AHRQ's Safety Program for Nursing Homes: On-Time Falls Prevention Training

Handout 1: Implementation Scripted Exercise – Change Team Meeting for Self-Assessment

Team consists of:

- Facilitator [Jim].
- Program Champion [Mary].
- Nursing Assistant A [Allison].
- Nursing Assistant B [Jolene].
- Nurse Manager A [Miranda].
- Nurse Manager B [Sally].
- Rehab Director [Anne].
- Director of Nursing [Joanie].

Program Champion: Good morning, team, and welcome back to the On-Time training. We are meeting today because we're going to discuss the On-Time Falls Prevention Self-Assessment and begin thinking about how you might use the On-Time reports as part of daily practice here at the facility. Jim, our Facilitator, has reviewed our self-assessment.

Last week, I asked the three nurse managers to work with the staff on their units to complete the Self-Assessment. We also asked Anne [Rehab Director] to work with the therapy staff to do the same. We asked the nurse managers to ensure that their Self-Assessments included feedback from staff on all three shifts and that all levels of staff were included.

I have consolidated your thoughts and Jim has reviewed the Self-Assessment. Does anyone have any thoughts about why we thought that gaining these varied perspectives was important?

Nursing Assistant A: Well, I work the night shift and I can tell you that the other night shift nurses were thrilled to be asked about this. Falls are a serious problem for our residents. Sometimes when residents fall, they can never walk again. We want to keep our residents safe but we have much fewer staff on the night shift than on the other shifts. When we heard these reports might help us better identify who is at high risk, we thought it would help us keep a closer eye on those residents and help keep them safe.

Nurse Manager A: Clay, the evening shift nursing assistant who is on the Change Team, couldn't make it today but he gave me input into our Self-Assessment. He said that each shift has its own set of challenges. That, I think, is a really important reason to gain multiple perspectives on the Self-Assessment.

Program Champion: I really appreciate the time the Nurse Managers and Anne [Rehab Director] took to complete the Self-Assessments before today's meeting. As we go through the Self-Assessment today, I'd like to ask each of them to offer the collective input of their unit or department and I would like to hear each of your perspectives as we discuss the Self-Assessment.

Facilitator: Let's review where you are in the training process: Last week we covered the introductory sections, which gave us an overview of the On-Time reports and implementation process. We've gone over each of the electronic reports. Today you will discuss the Self-Assessment to help determine ways On-Time reports may help you improve you prevention practices.

Program Champion: I want everyone to understand that the information on the Self-Assessment and what we'll talk about today will not be shared with anyone outside our facility. We're here to review the Self-Assessment and think, as a team, about ways we can prevent falls for our residents.

While we want to prevent falls in all residents, identifying those residents who are at greatest risk of falls is very important and On-Time will help us do that. It will also help identify residents who had new issues in the past week that make them more vulnerable to a fall, so we can intervene in a timely way to prevent the fall from happening. It will also allow us to look at common patterns like more falls at certain times of the day or types of residents who fall more, or patterns that are common every time a particular resident falls. We can then use this information to change the way we practice to also help reduce the number of falls we have.

Facilitator: Can I hear some of the discussions you had when looking at the Self-Assessment?

Nurse Manager A: I already mentioned that Clay, who works on the evening shift on my unit, gave me some input. As you all know, the evening shift on my unit (which is our facility's dementia care unit) is a very busy place. Many of our residents are very active in the evening and it seems like we have an awful lot of falls between the change of shift and suppertime.

One part of the assessment asked whether care plans address situational factors, including time of day. That really got the evening shift's attention on my unit and we talked about how it seems residents so often fall during that late afternoon or early evening time. Maybe one day we can figure out just how often this is a factor; my guess is that would take some work.

Facilitator: Well, this is jumping the gun. Remember the Monthly Contextual Factors Report? It was designed to help you answer questions like that.

Nurse Manager A: That sounds great; we can actually find out about these patterns without additional work. We just have to fill out the Postfall Assessment and the computer does the work for us. We could use that report as part of our falls and care planning meetings but certainly at our monthly QAPI meeting. I am sure the Managers' meeting would be a place to discuss the results as well. We could then share what we learned at the falls and care planning meetings. I would love to also talk about it with the nursing assistants on the unit to see if what is reported jibes with their experiences with their residents who have fallen.

Nurse Manager B: I met with each shift to complete the assessment. In particular, I felt it was really necessary to get the nursing assistants' input regarding whether our care plans include interventions to address the various risk factors. This was really eye opening for me.

I thought our care plans were pretty comprehensive but when I started to talk about all the risk factors that are possible and asked whether our care plans address them, the nursing assistants really helped me to see that the care plans list a bunch of risk factors and a bunch of interventions but the nursing assistants were often not aware why a particular resident had a particular intervention or what risk factor was the target.

One thing I hope happens is that we're better able to engage our nursing assistants to identify what risk factors are important for falls so that they are more sensitive to changes in these risks and to helping us identify residents whose risks are changing and to alert Nurse Managers earlier.

Program Champion: It seems we may have another opportunity for improvement. Sally [Nurse Manager B], when we get to the care planning section of the Self-Assessment, we'll examine this a bit more.

DON: We agreed that the processes surrounding resident assessment after a fall needed to improve. One nursing assistant, in particular, said she was so surprised when she heard the list of information we were asked about in our postfall assessment. She said she had no idea that all of that information would be helpful. I understand that the new Postfall Assessment is about to go live in our electronic medical record system. I am so excited that we will have something to efficiently guide us through our assessment when a resident does fall and we will document everything we need.

