CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

Quarterly Collaborative Call #53

October 22, 2024

2:00 – 2:30 p.m. CT

Topic:

Learning from Falls – What We Can Learn from Post-Fall Huddles

University of Nebraska Medical Center℠

AGENDA

- Housekeeping
- Learning from Falls – What We Can Learn from Post-Fall Huddles

Housekeeping

1. **Know Falls Event Reporting**
   - 2024 Quarter 3 reports will be sent early November; please have falls entered by 10/31/24 for up-to-date reports
   - Reports will be sent to any hospital that reported at least one fall within the past year
   - 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. **Collaboration with Strategic Quality Support System (SQSS)**
    - Many CAHs in NE use SQSS to support their QI efforts
    - Exploring ways to “push” fall event data from SQSS into Know Falls (REDCap) to ease reporting burden
    - Two CAPTURE Falls hospitals are beta-testing the process with SQSS and us
    - Update: SQSS has the question template built and it seems to be working with test fall data. Timeline for full roll-out still TBD.

Housekeeping

3. **Contact List Updates**
   - Emails recently sent to one “key contact” from your hospital’s fall team with a request to confirm and/or update our list of contacts for you
   - Annually, we verify the following:
     - Key contact: Usually the leader of your fall team; the primary person with whom we communicate; can have multiple key contacts
     - Know Falls (REDCap) access: Anyone with a responsibility for entering data or needs to be able to view data in that platform
     - All other contacts: Members of your fall team who you would like to receive periodic information from us about falls (e.g. invitations for collaborative calls; quarterly fall reports, etc.).

Housekeeping

4. **Coordinated Action Toward Community Health: RedUce Risk And Limit (CATCH RURAL) Falls update**
    - Survey of fall risk management in Rural Health Clinics - **Thank You** for helping us encourage participation in the survey!
    - Presented a summary and our plans for the program at the Nebraska Hospital Association: Health Administration Best Practices and Research Symposium October 16, 2024 (copy of poster provided)
    - Our first 6-month CATCH RURAL Falls program cohort for RHCs will begin in January and will focus on fall risk screening. We will share recruitment information with you in November – please distribute it to any RHCs affiliated with your CAH/community if you are willing and able!

Learning from Post-Fall Huddles

Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle

Team who convenes after a patient fall to gather and discuss information about the patient fall and factors that contributed to the fall, and to identify changes necessary to reduce the risk of another fall for that patient

Evidence to Support the Use of Post-Fall Huddles

Recommended practice in many fall risk reduction toolkits

- VHA National Center for Patient Safety Falls Toolkit
- AHRQ Fall Prevention Toolkit (*root cause analysis)
- CAPTURE Falls Toolkit

An intervention with good adoption over time

Use of post-fall huddles increased from 40 to 80% in our first CAPTURE Falls cohort

Associated with fewer repeat falls

Greater proportion of falls followed by a post-fall huddle was associated with a lower repeat fall rate

Safety norms affect perceived success of huddles

Organizational and group safety norms had a positive association with perceptions of huddle effectiveness, explained in part by demonstration of good leadership by the huddle leader

Staff participation in huddles affects perceptions of teamwork and safety culture

Participation in at least one or more huddle was associated with more positive perceptions of aspects of team structure, team leadership, situation monitoring, teamwork across departments, handoffs/transitions, and organizational learning

Reiter-Palmon R, Kennel V, Allen JA, Jones KJ, Skinner AM. Naturalistic Decision Making in After-Action Review Meetings: The Implementation of and Learning from Post-Fall Huddles. *J Occup Organ Psychol*. 2015;88(2):322-340. doi:10.1111/joop.12084

Allen JA, Reiter-Palmon R, Kennel V, Jones KJ. Group and Organizational Safety Norms Set the Stage for Good Post-Fall Huddles. *J Leadersh Organ Stud*. 2019;26(4):465-475. doi:10.1177/1548051818781820

Jones KJ, Crowe J, Allen JA, et al. The impact of post-fall huddles on repeat fall rates and perceptions of safety culture: a quasi-experimental evaluation of a patient safety demonstration project. *BMC Health Serv Res*. 2019;19(1):650. Published 2019 Sep 9. doi:10.1186/s12913-019-4453-y

Case Studies and Discussion

University of Nebraska Medical Center

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

University of Nebraska Medical Center

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:

