# CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

**Quarterly Collaborative Call #51**

**April 23, 2024**

**2:00 – 2:30 p.m. CT**

**Topic:**

**Learning from Falls – Promoting Patient Independence vs. Reducing Fall Risk**

University of Nebraska Medical Center℠

# AGENDA

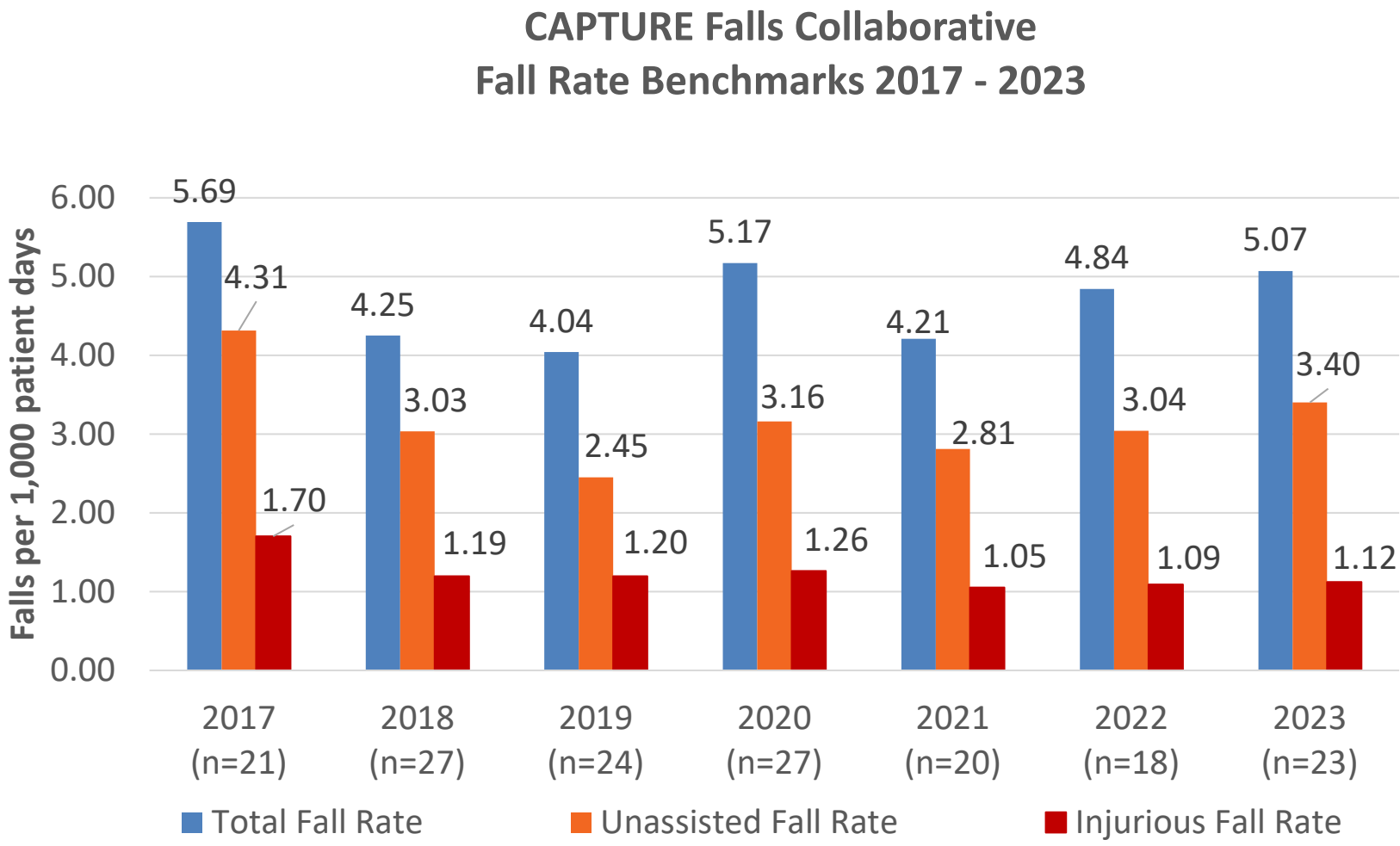
- Housekeeping
- Promoting Patient Independence vs. Reducing Fall Risk

# Housekeeping

1. Know Falls Event Reporting
    - 2024 Quarter 1 reports will be sent in early May
    - For the accuracy of your reports, please have all fall events entered into REDCap by **April 30, 2024**
    - Continue reporting to help facilitate learning from fall events and track your outcomes
    - Reminder for NCPS members: reporting to Know Falls = reporting to NCPS
    - Contact us with REDCap issues (add users, remove users, etc).

