Falls Rewind
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October 31, 2019
Objectives

• Review HIIN data
• Discuss targeted interventions for fall prevention
• Review resources to assist with harm reduction
Did you know?

Every 20 minutes, an older adult dies from a fall in the United States. Many more are injured. Take a stand to prevent falls.
HRET/HIIN Goal

20 percent reduction in patient falls by 2019.

• Partnership for Patients (PfP) Goal
### State HIIIN Improvement Data

**Current Rate:** 0.54  
**Target Rate:** 0.53

<table>
<thead>
<tr>
<th>Harm Measure</th>
<th>Most recent Month Reported</th>
<th>Project to Date Relative Reduction</th>
<th>Monthly Baseline Numerator</th>
<th>Monthly Baseline Denominator</th>
<th>Project to Date Numerator</th>
<th>Project to Date Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls with Injury</td>
<td>July</td>
<td>19%</td>
<td>151</td>
<td>226,153</td>
<td>2,594</td>
<td>4,797,865</td>
</tr>
</tbody>
</table>
Snapshot of State HIIN Data

(All) (92 hospitals) for measure(s) selected with the slicer on the left, including Falls with Injury
The Numbers

Of 92 HIIN participating hospitals-

– 14 hospitals have a combined total of 2,016 falls with harm
– Total falls with harm = 2,594
What are you doing to reduce falls?
Consider this teach-back tool from the HRET Change Package. Not only does it encourage patient/staff collaboration, but it also promotes “scripting” and helps staff to become more comfortable with conversations about falls.

Post Fall Huddle- Study from AHRQ

Method: Used the TeamSTEPPS® Teamwork Perceptions Questionnaire (T-TPQ) to assess perceptions of teamwork support for fall-risk reduction and the Hospital Survey on Patient Safety Culture (HSOPS) to assess perceptions of safety culture.

Result: Repeat fall rates were negatively associated with the proportion of falls followed by a huddle. As compared to hospital staff who did not participate in huddles, those who participated in huddles had more positive perceptions of four domains of safety culture and how team structure, team leadership, and situation monitoring supported fall-risk reduction.


IHAconnect.org/Quality-Patient-Safety
“Patient falls are complex because they result from a combination of patient (e.g. lower extremity weakness), environmental (e.g. tripping hazards), and system factors. System factors that contribute to patient falls include the attitude that falls are inevitable, poor teamwork, and an inability to adequately learn from fall events.”

**CAPTURE FALLS: POST-FALL HUDDLE GUIDE**

1. Establish facts... a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient’s plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation
   a. Who attended
   b. Type of fall
   c. Type of error

**POST/FALL HUDDLE FACILITATOR TIPS**

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the front line to learn about why a patient fell – actively listen and be slow to judge)
2. Ask probing questions (e.g., ask “why?” until root causes are identified)
3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person’s contribution)
4. Give praise and acknowledge good work (e.g., say “thank you” and “nice job” when appropriate)
5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)

<table>
<thead>
<tr>
<th>Medical Record Number</th>
<th>Date of fall</th>
<th>Time of fall</th>
</tr>
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</table>

**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), and 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:  
   1.1. Did we know this patient was at risk? **YES** **NO**
   1.2. Has this patient fallen previously during this stay? **YES** **NO**
   1.3. Is this patient at high risk of injury from a fall? **YES** **NO**
   1.4. Age 95+ **YES** **NO**
   2. **Hand Written Notes**

2. Establish what patient and staff were doing and why.

3. Determine underlying root causes of the fall.

4. Make changes to decrease the risk that this patient will fall or be injured again.

5. Communicate to other departments, units or disciplines.

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[https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html](https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html)
Are you assessing mobility status and adding to the care plan?

<table>
<thead>
<tr>
<th>Test</th>
<th>Task</th>
<th>Response</th>
<th>Fail = Choose Most Appropriate Equipment/Device(s)</th>
<th>Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Level 1</strong></td>
<td><strong>Assessment of:</strong> Cognition - Trunk strength - Seated balance</td>
<td>Sit and Shake: From a semi-reclined position, ask patient to sit upright and rotate to a seated position at the side of the bed; may use the bedrail. Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across handwritten lines. Note: Consider your patient's cognitive ability, including orientation and CAM assessment if applicable.</td>
<td><strong>MOBILITY LEVEL 1</strong>&lt;br&gt;- Use total lift with string and/or repositioning sheet and/or straps.&lt;br&gt;- Use lateral transfer devices such as roll board, braxton reducing (side sheet transfer), or an assisted device. <strong>NOTES:</strong> if patient has 'slept bed rest' or bilateral 'non-weight-bearing' restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.</td>
<td>Passed Assessment Level 1 = Proceed with Assessment Level 2.</td>
</tr>
<tr>
<td><strong>Assessment Level 2</strong></td>
<td><strong>Assessment of:</strong> Lower extremity - Strength - Stability</td>
<td>Stretch and Point: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and strengthen the knee, then bend the ankle/foot and point the toes. If appropriate, repeat with the other leg.</td>
<td><strong>MOBILITY LEVEL 2</strong>&lt;br&gt;- Use total lift for patient unable to weight bear on at least one leg.&lt;br&gt;- Use sit-to-stand lift for patient who can weight bear on at least one leg.</td>
<td>Passed Assessment Level 2 = Proceed with Assessment Level 3.</td>
</tr>
<tr>
<td><strong>Assessment Level 3</strong></td>
<td><strong>Assessment of:</strong> Lower extremity - Strength - Stability</td>
<td>Stand: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, walker). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patient's cognitive ability, including orientation and CAM assessment if applicable.</td>
<td><strong>MOBILITY LEVEL 3</strong>&lt;br&gt;- Use non-powered straight back chair, default to powered sit-to-stand lift if no stand aid available.&lt;br&gt;- Use total lift with ambulation accessories.&lt;br&gt;- Use assistive device (cane, walker, crutches). <strong>NOTE:</strong> Patient passes Assessment Level 3 but requires assistive device to ambulate, patient is MOBILITY LEVEL 3.</td>
<td>Passed Assessment Level 3 AND no assistive device needed = Proceed with Assessment Level 4. Consult with Physical Therapist when needed and appropriate.</td>
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</tbody>
</table>
| **Assessment Level 4** | **Assessment of:** Standing balance - Gait | Walk: Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness. | **MOBILITY LEVEL 4**<br>- MOBILITY INDEPENDENCE. Passed = No assistance needed to ambulate, use your best clinical judgment to determine need for staff assistance during ambulation. | MOBILITY LEVEL 4  
MOBILITY INDEPENDENCE. Passed = No assistance needed to ambulate, use your best clinical judgment to determine need for staff assistance during ambulation. |

*Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.*

Originate: 2011; revised: 2/27/12, 3/2/12, 5/9/12, 7/19/12, 4/19/12, 5/6/12, 5/23/12, 05/02/2013
Adoption of Evidence-Based Fall Prevention Practices in Primary Care for Older Adults with a History of Falls

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A multistep approach to assess and manage modifiable risk factors is recommended for older adults with a history of falls. Limited research suggests that this approach does not uniformly occur in clinical practice, but most needed studies are based on provider self-report, with the last chart audit of United States practice published over a decade ago. We conducted a retrospective chart review to assess the extent to which patients aged 65+ years with a history of repeated falls or fall-related health care use received multifactorial risk assessment and interventions. The setting was an academic primary care clinic in the Pacific Northwest. Among the 145 patients meeting our inclusion criteria, 46% had some type of documented assessment. Their mean age was 71.9 ± 11.9 years; 86% were female, and 10% were non-white. They averaged 1.6 primary care visits over a 12-month period subsequent to their index fall. Frequency of assessment of fall-risk factors varied from 24% (for home safety) to 75% (for vitamins B12). An evidence-based intervention was recommended for identified risk factors 72% of the time, on average. Two risk factors were addressed in fewer interventions: medications (21%) and home safety (24%). Use of a structured visit note template independently predicted assessment of fall-risk factors (p = 0.003). Geriatrics specialists were more likely to use a structured note template (p = 0.04) and perform more fall-risk factor assessments (4.6 vs. 3.6, p = 0.002) than general internists. These results suggest opportunities for improving multifactorial fall-risk assessment and management of older adults at high fall risk in primary care. A structured visit note template facilitates assessment. Given that high-risk medications have been found to be independent risk factors for falls, increasing attention to medications should become a key focus of both public health educational efforts and fall prevention in primary care practice.

https://www.frontiersin.org/article/s10.3389/fpubh.2016.00190/full#T2
Patient & Family Engagement

• **Recommendations for Practice: Use the STEADI Materials**
  
  • STEADI is a comprehensive set of materials that provides a foundation to systematically evaluate and address fall risk.
  
  • STEADI includes an algorithm to assess fall risk, tips for integrating fall risk management into clinical practice, assessment tools for modifiable fall-risk factors, descriptions of interventions, and patient education materials.
  
  • It is a systematic, evidence-based, accessible, and free resource for PCPs and their practice teams to evaluate and manage their patients’ fall risk.

https://www.cdc.gov/steadi/patient.html
Resources

IHAconnect.org/Quality-Patient-Safety
Falls PI Tool

Go to this website to access these resources:


**Mobility Resources to Get You Started**

- **Mobility Assessments**
  - Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool
  - Timed Get up and Go Test
  - Get Up and Go Test

- **Staff Training**
  - CAPTURE Falls mobility training videos, mobility tools

- **Mobility Change Package**
  - Project HELP Mobility Change Package – Staff training and competency checklists

- **Mobility Protocols and Resources**
  - Med Surg Mobility Protocol
  - ICU Mobility Protocol
  - Beach Chair Postioning Article

- **Patient and Family Engagement Resources**
  - Staying Active in Hospital - handout
  - Teach Back Tool for Fall Prevention
  - Lutheran Fall Questionnaire

- **Mobility Tracking Tools**
  - Mobility is Medicine Bedside Tracker
  - Daily Mobility Patient Goal sign
  - Let’s Get Moving Bedside Mobility Tracker
  - Walk of Fame Mobility Board – hallway board to make mobility visible

- **Environmental Safety**
  - Guide: Creating a Safe Environment to Prevent Toileting Related Injuries

- **Developing a Business Case for Mobility**
  - Financial modeling for mobility program: Pub med link
HRET Change Package

PREVENTING HARM FROM INJURIES FROM FALLS AND IMMObILITY

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HRET Change Package

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