

CAPTURE Falls

Collaboration and Proactive Teamwork Used to Reduce

NHA and CAPTURE Falls HQIC Virtual Learning Cohort

Session 3: September 1, 2021

- Results of Gap Analysis
- Creating an Auditing Program

Housekeeping



- ✓ Zoom etiquette
- ✓ Add team to chat
- ✓ Where to find prior recordings

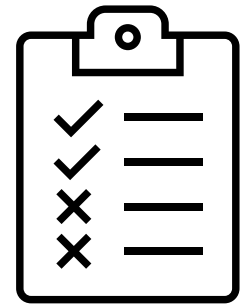
NHA and CAPTURE Falls HQIC Falls Virtual Learning Cohort

3-Month Rapid Cycle Improvement Project

All Sessions will be held via Zoom

- **Session #1 Kick-Off** – Wednesday, August 4, 2021 – 12:00 to 12:45 PM CT
Program goals, team creation, introduction to fall risk reduction gap analysis
- **Session #2** – Wednesday, August 18, 2021 – 12:00 to 1:00 PM CT
Tour CAPTURE Falls Roadmap, completion of gap analysis due
- **Session #3** – Wednesday, September 1, 2021 – 12:00 to 1:00 PM CT
Review gap analysis findings, education on auditing process measures
- **Session #4** – Thursday, September 16, 2021 – 12:00 to 1:00 PM CT
Support call for technical assistance – Optional time for additional Technical Assistance
- **Session #5** – Wednesday, September 29, 2021 – 12:00 to 1:00 PM CT
Review audit data, create PDSA, topic-specific education
- **Session #6** – Wednesday, October 27, 2021 – 12:00 to 1:00 PM CT
Review PDSA results, topic-specific education
- **Session #7** – Wrap-up – Tuesday, November 30, 2021 – 12:00 to 1:00 PM CT
Identify future areas of opportunity, review additional resources

Results of the Fall Risk Reduction Gap Analysis



Interprofessional
fall risk
reduction team

95% have a team
accountable for
implementing the fall
risk reduction program



Gap analysis

10% have completed a
gap analysis within the
past 1-2 years

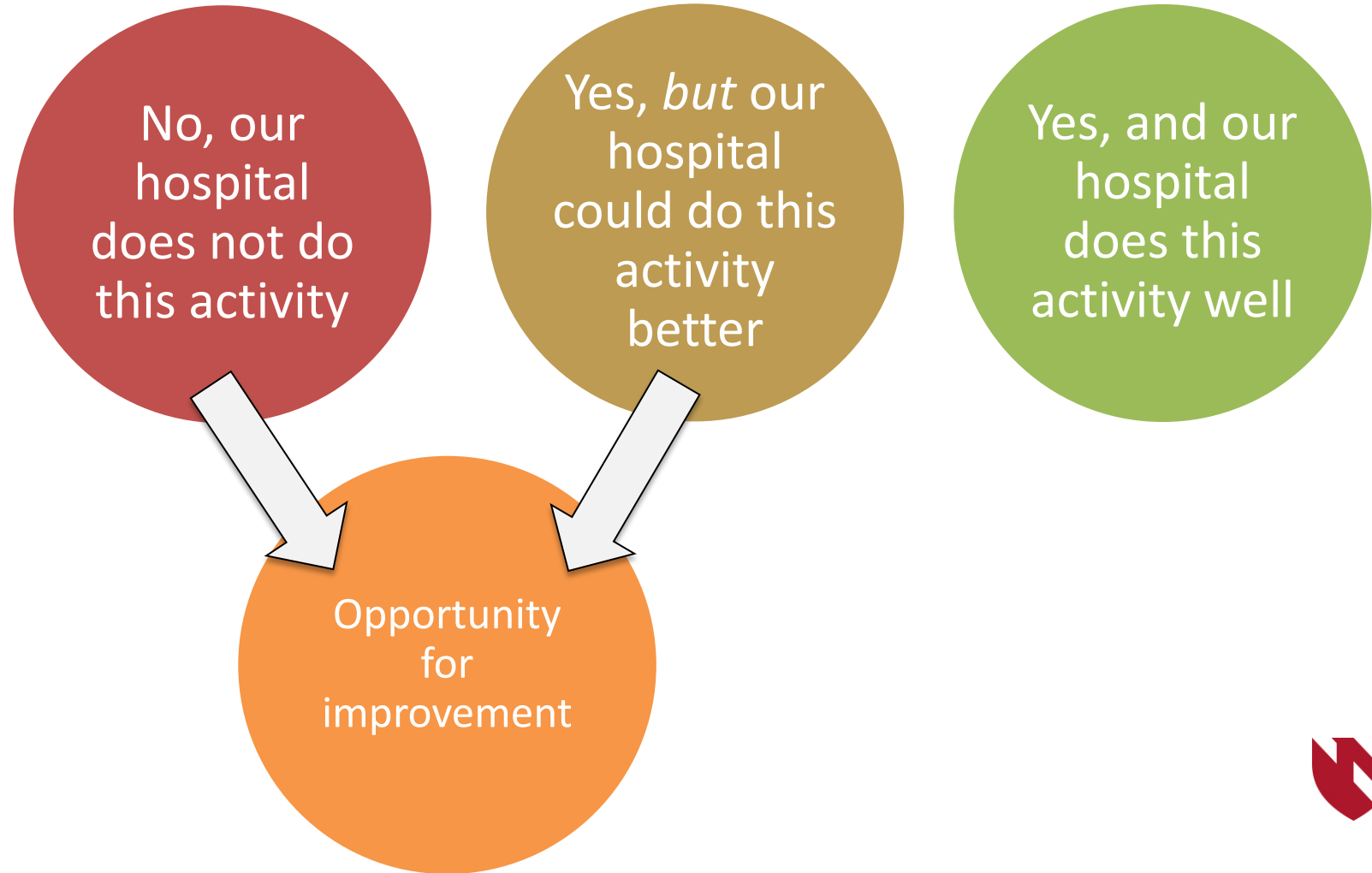
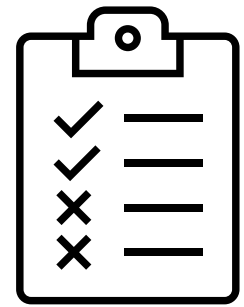


