VISN 8 Patient Safety Center of Inquiry Previous/Ongoing Projects and Products

## Many of our products are available for download. Please visit <http://www.tampavaref.org/conferences.htm> to review available downloads. If you cannot find a particular product, please contact [Valerie.Kelleher@va.gov](mailto:Valerie.Kelleher@va.gov) or call 813-558-3948.

**Projects**

**Falls**

**CDC/STEADI Modified for VA PACTs**  
We trialed the CDC STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Toolkit in one PACT Team. We encountered a number of organizational, provider and patient barriers trying to implement fall risk assessment as recommended by CDC/STEADI in VA PACT. The STEADI Toolkit was not easily incorporated in to the workflow within the test VA PACT team. The overall interest and use of the toolkit was low due to complexity and time required to complete it.

**Evaluation of Protective Properties of Commercially-Available Medical Helmets**  
**Plan:** We evaluated 11 different helmets to assess their ability to decrease linear acceleration, angular acceleration and head injury criterion (HIC) to as a result prevent serious head injury. Manuscript Pending

**Update of the NCPS Falls Toolkit for VHA:** Following an evaluation by the Falls Toolkit Expert Advisory Group, the VA National Falls Toolkit was updated and revised with additional materials to move beyond setting up falls programs, to improving and sustaining them, and emphasizing injury prevention, rather than falls prevention. The toolkit is available at <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>

**Customized Fall Injury Reduction Program for VA Medical/Surgical Units:** 32 medical/surgical units from VISN 8 participated in an organizational assessment of readiness to prevent injurious falls, identify gaps in practices, provide curriculum and assess for change in the units' readiness. We developed a customized curriculum for all participating units, focusing on interdisciplinary involvement.

**VA Live Falls Collaborative—Multifaceted Program to Reduce Risk for Fall Injury:** We organized and delivered an 8 session webinar series to interested VA facilities nationwide to improve skills and knowledge base in the prevention of injurious falls from October 2012 to February 2013 and had a participation from large number of VA medical centers.

**Advancing Typology of Falls:** The objective of this project was to develop and test a clinical decision- process to classify fall events that could improve fall prevention program evaluation related to preventable and non-preventable falls. This information was added to the VA National Falls Toolkit under Post-Fall Huddle tab.

**Extracting Information from Text to Assess Adherence to Fall Prevention Guidelines:** The objective of this “proof-of-concept”  project was to complete a multi-site pilot study employing Information Extraction (IE) techniques applied to text documents from the EHR to determine if Veterans, who fall, receive Fall Prevention Guideline-based care.

**Evidence Review and Current Practices on Use of Sitters Objective:** We developed an evidence review to describe current policies and best practices on use of sitters for fall prevention in inpatient areas. Evidence was of very poor quality and we were unable to draw any conclusion for or against use of sitters for fall prevention.

**Biomechanical Determination of Safe Footwear for Institutional Patients:** The objective of this project was to conduct laboratory evaluations of footwear and flooring used in institutions, as a function of static and dynamic coefficient of friction for various flooring materials and conditions.

**Tailored Medical Helmets for Specific Patient Populations and Co-Morbidities:** The objective of this project was to determine head impact characteristics as a function of patient type and fall conditions, to provide guidance for future design of helmets for head injury prevention.

**VA Live Falls Collaborative: Falls Journey for Change:** The objective was to organize a series of 8 webinars for falls teams, to help integrate innovations in fall-injury reduction into acute care practices throughout VHA. The webinars were presented from January to April, 2012.

**Data Extraction Protocol from CPRS for Falls and Fall-Related Injuries:** The objective was to determine if an open source natural language processing program can reliably extract information from VistA to generate reports.   
Feasibility and Safety Testing of a Combination Chair/Walker Mobility Device (enclosed walker): The objective was to, using qualitative and lab-based methods, explore the feasibility and safety of an alternate mobility device, a chair/walker combination (enclosed walker).