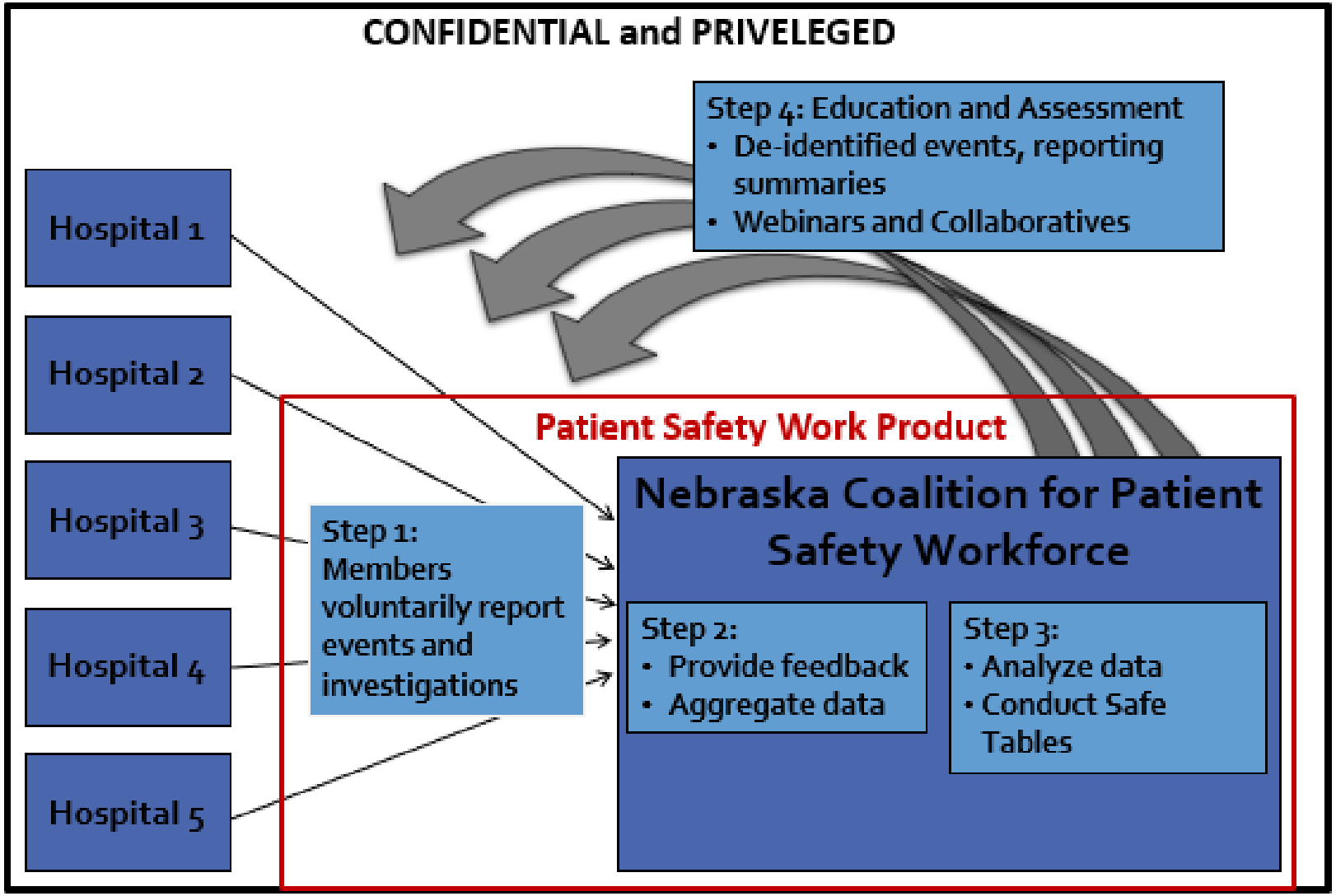
- ✓ Discussion of case studies
- ✓ Sharing information about best practices and protocols such as conducting debriefs
- ✓ Structuring collaborations to implement change

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.

