IHI Expedition

Protecting Your Patients from Injurious Falls

Session 2

February 13th, 2013

These presenters have nothing to disclose

Pat Quigley, PhD, ARNP, CRRN, FAAN, FAANP
Kathy Duncan, RN
Kayla DeVincentis, CHES, Project Coordinator, has worked at IHI since 2009, starting as an intern in the Event Planning department. Since then, Kayla has contributed to the STAAR Initiative, the IHI Summer Immersion Program, and the Expeditions. Kayla obtained her Bachelor’s in Health Science from Northeastern University and brings her interest in health education and wellness to IHI’s Work-Life Wellness Team.
Welcome to today’s session!
Please use chat to “All Participants” for questions
For technology issues only, please chat to “Host”
WebEx Technical Support: 866-569-3239
Dial-in Info: Communicate / Join Teleconference (in menu)
When Chatting...

Please send your message to All Participants
Poll Question

How many people are calling in with you today?
Expedition Director

Kathy D. Duncan, RN, Faculty, Institute for Healthcare Improvement (IHI), co-leads IHI's National Learning Network and manages the 24 IHI Improvement Map support care processes. Ms. Duncan also directs IHI Expeditions, manages IHI's work in rural settings, and provides spread expertise to Project JOINTS. Previously, she co-led the 5 Million Lives Campaign National Field Team and was faculty for the Improving Outcomes for High Risk and Critically Ill Patients Innovation Community. She also served as the content lead for the Campaign's Prevention of Pressure Ulcers and Deployment of Rapid Response Teams areas. She is a member of the Scientific Advisory Board for the AHA NRCPR, NQF's Coordination of Care Advisory Panel, and NDNQI's Pressure Ulcer Advisory Committee. Prior to joining IHI, Ms. Duncan led initiatives to decrease ICU mortality and morbidity as the director of critical care for a large community hospital.
Today’s Agenda

- Introductions
- Debrief Session 1 Assignment
- Injury Risk Assessment
- Communication of Risk
- Homework for next session
Ground Rules

- We learn from one another – “All teach, all learn”
- Why reinvent the wheel? - Steal shamelessly
- This is a transparent learning environment
- All ideas/feedback are welcome and encouraged!
Overall Program Aim

To provide you, your teams and organization with tools and strategies to reduce preventable falls incidence, injury from falls, and outline the key components of sustaining and spreading successfully.
Expedition Objectives

At the end of the Expedition each participant will be able to:

- Differentiate types of falls as a basis for analysis of program effectiveness
- Integrate injury prevention into existing fall prevention programs
- Inventory tests of change in fall and injury prevention interventions
- Summarize successes ready for adoption and spread
- Plan small tests of change they can test throughout the Expedition
Schedule of Calls

Session 2 – Injury Risk Assessment and Communication of Risk  
**Date:** Wednesday, February 13, 1:00 PM – 2:00 PM ET

Session 3 – Interventions to Reduce Falls and Falls Harm Part I  
**Date:** Wednesday, February 27, 1:00 PM – 2:00 PM ET

Session 4 – Interventions to Reduce Falls and Falls Harm Part II  
**Date:** Wednesday, March 13, 1:00 PM – 2:00 PM ET

Session 5 – Preventing Falls with Injury Assessment Tool and Patient Education Resources  
**Date:** Wednesday, March 27, 1:00 PM – 2:00 PM ET

Session 6 – How to Sustain and Spread Improvements in Reducing Falls and Injury from Falls  
**Date:** Wednesday, April 10, 1:00 PM – 2:00 PM ET

Session 7 – Accomplishments, Barriers, and Next Steps  
**Date:** Wednesday, April 24, 1:00 – 2:00 PM ET
Faculty

Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Associate Director, VISN 8 Patient Safety Center of Inquiry, is both a Clinical Nurse Specialist and a Nurse Practitioner in Rehabilitation. As Associate Chief of Nursing for Research, she is also a funded researcher with the Research Center of Excellence: Maximizing Rehabilitation Outcomes, jointly funding by HSR&D and RR&D. Her contributions to patient safety, nursing and rehabilitation are evident at a national level – with emphasis on clinical practice innovations designed to promote elders’ independence and safety. She is nationally known for her program of research in patient safety, particularly in fall prevention. The falls program research agenda continues to drive research efforts across health services and rehabilitation researchers.
Assignments for Session 2