Action plan

50% have a current
action plan for your fall
risk reduction program



Results of the Fall Risk Reduction Gap Analysis



Areas with Greatest Opportunity for Improvement



Auditing fall
risk reduction
practices

70% conducting audits to monitor adherence to fall risk reduction practices

75% communicating results of audits to staff



Post-fall
clinical
assessment

60% adopting a post-fall clinical assessment protocol

65% educating staff to use the post-fall clinical assessment protocol

60% utilizing the post-fall clinical assessment protocol after a patient fall



Post-fall
huddle

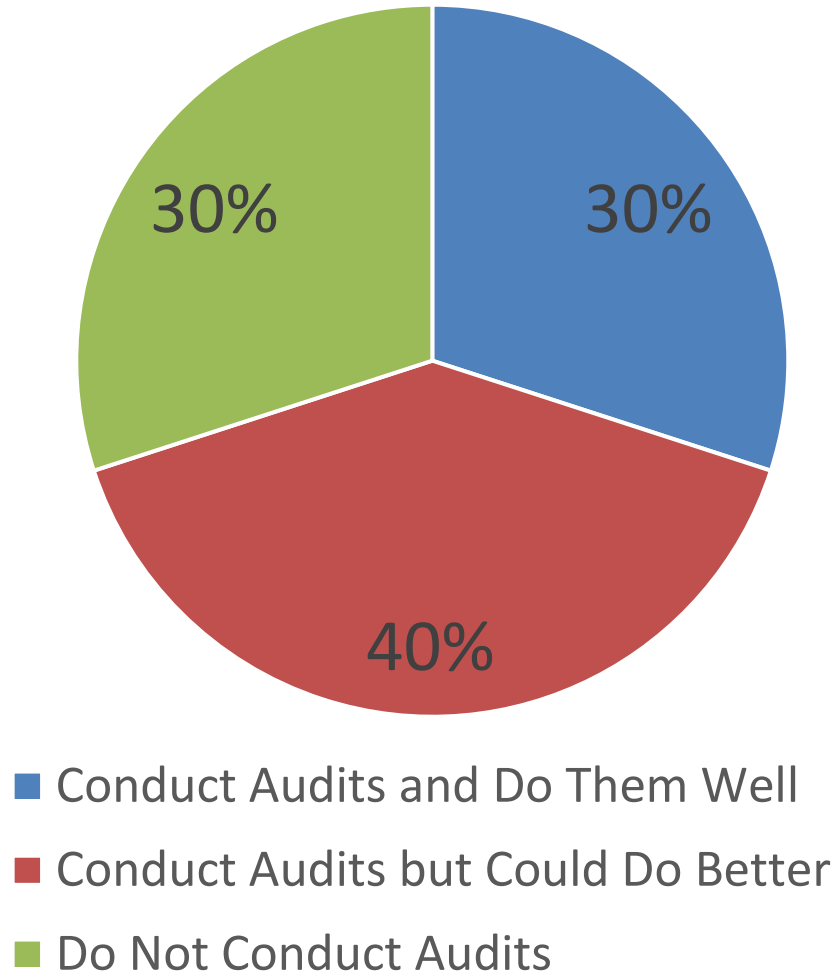
65% adopting post-fall huddle tools and processes

75% educating staff to conduct post-fall huddles

65% conducting a post-fall huddle after a patient fall



Why Are We Presenting Today About Auditing?