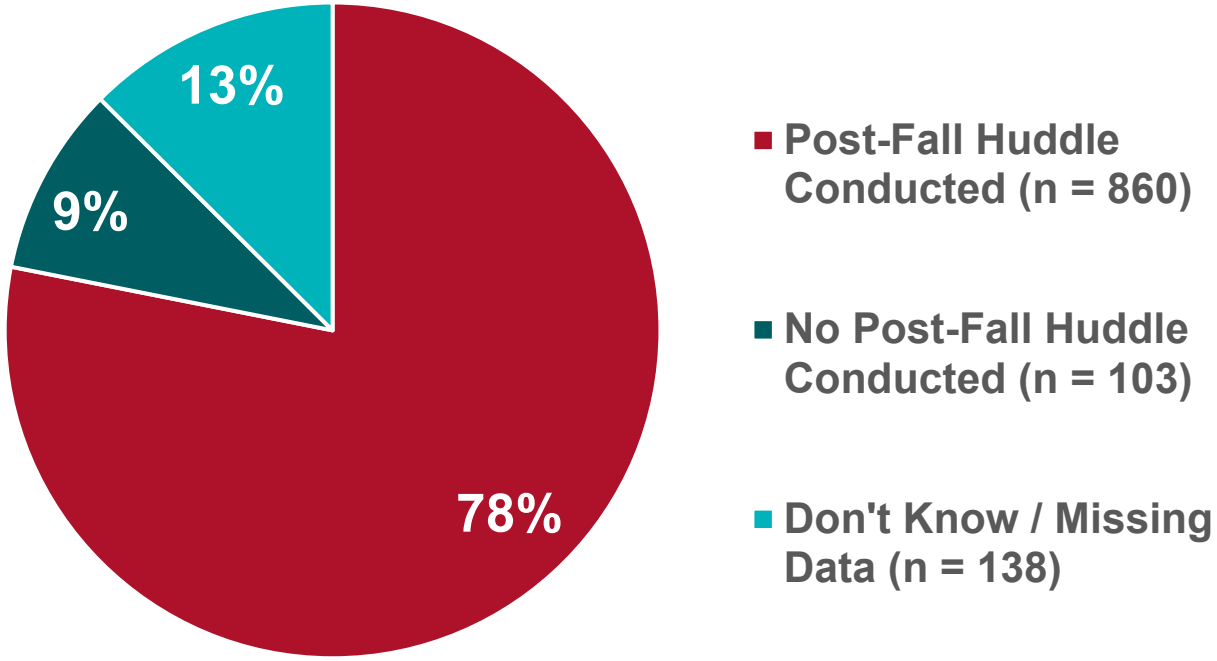
Participants may not disclose any identifiable Patient Safety Work Product discussed at this Virtual Session except to provide learnings and feedback to provider members of NCPS PSO for quality improvement purposes.

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.