# Housekeeping

2. Annual Benchmark Fall Rates



# Housekeeping

3. FYI: Survey of Fall Risk Reduction Practices in Rural Health Clinics (RHCs)
    - CATCH RURAL Falls: Coordinated Action Toward Community Health: RedUce Risk And Limit Falls
        - Began as a 9-month QI pilot for 6 RHCs from 9/22-6/23
    - Next step: Survey all RHCs in NE to evaluate the current state of fall risk management practices (screening, assessment, and intervention) in clinic settings
        - Survey invitation letters sent by mail with the link to complete the survey – please encourage your clinic managers to complete the survey!
    - We are still supporting CAHs for inpatient fall risk reduction!

# Promoting Patient Independence vs. Reducing Fall Risk

University of Nebraska Medical Center

# What Factors Shape Health Care Professional (HCP) Decision-Making Regarding Mobility and Safety?

Review article summarized results of 28 studies related to:

- Clinical decision-making in the absence of a pre-determined clinical pathway
- Decision-making processes for patients in inpatient settings
- Situations where staff were considering how to balance safety and mobility

Bainbridge L, Fary RE, Briffa K, Hill KD, Burton E. Health care professionals' decision making related to mobility and safety for people in the hospital: A scoping review. *Phys Ther*. 2023;103(5):pzad024. doi: 10.1093/ptj/pzad024.

# Common Themes Related to Decision-Making

| | | |
|---|---|---|
| Discipline-Specific Observation and Assessment | Clinical Experience and Knowledge of the HCP | Reliance on More than just Standardized Tests |
| Impact of Resources and Institutional Governance | Risk-Benefit Trade-Off | Capacity of the Patient for Decision-Making |
| Shared Decision Making with Patients, Family, and Multidisciplinary Team | Communication as a Driver of Decision Making | Fear and Avoidance of Negative Outcomes |

Bainbridge L, Fary RE, Briffa K, Hill KD, Burton E. Health care professionals' decision making related to mobility and safety for people in the hospital: A scoping review. *Phys Ther*. 2023;103(5):pzad024. doi: 10.1093/ptj/pzad024.

# What Factors Shape Health Care Professional (HCP) Decision-Making Regarding Mobility and Safety?

*"…there appear to be no widely accepted guidelines for health care professionals as to what factors they should consider, or how to structure their decision-making process."*

*"Where clarity in deciding on a best course of action was challenging, communication with the multidisciplinary team was noted to be a key driver of decision-making, where health care professionals sought validation and support from each other."*

Bainbridge L, Fary RE, Briffa K, Hill KD, Burton E. Health care professionals' decision making related to mobility and safety for people in the hospital: A scoping review. *Phys Ther*. 2023;103(5):pzad024. doi: 10.1093/ptj/pzad024.

# Safe Table Confidentiality Training

**with acknowledgement to:**

**Emily Barr, OTD, MBA, OTR/L, BCG, Executive Director**
**Carla Snyder, MHA, MT(ASCP)SBB, Patient Safety Program Director**
**Nebraska Coalition for Patient Safety (NCPS)**

NCPS
Nebraska Coalition for Patient Safety

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# Definitions

**Patient Safety Evaluation System (PSES)** means the collection, management, or analysis of information for reporting to or by a Patient Safety Organization (PSO).

**Patient Safety Work Product (PSWP)** means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) which could improve patient safety, health care quality, or health care outcomes, including information:

- Which is assembled or developed by a provider for reporting to a PSO and are reported to a PSO,
- Which is documented as within a patient safety evaluation system for reporting to a PSO, or
- Are developed by a PSO for the conduct of patient safety activities, or
- Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

# What is a Safe Table?

A Safe Table is a forum where healthcare providers review and discuss issues related to quality and patient safety improvement in a confidential and privileged space to facilitate group problem solving. Examples:

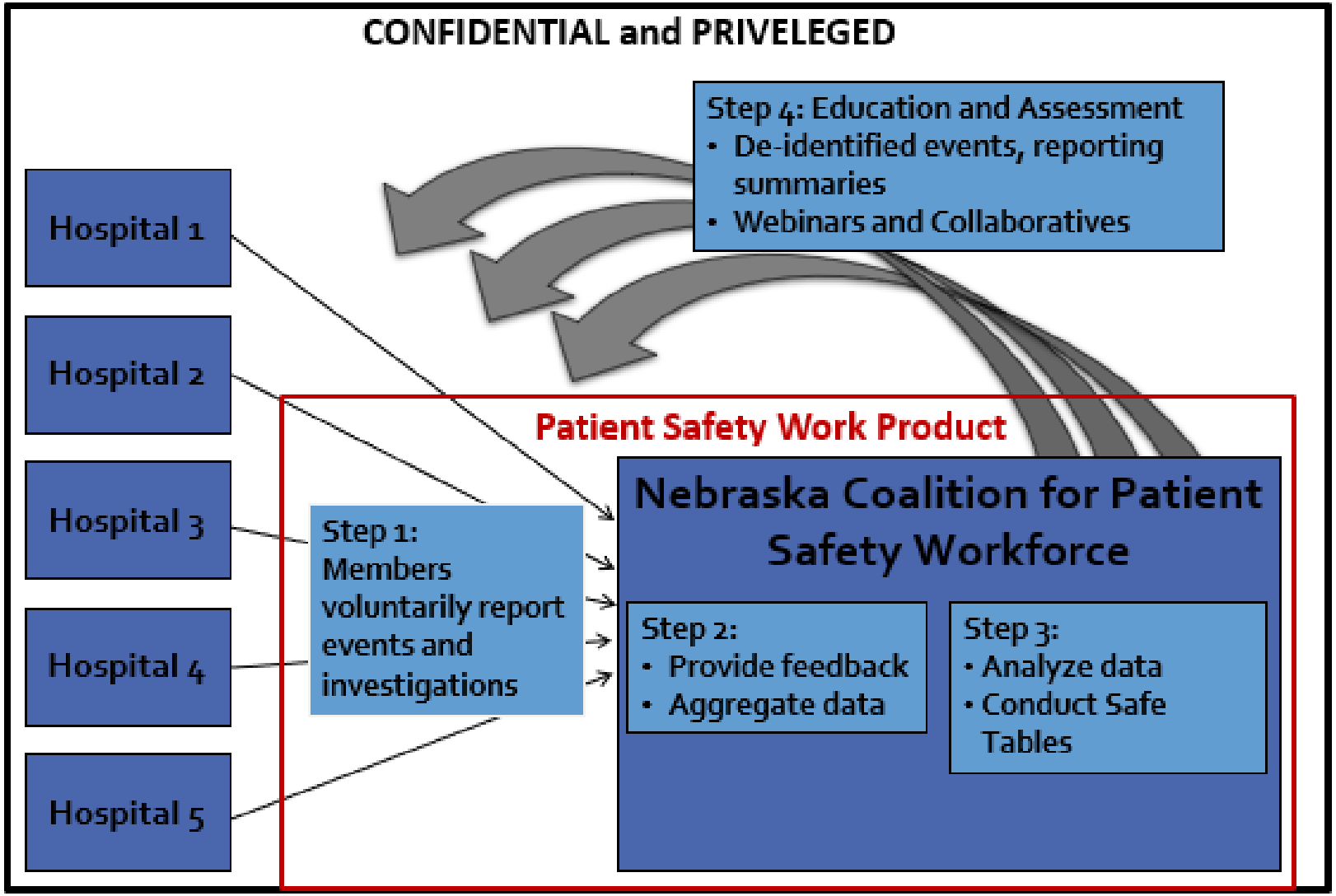
- ✓ Discussion of case studies
- ✓ Sharing information about best practices and protocols such as conducting debriefs
- ✓ Structuring collaborations to implement change

The diagram on the next slide illustrates that a Safe Table takes place within NCPS's and UNMC CAPTURE Fall's Patient Safety Evaluation System.

Through our affiliation with NCPS, a PSO, we maintain the confidentiality and privilege of the information shared during a Safe Table as Patient Safety Work Product.

To do so, participants in the Safe Table agree to serve as temporary volunteer workforce of NCPS and UNMC CAPTURE Falls.