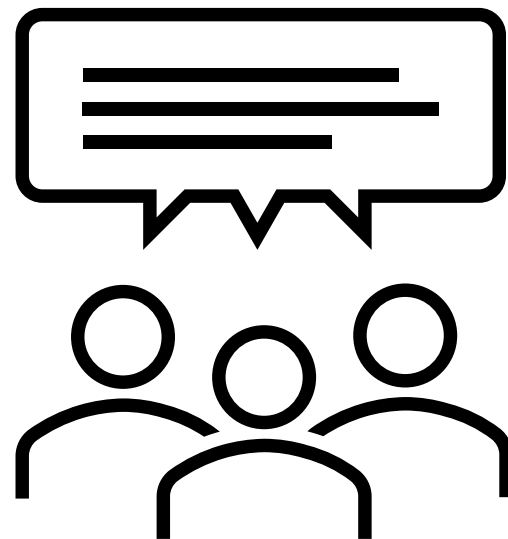
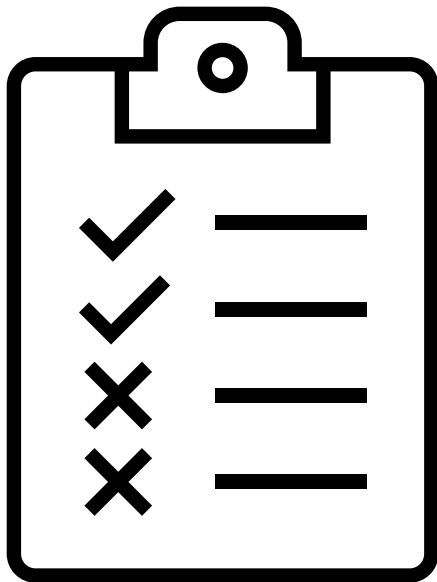


N = 20 hospital respondents



Auditing Fall Risk Reduction Practices

- ✓ Real-world example of auditing in action
- ✓ Best practices for building an auditing and feedback program



AUDITING



WHAT? A systematic process to obtain evidence to verify that activity is being conducted in compliance with policies and procedures.



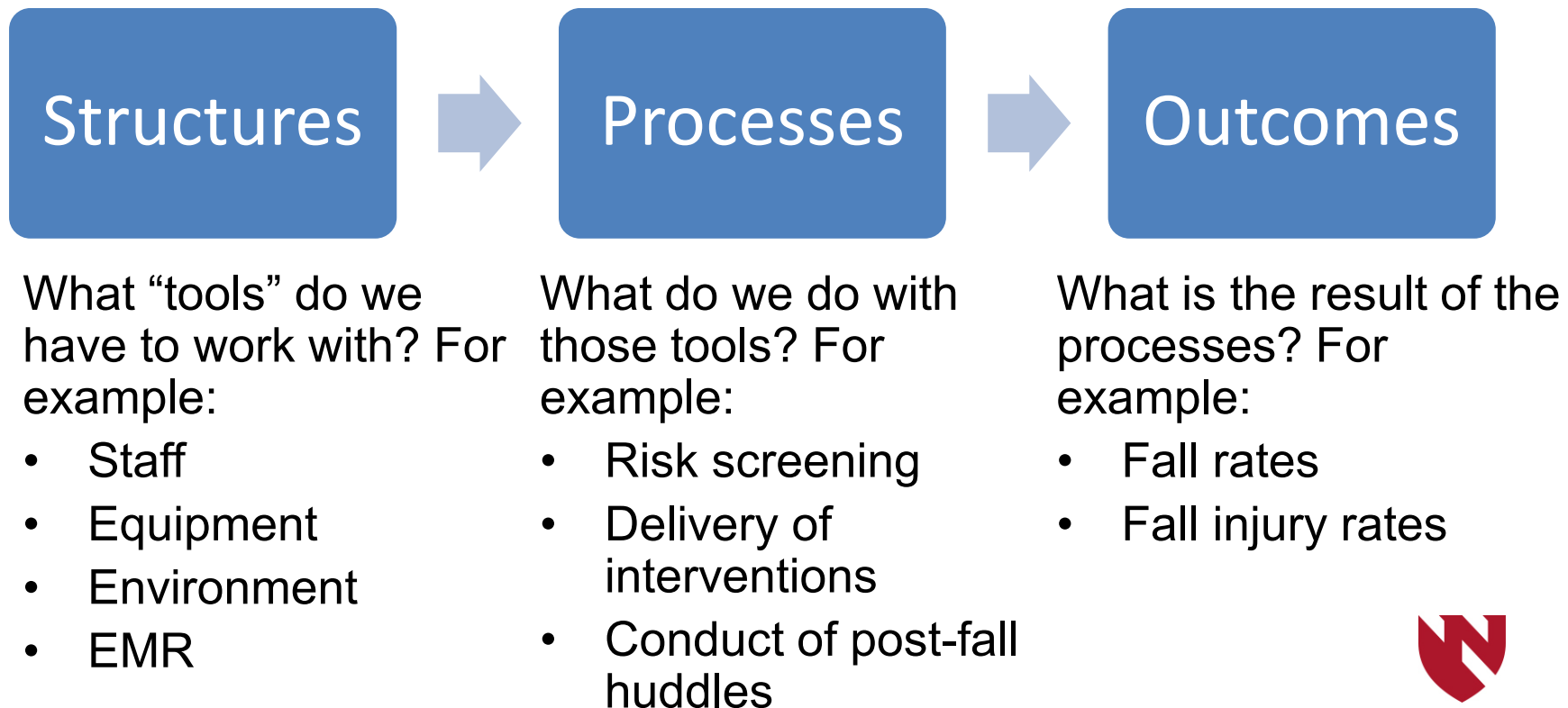
WHY? Determining the consistency of your processes gives you another metric of the success of your program beyond considering only fall and fall injury rates.



