**“Falls Reduction” Part 2**

**VA National Center for Patient Safety**

**May 8, 2015**

**Time − 10:47**

**Participants**

***Julia Neily, R.N., M.S., M.P.H.***

*Associate Director, VHA National Center for Patient Safety Field Office*

*White River Junction, Vt.*

**Pat Quigley, Ph.D., M.P.H., A.R.N.P., C.R.R.N., F.A.A.N., F.A.A.N.P.**

ACNSR/Associate Director VISN 8 Patient Safety Center of Inquiry, James A. Haley VA Medical Center, Tampa, Fl.

HSR&D/RR&D Center of Innovation on Disability and Rehabilitation Research, VISN 8, St. Petersburg, Fl.

**Interviewer**

**Joe Murphy, APR, M.S.**

VA National Center for Patient Safety, Ann Arbor, Mich.

**The Transcript**

**Music Builds**

Joe

This podcast is being brought to you by the VA National Center for Patient Safety. I’m you host, Joe Murphy, public affairs officer.

My guests are Pat Quigley and Julia Neily. As Associate Director, VISN 8 Patient Safety Center of Inquiry, Pat leads many of the center’s fall and injury reduction efforts.

Julia is Associate Director for the VA National Center for Patient Safety’s Field Office, and has been involved in many quality improvement initiatives.

Both have authored or coauthored numerous articles on a wide range of patient safety issues,

given conference presentations, and recently worked together to revise and update the Falls Toolkit.

Falls reduction is a critical aspect of VA’s patient safety program.

Pat and Julia joined me on a conference call to discuss this important issue.

So Julia, can falls be prevented?

**Music Fades**

Julia

No. Not all falls can be prevented. This is a really important aspect of fall work. Especially for the leadership to look at and for staff when we look at their falls aggregated review process.

Certain types of falls – and this is from the work of Janet Morse – an unanticipated physiological fall cannot be prevented. This, for example, is a first time seizure or an unexpected cardiac event and the patient falls and there is no way we could have predicted that would happen. These are the falls that we can’t control; we can’t prevent. So we don’t spend our time and energy trying to prevent those. And this is also why when we look at our fall and fall injury rate, we would not be trying to examine those along with all the other falls.

The other two types of falls are the anticipated physiological falls. And these are falls that we could predict would happen, expect might happen, if we don’t try and intervene on the modifiable falls risk factors.

And then there are the accidental or environmental falls. And these are falls that occur because of uneven flooring, for example, lack of proper lighting; perhaps we don’t have hand rails we should have. And so, as you can see, these are actions we can take to prevent these types of falls.

So this viewpoint can be really helpful when we are trying to decide where to put our efforts and have as much impact as we can have on falls prevention.

Joe

If you could change practice tomorrow, what four changes would you suggest?

Pat

Joe, this is Pat. I’d like to go ahead and get started answering that, in terms of four changes.

The first thing that I would suggest, and I think this has been a commitment, it’s not just me, but the Department of Veterans Affairs, is that we have made a commitment to not have an over-reliance on these falls screening tools.

So many nurses − so many hospitals – are requiring that nurses use these screening tools to be completed every day, every shift. And the tools that are used in health care to identify the risk of someone falling are not an assessment. And many hospitals implement them as if they were an assessment tool and they are not. They are a screening tool.

So we have been very clear, since at least 2008, in the Department of Veterans Affairs, that the tools are only a driver for assessment. If there is a positive response to any of the variables on the screening tool – and we predominantly use the Morse Falls Scale in the VA – then the positive response to a screening question, for example “history of falls,” nurses will go ahead and do an assessment. They will ask about the falls history, they will ask about any indicators, about why falls are occurring. But then they go beyond that and ask about injury history. So for us, we have really implemented these tools as they were intended – as a screening tool as a driver for assessment.

But for the most part, there is an over reliance on them, so nurses are collecting information on these tools, and getting a score, and then the score drives practice. And we don’t want to do that. We don’t want a score to drive practice or a level of fall risk. What we want to focus on is identifying actual risk factors that an individual has and seeing what we can do to mitigate or eliminate that risk factor.

For us, it’s about individualizing plans of care and getting to risk factors and being able to help someone be *better*, because we were better able to identify and treat those risk factors.