- Declare an Aim Statement
  - Identify which risk assessment tool you will use
- Identify at least one gap between current performance and stated aim
- Complete the Injurious Fall Prevention Organizational Self-Assessment with your team
- Complete the Injurious Fall Data Collection Tool for 5 patients
Aim Setting

- What will be done
- Within what timeframe
- Outcome that is measurable

Volunteers

- Nicole Harrison, Memorial Hermann
- Joan Miller, Indiana University Medical Center
- Dawn Voss, Mahaska Health Partnership
Injury Risk Assessment and Communication of Risk

Special Recognition: Robert Wood Johnson Foundation Funding
This material is the result of work supported with resources and the use of facilities at the James A. Haley Veterans’ Hospital.
Today’s Topics

- Protection from Injury – a New Approach
  - ABCS Tool
  - IHI Matrix
  - Strategies to integrate injury assessment and identification into clinical practice

- Hand-off Communication Methods
  - Signage revisited

- Patients as Partners in Care
  - Teach Back strategies
Protect from Injury

Protecting Patients from Harm – Our Moral Imperative
ABCS: Moderate to Serious Injury

- Those that limit function, independence, survival
- Age
- Bones (fractures)
- C - Bleeds (anticoagulation; hemorrhagic injury)
- Surgery (post operative)
Age: > 85 years old

- Education: Teach Back strategies
- Assistive devices within reach
- Hip protectors
- Floor mats
- Height adjustable beds (low when resting only, raise up bed for transfer)
- Safe exit side
- Medication review
Bones

- Hip protectors
- Low beds
- Floor mats
- Evaluation of osteoporosis
Bleeds

- Evaluate use of anticoagulation: Risk for DVT/Embolic stroke or fall-related hemorrhage
- Patient education
- TBI and anticoagulation: Helmets
- Wheelchair users: Anti-tippers
Surgical Patients

- Pre-op education:
  - Call, Don’t Fall
  - Call lights

- Post-op education

- Pain medication:
  - Offer elimination prior to pain medication

- Increase frequency of rounds
ABCS Tool

- **A**: Age >85
- **B**: Bones: History of fractures- Hip (although multiple fx could be a sign); Certain Diagnoses- (osteoporosis, bone metastasis); Treatments or medications that cause bone to be weak
- **C**: Coagulation: Blood Thinners (coumadin, heparin gtt); Coagulopathy
- **S**: Risk of Surgical complications post surgery (Recent Abdominal, thoracic surgery, lower limb amputation)
IHI Matrix: Putting It All Together......

- For all patients:
  - Cultural infrastructure/leadership for safety
  - Universal fall preventions
  - Assess for risk of fall *and* harm from fall

- Interventions according to assessment as on matrix
  - Reduce falls
  - Prevent injury
## Fall Prevention and Injury Reduction Matrix
(Assumes Universal Falls Prevention Implemented)

<table>
<thead>
<tr>
<th>RISK OF FALL</th>
<th>+RISK FALL/−RISK INJURY</th>
<th>−RISK FALL/−RISK INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Implement fall reduction interventions</td>
<td>Implement injury prevention interventions</td>
</tr>
<tr>
<td></td>
<td>Assess, intervene and communicate if <em>injury risk</em> changes</td>
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</tr>
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</tr>
</tbody>
</table>

+ RISK FALL/+ RISK INJURY

− RISK FALL/+ RISK INJURY

− RISK FALL/− RISK INJURY

+ RISK OF INJURY FROM A FALL
Question

- How many people are currently using the matrix?
  - Use the “Raise Hand” button if you are!

26
Using the Matrix

- Implement universal falls prevention
- Assess every patient initially for both fall and injury risk, and place in one of the four quadrants
- Implement interventions (per matrix) for each patient within their individual plan of care
- Evaluate for specific triggers that will move the patient from one quadrant to another
Green Quadrant:
– Risk Fall and – Risk Injury

○ Assess, intervene and communicate if fall risk or injury risk changes

○ Triggers include (but are not limited to):
  – Fatigue/weakness
  – Change in meds
  – Change in elimination status (for example for 24 hours after removal of urinary catheter)
  – Change in cognitive status
  – Change in bleeding status (new dx or addition of anticoagulants)
  – Recognition of osteoporosis/osteopenia
  – New surgery
Yellow Quadrant:
+ Risk Fall / – Risk Injury

