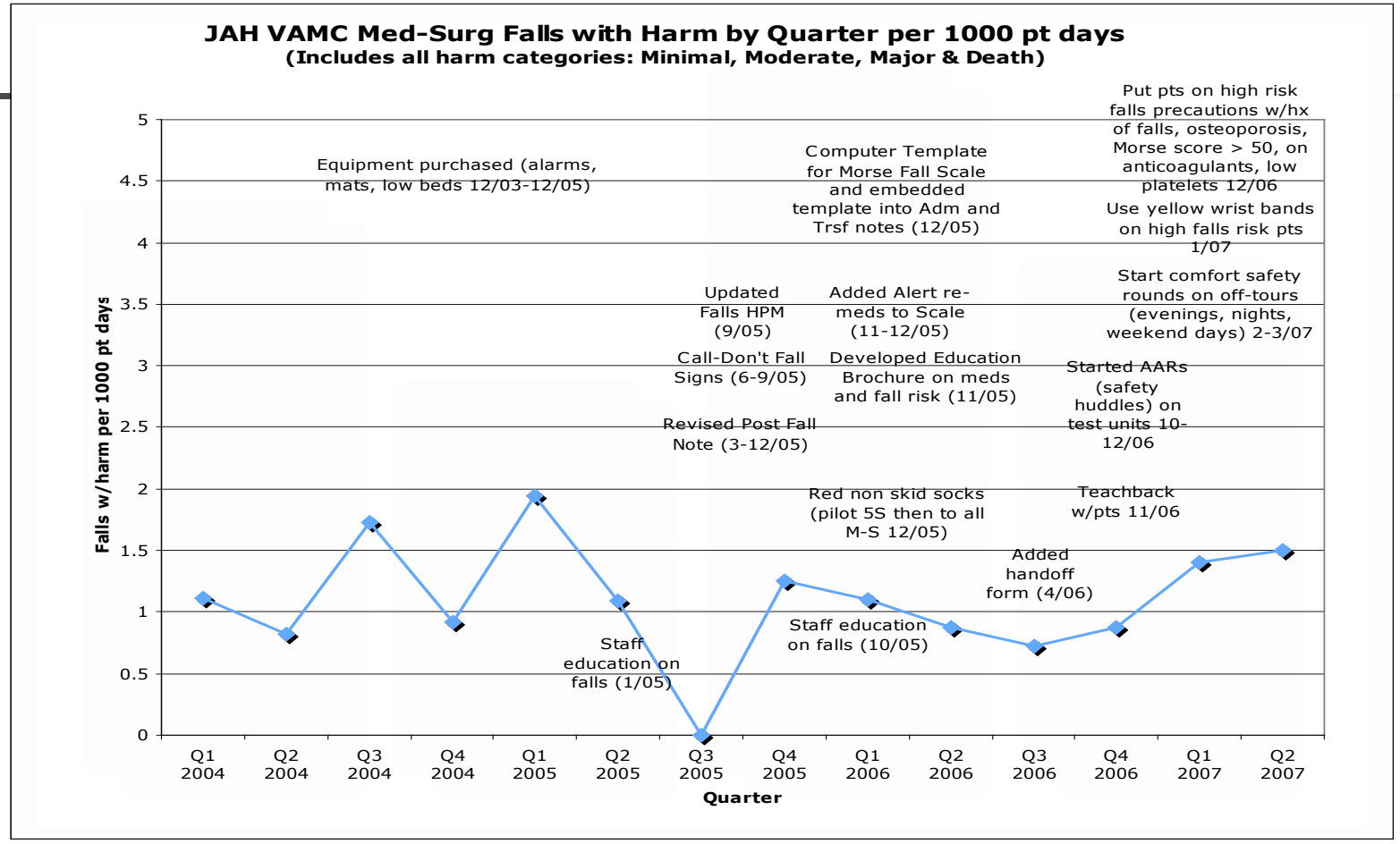
Fall Rate by Type of Fall per 1000 Patient Days



