CalNOC Partners for Quality
TRIP to Reduce Hospital Falls

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CalNOC Partners TRIP to
Reduce Patient Falls Project

The primary aim of this 4 year quality improvement demonstration project is to reduce the incidence of patient falls and severity of fall related injury in medical surgical patient care units in CalNOC hospitals through evidence-based coaching, education and consultation; through improving falls risk assessment and prevention intervention clinical effectiveness.
CalNOC TRIP Hospitals

- Anaheim Memorial Medical Center
- Cedars-Sinai Medical Center
- Community Medical Center-Clovis
- Community Medical Center-Fresno
- Hoag Memorial Hospital Presbyterian
- Kaiser Panorama City
- Kaiser Redwood City*
- Kaiser Roseville Medical Center
- Kaiser Sacramento
- Kaiser South Sacramento
- Kaweah Delta Health Care District
- Mercy Hospital of Folsom
- Mission Hospital
- North Bay Medical Center
- Orange Coast Memorial Medical Center
- San Francisco General Hospital
- Scripps Memorial Hospital
- Sharp Healthcare Grossmont Hospital
- Sharp Memorial Hospital
- Kaiser Permanente Manteca
- St. Elizabeth Community Hospital
- St. Joseph's Hospital
- Sutter Delta Medical Center
- Stanford Medical Center
- Sutter Medical Center Santa Rosa
- Sutter Roseville Medical Center
- Tri-City Medical Center
- University of California, San Francisco
- University Medical Center
- VA San Diego Healthcare System
- Washington Hospital

Intervention Context—Leveraging CalNOC’s data and vibrant network to expedite EBP improvement

- Institutional baseline **self-assessment**
- Individualized falls related **drill down data** analysis report and facilitated presentation
- **Coaching** for performance improvement
- **Linker role** development
- **CE** for key staff related to falls coding and reduction
- Strategic **resources**—articles, media etc.
- **Networking, benchmarking & synergy**
Explicating Target Adoption Process Milestones

Through participation in the Coaching Intervention, participating clinical settings will strengthen their capacity to:

- **TARGET OUTCOME #1:** Use data to guide performance improvement
- **TARGET OUTCOME #2:** Use reliable and valid risk assessments as the basis for selecting and implementing individualized fall prevention interventions.
- **TARGET OUTCOME #3:** Implement individualized interventions to prevent falls/reduce injury that are linked to patient risk factors
- **TARGET OUTCOME #4:** Effectively document and communicate and engage staff, patient, family in fall risk status & interventions to prevent falls and fall related injury
- **TARGET OUTCOME #5:** Engage organization in systematic PI effort through strengthening evidence-based processes of care.

CalNOC Partners for Quality to Reduce Hospital Falls Project

PROJECT PLANNING WORKSHEET

<table>
<thead>
<tr>
<th>TARGET FALLS IMPROVEMENT OBJECTIVE</th>
<th>TACTICAL ACTIONS TO REACH OBJECTIVE (Specific Actions)</th>
<th>KEY OUTCOMES (Measurable Results)</th>
<th>RESOURCES &amp; PROCESS OWNER(S) (Staff, materials, etc.)</th>
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<tbody>
<tr>
<td>1. Evaluate and implement a Valid and Reliable Risk Assessment Tool</td>
<td>1. Pull articles</td>
<td>1. Review literature by end of May</td>
<td>1. Linda and Nancy</td>
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<td>2. Identify work group: Review literature, compare tools</td>
<td>2. First meeting of work group in May (6 mos)</td>
<td>2. Linda and Nancy</td>
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<td>3. Arrange conf. Call with users</td>
<td>3. Call with users of different tools</td>
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<td>4. Make recommendation to Councils</td>
<td>4. Identify one tool to pilot based on literature and calls.</td>
<td>Nancy D. for references</td>
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<td>5. Pilot &amp; evaluate on 2 units (3W, SW)</td>
<td>5. Staff educated on pilot</td>
<td>Harold &amp; Gail</td>
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<td>6. Identify documents and tools that need revision</td>
<td>6. Clinical Council has information to change P&amp;Ps and Forms</td>
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<td>7. Develop Education plan and communication plan</td>
<td>7. Ed Council identifies staff education plan and communication</td>
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<td>8. Implement on other units</td>
<td>8. Changes completed that allows for implementation on other units</td>
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<td>6. TBD</td>
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2004 TIMELINE

- X: Completed
- : In progress

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Documenting Coaching Contacts & Content

Year 2-3 Coaching Encounters by Focal Outcome---

<table>
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<tr>
<th>Focal Outcome</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Use of falls data</td>
<td>79-85%</td>
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<tr>
<td>Risk assessments</td>
<td>63-81%</td>
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<tr>
<td>Fall prevention interventions</td>
<td>5-71%</td>
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<tr>
<td>Engaging staff, patient/family</td>
<td>44-69%</td>
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<tr>
<td>Engaging organization in systematic PI</td>
<td>8-63%</td>
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FACT SHEET
Assessing Impact of Medications on Falls & Cues to Medication Related Falls Prevention in Acute Care

Key Facts
- JCAHO 2005 Patient Safety Goals highlight the need to improve medication related falls risk assessment and prevention.
- The majority of acute care patient falls occur in patients >65 years.
- History of falls within previous 3 months is highly predictive of fall risk today.
- A majority of patient falls in acute care are associated with toileting.
- Restraints, including side rails, are associated with greater fall related injury severity.
- Medications that impact patient balance, gait, coordination and judgment may increase fall risk and fall related injuries.
- Hospitalization may expose patients to new medications, medication interactions, or dosages that result in greater fall risk.
- Beers (1997) “Explicit criteria for determining potentially inappropriate medication use by the elderly has been updated (Fick et al., 2003) and provides a foundation for medication related risk assessment.”
- Individualized patient and family education is critical to any fall prevention effort.