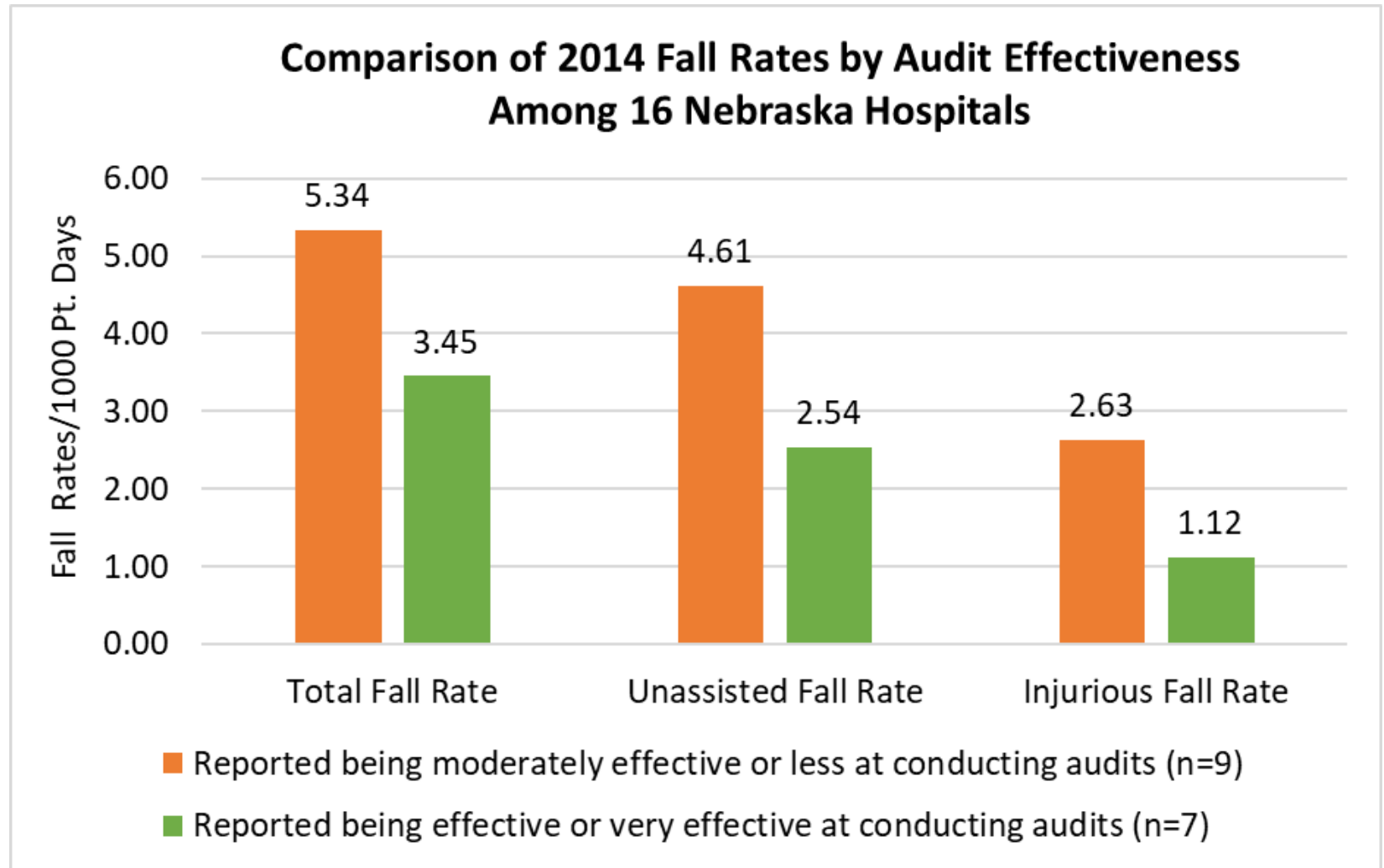
HOW? Information on subsequent slides

More WHAT: Donabedian's Quality Framework

AUDITING



More WHY: Relationship of Auditing and Fall Rates in a Sample of NE Hospitals



Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
What to audit?	<ul style="list-style-type: none">- Completion of risk assessment tool- Care processes (e.g. interventions)- Completion of relevant documentation if a fall occurs	<ul style="list-style-type: none">- Equipment safety and function (e.g. w/c parts, call lights, alarms)- Environment (e.g. clutter, lighting)	<ul style="list-style-type: none">- Individual Patient's Environment (e.g. Does equipment or furniture fit patient? Do w/c brakes work?)- General Environment (e.g. clutter, lighting, security of grab bars)