- Implement fall *reduction* interventions
- Assess, intervene and communicate if *injury risk* changes
- Triggers for reassessment include:
  - Change in bleeding status (new diagnosis or addition of anticoagulants)
  - New diagnosis of osteoporosis/bone-thinning disorder
  - New surgery
  - Use critical thinking to identify other triggers
Orange Quadrant
– Risk Fall / + Risk Injury

Implement injury prevention interventions

- Assess, intervene and communicate if *fall risk* changes
- Triggers include (but are not limited to):
  - Fatigue/weakness/impaired mobility
  - Change in medications, elimination status, cognitive status
Red Quadrant:
+ Risk Fall / + Risk Injury

- Implement fall reduction interventions
- Implement injury prevention interventions
- Assess, intervene and communicate if fall risk or injury risk changes
Questions?

Raise your hand

Use the Chat
Universal Injury Prevention

- Educate patients / families / staff
  - Remember 60% of falls happen at home, 30% in the community, and 10% as in-patients
  - Take opportunity to teach
- Remove sources of potential laceration
  - Sharp edges (furniture)
- Reduce potential trauma impact
  - Use protective barriers (hip protectors, floor mats)
- Use multifactorial approach: COMBINE Interventions
- Hourly patient rounds (comfort, safety, pain)
- Examine environment (safe exit side)
# Fall Prevention and Injury Reduction Matrix

(Assumes Universal Falls Prevention Implemented)

<table>
<thead>
<tr>
<th>RISK OF FALL</th>
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<tbody>
<tr>
<td>+</td>
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Integrate Injury Risk into Assessment

Add to:
- Fall program policy
- Patient admission assessment policy and tools
- Handoff reports
- Patient problem list, i.e. Hx of hip fracture
Team Assessments

- Progress report?
- Any gaps identified yet?
  - Action steps started?

Please share!
Learning from Analysis

Lessons from examining 3 injurious falls

What did you learn?
Patient Characteristics

Percentage of patients with one or more characteristics who suffered moderate or higher injury from a fall

- Blood (anticoagulants or bleeding disorder): 54.2%
- Toileting issues: 50.0%
- Antihypertensives: 37.5%
- Mobility (up and go test): 37.5%
- Bones (osteoarthritis): 33.3%
- Ages 65+: 29.2%
- History of previous fall: 25.0%
- Psychotropic meds: 16.7%
- Anticonvulsants: 4.2%
Reducing Patient Injury from Falls

- Assess Risk of Falling and Risk for a Serious / Major Injury from a Fall
- Communicate and Educate (Staff, Patients and Family Members)
- Standardize Interventions for Patients at Risk for Falling
- Customize Interventions for Patients at Highest Risk of a Fall-Related Injury

Our aim achieve a 95% or better reliability for each process step
Moderate to Serious Injury

- Those that limit function, independence, survival
- Age
- Bones (fractures)
- Bleeds (hemorrhagic injury)
- Surgery (post operative)
Communication of Risk

- Handoff communication
- Hardwire content
- Hardwire process
Communication With Patients/Staff About Fall Reduction/Injury Prevention

Label or signal patients assessed at risk of fall or injury

- Use signage/other visual indicators (bracelets, colored socks, special blankets, etc.)

Ensure Safe Handoffs

- Verbalize and repeat-back risk of fall and risk of harm from fall at change of shift
- Verbalize and repeat-back risk of fall and risk of harm from fall between departments
Communication With Patients/Staff about Fall Reduction/Injury Prevention

Verify Understanding

- Use teach-back strategies to verify what patients and families understand and customize education about harm risk accordingly

Learn from Failures and Transfer Learning

- Use unit-based post-fall team huddles to learn what happened and how to prevent injuries from future falls
- Discuss post-fall huddle findings at house-wide nurse manager meetings
Visual Cues

- Re-evaluate use of visual cues
  - Patients
  - Staff
- Reinvent usage to identify vulnerable patients at risk for injury
Health Literacy

“Teach Back”
and
Ask Me 3

gnielsen@ihi.org
Patients

And Family
  – Partners in Care
Health Literacy

How many patients understand what we tell them or give them to read? According to the research, about 52%

Health Literacy Definition: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

(Ratzan and Parker, 2000)

IOM Report: Health Literacy: A Prescription to End Confusion 2004
healthliteracy@ama-assn.org
“Teach Back”

“Teach Back” Testing: what are the trends in patients’ difficulty to understand what is taught?

