CAPTURE Falls Virtual Educational Series

Session 4: Auditing Fall Risk Reduction Practices

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Housekeeping for Today's Presentation

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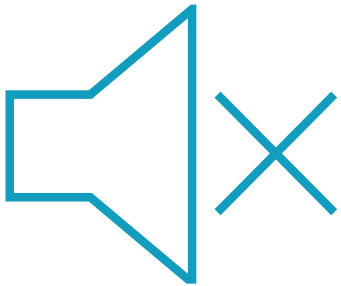

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The content is solely the responsibility of the presenters and does not necessarily represent the views of any funding source.

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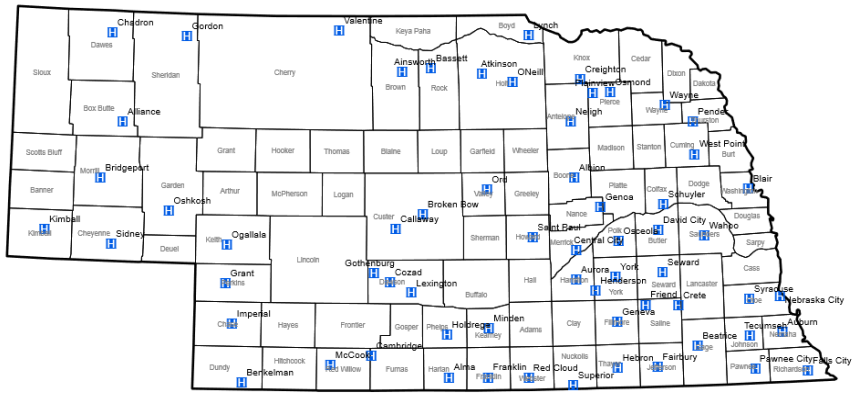

Image Credit: https://dhhs.ne.gov

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What is the CAPTURE Falls Virtual Educational Series?

- 6-month education series on fall risk reduction in Critical Access and rural hospitals led by the University of Nebraska Medical Center's CAPTURE Falls program
- Invited by Wanda Hilton, the Rural Hospital Flex/SHIP Program Coordinator for the Iowa Department of Health and Human Services to provide this series.
- All sessions will be held on the 3rd Wednesday of the month, 1-2pm CT via Zoom.
- All session recordings are posted under the Quality Improvement tab on the following website: Rural Hospital Programs | Health & Human Services (iowa.gov)

Date	Fall Risk Reduction Topic
February 21, 2024	Interprofessional Approaches to Reducing Fall Risk; Defining a Fall
March 20, 2024	Fall Risk Assessment
April 17, 2024	Fall Risk Reduction Interventions
May 15, 2024	Auditing Fall Risk Reduction Practices
June 19, 2024	Post-Fall Clinical Assessment; Fall Event Reporting
July 17, 2024	Post-Fall Huddles

CAPTURE Falls Roadmap

Establish Readiness for Change

Explore the resolve of members of an organization to implement change to improve fall risk reduction practices, and their collective belief in their capacity

Interprofessional Fall Risk Reduction Team

Create an inter-professional fall risk reduction team responsible for managing and implementing the facility's fall risk reduction program.

Gap Analysis

Conduct an assessment of the current state of fall risk reduction practices in your facility compared to evidence-based best practices.

Action Plan

Document and monitor the steps your team needs to take to reach your program goals.

Fall Risk Reduction Policies and Procedures

Set expectations and influence decisions, actions, and activities necessary for your fall risk reduction program.

Fall Definition

Specify what "counts" as a fall, and differentiate various types of falls (e.g. assisted vs. unassisted) as well as injuries.

Fall Risk Assessment

Identify patients who are at risk for falls and recognize their respective risk factors.

Fall Risk Reduction Interventions

Implement interventions to reduce the influence of patient risk factors for falls and fall-related injury.

Auditing Fall Risk Reduction Practices

Identify if fall risk reduction practices are being implemented as intended in your facility.

Post-Fall Clinical Assessment

Establish a protocol to guide staff in the assessment of patients for potential injury after a fall occurs.

Post-Fall Huddle

Create a safe environment to understand the 'story' behind a fall in order to learn and take action to prevent a future fall.

Fall Event and Rate Reporting

Report and monitor falls and fall rates to track progress within your organization and allow for external benchmarking.

Learning from Data

Use data to understand how well your fall risk reduction program is working to reduce fall risk in your facility.