Rehab Director: The therapy staff were particularly interested in being more proactive before a resident falls. Any help we can get to identify likely candidates for therapy would be an improvement. Right now we are mostly involved if the resident has an injurious fall.

Program Champion: Let's get started with talking about our fall risk assessment policy. Joanie [DON], you mentioned to me that you have some thoughts about our fall risk policies, but we haven't talked much about it. Can you summarize your concerns?

DON: Okay. There are three things that I think we try to do but are not clearly defined in our policy that I think we could improve on. We don't always gain interdisciplinary input regarding fall risk interventions and we don't always communicate the fall risk changes or the prevention strategies to the care plan teams or the direct care staff. I think we include general information on the care cards but the team often has more specific interventions in mind that are not well communicated.

Program Champion: Does anyone have any additional insights regarding your policy or comments regarding what Joanie [DON] said?

Nurse Manager A: This was an issue that we talked about quite a bit on my unit. The nurses and the nursing assistants had differing opinions about how well we communicate interventions to the nursing assistants. The nurses expressed that they thought we did a good job with this.

The nursing assistants gave several concrete examples where their care cards listed very vague information that could really be improved on so that all direct care staff have a better idea of the individualized care plan approaches in place for our residents. The conversation that happened on my unit regarding this issue was very eye opening. I'll have to reread our procedures to see if this is a policy issue or we're just not following it well enough.

Nursing Assistant B: I think that our care cards are helpful but they don't tell us what puts the resident at risk and the interventions are often vague. It's during our reports with the charge nurses when we really learn the details of changes in the resident and care plan updates. To better help falls prevention efforts, we need to better understand how changes we see in residents may contribute to the resident falling.

Program Champion: Perhaps we need an inservice for nursing assistants on falls risk factors. Let's think about that. So, what I am hearing is that as we reexamine our fall prevention policies, we may want to focus on communication practices. The On-Time reports may also take some of the pressure off communication practices by automatically providing information about falls risk changes, but it focuses on the highest risk group. We just need to make sure we discuss the information with the staff who can influence our care plan changes.

Facilitator: Sally [Nurse Manager B], do you use a standardized assessment tool to assess resident risks for falls?

Nurse Manager B: No, nursing doesn't use a standardized tool. We created a tool that includes all of the risk factors listed in the Self-Assessment except high-risk medications or a recent hospitalization. Nursing completes these assessments with every admission or readmission and then in conjunction with each MDS. That is at least quarterly but may be more often if the resident has a significant change in status.

Rehab Manager: Rehab uses the Tinetti Performance Oriented Mobility Assessment as part of our comprehensive assessment for residents receiving therapy aimed at improving their ambulation abilities. For these residents this standardized assessment is used to make resident-specific recommendations.

Facilitator: What's most important is to pay attention to the major risk factors. High-risk medications and recent hospitalizations are important risk factors, so you probably should add them to your assessment and consider ways to minimize their effect. Some hospitalizations may be preventable and sometimes it is possible to reduce the number of medications or use substitute meds that are low risk for falls in place of the high-risk meds if they are as effective. Making changes in care planning to affect these risk factors often involves discussion with both the pharmacy consultant and the attending physician.

Nursing Assistant A: Shouldn't we intervene on all risk factors?

Facilitator: Yes. The On-Time High-Risk Report makes it easy to find the highest risk residents who also had changes during the week that increase the risk for a fall. Then you can easily focus first on those most likely to fall and who also are likely to need adjustments in their care plans. It helps clinical staff make timelier changes in the plan.

You are very busy. You need to prioritize your prevention efforts. Your documentation of all your residents goes into creating this report and finding the high-risk residents. Of course, knowing that a resident has risk factors that make them more likely to fall is important and helps us intervene; being able to prioritize makes us more aware of those most likely to fall.

Nursing Assistant A: Knowing that the documentation we do plays such an important role in On-Time is gratifying. It will motivate me to do a more careful job. I thought no one cared about what I wrote. We do spend the most time with our residents and know about them well, but I see now we can help the nursing team prevent falls.

DON: You do have a lot of important information that the team needs; that's why it is so important that nursing assistants have input into discussions about resident falls.

Facilitator: Can we spend a few minutes talking about our fall prevention plan and discuss strengths and weaknesses. Mary [Program Champion], are care plans developed for all residents who are identified as at risk for falling?

Program Champion: Absolutely. We aim to prevent falls for those residents who have not fallen and put interventions in place to prevent additional falls in those who have already experienced a fall. I think most of us just think about the interventions as intended to keep our residents safe. We do recognize, though, that if a resident has had a fall, they are at more risk for another one. We may not intervene in a timely way on all risk factors identified in the Self-Assessment, though. We look at fall prevention one resident at a time. I don't think we do well at finding weaknesses in our overall preventive practices. You know at the unit level or across shifts?

DON: Anne [Rehab Director], I think our efforts to standardize the Postfall Assessment will make it easier to understand the circumstances of the fall and will help us determine what caused the fall. I understand we are thinking of updating our Postfall Assessment and that On-Time includes a recommendation for what should be included.

Nurse Manager A: We can definitely do better with this. Will On-Time help us do a better job developing care planning interventions?