Aggregate Gap Analysis Data

- What to audit?
- Of 14 hospitals who reported conducting audits:



Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
Who to conduct audit?	Unit Manager or Unit Champion	Management Staff, Nursing	<ul style="list-style-type: none">- Individual Patient's Environment: Nurse admitting the patient- General Environment: "Person in charge of the area"



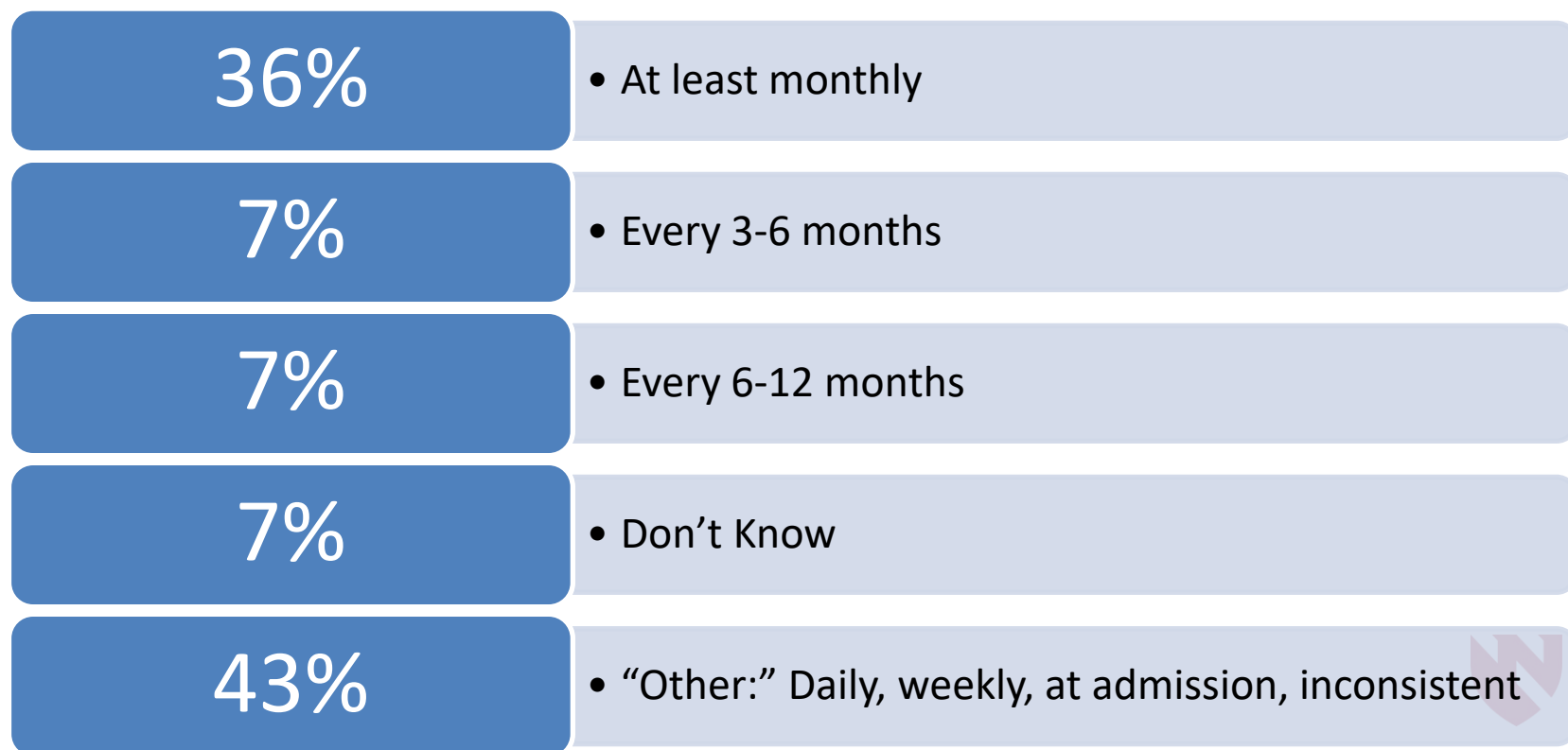
Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
Which patients to audit?/ When to audit?	OK to select arbitrary number of percentage of census	Not addressed	<ul style="list-style-type: none">- Individual Patient's Environment: every patient upon admission- General Environment : At regular intervals (e.g. monthly)