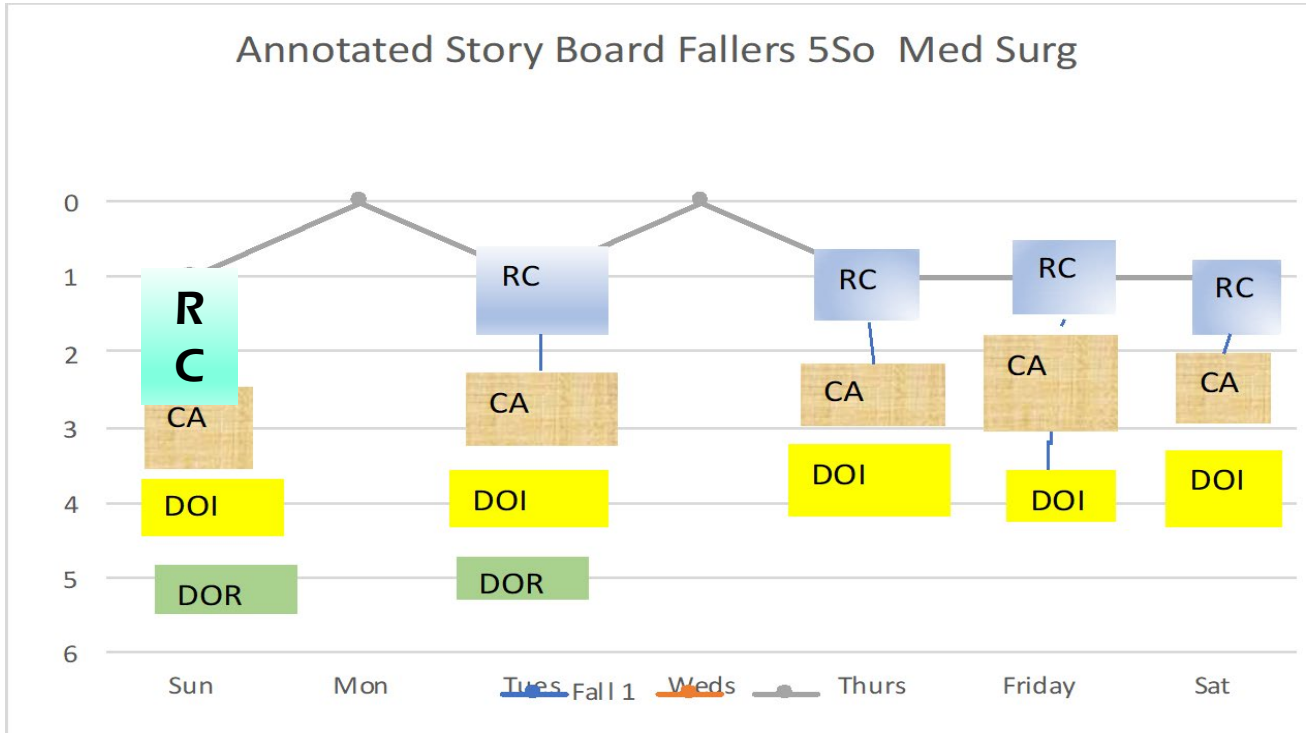
Days Between Serious Injury



Annotated Run Chart



My Unit Story Board



RC: Root Cause; CA: Corrective Action; DOI: Date of Implementation; DOR: Date of Resolution

Fall Injury Prevention Committee: Action Oriented toward Goals

- Plan agenda based on Strategic Plan
- Think Quarterly Workflow, Analysis and Support
- Meetings Month 1 and 2: Work on the task forces
- Meeting Month 3 of the Quarter: Task Force Chairs report on Progress; Evaluate Strategic Plan

Keep Thinking *Out of the Box*!

- Leadership: Culture of Safety
- Fall Rounds
- Signage
- Frequency of Fall Risk Screening
- Measurements of Effectiveness

Thank You and Please Share More!

- Thank you for attending, be a Champion for Change, and keep me posted – I am here for you!
- pquigley1@tampabay.rr.com

References

Clinics in Geriatric Medicine, May 2019 (Link)

Optimizing Function and Physical Activity in Hospitalized Older Adults to Prevent Functional Decline and Falls

- Barbara Resnick, Marie Boltz, p237–251

Preventing Falls in Hospitalized Patients: State of the Science

- Jennifer H. LeLaurin, Ronald I. Shorr, p273–283

Outcomes of Patient-Engaged Video Surveillance on Falls and Other Adverse Events

- Patricia A. Quigley, Lisbeth Votruba, Jill Kaminski, p253–263

AHA HRET 2018: Falls Change Package – Preventing Harm from Injuries from Falls and Immobility (Link)

Interactive Discussion

- Any suggestions on how to manage falls in the behavioral population who are on a lot of high risk falls medications ?
- Any work and/or thoughts on toileting associated falls? What about toilet seat sensor alarms?
- Best way to avoid alarm fatigue?
- Does anyone have examples of a falls dashboard they'd be willing to share?
- Ideas to reduce falls in outpatient departments and visitor falls?
- Is placing cameras in each patient's room for closer observation something that is being done to prevent falls?

Tools and Resources

- Injurious Fall Prevention Assessment Tool (Link)
- Fall TIPS Program
  - Videos (Link)
  - Patient Centered Prevention Toolkit (Link)
- Center for Disease Control's (CDC) STEADI Program (Link)
- Infographic: Opioids and Fall Risks in the Older Adult (Link)
- Article: Special Committee on Aging United States Senate Falls Report (Link)
- Factsheet: Facing The Facts About Falls in Hospitals (Link)

Register for the Next HQIC Collaborative Event!

How to Rebuild, Reengage and Reenergize Your Patient and Family Advisory Council (PFAC)

July 25, 2023, from 12:00-12:30 PM (CT)

Register (Link)

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Thank you for joining us today!

We value your input!

Please complete the brief evaluation after exiting the event

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