"Drilling Down" on Patient Falls: Implementation of an Intensive Falls Analysis Process

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Abstract:

Falls rates and/or falls with injury on selected units in a comprehensive cancer center remained higher than their NDNQI comparison groups. An innovative process using a fall analysis tool, NDNQI, and incident report data was developed and implemented. Results have been used by units to design interventions to successfully reduce falls.

Patient falls, the most frequently reported adverse event in adult inpatients, often result in harm, increased length of stay, and higher costs. Payment from the Centers for Medicare & Medicaid Services for costs associated with injuries associated with hospital acquired falls no longer occurs.

A systematic strategy to intensively analyze patient fall data was developed. Units with sustained fall rates exceeding their NDNQI and National Cancer Center (NCI) comparison groups participate in a focused fall analysis process. Data sources include unit specific fall data displayed graphically in relation to NDNQI comparison group means and NCI hospital medians. Elements include: fall and fall injury rates, hours per patient day, percent of unassisted falls, patients risk assessed within 24 hours, patients at high risk, and assessed and on the fall protocol. Detailed incident report information is reviewed and an *Injurious Fall Data Collection Tool* from the Institute for Healthcare Improvement is completed by the unit. Results are analyzed to identify factors or trends specific to the unit's population and used to develop a "falls bundle". This bundle serves as the basis for tailored interventions aimed at reducing falls, implemented in conjunction with as existing fall program.

Results are displayed and evaluated monthly; findings are compared to quarterly NDNQI and NCI data. Information is shared with nurse leaders and unit staff. Units participating in this process to date have reduced fall and injury rates to levels at or below the NDNQI and NCI comparison group means.

This systematic patient fall review and analysis process allows nurse leaders and staff at the local level to actively use data to develop unit and population specific interventions to reduce falls. Benchmarking and active participation promotes investment in the process and outcomes.

Background/Significance:

- Patient falls are the most frequently reported adverse event in adult inpatient settings. Though all patients who fall do not sustain harm, it is estimated that injuries are associated with 6% to 44% of inpatient falls (Currie, 2006).
- In addition to injury, consequences of falls include increased length of stay, higher hospital costs and other long term effects (Amador & Loera, 2007; Bates, Preuss, Souney, & Platt, 1995; Bemis-Daughtery & Delaune, 2008).
- As of October 1, 2008, falls sustained in hospitals were added to the Centers for Medicare & Medicaid Services (CMS) list of hospital acquired conditions (HACs), sometimes referred to as "never events". Hospitals do not receive additional payment for costs associated with injuries related to inpatient falls (Centers for Medicare & Medicare Services, 2008).

- Despite a robust institutional falls program, policy, and a targeted adult inpatient fall risk screening tool, adult inpatients on some inpatient units in a large comprehensive cancer center continue to sustain falls and harm.
- Fall rates on selected units were identified as exceeding their National Database of Nursing Quality Indicators (NDNQI) comparison group mean and National Cancer Institute (NCI) comparison group median.

Objectives/Aim:

- The objective of this intervention was to explore and identify specific factors that may have contributed to the fall rates on units that consistently exceeded benchmarks for their comparison groups for a 2-3 month period and/or experienced multiple falls with greater than mild harm.
- Additional aims were to involve staff and nurse leaders at the unit level in gathering, analyzing, interpreting findings, and using the data to develop and implement tailored unit-based interventions focused on reducing falls and harm in their patient population(s).

Approach/Methods:

- A systematic process, to focus or "drill down" on falls and intensively analyze fall data at the unit level, was developed and implemented.
- Meetings are held with nurse leaders and selected staff from targeted inpatient units. Both unit specific process and outcome data from the NDNQI database are reviewed. The data is graphically displayed data reflecting the unit's experience in comparison to NDNQI and comparison group means. Additional information displaying the unit's monthly "days between falls" is also supplied.
- After reviewing and discussing the information, nurse leaders and staff use data from the Patient Safety Reporting System (incident reporting system) and patient medical records to initiate an analysis of the 20 most recent unit falls with any level of harm. The *Injurious Fall Data Collection Tool*, from the Institute for Healthcare Improvement (IHI), is used to collect falls data for analysis.
- Participants are coached to consider additional unit-specific data/variables that may potentially contribute to falls and harm. Examples include: a new patient population, specific diagnoses, chemotherapy regimens, medications, symptom clusters, or staffing changes. These factors are added to the data collection tool and analysis.
- After completing the data collection tool leaders and staff review the data, quantify their findings, and look for patterns or trends. Results are discussed and next steps are planned. Based on the findings, units design interventions or "falls bundles" to test. Units continue to receive falls data monthly so evaluation of intervention(s) may occur.

Results:

- Since inception of the process, 5 units have participated in the process. Two units have completed it and both have decreased falls to levels at or below their comparison groups. An example of one unit's experience will be displayed on the poster displayed.

Discussion:

- Implementing a systematic, intensive falls analysis or "drill down" process has proven a useful process in identifying unit-specific factors that may contribute to falls and harm.
- Staff use the data to develop tailored nursing interventions focused on reducing falls and harm.
- The process actively involves nurse leaders and staff in examining, quantifying, interpreting, and benchmarking unit specific data, using it to generate planned interventions to reduce falls and harm.
- A similar process may be useful to other organizations as they address patient falls and harm.

References:

Currie, L. M. (2006). Fall and injury prevention. *Annual Review of Nursing Research, 24*, 39-74.

Amador, L. F., & Loera, J. A. (2007). Preventing postoperative falls in the older adult. *Journal of the American College of Surgeons, 204*(3), 447-453.

Bates, D. W., Preuss, K., Souney, P., & Platt, R. (1995). Serious falls in hospitalized patients: Correlates and resource utilization. *The American Journal of Medicine, 99*. 137-143.

Bemis-Daugherty, A., & Delaune, M. F. (2008). Reducing patient falls in inpatient settings. *PT Magazine*, May, 36-42.

Centers for Medicare & Medicaid Services. (2008. August 4). CMS improves patient safety for medicare and medicaid by addressing never events. Retrieved February 18, 2009, from www.cms.hhs.gov/HospitalAcqCond

Institute for Healthcare Improvement. Injurious Fall Data Collection Tool. Retrieved October 26, 2009, from http://www.ihi.org/IHI/Topics/PaReducingHarmfromFallstientSafety//Tools