Sustainment Strategies

Maintain an effective fall risk reduction program over time.

https://www.unmc.edu/patient-safety/capturefalls/roadmap/index.html

Session 4 Objectives

1. Define the concepts of auditing and feedback
2. Describe why auditing and feedback is an important component of a fall risk reduction program
3. Identify the key components of an auditing and feedback program for fall risk reduction
4. Determine strategies for education of staff on the fall risk reduction audit and feedback program

Objective 1:
Define the concepts of auditing and feedback

What is Auditing? What is Feedback?

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Hut-Mossel L, Ahaus K, Welker G, Gans R. Understanding how and why audits work in improving the quality of hospital care: A systematic realist review. *PLoS One*. 2021;16(3):e0248677. Published 2021 Mar 31. doi:10.1371/journal.pone.0248677 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8011742/

https://www.merriam-webster.com/dictionary/feedback

Auditing and Feedback's Relationship with Quality Improvement

A first step to identify potential improvement opportunities

Establish a baseline to use to analyze impact of tests of change

Part of rapid cycle evaluation during iterative testing phases

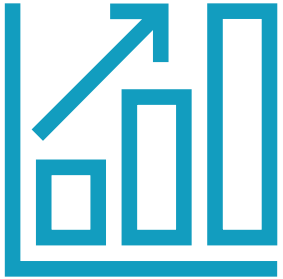
Quality assurance tool to track if improvements are sustained over time

Backhouse A, Ogunlayi F. Quality improvement into practice. *BMJ*. 2020;368:m865. Published 2020 Mar 31. doi:10.1136/bmj.m865

Objective 2:
Describe why auditing and feedback is an important component of a fall risk reduction program

What Does the Evidence Say About Audit and Feedback Interventions?

- Small but potentially important improvements in compliance with desired practice
- Feedback may be more effective when:
  - Baseline performance is low (not performing well to start with)
  - A supervisor or colleague is responsible for the audit and feedback
  - Feedback is provided more than once
  - Feedback is given both verbally and in writing
  - Feedback includes clearly defined target for improvement and an action plan to help get there



Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD000259. DOI: 10.1002/14651858.CD000259.pub3. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000259.pub3/full

What Does the Evidence Say About Audit and Feedback Interventions?

- How and why and in what circumstances do audits work?
  - Sense of urgency can trigger engagement with an audit
  - Champions influence perceptions that audits are worth the effort
  - Audits initiated from the ‘bottom-up’ more likely to result in sustained change
  - Healthcare professionals can use audit data to support requests for change from leaders
  - Audits legitimize the process of providing feedback to colleagues

Hut-Mossel L, Ahaus K, Welker G, Gans R. Understanding how and why audits work in improving the quality of hospital care: A systematic realist review. *PLoS One*. 2021;16(3):e0248677. Published 2021 Mar 31. doi:10.1371/journal.pone.0248677 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8011742/

What Does the Evidence Say About Audit and Feedback Interventions for Fall Risk Reduction?

- Auditing appears to be used often in practice but is not well-documented in the literature
- Overall impact not well-studied
  - Limited detail available about strategies to monitor adherence to care processes
  - Limited data collected about the direct/indirect impact of auditing and feedback

Hempel S, Newberry S, Wang Z, et al. Hospital fall prevention: a systematic review of implementation, components, adherence, and effectiveness. *J Am Geriatr Soc*. 2013;61(4):483-494. doi:10.1111/jgs.12169 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670303/

Morris ME, Webster K, Jones C, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis. *Age Ageing*. 2022;51(5):afac077. doi:10.1093/ageing/afac077 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9078046/

Stephenson M, Mcarthur A, Giles K, Lockwood C, Aromataris E, Pearson A. Prevention of falls in acute hospital settings: a multi-site audit and best practice implementation project. *Int J Qual Health Care*. 2016;28(1):92-98. doi:10.1093/intqhc/mzv113 https://academic.oup.com/intqhc/article/28/1/92/2363764?login=false

Monitoring Fall Risk Reduction Processes and Practices in Addition to Outcomes

- Fall rates are a critical outcome measure
- Fall risk reduction care processes are the actions taken to reduce fall risk
  - Are the care processes in place as intended?
  - What can we do to change our systems and behavior and increase adherence to fall risk reduction practices?