Implications for Practice
- Strengthen adoption of Updated Beers Criteria to reduce inappropriate prescribing of medications for use in patients > 65 years of age.
- Assess impact of new medications or changes in medications on patient balance, gait, coordination and judgment—ask patient directly; note family comments and observations; observe ambulation as key sources of patient risk assessment data.
- Conduct focused medication risk assessment as follow-up to actual patient fall (medications consumed by patients within 24 hours, and particularly within one hour of falling) and undertake medication related interventions, as well as, environmental prevention.
- Consult with Pharmacist and Physician to identify “trigger” medications and modify timing, dose or drug or medication interactions that may be associated with an episode of falls, near falling or change in balance, gait, coordination and judgment.
- Identify particular patient populations and sub groups in your hospital setting and implement universal fall precautions, including focused patient and family education.
- Remember that falls risk assessment on admission is actually a screening tool and that patients identified at risk then require individualized prevention interventions that are aligned with their particular risk factors.

References
1. Preventing Falls, A comprehensive fall prevention, risk management and intervention program featuring the Hendrich II Fall Risk Model®. A. Hendrich, Inc. [Web Site]. Available at: http://www.ahendrichinc.com/.
Reflections on Coaching Intervention

• Use of data is major issue—how to read, interpret and operationalize strategic implications
• Getting and sustaining strategic traction is crucial—JCAHO is mixed incentive
• Organizational capacity of transformational change varies widely but is very difficult
• Awareness of relevant new literature related to medication related assessment/interventions is big issue
• Confusion on benchmarks and screening vs. assessment is common

Leveraging Technology—Linking LINKERS and Resources

• Multi-site coaching calls
• Web-based E-Reserve
• Web-based bulletin board
• Site visits
Did we reduce falls?
Not yet....

Can We Document Impact?
We think so......

- Impact on Research Findings
- Impact on Policies & Procedures
- Impact on Clinical Practice
- Impact on Health Care Outcomes

Level 1
Level 2
Level 3
Level 4
Formative Evaluation Analyses—Final Results Pending

Formative Evaluation Analyses—Final Results Pending

Mixed regression model with units nested within facilities and repeated monthly measurements for each unit.
- Trend in falls was not significant
- Baseline unit fall level highly significant, i.e., best predictor of fall level at end of time period
- No TRIP effect

Sample size estimates
- Current sample has 33% power to detect difference between TRIP and Non-TRIP units
- 1200 units (900 Non-TRIP and 300 TRIP) required for 80% power to detect observed difference in falls.

Discussion

- TRIP units began project with notably higher fall rate, but difference disappears with square root transformation
- Standard deviations show shrinking variability for both groups from Pre to Post
- PRELIMINARILY, only statistically significant finding is increase in injury falls for TRIP units, which may be due to improved reporting. Findings will be investigated further!!!
Introduction

Just one year ago we launched the “coaching” phase of the CalNOC Partners to Reduce Patient Falls Project, engaging you and your teams in an ongoing evidence-driven, telephone-based educational and supportive dialogue with the aim of expediting your focused efforts to improve patient falls and fall related injuries in selected med-surgical units. Our coaching team feels strongly that we need feedback from you to help us refine our coaching efforts and optimize our effectiveness during the final 8 months of our coaching intervention. Please take a few minutes and respond to the brief questions below. You will note that we ask you to share what “has worked” for you—we will pull together these “better practices” and share them —so you can look forward to a special return on this survey investment! You may return your “survey” by email, or US mail, at your discretion. Special thanks, in advance, for your invaluable feedback and continuing commitment to this project!

First, please list the TOP 3 goals for falls related performance improvement in your hospital, what you have accomplished related to each goal, how the CalNOC TRIP Project has helped, and the help you still need to achieve your goal.
Preliminary Take Home Messages from CalNOC Partners TRIP Project

• Sites vary widely in their capacity to interpret and USE their CalNOC data to drive performance improvement; fall coding is still an issue too.

• Improving falls requires organizational commitment to change and barriers to transformational change impede progress.

• Sustaining the effort is difficult and shifting strategic imperatives/leaders slows progress and distract the teams—getting traction and managing distraction.

• SCREENING for risk and ASSESSMENT are not the same.

• Formative Evaluation based on 2005 data reveals NO intervention effect with baseline falls rate most predictive of fall rate in 2005; Final eval in 2006.

Emerging Dissemination Effort

• Formal agreement with ANA to disseminate selected products to 800+ NDNQI member hospitals (self assessment tool; milestones etc)

• CalNOC is launching a BEST PRACTICES initiative to explicate key levers of falls related practices among the upper quartile of hospitals who have sustained best performance……
Products emerging from this project for CalNOC and NDNQI dissemination:

- Unit level falls related self-assessment
- Milestones to guide falls PI activities
- FACT Sheet related to medications and falls
- Falls indicator tutorial/rater-to-standard training
- Characteristics of “best” practices
- References, resources and web links.

Translating CalNOC’s Coaching Intervention into a Self-Directed Web-based Approach

- **Step 1—Self-Assessment** and institutional consensus on improvement goals
- **Step 2**—Use milestones and results of self-assessment to develop institutional plan that focuses on unit level practices as well as organizational policies, procedures, training etc.; Use literature resources to help shape plan.
- **Step 3**—Implement the plan, monitor its adoption, measure its impacts; refine it as needed.
- **Step 4**—Refine and spread
If WE Knew Then What WE KNOW Now….

- One year intensive intervention effort
- Standardize and bundle EBP better practices
- Rater to Standard Training in Q1, Y1
- Explicate CalNOC Best Practices in Y1; package and disseminate in Y2
- Go with group coaching vs. one-to-one