# NCPS and UNMC CAPTURE Falls Patient Safety Evaluation System



# Confidentiality Reminder


***As temporary NCPS Workforce, you have a duty to maintain confidentiality by ensuring shared information is non-identifiable.***

***Non-identifiable*** PSWP may be used for Patient Safety Activities such as conducting a Safe Table.

PSWP becomes ***non-identifiable*** when all direct

- ***Provider*** identifiers are removed in compliance with the federal Patient Safety Act and
- ***Patient*** identifiers are removed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

If you do not want to identify your organization during the Safe Table, you may share information anonymously by typing a message in the chat box to the meeting organizers.

# Confidentiality Reminder


In addition to the confidentiality obligations under the Patient Safety Quality Improvement Act of 2005, each participant must also agree:

(1) not to share the link to the Virtual Session,

(2) not to record, photograph or screenshot the Virtual Session, and

(3) to attend the Virtual Session in a private area where no unauthorized individual may observe or listen to the virtual convening session.

The confidentiality protections of Patient Safety Work Product shall survive after the Virtual Session is adjourned.

Participants may not disclose any identifiable Patient Safety Work Product discussed at this Virtual Session except to provide learnings and feedback to provider members of NCPS PSO for quality improvement purposes.

The Patient Safety Act, 21 C.F.R. Part 3, imposes penalties of up to $11,000 for the knowing and reckless violation of these confidentiality requirements.

***Four de-identified fall case studies reported into Know Falls were discussed.***

*All were similar in that the patient had been deemed to be independent with mobility in the room and then went on to fall.*

*Details of falls not provided in this handout for the purposes of confidentiality.*

# Discussion Questions

- How does your facility handle the competing goals of promotion of independent mobility and fall risk reduction?
- Who makes the decision to determine the patient is independent?
- How is that information communicated to the patient and others providing care to the patient?
- What strategies has your facility implemented to encourage independent mobility while reducing fall risk?

# *Summary of Key Discussion Points*

# Proactive, Collaborative Decision Making about Independent Mobility Status

- Need proactive and clear communication among PT/OT, nursing, and other members of the health care team about factors that might affect decision to clear patient for independent mobilization
- Decision should be made with input from multiple members of the healthcare team to ensure all members have a complete picture of the patient's abilities
    - Patient's ability to move about independently may vary throughout the day (e.g. fatigue and weakness may increase throughout the day; cognition may vary throughout the day)

# Proactive, Collaborative Decision Making about Independent Mobility Status

- Goal clarity – what is the goal for patient at this point in their hospital stay?
  - If discharging home soon, the priority may be promoting independent mobility
  - If discharging home soon, but against advice of healthcare team (e.g. team recommends long term care, but patient/family declining that recommendation), reducing fall risk may outweigh allowing/promoting independent mobility

# Proactive, Collaborative Decision Making about Independent Mobility Status

- Fall risk score, and associated risk factors driving the score, weighs heavily in the decision to grant the patient independence
- Decision to “override” the score and allow independent mobility can occur but requires careful consideration of patient’s individualized fall risk factors and input from multiple members of the healthcare team.

# Proactive, Collaborative Decision Making about Independent Mobility Status

- Consider gradual ‘ramp-up’ to independence (hands-on assistance → mobility with supervision → independent mobility)
- Patient may be the best person to tell staff that they are more tired/weak, but may not want to do so for risk of removal of independent mobility status
- Clear handoffs among staff caring for the patient + the patient/family can help ensure a shared understanding of the patient’s mobility status

# Patient Education with Teach-Back

- What does the patient understand ‘independent’ to mean?
- What specific activities are cleared for independence?
  - e.g. transfer to bedside chair vs. walking to bathroom vs. walking further distances in hallway, etc.
- Explain why their ability to independently move around might change throughout the day and what they may be asked/instructed to do as a result
  - e.g. patient might be cleared for independence during the day, but need assistance at night
- Use checklists and teach back to ensure patient understanding

# Ensure a Clear Environment

- Double-down on environmental assessment when allowing a patient independent mobility (e.g., is the floor clear, no clutter or slipping/tripping hazards)
- Universal precautions that are in place for all patients (regardless of fall risk and mobility status) should still be in place

# If a Patient then Falls, use Post-Fall Huddles to Clarify Next Steps

- Engage PT/OT directly in these huddles at the time of the huddle if possible, to discuss the patient's mobility
- Team needs to clearly understand the factors that contributed to the fall and the changes (if any) that need to be made in the moment to reduce fall risk, particularly if this results in a change of mobility status
    - In some cases, only minor changes might be needed; in other cases, targeted fall precautions and a return to assisted mobility may be warranted

# Questions about any content covered today?

# Resources: Consultations with the UNMC CAPTURE Falls Team

We are here to support YOU!