Aggregate Gap Analysis Data

- When to audit?
- Of 14 hospitals who reported conducting audits:



Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
How to audit?	Use of checklist with <ul style="list-style-type: none">- Direct observation of care- Medical Record Review- Surveying staff	Use of checklist and direct observation of equipment and environment	Use of checklist and direct observation of equipment and environment



Suggestions from CAPTURE Falls:

What to audit?	Who to conduct audit?	Which patients to audit/When to audit?	How to audit?
<ul style="list-style-type: none">- Completion of fall risk tool per policy- Care processes (particularly new ones) to help routinize- Patient/Family awareness of interventions- Care processes uncovered as concerns through reflection on fall events or in past audits- Environment and equipment	Members of organization-wide fall risk reduction team	<ul style="list-style-type: none">- Select a random sample on a regular, recurring basis- Number or percentage of patients depends on your typical census and what is feasible	<ul style="list-style-type: none">- Use an existing checklist or modify one for your needs- Combination of direct observation, medical record review, and patient and staff interview depending on items being audited

Sample Auditing Tools (checklists)

- <https://www.unmc.edu/patient-safety/capturefalls/roadmap/fall-audit/tools.html>
- Some examples are directly from NE Hospitals (shared with permission)
- Other examples from other reputable sources

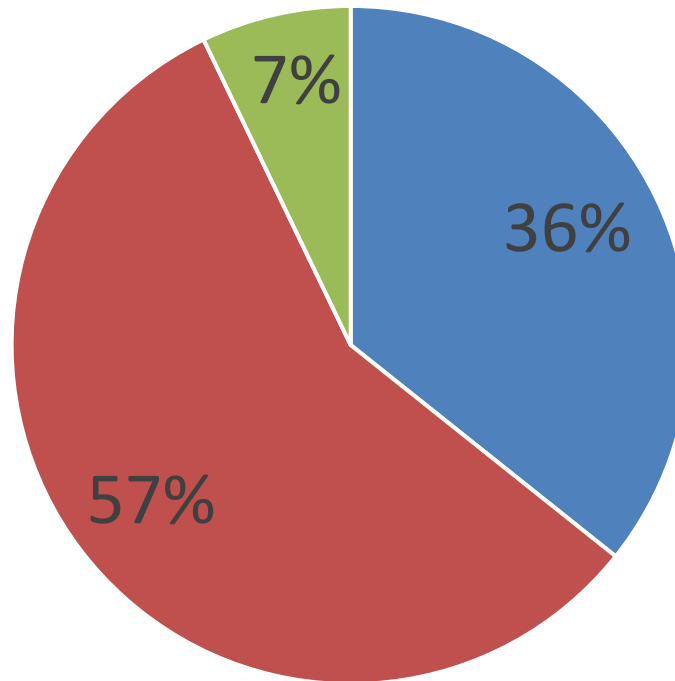


Best practices for auditing fall risk reduction interventions

	Agency for Healthcare Research and Quality	U.S. Department of Veteran's Affairs	Victorian Quality Council
What to do with results?	Reflect on barriers and develop plan to address unfavorable results	Not addressed	Immediately address issues for individual patients



Your Communication of Audit Results to Staff



- Communicate Audit Results Well
- Could Communicate Audits Results Better
- Do Not Communicate Audit Results



N = 14 hospital respondents who conduct auditing

What to do with audit results?