Data from the CAPTURE Falls Collaborative

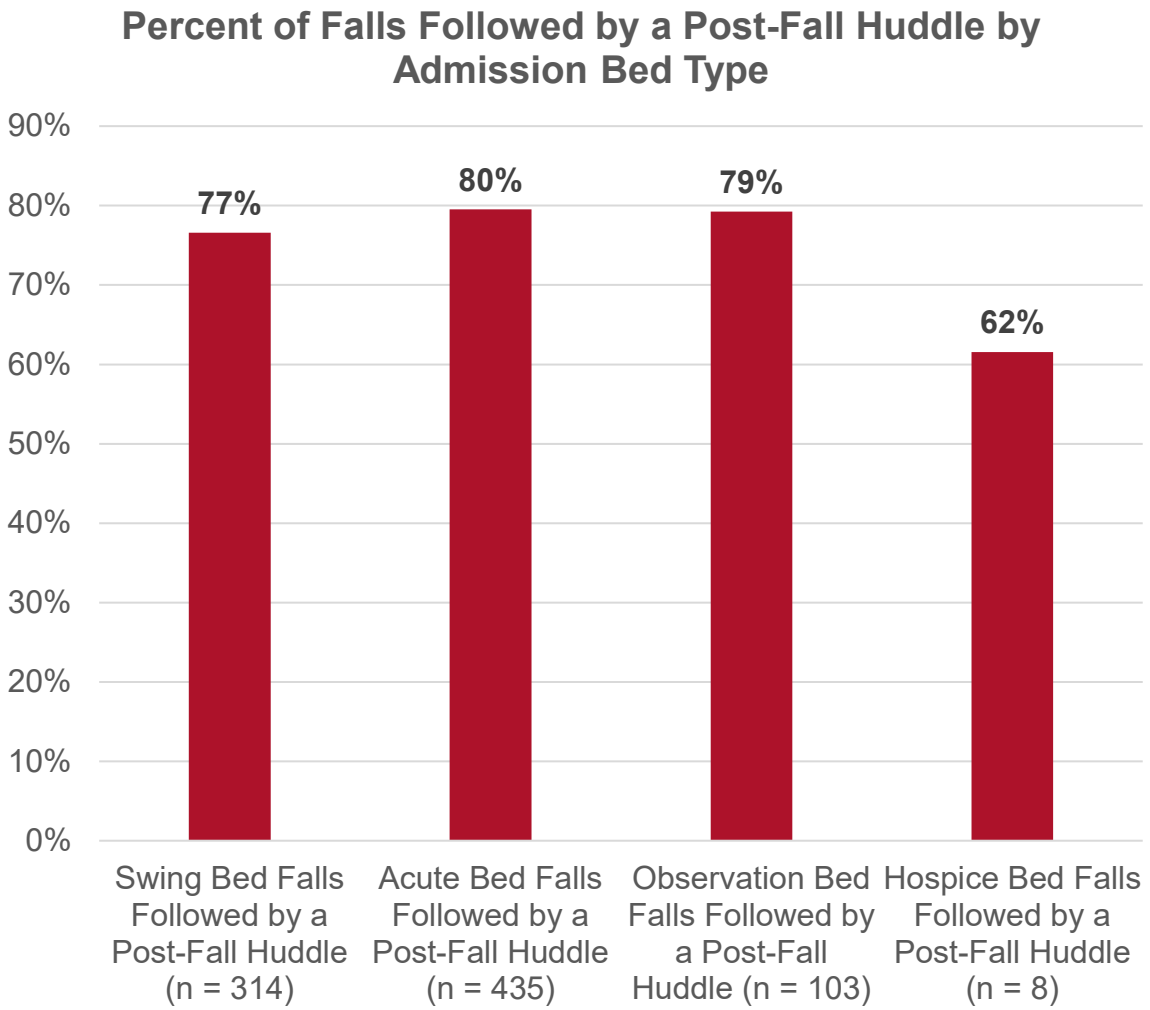
Of the 1,101 inpatient falls entered in Know Falls by current CAPTURE Falls hospitals since August 2015:

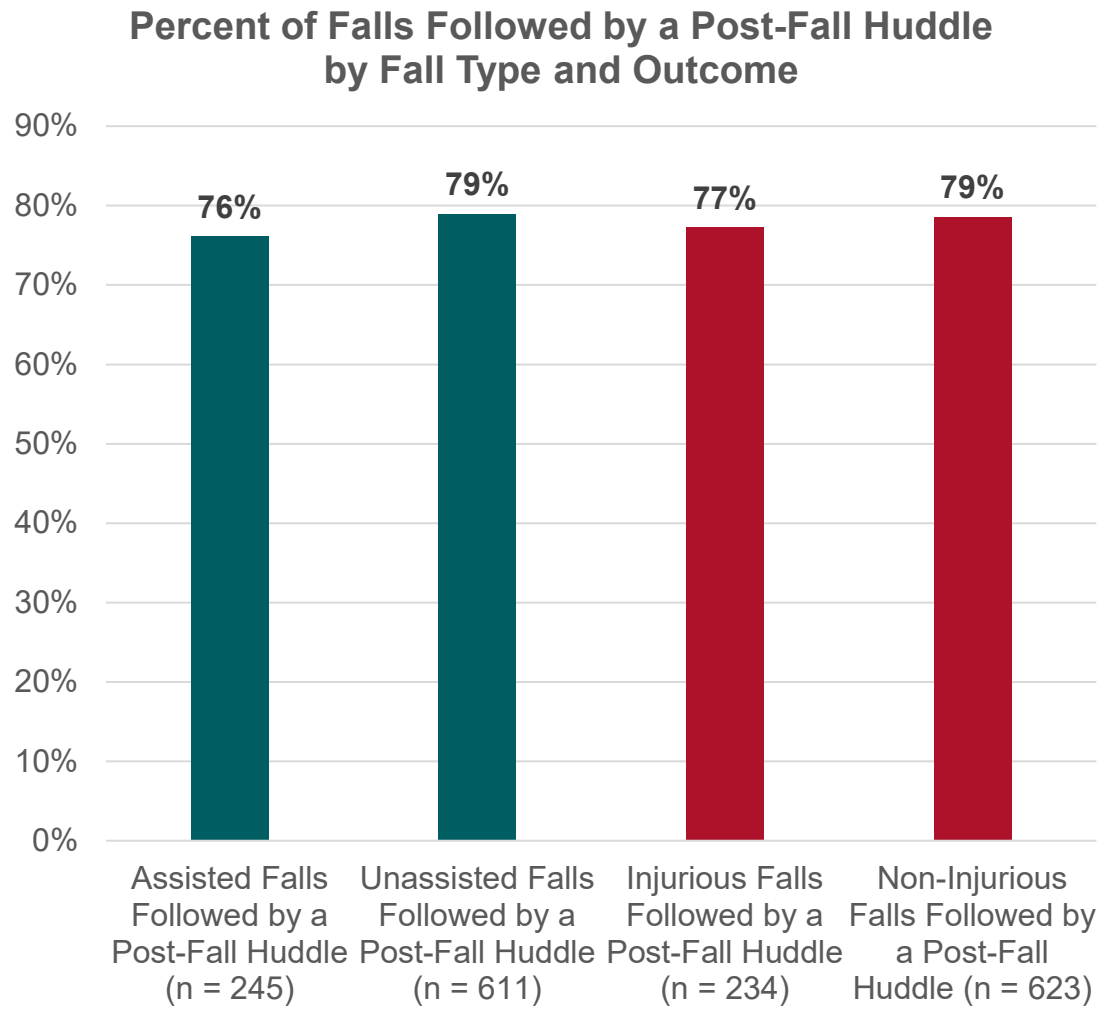
Percent of Reported Falls Followed by a Post-Fall Huddle