Facilitator: But preventing falls is only one aspect of health that the clinical staff are trying to manage, so On-Time provides some help with setting priorities and helps with providing easily available information that will help initiate discussions that may help prevent some falls.

The reports do not tell you how to intervene. On-Time tries to help set some priorities, improve the postfall assessment information, and provide information that is formatted to help identify patterns related to falls that may result in more system-related interventions. It also encourages you to think how you will use the reports to improve discussions of prevention and initiate changes in care plans to help reduce falls.

Program Champion: In addition to the components of the assessment that Joanie [DON] already mentioned, the Self-Assessment asks about several other issues for consideration as part of the postfall assessment process. Let's all take a look at that list; speak up if you see something that is not considered as part of your postfall process.

DON: I think if a resident falls and we notice the floor is wet or something like that in the environment, we make a note of it but I don't think we routinely document the surface where the resident was found if there isn't anything out of the ordinary about it.

Nurse Manager A: I agree with you but I also don't think that we always consider the medication regimen of the resident.

Facilitator: Miranda [Nurse Manager A], is the consultant pharmacist ever involved in discussions related to preventing resident falls?

Nurse Manager A: No, I don't think so. Based on our discussions today, it seems like that might be an opportunity for improvement.

Program Champion: Let's move on now and review the list of meetings in which fall risk and prevention are potentially discussed by the interdisciplinary team. Let's start with identifying the meetings that occur at your facility and then, for each of those, we can indicate whether fall risk and prevention are discussed, how often the meeting occurs, who leads the meeting, and who is invited and attends the meeting.

Nursing Assistant A: I can address the first two meetings listed: the care plan reviews and shift brief with nursing assistants. The nurse manager leads both of these and the nursing assistants attend a shift brief on each shift that we work. Just a few months ago, we started attending the care plan reviews as well. The nursing assistants love going to these meetings.

The care plan reviews are also attended by the interdisciplinary team members, including the dietitian, the social worker, the activities director, rehab staff for any resident receiving therapy, the resident and his or her family, and the MDS coordinator.

Program Champion: I can speak to the next four meetings. The daily brief with department heads is chaired by Zack, our administrator, and happens daily on weekdays. All department heads attend and we do talk about falls that occurred. Dr. Rickey, our medical director, chairs the medical staff meeting. All the attending physicians attend that meeting that occurs quarterly. I don't think they talk about falls at that meeting.

As the Quality Assurance Nurse, I chair the QAPI meetings that occur monthly. The QAPI steering committee includes all the department heads, all of the nurse managers, Zack (our administrator), Dr. Rickey (our medical director), and a nursing assistant from each unit. We have a falls meeting, but we don't talk about falls risk; we talk about falls that have occurred. This meeting is monthly in conjunction with our QAPI meeting.

Facilitator: Mary, do you think that talking about residents at risk for falling, in addition to those residents who have fallen, would be a positive addition to your falls meeting?

Program Champion: It seems like it would allow us to be much more proactive. We shouldn't wait until they fall before we intervene.

Rehab Manager: I think the meeting would take forever, though, if we talked about each resident at risk for falls. We already said earlier that most, if not all, of our residents are at risk.

Facilitator: Anne [Rehab Manager], what if you could use the High-Risk Report and focus on those residents at highest risk, say 20 percent of the residents, and perhaps focus more on those with new changing risk factors, would that be beneficial and perhaps more efficient than focusing on everyone at risk?

Rehab Manager: Absolutely. That approach makes a great deal of sense. Focusing our team discussions on those residents with new and changing risks seems like it would allow us to use our time efficiently and not overwhelm us.

Facilitator: Should we add to our to-do list that the team would like to consider incorporating discussions regarding those residents at high risk for falls into the falls meeting?

Rehab Manager: I think so.

DON: It sounds good to me, too. I worry that meeting only once a month may not be often enough. But let's think about it. We don't have these other reports or briefs listed in the Self-Assessment. Instead, these other departments join shift report as needed with the nurse and nursing assistants on particular units.

Nursing Assistant A: That's right. At least once a week someone from therapy, activities, and social work join us to talk about the residents on the unit. It works out well; they share information with the nursing assistants and vice versa.

Facilitator: That sounds great. Let's talk a bit now about training.

DON: I've added the dates for the training that was provided for nursing and therapy staff in the summer regarding conducting an accurate fall risk assessment and care planning to prevent falls, as well as documentation regarding risks for and prevention of falls. Therapy and nursing, including the nursing assistants, were trained about a month later regarding effective restorative/strengthening exercises and just a few months ago the nursing assistants received training on ADL and mobility documentation, including the importance of noting and reporting changes. Based on our discussion, we may want to add training for nursing assistants to learn more about the risk factors for falling.

Nursing Assistant B: That's right. We had that training around the time our medical record system was updated. The timing was perfect. Learning more about why our documentation was important to the team definitely motivated us more to do it.

Facilitator: It sounds like you are all doing a great job with education related to preventing falls and these related topics, but you have identified the need for nursing assistants to better understand what the important risk factors are for falls.

Program Champion: We have touched on our root cause analysis of falls, but let's think about our strengths and weaknesses. We look at the Postfall Assessment and we review the care plan and any recent falls assessments and try to determine if there were recent risk changes, but that is not easy to get at. We also determine if appropriate interventions were in place to prevent falls.