Audit *and* feedback

Organization
commitment to a
constructive, non-
punitive approach
to improvement

Analyze/interpret
results of audit*

Determine how to
share the data/results
(e.g., writing, verbal);
comparison data
provided

Determine who will
share the data/results

Determine when to
share the data/results
with the recipient(s)

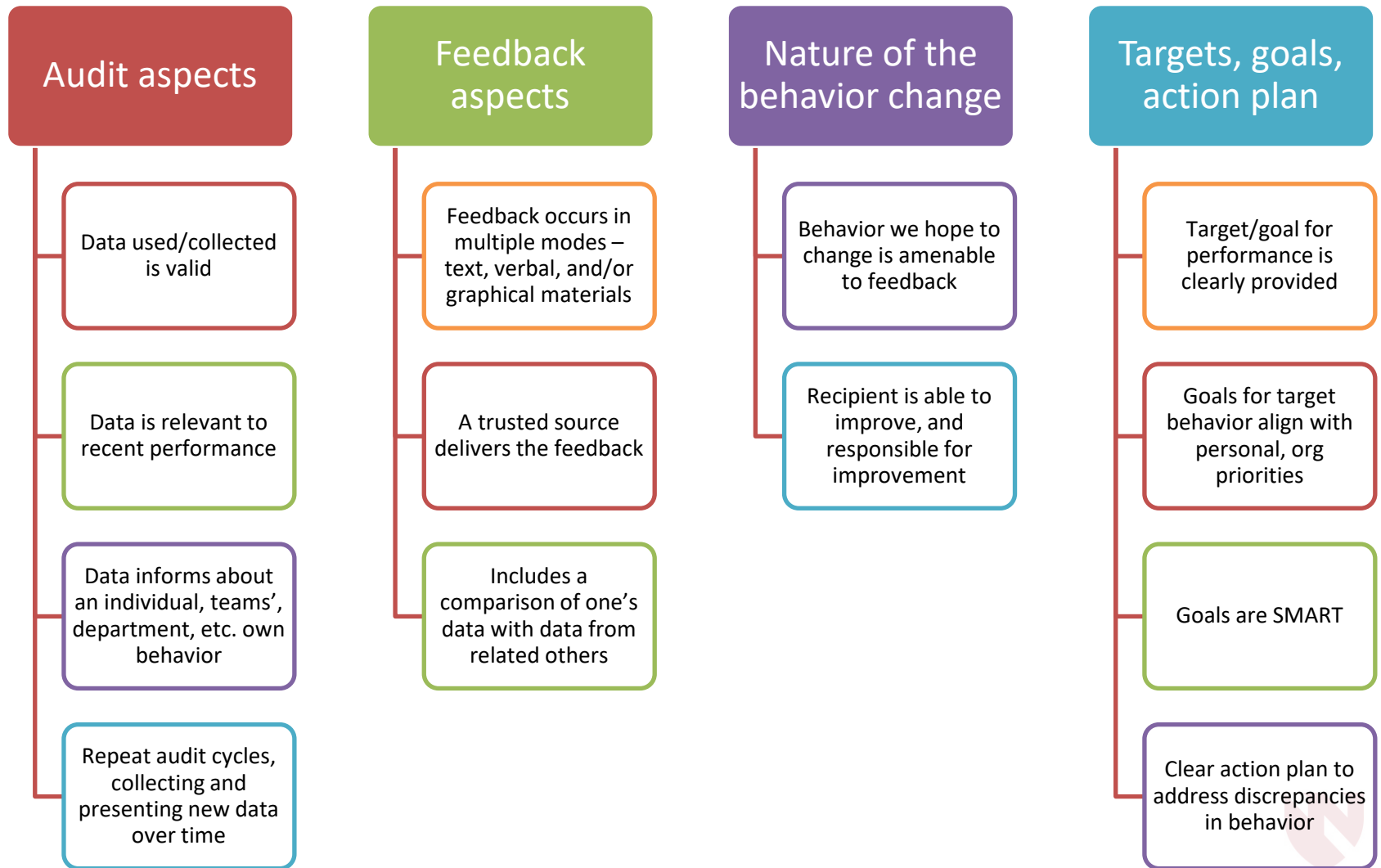
Reflect on/discuss
potential reasons for
successes and for gaps

Generate goals and
develop plan to
improve performance

*Immediately address issues for individual patients, document changes made after audit (e.g. update care plan, etc.)



Summary: Best practices for auditing and feedback interventions



Best practices for auditing fall risk reduction interventions – for more information:

Agency for
Healthcare
Research and
Quality

https://www.ahrq.gov/sites/default/files/publications/files/fallpx_toolkit_0.pdf
<https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original> (see link for “Measurement grid word template”)

U.S.
Department of
Veteran’s
Affairs

- <https://www.patientsafety.va.gov/professionals/onthejob/falls.asp> (see link for “Falls Policy” and then information re: “Environmental Checklist and Rounds” including Attachments 1 and 2 within that document)

Victorian
Quality Council

- <https://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/tools.pdf> (see section on “Environmental Audits” within this document)