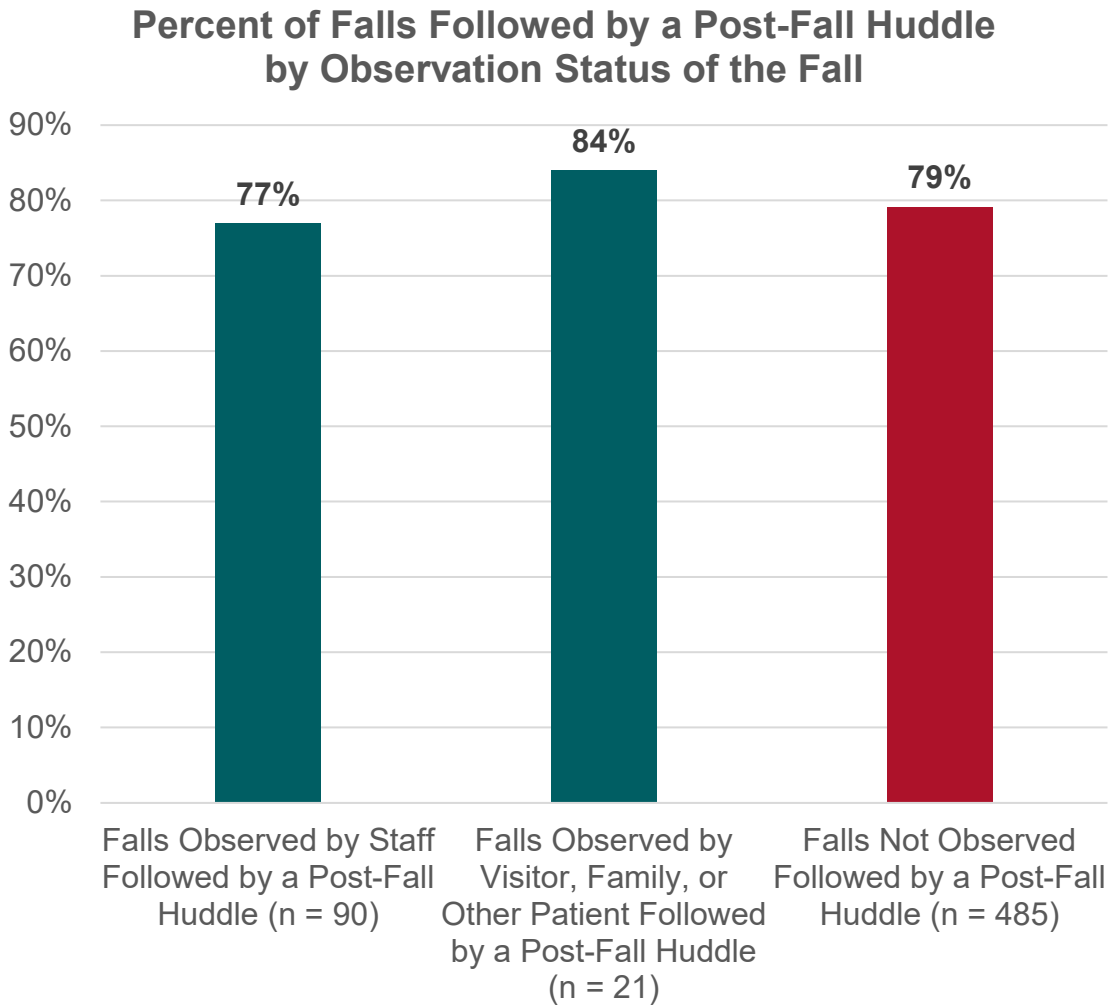
As of August 2024, **93%** of reported falls so far in 2024 were followed by a post-fall huddle