Ask the patient to describe or repeat back in his or her own words what has just been told or taught. Return demonstration is a similar technique used by diabetic educators, physical therapists, and others. When the health professional hears the patient’s description in her/his own words, further teaching can be accomplished to correct misunderstandings. Never ask whether patients understand; they always say “yes”.
When “Teach Back” Is Especially Important

- New medications
- A new diagnosis
- Instructions for calling for help to BR
- Instructions for self care
  - e.g. ask, “How can you stay safe from falling in the hospital?”
- Patients are cautioned on how to prevent falls in the hospital
  - e.g. young male patients who suddenly have high doses of pain meds but want to toilet themselves. Ask, “How will you best prevent yourself from falling when you are given this powerful drug for pain that is known to cause falls?”
Ask Me 3

How many patients understand what we teach them?

- Teach patients with this format:
  - Their main problem putting them at fall risk
  - What they need to do to keep from falling in hospital
  - Why is it important for them to do this

- Check the family‘s understanding:
  - What is the patient’s main problem?
  - What can the patient to do to stay safe from falling in the hospital?
  - Why it is important for the patient to do this?

http://www.askme3.org/
IHI’s Innovation Process for Reducing Patient Injury from Falls

- Review clinical evidence
- Review historical trending data to understand patterns
- Observe the current processes >> identifying failures and “best practices”
- Create a concept design of the “vital few” changes (to incorporate evidence-based interventions and current “best practices” and to mitigate the identified failures)
- Develop process and outcome measures
- Test individual changes and composite of all changes
- Design processes to reliably implement successful changes
- Continue to redesign and adapt the “vital few” changes until you achieve the desired results
Questions?

Raise your hand

Use the Chat
Assignments for Session 3

- Test injury risk assessment on admission on 3-5 patients
- Test use of ABCS tool on 3-5 patients
- Test use of visual cues
- Standardize and test risk communication – hand off tool
- Practice Teach Back Strategy on 2-3 patients
**Example PDSA Form**

**Worksheet For Testing Change**

**Aim:** (Overall goal you would like to reach)  
**Decrease injuries from inpatient falls by 50% by 12/31/13.**  
Every goal will require multiple smaller tests of change

<table>
<thead>
<tr>
<th>Describe your first (or next) test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/13/13: Test the Process for completing a fall injury risk assessment on admission to the hospital.</td>
<td>Bonnie</td>
<td>2/15</td>
<td>4N</td>
</tr>
</tbody>
</table>

**Plan**

List the tasks needed to set up this test of change

<table>
<thead>
<tr>
<th>1- Add a risk assessment tool to admission packet (Bonnie will add risk assessment to 10 admission packets on 4N on 2/15)</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonnie</td>
<td>2/15</td>
<td>4N</td>
<td></td>
</tr>
</tbody>
</table>

Predict what will happen when the test is carried out

<table>
<thead>
<tr>
<th>1- Adding cues to the admission packet will help ensure compliance with identification of patients at risk for injuries from falls on admission.</th>
<th>Measures to determine if prediction succeeds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Patients admitted to 4N on 2/15 will have a completed risk assessment</td>
<td></td>
</tr>
</tbody>
</table>

**Do**

Describe what actually happened when you ran the test.

*Bonnie clipped the 10 risk assessments to the already compiled admission packets.*

**Study**

Describe the measured results and how they compared to the predictions.

*8 patients were admitted to 4N on 2/15 and 7 had completed risk assessments. All of the assessments that were completed were completed appropriately.*

**Act**

Describe what modifications to the plan will be made for the next cycle from what you learned.

*Bonnie will add 10 additional assessments to the admission packets and mention in early morning huddles the next 3 days she is working.*
Volunteers?
Questions?

Raise your hand

Use the Chat
Expedition Communications

- Listserv for session communications: FallsExpedition@ls.ihi.org
  - To add colleagues, email us at info@ihi.org

- Pose questions, share resources, discuss barriers or successes
Next Session

Wednesday, February 27, 1:00 PM – 2:00 PM ET
Session 3 – Interventions to Prevent Falls and Fall Injury Part 1
Next Session – Office Hours

All are invited to spend 30 minutes after our next call with Pat Quigley for additional Q&A
2:00-2:30 PM ET