**Social Marketing to Support Fall Prevention in Inpatient Psychiatry Units (2010-11):** The purpose of this project was to produce market segment specific recommendations for “selling” falls prevention in acute inpatient psychiatry, using social marketing methods. We conducted a total of 5 focus groups with different inpatient psychiatry providers (VA and non-VA) and have used the finding to guide the implementation efforts in falls projects. (Quigley, P. A., Barnett, S. D., Bulat, T. & Friedman, Y. (2014). Reducing falls and fall-related injuries in mental health: a 1-year multihospital falls collaborative. Journal of Nursing Care Quality, 29(1), 51-59. doi: 10.1097.92.NCQ.0000437033.67042.63).

**Product: Injurious Fall Prevention Organizational Self-Assessment Questionnaires:** The purpose of these questionnaires was to determine the implementation level of key fall injury program attributes within hospitals and inpatient mental health units. By completing this survey, organizations sought information from administrative, advanced practice and direct care staff who currently practice in inpatient mental health units.

Mental Health Questionnaire available from: <http://www.tampavaref.org/conferences-visn8.htm>

Med/Surg Questionnaire available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Unit Peer Leader Program (UPL) for Falls in Psychiatry Units (2010-11):** The goal of this project was to customize UPL role to inpatient psychiatry, as a mechanism to promote and sustain fall prevention programs. We developed a functional statement, criteria for selection and the Toolkit for UPL for Falls in Psychiatry. Each VISN 8 site chose a UPL, who participated in a curriculum and implementation efforts. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Safe Patient Handoffs for Patients at Risk for Falls in Psychiatry (2010-2011):** The goal of this program was to develop and test a standardized hand-off communication tool for use in inpatient psychiatry that includes fall prevention/protection information. We collected and reviewed all hand-off tools from VISN 8 and drafted a new tool that includes fall and injury risk assessment. It was reviewed and distributed to VISN 8 Clinical Experts for content validation. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

The area of inpatient psychiatry presents unique challenges to organizations seeking to implement a safe patient handling (SPH) program. With existing equipment such as ceiling-mounted lifts providing opportunities for patients to harm themselves or others, and floor-based or sit-to-stand lifts proving incompatible with the platform beds present in psychiatric units, maintaining a work environment that reduces the caregiver's risk of back and other musculoskeletal injury is difficult. Following a literature search and review on the subject of safe patient handling and psychiatry, a review of environmental design guidelines for inpatient psychiatric units, discussions with clinical staff and experts in this field, and a review of existing patient handling equipment specifically made to be used in a psychiatric unit, it was determined that there were two key areas of equipment development that would be required to meet the safe patient handling needs of this type of unit in and around the immediate vicinity of the patient's bed area. This report highlights the process by which a list of criteria was developed for the design of a height adjustable platform bed that meets the design guidelines for psychiatric units, and a list of criteria that articulates changes that could be made to existing SPH equipment design to meet the needs of this patient group and be compatible with the platform beds used in inpatient psychiatric units. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Ultra Wideband Radio Frequency Identification (UWB RFID) to Improve Fall Detection and Patient Care in Community Living Centers (CLCs) (2010-11):** The objective of this study was to determine whether UWB RFID technology may be used to detect falls in a clinical setting. This project examined the sensitivity and specificity of the technology to detect falls using 12 unique patients over the course of 100 days and fall precursors – the tortuosity or randomness in the patient’s path over time, and their total distance travelled. More research is needed before recommendations can be made about this technology application.