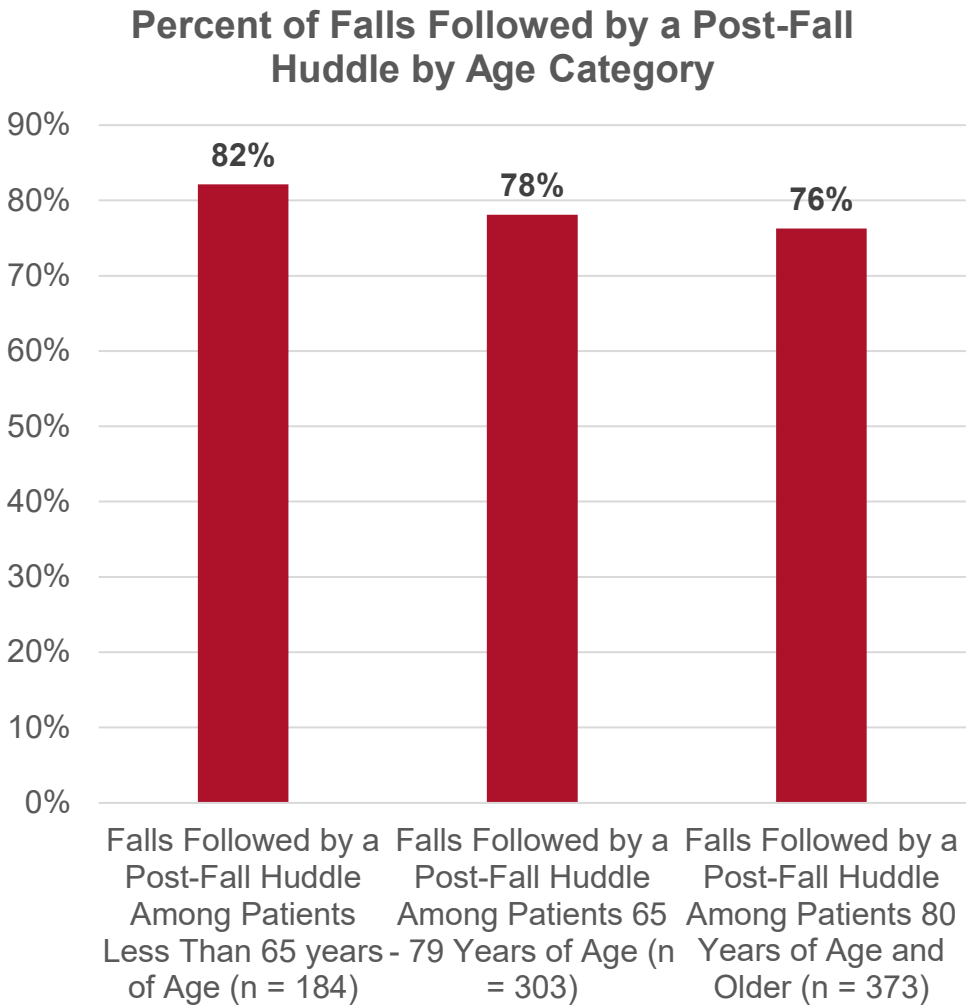
Data from the CAPTURE Falls Collaborative





Data from the CAPTURE Falls Collaborative





Data from the CAPTURE Falls Collaborative

Patients involved in **36%** of the huddles

Family or caregiver involved in **12%** of the huddles

Patient + family or caregiver involved in **8%** of the huddles

Professions involved in huddles:

Nursing involved in **93%**

OT involved in **15%**

PT involved in **17%**

Pharmacy involved in **19%**

QI involved in **11%**

'Other' involved in **26%**

Nursing + patients involved in **36%** of the huddles

'Gold standard' huddle of patient + nursing + PT or OT, + pharmacy + QI – **1%** of the huddles

Three fall case studies were shared, with a focus on the post-fall huddle component of the documentation. Discussion followed.