Facilitator: Does the team attempt to determine if the resident's care plan was being followed at the time of the fall?

DON: We do. This was not always so easy here but we have worked hard to implement TeamSTEPPS and the culture of our facility is completely different than it once was. We work together as a team with a constant focus on resident safety. Staff know it is safe to report things honestly. When we talk with staff, sometimes we find out a care plan was not followed, but we work to figure out why it wasn't followed. When a system issue led to the care plan not being followed, we fixed the system. Good root cause analysis can't happen in an environment in which staff don't feel it is safe to be honest.

Facilitator: It's wonderful to hear about such a change in facility culture, Joanie [DON]. Do you find any obstacles or challenges to investigating falls?

Program Champion: I don't think so. We are updating the Postfall Assessment so we will have a consistent process for reviewing the cause of falls and populating the On-Time reports. We still think we need to look at root cause more globally so we can find ways to change our practices at the unit or facility level. We need to look at patterns of who is falling and the circumstances leading to the falls. I think that would help us make some important changes.

Facilitator: That sounds great! We have definitely identified opportunities for process enhancement during this meeting but I have also heard a great deal that seems to be working really well for your team. It's so exciting to see how enthusiastic you all are about making improvements in order to prevent falls.

Program Champion: To wrap up the meeting, let's quickly recap what we've heard today:

- Through the use of the Monthly Contextual Factors Report, the team will be able to identify patterns regarding falls such as what time of day they occurred. We thought that this report could be used during your falls and care planning meetings and thought that it would be useful during reports with the nursing assistants.
- We identified opportunities to enhance your policy and procedure regarding fall risk specifically related to the communication of fall risk and prevention strategies and gaining the interdisciplinary input of the team regarding fall risk. You also identified a need for additional training about the risk factors for falls for nurse assistants.
- When we heard from the nurse managers about fall prevention care plan interventions, they identified several important items (recent hospitalizations and high-risk medications) that were not routinely considered when developing fall prevention interventions.
- Involving Annmarie, the consultant pharmacist, in discussions related to fall prevention was identified as an opportunity for improvement.
- Incorporating discussions regarding residents at high risk for falls into the fall risk meeting would help the team to more proactively prevent falls.

Did I miss anything?

Facilitator: I will work with you to identify the reports you want to adopt and how to integrate the use of the reports into existing meetings. If you decide a new meeting will be needed to communicate the information, I'll help you through the processes related to creating that meeting as well. That will be the focus of our next session.

Program Manager: Thanks for a great discussion, team.

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AHRQ's Safety Program for Nursing Homes: On-Time Falls Prevention Training

Handout 2: Implementation Scripted Exercise – Selecting Falls Prevention Reports and Meetings in Which To Use Them

Team consists of:

- Facilitator [Jim].
- Program Champion [Mary].
- Nursing Assistant A [Allison].
- Nursing Assistant B [Jolene].
- Nurse Manager A [Miranda].
- Nurse Manager B [Sally].
- Rehab Director [Anne].
- Director of Nursing (DON) [Joanie].

Scene One: Change Team Meeting

Setting: At this point, the team has completed their review of the self-assessment and is ready to move ahead with implementation of the On-Time program. The Menu of Implementation Strategies Worksheet has been completed by the DON and reviewed by the Facilitator and Program Champion. The team is assembled: the Facilitator [Jim], the Program Champion [Mary], the DON [Joanie], the Nurse Manager from each unit [Miranda (Nurse Manager A)], and Sally (Nurse Manager B)], the Rehab Director [Anne], and two nursing assistants [Allison (Nursing Assistant A, who works during the day shift) and Jolene (Nursing Assistant B, who works during the night shift)]. Clay, a nursing assistant on the evening shift, is part of the Change Team but could not attend today's meeting.

Program Champion: The task at hand this afternoon is to determine which On-Time Falls Prevention reports we would like to use to improve our ability to prevent falls, how we will use the reports, and how we will pilot the reports. Let's think about how these reports can help us, but also note some priorities for starting in one unit with a few reports first and then think about expanding to the whole facility.

Facilitator: Starting small allows us to refine the rollout process before rolling out to the remainder of the facility. Have you given any thought as to which unit you will begin the pilot on?

Nurse Manager A: We thought we'd start on my unit, the Elms.

Facilitator: Miranda [Nurse Manager A], why the Elms?

Nurse Manager A: Well, our unit has a high-acuity population. We have a number of residents who periodically need to be hospitalized and recently we've had some turnover, so we have some residents who are new to our unit.

When residents go to the hospital, they often return with changes in medications and may have as many as 12 medications to manage. Many of these medications may put them at risk of falling. They also are more frail and unstable when they come back.

Unfortunately, we've had an increase in the number of residents who have fallen lately, so we need to bring that number down. We need to get ahead of this situation and not wait until they fall before we change their care plans.

Nurse Manager B: My unit wasn't a good candidate because we've had a lot of staff turnover. I was afraid that introducing another initiative on the unit would set the staff up for frustration and maybe even failure.

Donna, the assistant nurse manager, is out on maternity leave. She just had her baby, so she will be out several more weeks. And Chrissy, the evening charge nurse, was just promoted to be the evening supervisor, so we have a brand new evening charge nurse, Curt. Once the dust settles on my unit, we'll be in better shape to begin using On-Time.

Facilitator: It's great that you have thought about these issues. You want to begin this in a setting where staff can handle a new quality improvement effort.