Agency for Healthcare Research and Quality. Preventing Falls in Hospitals Toolkit. How do you measure fall rates and fall prevention practices? https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/measure-fall-rates.html

Objective 3: Identify the key components of an auditing and feedback program for fall risk reduction

Guidance on Auditing and Feedback in Fall Risk Reduction

Agency for Healthcare Research and Quality

- Preventing Falls in Hospitals Toolkit

U.S. Department of Veteran's Affairs

- VHA National Center for Patient Safety Falls Toolkit

CAPTURE Falls Program

- CAPTURE Falls Roadmap

Key Components of an Auditing and Feedback Program for Fall Risk Reduction

What is your goal/intent for this audit?

What to audit?

What is the sample you will audit?

Who will conduct the audit?

When/how to conduct the audit?

What will you do with the audit results?

Determine the Goal or Intent for this Specific Audit

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

- Identify initial potential areas for improvement in fall risk reduction practices?
- Gather data on fall risk reduction practices to establish a baseline for which you hope to see improvement over time?
- Targeted focus on a fall risk reduction practice as part of rapid cycle evaluation during tests of change?
- Track if improvements made in fall risk reduction practices are sustained over time?
- Specific concerns about a particular shift, team/unit's performance in fall risk reduction?

What to Include in the Audit

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

- Completion of fall risk assessment tool per policy
- Implementation of care processes – interventions (universal, targeted) as intended
- Environment and equipment (specific to the patient and generally in the broader environment)
- Patient/family education, awareness of limitations and role of interventions
- Other – completion of post-fall clinical assessment, conducting post-fall huddles, completing reporting forms, etc.

Clearly Defining the Audit Criteria

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Fall Risk Safety Rounds

Date:

Room Number:										
Medical Record Number:										
Reviewed by:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
High Fall Risk Marked on whiteboard?										
High Fall bracelet in place?										
High Fall Risk Interventions										
Cluttered Room?										
Call light within reach?										
Side Rails up all the way?										
Tabs alarm in place and on?										
Gripper Socks?										
Gaitbelt used?										
Walker or Assistive device close to patient?										
Left alone in restroom, if high fall risk?										
Patient able to tell you why they are high fall risk?										

Patient Safety – Falls Survey Instruction Sheet

1) High Fall Risk Marked on Whiteboard?
   a. Is the box checked on the whiteboard next to a shooting star?
2) High Fall Bracelet in Place?
   a. Is the patient wearing a yellow bracelet?
3) High Fall Risk Interventions?
   a. Are there obvious interventions in place?
4) Cluttered Room?
   a. Is the room free of clutter? Are there objects on the floor? Are there chairs which
      left out in the middle of the room? Is there a clear path to the bathroom or bed f
      patient if needed?
5) Call light within reach?
   a. Is the call light placed within reach of the patient?
6) Side Rails all the way up?
   a. Are the TOP siderails all the way up – not in the halfway up position?
7) Tabs Alarm in place and on?
   a. Is the alarm under the patient whether they are in bed or in the chair? Is the alar
      connected to the control box? Is the alarm on and the green light flashing?
8) Gripper socks?
   a. Is the patient wearing yellow gripper socks if they have a yellow bracelet? If they
      have a yellow bracelet do they still have gripper socks on?
9) Gaitbelt used?
   a. If the patient is being transferred is staff using a gait belt?
10) Walker or assistive device close to the patient?
   a. If a patient uses an assistive device is the device close to the patient if they are in
      bed or chair? Or is it stored across the room or behind the door?
11) Left alone in restroom if high fall risk?
   a. If a patient is in the restroom are they left alone?
12) Patient able to tell you why they are high fall risk?
   a. Ask the patient if they understand why they are at an increased risk of falls? Do they
      understand all of the interventions that are in place to increase their safety?

Presence, absence, or not applicable?

Specific numbers?

Open-ended comments?

Other criteria to inform judgment?

Selecting your Audit Sample

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Number or percentage of patients (sample size) often influenced by census

Sample size adequate enough to detect patterns that may indicate improvement (or lack of)

Resources (time, staff) available may inform feasibility

Knowledge of and implications of impacts in a particular area(s) may also inform decisions

Perla, R. J., Provost, L. P., Murray, S. K. (2013). Sampling considerations for health care improvement. *Quality Management in Health Care,* 22(1), 36-47.
Perla, R. J., & Provost, L. P. (2012). Judgment sampling: a health care improvement perspective. *Quality Management in Health Care*, 21(3), 169–175.

Conducting the Audit – Who Will Help?