Open Access Resource on Auditing and Feedback

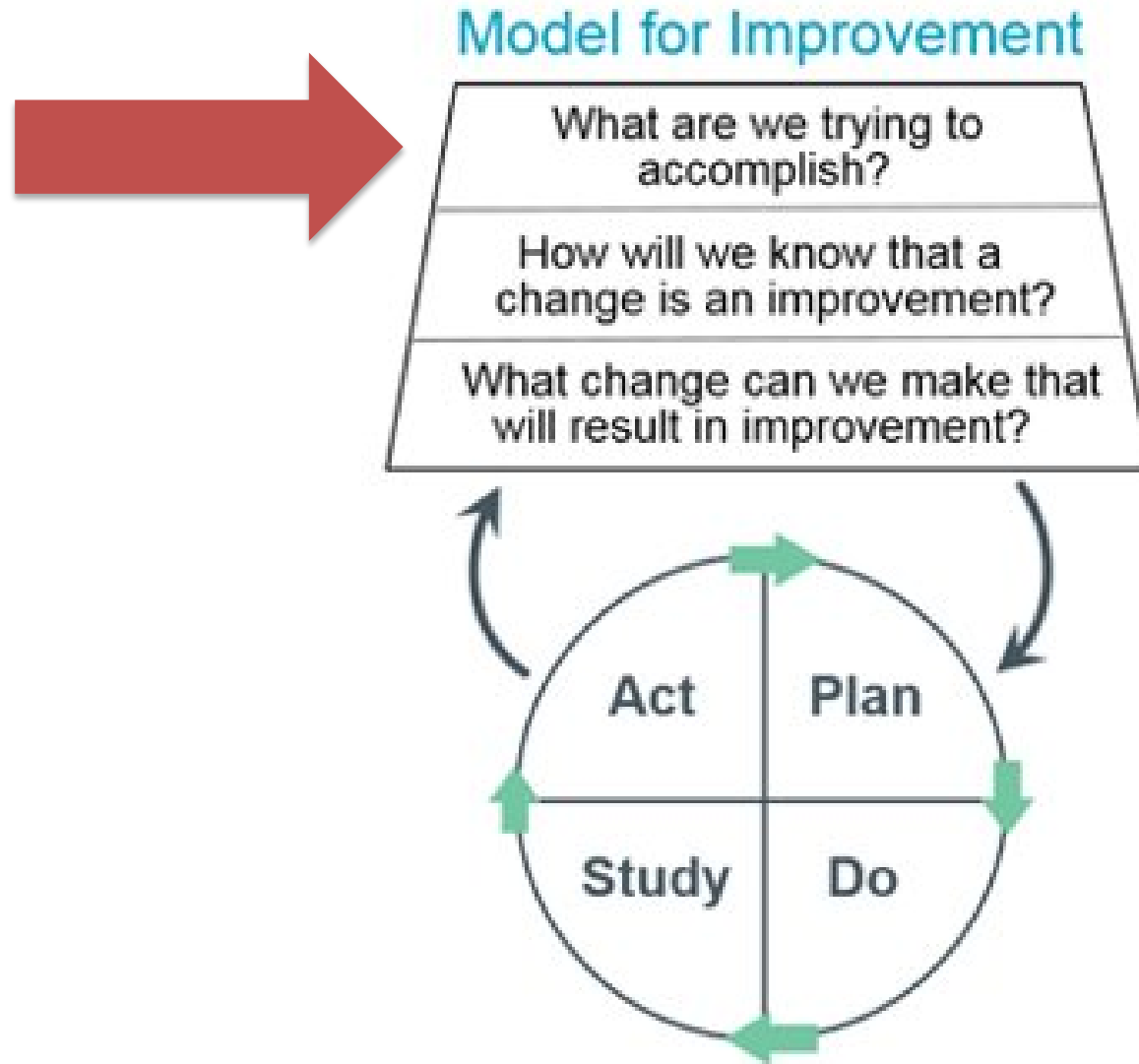
- Ivers N, Jamtvedt G, Flottorp S, et al. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database Syst Rev. 2012 Jun 13;(6):CD000259. doi: 10.1002/14651858.CD000259.pub3.
- <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000259.pub3/full>



Pause for Questions



Model for Improvement



Session #3 Wrap Up, Action Items

✓ Action Items:

- ☐ Decide what you want to audit within the next month
- ☐ Explore audit tools, select and/or adapt tool to use
- ☐ Develop plan for who will conduct audit
- ☐ If consultation is desired, plan to attend on Sept 16 (Session #4)
- ☐ Conduct audit by Sept 29 (Session #5) so you can share your experience



Next Steps for NHA HQIC Programming

- Next Session (#4): Sept 16, 2021, 12:00 – 1:00 PM CT
 - Optional technical assistance time: support, guidance, and collaboration as you create your auditing tool and process
- Session 5: Sept 29, 2021, 12:00 – 1:00 PM CT
 - Discussion of your auditing experience



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(2012 – 2015)