Program Champion: Let's take a minute and review what we discussed when we went through the Self-Assessment Worksheet. We wanted to strengthen policies and procedures regarding fall risk communication and prevention strategies and improve interdisciplinary input.

Falls prevention is not just a nursing concern. We wanted to identify ways to improve care plans and intervene in a timelier manner and better involve Annmarie, the consultant pharmacist. We talked about expanding the focus of the falls meeting to include discussion of those residents at high risk for falls in order to help the team more proactively prevent falls, not just residents who had a new fall.

Finally, we had specific ideas for the use of the Monthly Contextual Factors Report to help identify patterns such as what time of day falls occurred. We thought that this report could be used during care planning meetings and that it would be useful during reports with the nursing assistants. We also talked about adding training for nursing assistants on risk factors for falls. Does that cover everything?

All (except Facilitator): Yes, that sounds right.

Facilitator: Before we go on, I want to review the Menu of Implementation Strategies. It identifies the meetings you have and suggests what reports may enhance discussions of falls prevention or causes of new falls. It also suggests additional meetings or huddles that could also help.

The list is intended to give us ideas. It's there to help us think about our options. Remember, On-Time is not a one-size-fits-all program. We determine how it will fit best into our processes rather than trying to fit our processes into it.

Nurse Manager B: This Menu does help us think about some options.

Nurse Manager A: We thought the High-Risk Report might be the best report to start with. It identifies residents who are at high risk for a fall and prioritizes those who have had recent risk increases. It also gives us a quick view of what is changing and what makes them high risk. This information should help us make timely changes to our care plans.

Program Champion: It is difficult to keep track of all residents who are becoming more vulnerable to falling. We rely on our nursing assistants to let us know when they see new problems, but they are so busy taking care of their residents it is difficult for them to know when they need to point something out. I am hoping the High-Risk Report can help us get the information we need without having to rely so much on them. When would we discuss the High-Risk Report?

DON: Well, we have a number of possibilities in the meetings we already have. Let's talk about them. We don't have a weekly fall risk huddle or weekly fall risk or safety meetings.

Nurse Manager B: Right now our falls meeting is held monthly in conjunction with our QAPI meeting. Were you thinking we should meet weekly rather than monthly?

Nurse Manager A: We're really hoping to decrease residents' falls. Maybe meeting weekly would allow us to be more proactive in preventing falls. I hate to add another meeting, but maybe we could hold the weekly falls meeting right after morning report on Thursdays. We don't have any other meetings on Thursday mornings and almost all of the team that meets regarding falls would already be assembled there in the conference room after report.

DON: I like the way you think, Miranda [Nurse Manager A]. Having our meeting right after report would make it efficient for us. As you said, most of us needed for the falls meeting will be in morning report. We'll just need to develop a system to alert the others when report is wrapping up so they can join us for the falls meeting. And we'll be expanding the focus of the meeting, right?

Program Champion: Right, we'll use the Falls High-Risk Report to drive discussion that focuses on prevention for the residents who appear on the report. Remember, for now we'll only have the report for the residents on Miranda's [Nurse Manager A's] unit to work with. Once we feel comfortable with how we are doing with the reports for the Elms unit, we'll expand the use of it to another unit and eventually to both of the other units.

Nurse Manager A: We can use that report for care planning meetings, too. I thought that when we started using the report, we should meet with the nursing assistants on the unit about it. Allison [Nursing Assistant A] and Jolene [Nursing Assistant B], how do you think it would work best to introduce the report to the nursing assistants?

Nursing Assistant A: I think it would work well for the nurse managers or charge nurses to meet with the nursing assistants during our Shift Report and highlight the findings of the report. I'm sure the other nursing assistants will be interested in which of their residents are considered to be at high risk for falls and what has changed in the last week.

Nursing Assistant B: Is that the plan? Are we going to use this everyday with report? That seems like it will add a lot of time to report everyday.

Facilitator: Some nursing homes have nursing assistants and charge nurses or nurse managers meet weekly in falls huddles to talk about the residents who are considered high risk for falls. This huddle could be in conjunction with report but doesn't have to be. How would that work out? This way the nursing assistants can chime in on their view of what's happening to these residents. It can also be a check on the report information.

Nursing Assistant A: That seems more feasible than reviewing this report everyday in report.

Nurse Manager A: How about we plan for falls huddles a day or two before a weekly falls meeting? That way the nurse managers would all have the information from the rest of the nursing staff on their units. The falls huddle is supposed to happen on every shift, right?

DON: There is no question that residents vary from day to day and from shift to shift, so it would be helpful to have the insights of all three shifts. Aides in all shifts need to know who's at high risk and have insights about these residents. Information from all three shifts is brought to the team because documentation from all three shifts goes into the reports.

Discussing the high-risk residents with staff on all shifts with the goal of ensuring the best possible prevention plan is in place sounds like a great idea. Would nurse shift report be the best way to share the reports with the charge nurses on the different shifts to facilitate the huddles?

Nurse Manager A: I think so. I like that we can quickly discuss any issues that arise. I'll meet with the charge nurses on the unit to determine exactly what process will work best and get back to the team with that information.

Rehab Director: I'd like to use the High-Risk Report to help identify any residents who may need PT for our weekly Rehab Department meetings. It would help us identify residents who need help with balance and ADLs and may identify candidates for PT or other therapies. Therapy may help prevent falls and shouldn't just be for residents who have fallen.