## Initial Steps

- Begin engagement or re-engagement with UNMC team on a rolling basis
- Form your team
- Complete gap analysis
- Form action plan

## Resources Available

- At least one consultative meeting with UNMC team to review gap analysis and action plan
- Use of CAPTURE Falls online roadmap
- **Additional consultation with UNMC team "on-demand"**
- Quarterly collaborative calls for education and program updates
- Know Falls database for reporting and learning from falls

## Sustainment

- Monitor progress towards goals on action plan
- Monitor fall rates; compare with benchmarks
- Update gap analysis when appropriate

**Can also "jump in" anywhere in your fall risk reduction process for focused topic-specific support**

# Reminders

1. Future Collaborative Calls/Educational Opportunities: Let us know if there is a topic or series of interest!
    - Tuesday August 20, 2024, 2:00-2:30pm CT (*note the August date, not our typical July)
    - Tuesday October 22, 2024, 2:00-2:30pm CT
2. Looking for fall risk reduction resources?

**Click here:** https://www.unmc.edu/patient-safety/capturefalls/index.html

Still can't find what you are looking for? Let us know what we are missing!

# Assistance is an email away!

Contact us for more information about:

- Fall risk reduction best practices: Dawn (dvenema@unmc.edu)
- Team performance, quality improvement and implementation challenges: Vicki (victoria.kennel@unmc.edu)
- Know Falls and Online Learning (REDCap): Dawn (dvenema@unmc.edu) and/or Matt (matthew.mcmanigal@unmc.edu)
- General questions or not sure?: CAPTURE.Falls@unmc.edu

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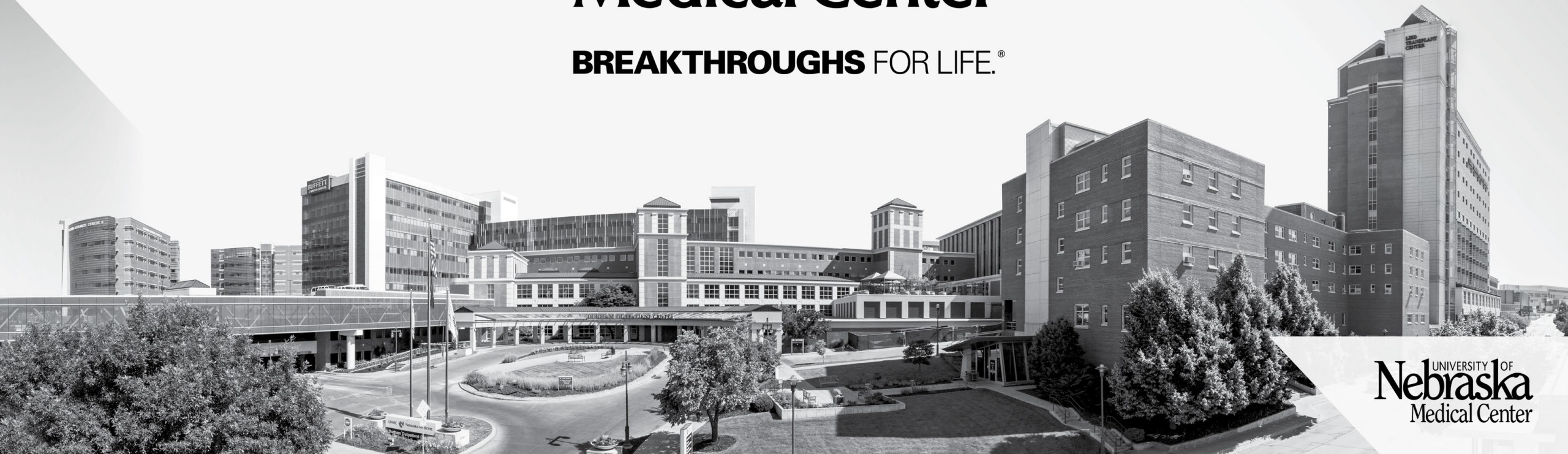


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