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Members of your fall risk reduction team

Well-respected local champions/peers passionate about fall risk reduction

Consider opportunities for representatives from other departments

If talking with patients – patients may be more comfortable responding to staff who do not provide routine care

Team member participation may vary by audit

Timing and frequency

What is audited

Purpose of the audit

Improvement cycle vs. assurance

Conducting the Audit – Sources and Resources

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Use an existing checklist or worksheet, or modify or create one to meet your specific goals/needs

May combine direct observation, medical record review, and patient and staff interviews depending on focus of the audit

Consider how the data documented during the audit will be used/transformed into information useful for feedback

Conducting the Audit – Example Audit Tools

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices – Fall Audit Tools

Fall Audit Tools

Fall Audit Tools

- **Example Process Audit Tools:** The following auditing tools were shared by hospitals who have participated in the CAPTURE Falls program. These tools can be used as is or adapted to fit your own needs.
- Process Audit Tool Example 1 [word document]
- Process Audit Tool Example 2 [word document]
- Process Audit Tool Example 3 [word document]
- Process Audit Tool Example 4 [word document]
- **Assessing Fall Prevention Processes:** Tool 5B Assessing Fall Prevention Care Processes in the AHRQ Fall Prevention Toolkit offers a sample fall prevention intervention auditing protocol.
- **Equipment Safety and Environmental Checklist:** The VA National Center for Patient Safety Falls Toolkit policy document offers an example Equipment Safety Checklist (see attachment 1) and an example Environmental Checklist and Rounds (see attachment 2).

Fall Audit Education

Conducting the Audit – Example Audit Tools

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices – Fall Audit Tools

FALL REDUCTION AUDIT TOOL

Auditor's Name:
Date: Room #: Patient Initials:
Documented Morse Score:
Active Risk for Fall Care Plan (circle): Universal Med High

"Call Don't Fall INTERVENTION" identified (circle) in the patient's room:
Universal Med High

Proceed to the appropriate INTERVENTION level that corresponds to the above question to verify all interventions are active

UNIVERSAL INTERVENTIONS :

Call light in reach	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a = not applicable due to patient's condition)	YES	NO	n/a

MEDIUM RISK INTERVENTIONS:
(Morse >45, No Fall History, No memory limitations, No cognitive deficit)

Call light in reach	YES	NO	
Yellow "fall risk" light illuminated in hallway	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a = not applicable due to patient condition)	YES	NO	n/a
Bed in low position	YES	NO	
Gait belt in use for transfer/ambulation (n/a = No chance to observe)	YES	NO	n/a

HIGH RISK INTERVENTIONS
(History of fall OR memory limitations OR cognitive limitations)

Call light in reach	YES	NO	
Yellow "fall risk" light illuminated in hallway	YES	NO	
Nonskid footwear on or accessible at bedside	YES	NO	
Decluttered environment	YES	NO	
Appropriate lighting	YES	NO	
Rounding sheet visualized and shows charting every 1-2 hours	YES	NO	
Patient/Family state Nurse has reviewed measures to prevent fall (n/a= not applicable due to patient condition)	YES	NO	n/a
Bed in low position	YES	NO	
Gait belt in use for transfer/ambulation (n/a = No chance to observe)	YES	NO	n/a
Alarm in place (bed and chair-may share on for both places)	YES	NO	
Consider room by the nurses station (Room #14-25)	YES	NO	
Consider sitter at bedside	YES	NO	

Changes made after observation:
___ Intervention level changed
___ Care Plan Updated
___ Primary Nurse Updated
___ Additional Interventions initiated (LIST:_____,
___ Education provided to patient
___ Other (LIST:_____

Comments:

Conducting the Audit – Example Audit Tools

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices – Fall Audit Tools

Fall Risk Audit Form	Observation # Room		Observation #
Reviewer: _____	Date: _____ Time: _____ Fall Risk Score = _____		
	Yes	No	N/A
Falls History Assessment done on Admission profile.			
At risk for falls documented in chart.			
Falls Prevention Education given to patient and/or family.			
FALL RISK REDUCTION ACTIONS (Tailor to Hospital Policies)	Yes	No	N/A
Falls Risk sign posted near door.			
Yellow armband in place.			
Is patient aware of own fall risk?			
Is sitter or family companion aware of patient's fall risk?			
Is call light within reach?			
Does bed alarm work?			
Is a bed alarm in use?			
Is a chair alarm in use?			
Is the environment free of clutter?			
Is RN documenting "Falls Precautions" in patient chart?			
Is RN documenting Bed and/or Chair alarm use in patient chart?			