We'll be looking forward to the weekly falls meeting so we can contribute to that discussion. Let's talk about whether it makes sense for us to be involved in the falls huddles as well.

Program Champion: We might also consider printing the weekly High-Risk Reports for Annmarie, our pharmacist consultant, when she comes monthly. She could refer to it while conducting her record reviews and then leave recommendations for us as she usually does.

We may try to huddle with her to discuss the possibility of substituting prescriptions with lower falls risk for some currently prescribed drugs that have a high falls risk for some residents. This huddle would help us when we discuss residents with their attending physician.

Nurse Manager A: We are due to have Annmarie on the Elms unit next week. I can introduce her to the reports then.

DON: That sounds like a great idea. I will talk to her about it when she comes in. I'll also bring a copy of the report to the behavior meetings on Tuesdays to identify any high-risk residents with behavior issues.

Facilitator: Okay. It seems like you all have a great plan for using the first report that you're planning to implement: the Falls High-Risk Report. Let's talk about how you might want to use the Quarterly Summary of Fall Risk Factors or the Monthly Contextual Factors Report.

These reports provide a view of patterns associated with all falls, or injurious falls, if you want to focus only on those. These are falls that occurred during the quarter. It allows you to find patterns that are different by unit or for a unit over time.

The Falls Risk Report provides a count of all risk factors associated with the falls that have occurred over the report period. Each resident who experienced a fall could have multiple risk factors and they would, therefore, all be attributed to the fall.

Nurse Manager B: So, for instance, if a resident who fell once had gait and balance instability, a fall 31 to 180 days ago, and a psychoactive medication, he will be counted in each of those columns on this report?

Now it makes sense why the percentages here on the report add up to more than 100 percent.

Facilitator: Great. The Monthly Contextual Factors Report focuses on the circumstances around the fall, such as time of day, location, activity just before the fall, and possible reason for the fall. This report is also designed to help find patterns that may suggest interventions affecting how we provide care. What were you all thinking about these reports?

Program Champion: I really think these reports will be useful for our root cause discussions at nurse report and during discussions at the weekly falls meetings. I'm really excited to use this as part of our QAPI meetings. I think we may miss some systematic reasons that result in residents falling that we miss when we look at each resident separately. It will help us identify patterns by nursing unit and target followup with staff.

For instance, we may determine that we need to provide educational inservices or maybe determine that we need to implement resident-level changes, such as developing new strategies or adjusting existing prevention strategies. It will be interesting to compare trends across the nursing units with this report. We know that we have three very different populations on the three units, so it will be interesting to see if the risk factors are very different as well. The analysis of this report may even help us determine if we need a unit-specific inservice on a particular risk factor or something along those lines.

DON: I can definitely see where both the unit-level and facility-level findings from these reports will help. Sometimes when we look at an issue across the whole facility, there does not seem to be a concern but when we drill down to the unit level we realize that all the instances of the issue are clustered on one unit and we actually do have a problem to address. Unit-level analysis is so helpful.

Program Champion: I am really excited about using the Contextual Report during the QAPI meetings when we look for patterns related to new falls during the root cause discussions we have. To be able to view these contextual factors in aggregate is going to be great. I think of this report as a great tool to help us determine unit-level falls prevention strategies. For instance, if we see there are lots of falls at a certain time of day, perhaps we need to examine activities that are occurring at that time or maybe evaluate nursing assistant assignments so that there is more assistance available at that particular time.

Facilitator: That sounds great. Does anyone have other ideas about using this report?

DON: I'm eager to start using it. The information regarding day of the week, shift, and time during which most falls occur will be very interesting to see.

Facilitator: Let's move on to our final report, the Postfall Assessment Summary Report. It displays information for up to the six most recent falls for each resident who has fallen, including information such as fall location, position the resident was found in, if the fall was witnessed, activity the resident was engaged in at the time of the fall, and suspected causes of the fall.

Nursing Assistant A: This report seems like it will be great to help us doublecheck that we haven't missed anything when we are discussing a particular resident's falls prevention care plan.

Nurse Manager B: I agree, Allison [Nursing Assistant A], it will be wonderful to have this for care plan meetings and our weekly falls meetings. I also think it will be great to review this report during our root cause discussions.

Rehab Manager: We would want to use it at the Rehab Department Internal Review meeting to help identify residents who have recently fallen who may need therapies after falling. It will also help provide insights for determining if new therapy is needed. If they have had more than one fall, they may fall in similar circumstances and that knowledge may help fine tune our recommended rehab plan.

Facilitator: It sounds like you all have a great plan for how you will eventually use all of the reports but let's decide now exactly which report or reports you want to begin using on the Elms unit. Miranda [Nurse Manager A], do you have any thoughts about how you'd like to start using On-Time on the Elms unit?

Nurse Manager A: I'd like to start with the Falls High-Risk Report and the Postfall Assessment Summary.

Facilitator: Mary [Program Champion], I know you have been taking notes. Can you recap for us how you all decided to use the Falls High-Risk Report?

Program Champion: Sure. Let's see. We said we would use that report for our weekly falls meetings, in care plan meetings, and in conjunction with our root cause analysis discussions that we have with report.