**Quantifying Fall Risk in Persons with Lower Extremity Amputation(s) (2010):** An educational module was designed by clinical researchers at the Tampa Patient Safety Center of Inquiry and the HSR&D/RR&D Center of Excellence: Maximizing Rehabilitation Outcomes for use by clinicians and researchers involved in the rehabilitation/study of persons with lower extremity amputation(s). Click here to download the presentation. Information described in this module includes:

* The prevalence and significance of falls in lower extremity (LE) amputees
* The identification of situations and circumstances most likely to cause or result in falls
* The detailed description of selected functional performance measures to identify fall risk in this population
* Identification of interventions to minimize falls and fall related injury in this population

This module assist with the pursuit of excellence in delivering rehabilitative services to individuals with lower extremity amputation(s). Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Floor Mat Technology Guide (Excel) (2010):** The goal of this guide is to provide information about currently available floor mat technology and provides vendor contact information. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Injurious Fall Prevention Assessment Tool (2009):** This survey, "Injurious Fall Prevention Organizational Self-Assessment," is a product from the VISN 8 Patient Safety Center and the IHI-RWJF Project "Reducing Serious Injuries in Medical Surgical Units," Project #57527. This survey was designed to help you determine the implementation level of key fall injury program attributes within your hospital and the inpatient unit that you work. After analysis of results, you can prioritize strategic planning to increase your organizational fall injury program scope and capacity. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Hip Protector Toolkit (Word) (2009):** The goal of this toolkit is to promote the routine use of hip protectors in nursing homes by providing physicians, nurses, therapists and others with information and tools to assist them and overcome barriers to hip protector use. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Prevention of Fall-Related Injuries: A Clinical Research Agenda 2009-2014 (.PDF):** This report details the collective consensus of falls experts to establish a research agenda for the prevention of injury due to falls for the next 5 years. We hope this research agenda will influence funding agencies to establish requests for research proposals to advance knowledge of falls prevention and management. http://www.tampavaref.org/conferences-visn8.htm

**Osteoporosis DVD (2007):** This educational program about osteoporosis is unique as it has a special focus on men, unlike current osteoporosis educational materials. This video is designed to teach men about osteoporosis risks, prevention and diagnosis. This 13 minute video was prepared by the VISN 8 Patient Safety Center, funded by Merck & Co, Inc., and produced by the University of South Florida Health Media Center. Contact Valerie Kelleher at [Valerie.Kelleher@va.gov](mailto:Valerie.Kelleher@va.gov) for availability of the video.

This video is not closed captioned. A transcript is available from: <http://www.tampavaref.org/conferences-visn8.htm>

**Blood Thinners: Risk Factors Associated with Falling and What to Do When you Fall (.pdf) (2007):** This brochure is an information guide for patients on blood thinners and the risks associated with falls. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**James A. Haley Veterans Hospital: Reducing Severe Injury from Falls in Two Medical Surgical Units:** Institute for Healthcare Improvement Collaborative Final Report July 1, 2006 to July 31, 2007 (.pdf): This report summarizes the projects tests of change, lessons learned and outcomes for the initiative. The primary measurable goal of the project was to dramatically reduce injury from falls on medical-surgical units. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**The Functional Balance Class Guide (Word) (2005):** This manual was devised to disseminate a successfully proven balance intervention strategy which was developed by the VISN 8 Patient Safety Center Falls Clinical Division. This treatment intervention consists of an 8-week Functional Balance Class with accompanying home exercise program. The class is led by a therapist (PT or KT), and convenes once per week. This intervention is targeted towards community-dwelling patients with balance and gait difficulties. Available from: <http://www.tampavaref.org/conferences-visn8.htm>

**The Falls Toolkit (2004):** Many facilities are working to find ways to reduce the number of falls as well as the severity of the falls that do occur. In an effort to help facilities, we worked in conjunction with the National Center Patient Safety to create the Falls Toolkit.  
The Falls Toolkit provides information on:

* Designing a falls prevention and management program
* Effective interventions for high-risk fall patients
* Implementing hip protectors for fracture-risk fall patients
* Educating patients, families and staff on falls and fall-injury prevention

The toolkit is available online at: <http://www.patientsafety.gov/SafetyTopics/fallstoolkit>

**Fall Risk Assessment for Home-Based Primary Care (HBPC)** Developed an evidence-based fall risk assessment for HBPC programs, pilot tested it in VISN 8, modified based on feedback and developed a toolkit to be shared with HBPC programs nationally.