Sample Results of Audit

Unit A	Falls History Assessment done on Admission profile			At Risk for Falls on Problem List in chart			Patient Education form indicates Falls Education given to patient and/or family			Falls Risk sign posted near the door.			Yellow armband in place.			Is patient aware of own fall risk?			Is sitter or family companion aware of patient's fall risk?			Is call light within reach?			Does bed alarm work?			Is bed alarm in use?			Is a chair alarm in use?			Is the environment free of clutter?			Is RN documenting Falls Precautions in chart?			Is RN documenting Bed and/or chair alarm use in chart?		
	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a	Yes	No	n/a
November totals	11	1	0	10	2	0	0	3	9	8	4	0	7	4	0	10	2	0	4	0	8	12	0	0	3	0	9	0	0	12	2	0	10	11	0	1	12	0	0	2	0	10
November compliance %	92 %	17 %	0%	83 %	17 %	0%	0%	25 %	75 %	67 %	33 %	0%	64 %	36 %	0%	83 %	17 %	0%	33 %	0%	67 %	100 %	0%	0%	25 %	0%	75 %	0%	0%	100 %	17 %	0%	83 %	92 %	0%	8%	100 %	0%	0%	17 %	0%	83 %

What to do with Audit Results?

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Immediately address issues for individual patients

Compile and analyze the audit data and summarize results

Document changes made after audit (e.g. update care plan, patient/family education)

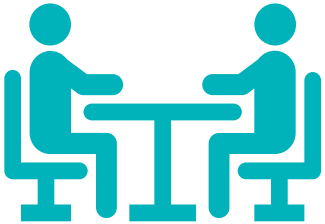
Provide feedback to relevant stakeholders (e.g., individual staff, teams/units, fall risk reduction team)

Delivering Post-Audit Feedback to Staff

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

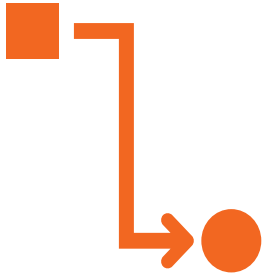
Feedback about behavior most common behavior change technique reported in studies of audit and feedback

Performance was initially low (not meeting standards)



Supervisor, colleague delivers the feedback

Feedback offered both verbally and in writing



Includes clear targets for improvement and action steps to get there

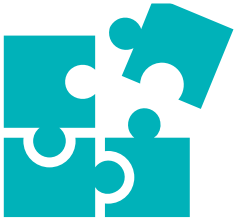
Crawshaw J, Meyer C, Antonopoulou V, et al. Identifying behaviour change techniques in 287 randomized controlled trials of audit and feedback interventions targeting practice change among healthcare professionals [published correction appears in Implement Sci. 2023 Dec 18;18(1):73]. *Implement Sci*. 2023;18(1):63. Published 2023 Nov 21. doi:10.1186/s13012-023-01318-8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10664600/

Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD000259. DOI: 10.1002/14651858.CD000259.pub3. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000259.pub3/full

Delivering Post-Audit Results and Feedback to Fall Risk Reduction Team

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

Review at regularly scheduled meetings



Consider audit data in light of other fall risk reduction program data (e.g., fall event reports, huddle documentation, fall rates, etc.)

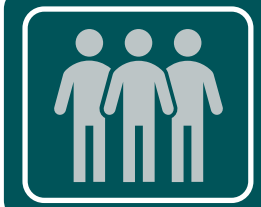
Look for patterns and trends that indicate improvement, gaps, and sustainment of fall risk reduction practices

Establish priorities for improvement and action steps to move forward

Recognize and celebrate successes along the way!

Auditing Fall Risk Reduction Practices

Lessons learned and anecdotes from our work



Patients and family members can provide a lot of valuable information

- Must be able to communicate and have adequate cognition
- Monitor for the socially desirable response

Engage multiple departments if able

- Multidisciplinary input and different perspectives
- Promote hospital-wide involvement in fall risk reduction
- Facilitate cross-departmental communication

Developing an auditing program benefits from its own tests of change

- Revising auditing criteria, tool, process, etc.
- Impacts may be seen in fall rates, but also in day-to-day practice change

Objective 4: Determine strategies for education of staff on the fall risk reduction audit and feedback program

Staff Education about Auditing and Feedback

CAPTURE Falls Roadmap Auditing Fall Risk Reduction Practices

- Describe the auditing program in its entirety
- Emphasize the importance of auditing as a proactive strategy to manage risk - this is not a form of competency assessment, performance appraisal, or a disciplinary process
- Provide examples of the types of feedback staff may receive during/after an audit
- Ask for staff feedback on the auditing program

New employee orientation

Annual education

Fall Prevention Awareness Week (September)