Miranda [Nurse Manager A] had said she wanted to meet with the nurses to determine the best process for weekly falls huddles with the nursing assistants on her unit and that the report would be introduced to the nursing assistants in conjunction with report. We also thought that Annmarie, the consultant pharmacist, could use this report when she does her monthly medication reviews. Rehab wanted to use it in their weekly department meetings. Did I miss anything, Joanie [DON]?

DON: I don't think so. I'd like to meet with the unit secretaries about how we will ensure that the reports are run at the appropriate times, including for Annmarie when she visits.

Facilitator: That's a great idea, Joanie. Now team, what about the Postfall Assessment Summary Report? How did you decide to use that report?

Nurse Manager A: We said we wanted to use that in care planning and during the weekly falls meetings as well as during our root cause analyses.

Rehab Director: Right. And I said that I wanted it for our weekly Rehab Department meetings.

Nurse Manager B: Aren't we also giving those reports to Annmarie for any residents she is reviewing.

Program Champion: That's right, Sally. You guys are good. You remembered all the uses I had noted regarding this report. So, our next step is to meet with the unit secretaries to decide exactly when the reports should be printed. Joanie will meet with Annmarie when she comes here next week to talk about the reports, in general, and then Miranda will follow up with her on the Elms unit. Sally will meet with the nurses on the unit to determine next steps regarding the on-unit huddles. I'll bring the reports for any residents we are going to discuss in report for root cause analysis and to the weekly falls meeting. I think we have a plan.

Facilitator: It sounds like a great plan. Well done, team. In a couple weeks, we'll chat on the phone and you can let me know how it is progressing. Of course, if there are questions before that, you know how to reach me.

Program Champion: We sure do, Jim [Facilitator]. Thanks for all your help.

Scene 2: Change Team Followup Meeting

Setting: It is 2 weeks since the Change Team last met. Two reports have been implemented on one unit (the Elms). The team has assembled to discuss how the trial is going.

Program Champion: Thank you all for coming. We're meeting today to hear how the trial of the Postfall Assessment Summary and the Falls High-Risk Report on Miranda's units went. Jim [Facilitator] is on the phone.

Facilitator: Hi, everyone. How did it go?

Program Champion: We have started having weekly falls meetings; they are going pretty well. We are using the Falls High-Risk Report and the Postfall Assessment Summary at those meetings. The Falls High-Risk Report is definitely helping us identify residents with risks associated with falls. We had some initial issues with printing the reports but the vendor identified the problem.

The first meeting took us forever because we were now reviewing residents who fell and residents at risk of falling. I think we were trying to discuss all the high-risk residents rather than prioritizing based on recent changes. The next week it went much quicker. We are also using the Postfall Assessment Summary during that meeting to help us in determining individualized care plan interventions. We have had a couple of really valuable discoveries with the use of this report.

DON: I'll say so. For one of our residents, the Summary report showed commonalities in the day, time, and location of all her falls. We looked into it more and realized that her daughter visited on those days and the resident was falling shortly after her daughter left. We have implemented a plan with the daughter to alert staff when she is leaving so we can take the resident to the rest room if needed or get her situated with one of her activities.

Facilitator: That's a great example, Joanie [DON], for how this report can really help drive individualized care planning. That's super.

Nurse Manager A: We are using both of these reports in care plan meetings and in conjunction with our root cause analysis discussions that we have with report. That seems to be working well.

Facilitator: Has the consultant pharmacist begun using the reports?

Nurse Manager A: Annmarie used them during her last visit. She did make a recommendation for a medication change and some increased monitoring of blood pressure for one of the residents who appeared on the Falls High-Risk Report. When I talked to the resident's daughter about the medication change she couldn't believe that our pharmacist was helping us prevent falls. She was really happy to hear about what we're doing.

Facilitator: That is great, Miranda [Nurse Manager A]. How are the falls huddles going with the nursing assistants?

Nurse Manager A: They're going well. The nursing assistants were excited to see all the information that originates from their documentation in the reports. The huddles are happening on all three shifts. The charge nurses have told me that the discussion has helped raise the staff's awareness of not only what to do to prevent falls but also why certain interventions are in place for particular residents. For one resident who was at high risk, her nursing assistant discussed that she became combative just before lunch and we have been giving her a snack earlier and that seems to have calmed her down. Sometimes the solutions are simple.

Facilitator: Anne [Rehab Director], how are you and your colleagues finding using the reports?

Rehab Director: The report gives us additional information to capture high-risk residents who may need therapy. We have an occupational therapist working with one of the new residents and she seems to be settling in better.

Facilitator: You have all done a great job. Have you thought about expanding the rollout of On-Time?

Nurse Manager B: We decided that we would implement these same two reports on my unit next. If all is still going well for Miranda and the Elms team in 2 more weeks, we're going to start using them at that time.

Program Champion: Then, after 4 more weeks, we'll implement the rest of the reports the same way. The managers have been looking at the unit and facility reports to get used to them and see what we can learn and how to use them to help identify more global changes in how we prevent falls. We'll start introducing them in the QAPI meeting in a few months.

Facilitator: I'll be anxious to hear how the rollout is going. You should be proud of the work that you have done thus far. Well done, team.