**Novel Compliant Flooring for Fall Injury Prevention** Evaluated the effectiveness of standard and compliant flooring types in preventing falls and fall-related injuries.

**Standbar to Improve Safety and Independence in Power Wheelchair Users** Evaluated the effect of a novel standing device, the Standbar, on standing balance, transfers, and level of supervision required during those activities, and safety of the device.

**Safe Patient Handling and Mobility**

**Preventing Adverse Patient Events Using Safe Patient Handling Equipment:** We worked on refining SPH clinical tools to reduce patient safety risks associated with equipment and enhance the safety of patient handling through improved clinical practice in VA. We convened a panel of experts nationwide who participated in review of the literature/evidence of adverse patient events associated with SPH programs in the VA, analyzed potential actions for quality improvement and prevention of adverse patient events; and developed recommendations for actions at various levels of the organization for review and dissemination in collaboration with the SPH program leadership.

**Mitigating Adverse Patient Events Associated with Patient Lifting Devices:** The objective was to describe the types of adverse patient events associated with lifting devices (contextual factors e.g. organization, lifting device, patient, provider; barriers and facilitators for preventing adverse patient events; strategies for overcoming barriers) to help with the re-design of current SPH technology.

**Safe Patient Handling and Mobility (SPHM) Technologies in Rehabilitation to Improve Patient Mobility and Function I**dentified and disseminated best practices in rehabilitation with the use of SPHM equipment to maximize patient function, mobility, freedom and independence.

**Wandering and Missing Incidents**

**Analysis of Early Trajectory of Wandering Study**  
**Plan:** We will review and clean the extant data, conduct analyses and develop a report to disseminate the results.

**Best Practices on Missing Incidents for Informal and Formal Caregivers:** We developed evidence-based practice education modules for caregivers of persons with dementia providing strategies to rapidly locate a missing Veteran with dementia.

**Healthcare Practitioner and Informal Caregiver Safety Resource Guides:** The objective was to develop a resource manual for health care providers and informal caregivers providing information on effective technologies for managing wandering/missing incidents.

**Missing in the Community: Prevention and Action:** The objective was to develop training to increase skills and knowledge of health care providers related to the prevention and management of missing events in persons with dementia.

**Hazardous Wandering Conference:** The objective was to organize a one day conference preceding the Falls Conference to increase provider knowledge and skills, improve research opportunities and improve practice in the area of hazardous wandering, as well as present the work of PSCI in the areas of Wandering/Getting Lost/Missing Incidents. The conference was held 5/22/12 in Clearwater Beach, FL.

**Wandering Behaviors and Negative Outcomes among Early Trajectory of Wandering Study Participants** Determined the incidence and progression of wandering behaviors and negative outcomes (e.g., falls, emergency room visits, nursing home placement, and death) post-study, of veterans enrolled in *Early Trajectory of Wandering in Veterans with Mild Dementia*.

**Conferences**  
**Plan:** We have an annual conference on Safe Patient Handling and Mobility/Falls. Our conference is designed to meet the needs of direct care providers, managers, administrators, risk managers, educators, industrial hygienists/safety professionals, and researchers of any discipline who are interested in advancing safety for patients and caregivers with tracks on Safe Patient Handling and Mobility in Rehabilitation, Challenges for Special Populations & Settings in SPHM, and Implementation/Evaluation Research in SPHM as well as a specialty track on Fall and Fall Injury Prevention. These conferences have been providing an opportunity for sharing our work and creating collaborative opportunities since 2001. The falls track assembles faculty whose expertise is nationally known for shaping healthcare delivery systems and approaches to improving patient safety focusing on falls including lessons learned, best practices, and cutting-edge research findings related to safety for patients at risk for mobility-related adverse events. For more information please contact Valerie Kelleher at Valerie.Kelleher@va.gov.