Patient Safety Awareness Week (March)

Resources: Auditing Fall Risk Reduction Practices

Education Resources

- ✓ Auditing Fall Risk Reduction Interventions
- ✓ Human Behavior and Fall Risk Reduction

Example Auditing Tools:

- ✓ Process Audit Tools from CAPTURE Falls Hospitals
- ✓ Assessing Fall Prevention Processes
- ✓ Equipment Safety and Environmental Checklist (see pages 16-19 of linked document)

Summary

1. Research for auditing and feedback interventions specific to fall risk reduction is lacking, but we can learn from and apply lessons learned from the broader evidence base around auditing and feedback interventions to inform our work in fall risk reduction

2. Auditing can help us monitor compliance/adherence to fall risk reduction care practices, and inform process measures for our fall risk reduction programs

3. Auditing AND feedback is key – must close-the-loop with care teams/units and the fall risk reduction team about performance successes and areas for improvement

4. For staff education, ensure staff understand the purpose of the audit, the process used to conduct the audit, and how they will receive feedback

Post-Education Evaluation

Evaluation survey link:
https://redcap.link/xp1j1qvw

QR code:

- Responses are anonymous
- Feedback will be used to inform future improvements to this education

Join us for Next Month's CAPTURE Falls Virtual Educational Series

- 6-month education series on fall risk reduction in Critical Access and rural hospitals led by the University of Nebraska Medical Center's CAPTURE Falls program
- All sessions will be held on the 3rd Wednesday of the month, 1-2pm CT via Zoom.
- All session recordings are posted under the Quality Improvement tab on the following website: Rural Hospital Programs | Health & Human Services (iowa.gov)

Date	Fall Risk Reduction Topic
February 21, 2024	Interprofessional Approaches to Reducing Fall Risk; Defining a Fall
March 20, 2024	Fall Risk Assessment
April 17, 2024	Fall Risk Reduction Interventions
May 15, 2024	Auditing Fall Risk Reduction Practices
June 19, 2024	Post-Fall Clinical Assessment; Fall Event Reporting
July 17, 2024	Post-Fall Huddles

References and Resources

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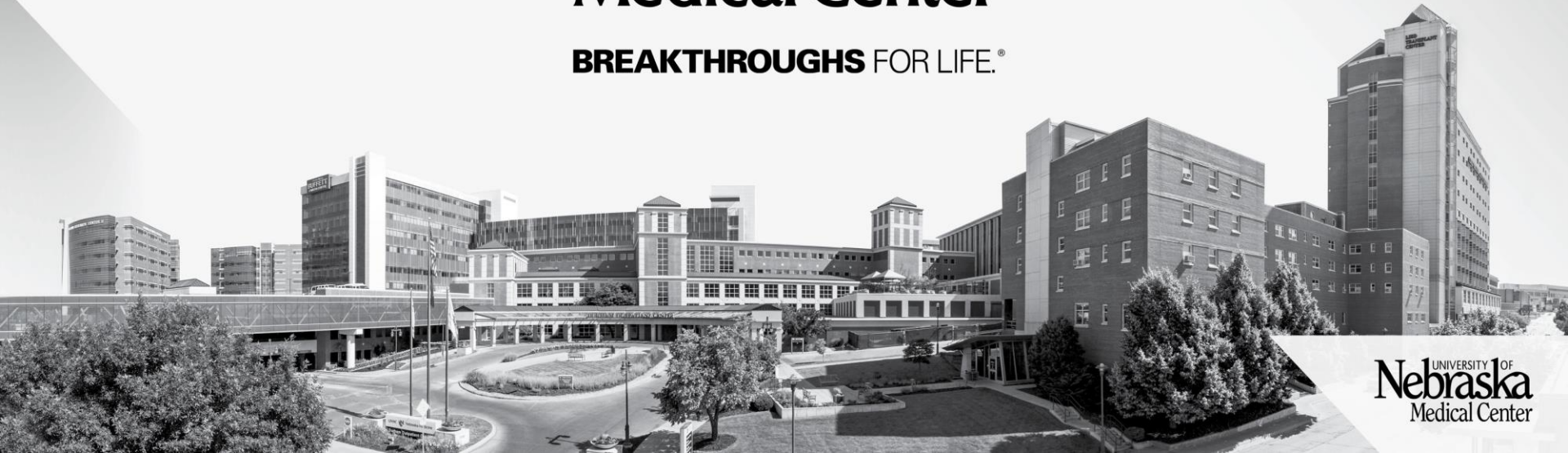

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