Discussion Questions

- How do post-fall huddles add value to learning about fall events in your facility?
- What has helped and hindered implementation of post-fall huddles in your facility?
- The patient and family were included in the huddles we reviewed today – what does their engagement in post-fall huddles look like in your facility?
- How does your facility ensure input from multiple professions in a post-fall huddle?*

**Discussion during the call focused on the final question.*

Post-Fall Huddle: Who to Include

Ideal

All relevant parties

- Staff providing direct care for the patient at the bedside
- Other members of interprofessional team involved in the patient's care at the time of the fall
- Patient
- Family/caregiver(s)

Reality

Whomever is available

- Time of day and workload level often limits who participates in the huddle
- Patient ability to participate
- Family/caregiver(s) availability to participate
- Consider creative ways to engage members of the interprofessional team (e.g., use technology; team members 'on-call' for a huddle)

Post-Fall Huddle: Who to Include Considerations

- Conduct immediate huddle with staff available at the time of the fall
- If not available at the time of the fall, engage other members of the interprofessional team (e.g. PT/OT, pharmacy) within the next day, if possible – for example,
  - Send an email notification about the fall; Ideally the recipients close the loop on this communication.
  - Incorporate discussion of the fall event into interprofessional daily rounds/safety huddles the next day
- Use checklists or other strategies to ensure that interprofessional team members are contacted and to document contact and contributions

Post-Fall Huddle: Who to Include Considerations

- A suggestion was made for an edit to Know Falls to allow for documentation of delayed interprofessional input following a post-fall huddle.
- Stay tuned for a potential change to our form to allow for that!

Additional Suggestions for the Conduct of Post-Fall Huddles

Post-Fall Huddle: Who to Lead

Huddle facilitator

- Accountable for calling and leading the huddle
- Ensures all aspects of the fall event are reviewed
- Elicits and clarifies multiple versions of the story
- Encourages positive behaviors and limits negative behaviors from huddle team members

Ideal

Trained facilitator

- Experienced in guiding conversations about fall events
- Skilled in encouraging participation and dialogue among all team members in the huddle
- Ability to keep team focused on learning for improvement

Reality

Whomever is available even if not a trained facilitator

- Nurse assigned to the patient
- Lead/charge nurse
- Fall risk reduction team member

Post-Fall Huddle: What to Discuss

CAPTURE Falls Roadmap Post-Fall Huddle Pocket Guide

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?

Ideal

Structured questions for each huddle

- Generate a clear understanding of the fall based on multiple perspectives
- Ask clarifying questions and 'why?' to identify actual issues and contributing factors

Reality

Minor modifications as needed

- Stick as close to the guide as possible
- Avoid getting 'stuck' in checklist mode
- Accommodate unexpected variations in the situation
- Allow space for ambiguity and follow-up needed

Post-Fall Huddle: When to Conduct

Ideal

As soon as possible

- Immediately after the fall
  - Within 15 minutes
- Preserve adequate recall of important details relevant to the fall
- Changes identified to reduce fall risk should be implemented as soon as possible

Reality

It depends

- The nature of the fall
- Time necessary to complete post-fall clinical assessment
- Emotional state of huddle team members
- Availability of members of the interprofessional team

Post-Fall Huddle: Where to Meet

Ideal

Location where the fall occurred

- Similar environment may trigger better recall of the circumstances of the fall
- Allows for adequate assessment of environmental factors that may have contributed to the fall

Reality

A feasible physical/virtual space

- A space similar to where the fall occurred or space for the team to openly discuss the event
- Consider patient ability to engage/be involved
- Consider use of technology to engage other team members and/or family

Post-Fall Huddle: Implementation

Lessons learned and anecdotes from our work

Creative approaches help to engage non-nursing professionals in a huddle

- Fall risk reduction team member ‘on-call’ for post-fall huddles
- Gather interprofessional team member input within 24 hours
- Email/system alert for written input on falls

Post-fall huddles after assisted falls are still helpful!