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AHRQ's Safety Program for Nursing Homes: On-Time Falls Prevention

Implementation Materials Training

Handout 3: Meeting Descriptions and Suggested Falls Reports

Nursing Home Meetings	Meeting Description	Typical Attendees and Leads	Falls High-Risk Report	Quarterly Summary of Fall Risk Factors by Unit or Facility	Monthly Contextual Factors by Unit or Facility	Postfall Assessment Summary
Care Plan Meetings	Weekly review of resident care plans. Reports help care plan change decisions.	Multidisciplinary team DON or ADON typically leads the meeting.	**X**			**X**
CNA Shift Change Report	CNAs meet at shift change to share summary of residents' clinical status and residents' care plan interventions for CNA followup. The charge nurse typically generates the On-Time reports for the CNA staff at the beginning of the shift to identify residents with changes in risk.	Charge nurse/nurse manager and CNAs Charge nurse or nurse manager typically leads the meeting.	**X**			
Nurse Shift Change Report	Nurses meet at change of shift to review resident clinical and risk status. On-Time Risk reports help identify residents at risk for falls that need attention.	Nurse managers or charge nurses Nurse managers or charge nurses typically lead the meeting.	**X**			
Quality Improvement Review	The QI Committee may use the reports to identify risk factors most commonly associated with falls in order to help identify facilitywide or unit-level performance improvement projects that may be needed to mitigate fall risk.	QI Committee, department heads, including administrator and medical director (or physician/ANP designee) Nursing or QI director leads the meeting.		**X**	**X**	
Rehab Department Internal Review	Department team weekly review of rehab patients or residents in need of rehab. Report data help identify residents with factors such as ADL decline or balance changes that indicate an increased risk for falls and the potential need for therapy.	Rehab Department staff Rehab director typically leads the meeting.	X	**X**		**X**
Root Cause Analysis for New Falls	Multidisciplinary team review of new falls. Risk and trended reports provide insights into why these persons had a new fall.	DON or ADON, nurse manager, QI director, rehab therapist or director, restorative nurse DON, QI director, or QI staff leads the meeting.	**X**	**X**	**X**	**X**

Nursing Home Meetings	Meeting Description	Typical Attendees and Leads	Falls High-Risk Report	Quarterly Summary of Fall Risk Factors by Unit or Facility	Monthly Contextual Factors by Unit or Facility	Postfall Assessment Summary
Weekly Fall Risk Huddle	Nurse/therapist/CNA weekly huddle to review fall risk status and confirm appropriate interventions are in place for fall prevention. Reports identify residents with fall risk. The meeting elicits feedback from CNA staff caring for the residents and perspectives of the nurse and therapist.	Charge nurse, therapist, restorative nurse, and CNAs Other staff may attend such as activities staff, social services, and the MDS nurse. Nurse and a therapist may colead the meeting.	X			X
Weekly Behavior Review Meeting	Multidisciplinary team review of residents with potentially unsafe behaviors. The purpose of using the reports is to identify persons with risks associated with unsafe behaviors, review care plans, and help update interventions.	Multidisciplinary team Nurse and social worker and/or activities director colead the meeting.	X			
Pharmacist Monthly Medication Review	The pharmacy consultant and director of nursing or nurse manager review resident medication regimens and fall risk profiles to determine if medications are contributing to a resident's fall risk and if medication adjustments should be recommended based on resident status.	Pharmacy consultant and director of nursing or nurse manager; medical director may also participate.	X			X
Weekly Fall Risk or Safety Meetings	Multidisciplinary team review of residents at risk. The purpose of using the reports is to identify persons with risks associated with falls, review care plans, and help update interventions.	DON or ADON, nurse manager, restorative nurse and rehab director or rehab therapist, depending on focus of meeting; other interdisciplinary team members, depending on focus of meeting (e.g., activities staff may participate regarding exercise programs). DON or ADON or rehab director leads the meeting.	X	X		X
Medical Staff Meeting	Quarterly meeting with medical director and attending physicians to discuss administrative, coordination, and clinical issues.	Attending physicians. Medical Director leads the meeting.		X		

Abbreviations used: ADON = Assistant Director of Nursing; DON = Director of Nursing; CNA = Certified Nursing Assistant; ANP = Advanced Nursing Practitioner; MDS = Minimum Data Set; QI = Quality Improvement; APRN = Advanced Practice Registered Nurse.

AHRQ's Safety Program for Nursing Homes On-Time Falls Prevention

Implementation Materials Training

Menu of Implementation Strategies

	Existing	New
Falls High-Risk Report		
Care Plan Meetings	X	
Nursing Assistant Shift Change Report	X	
Nurse Shift Change Report	X	
Root Cause Analysis for New Falls	X	
Weekly Fall Risk Huddle		X
Weekly Behavior Review Meeting	X	
Pharmacy Consultant Monthly Medication Review	X	
Weekly Fall Risk or Safety Meetings		X
Rehab Department Internal Meeting	x	
Quarterly Summary of Fall Risk Factors by Unit or Facility		
Quality Improvement Review	X	
Rehab Department Internal Review	X	
Root Cause Analysis for New Falls	X	
Weekly Fall Risk or Safety Meetings		X
Medical Staff Meeting	X	
Monthly Contextual Factors by Unit or Facility		
Quality Improvement Review	X	
Root Cause Analysis for New Falls	X	
Postfall Assessment Summary by Resident		
Care Plan Meetings	X	
Rehab Department Internal Review	X	
Root Cause Analysis for New Falls	X	
Weekly Fall Risk Huddle		X
Pharmacy Consultant Monthly Medication Review	X	
Weekly Fall Risk or Safety Meetings		X