The second opportunity for change that I would do tomorrow is to help nurses focus on *clinical assessment*. And this really builds upon the first change that we would make. Rather than these screening skills, to really focus on doing a clinical assessment and identifying if patients have impaired vision, if patients have problems with their blood pressure dropping when they stand up; or, the static assessment. If patients have trouble being able to feel their feet, because they have lower extremity sensory neuropathy; if they have ben diabetic for some time.

So we really want to help our nurses focus on clinical assessment and come back to clinical practice. And if that is done, then the nurses can actually identify interventions that are specific to that risk factor − that impaired vision, that dropping blood pressure, that trouble being able to feel their feet.

So those are the two things that I would like to see change tomorrow. How about you, Julia?

Julia

Well Pat, thanks so much, I agree with everything you’ve said. The two items that I would change tomorrow if I could would be for people to implement a population-based approach to care. And one of the tools we really have recommended to people is the “ABCS” tool.

First the “A” being for age, equal to or greater than 85 or frail elders in general. And “B” for looking at bones; fracture risk or history of that. And then the “C” for anticoagulation. As we all know patients might be on anticoagulant meds, and these might contribute to increased risk for injury related to bleeding. And lastly the “S” stands for surgery. Many times we’ve seen a patient who was admitted and they were not at risk for falls or falls-related injury. But then after the have surgery, they are at greater risk for falls or falls-related injury.

So these population-based approaches can be really useful. The other reason why I really like using this approach and recommend this, in the VA, that we recommend this, is because so many times staff will share, “Well, I don’t know what else to do to prevent falls. I feel at a loss. I feel like I have done everything I can do.” And that’s when we really like to point them to these actions to prevent falls-related injuries and looking at the population-based actions that we can implement.

The fourth item that I would really recommend for people, and that we do in the program at the VA, is to redesign our patient education so that patients are full partners in their care for preventing falls and falls-related injuries.

Why is this so important? Well, we really have a strong population that is fiercely independent, which is great, and we really promote patient autonomy. So when we teach patients to say, “Please ask me for help,” before you get up, or go to the bathroom or ask for something. We need to understand if that is something they are willing to do. They need to agree to that. And if we don’t check back with them to see if they agree with this plan of care, then we are missing a very important piece of our approach.

So I would really emphasize redesigning our patient education to use teach-back and also to really see what is important to the patient and what are they willing to do. What kind of help are they willing to accept?

Pat

I think these four changes are to be made tomorrow are so important and they are very do-able, very relevant. These are action steps that organizations can take at the unit level throughout their entire organization.

But as we finish this podcast, Joe, I would like to say that when you do the work in patient safety and you focus falls or injury reduction that it’s so easy to focus on an adverse event that occurs. The fall that occurred; whether you could have prevented it or not.

But there are many of our Veterans who don’t fall; who are not falling every day. Falls are so relatively rare, there are opportunities to be able to celebrate success – in those patients who are really difficult, they are difficult to manage; people who are confused; patients who are very, very vulnerable that we do keep safe because they are in our care.

So I encourage though this podcast, and I know Julia is so supportive of this as well, you know the National Center for Patient Safety, is to find ways to celebrate all the patients that are kept safe every day or patient who are really difficult who you prevented from falling today.

Find ways to celebrate success, it’s not just about the adverse events − and then still focus on reducing risk. You’ve got to get to those risk factors.

But I would like to thank you so much, Joe. We have such great leadership in the VA for reducing falls and falls-related injuries. And everybody should feel very good about the leadership that VA has taken in reducing injuries from falls over the years. Because that’s what has helped set us apart and that’s what brings people looking to us for help.

Julia

Joe, there is one more point that I’d like to add that is consistent with everything we have shared so far, but also with the National Center for Patient Safety promoting a culture of safety, a culture of not blaming.

As much as we promote a blame-free culture for patient safety, sometimes people have shared that there’s still some guilt when a patient falls. And we don’t want that, we want people to feel that they can bring forth events that occurred. Do a post-fall huddle or an after action review and really look at what happened, why did it happen, and what can we do to prevent it from happening again − without people feeling badly about that.

When we promote mobility, there may be falls and we just want to try and to prevent injury with that. That’s the last thing I want to share, in agreement with everything that’s been said so far. Especially, Pat, with focusing on celebrating success, is to take away the blame. For leadership and staff to all come together and promote mobility, patient independence and not feel blame when patients do fall.

**Music Builds**

Joe

This podcasts has been brought to you by the VA National Center for Patient Safety. Thanks for listening.

**Music Fades**