- Recognize behaviors that are consistent with safe transfer and mobility practices

Can reinforce what went well in addition to identifying areas for improvement

- Staff do a lot of things right – recognize adherence to policies and procedures

Resources: Post-Fall Huddle

CAPTURE Falls Roadmap Post-Fall Huddle

Education Resources:

- ✓ Webinar on Effective Huddles and Debriefs
- ✓ “Good” Post-Fall Huddle and “Bad” Post-Fall Huddle Videos
- ✓ Human Behavior and Fall Risk Reduction Handout

Example Huddle Tools:

- ✓ Post-Fall Huddle Guide and Documentation Form
- ✓ Post-Fall Huddle Pocket Guide
- ✓ Post-Falls Huddle Guide and Post-Fall Huddle/After Action Review

Questions about any content covered today?

Engagement with the CAPTURE Falls Program

Initial Steps

- Begin engagement or re-engagement with UNMC team on a rolling basis
- Review and sign Data Registry and Quality Improvement Agreement that acknowledges UNMC's relationship with the Nebraska Coalition for Patient Safety (NCPS) and associated confidentiality protections for data and information sharing.
- Form your team
- Complete gap analysis
- Participate in at least one consultative meeting with UNMC team to review gap analysis and establish priorities/goals

Additional Resources Available

- Use of the CAPTURE Falls online roadmap
- Further consultation with UNMC team "on-demand"
- Quarterly collaborative calls for education and program updates
- Know Falls REDCap database for reporting and learning from falls
  - Quarterly reports for hospitals that report into Know Falls
  - Participation in establishing CAH-specific fall rate benchmarks

Sustainment

- Monitor progress towards goals
- 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!
    - January 21, 2025 at 2:00pm CT
    - April 22, 2025 at 2:00pm CT
    - July 22, 2025 at 2:00pm CT
    - October 21, 2025 at 2:00pm 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 (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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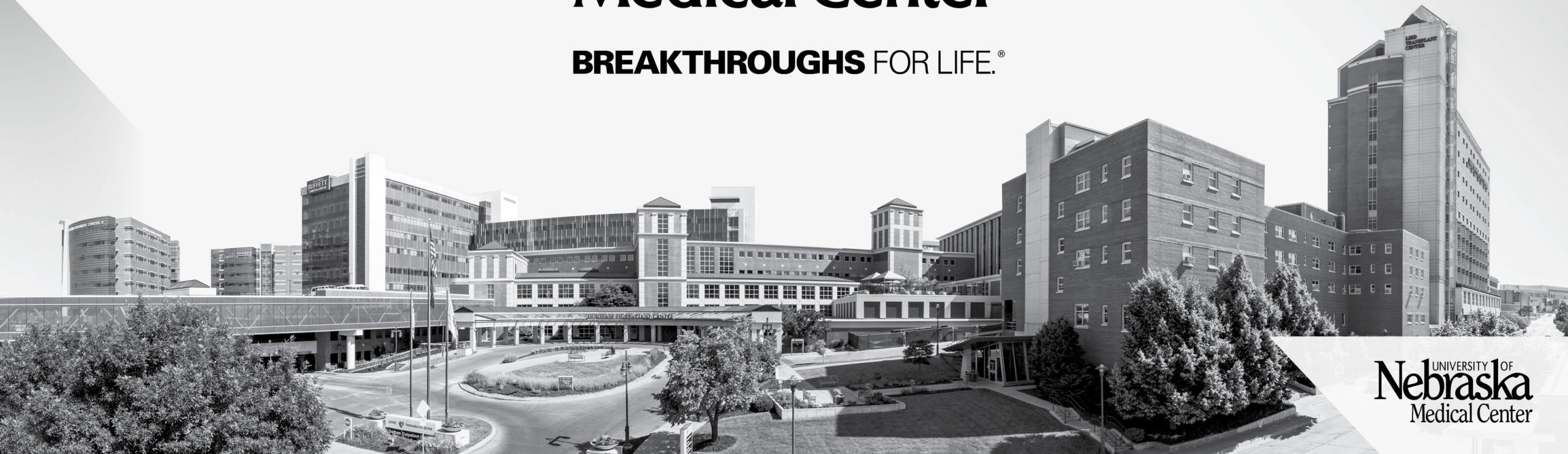

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