# Reducing Fall Rates Through Rapid Cycle Tests of Change

YALE-NEW HAVEN HOSPITAL

## Stay With Me


Early version of sign


Final version of sign front and back


## Purpose

- To develop sustainable strategies for reducing the incidence of falls related to toileting at YNHH by 50% by October 2010 through the rapid cycle change process.
- To hardwire the "Stay With Me" intervention on adult in-patient units.

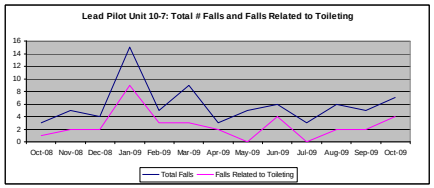
## Significance

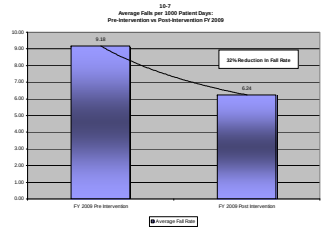
- Research has shown that 38% of falls in the hospital setting are related to toileting. (Krauss M, et al., 2007)
- The average cost per case of a fall with harm can be more than $15,418. (CMS Nursing Executive Center Interview and Analysis)
- In October 2008, CMS stopped reimbursing hospitals for costs associated with inpatient falls.

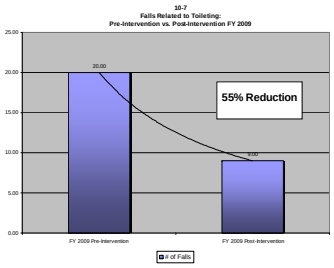
## Strategy: Innovative Intervention

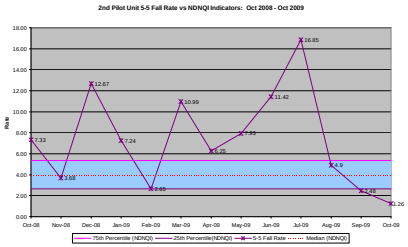
- We chartered a rapid cycle team to address falls incidence at YNHH starting on one General Medicine unit (10-7).
- The team chose to implement the "Stay With Me" intervention: staff members stay within arms reach of designated patients during toileting.
- The multidisciplinary team consists of staff from quality improvement, nursing administration, and patient care units, including managers, RNs, Patient Care Associates (PCA), and physical therapy.
- Staff from additional units are incorporated into the team as the fall safety practice changes spread throughout the organization and only after previous units have had full education and demonstrate success in all elements.
- The 2nd Pilot General Medicine unit (5-5) launched "Stay With Me" in July and Medical Oncology launched in October.
- Celebrations are regularly scheduled.

## Results




## Voices from the Front Line

You remind them [patients] that you are there for them... you follow your instinct. Stay With Me is really good. For instance, if you have a patient going to the bathroom a lot, you round on him and ask him to go. Sometimes they forget they need to go, and when you get into the room they get up and go. You tell him you have the time to be there with them. They say, "you're busy," but you say to them "I can take the time to take you to the bathroom."
-Ana, PCA

It was excellent to have input in terms of changing the current practice to improve patient safety and quality. Fellow staff members are more respectful when it comes from another staff member—it [Stay With Me parameters] came from your peers. The fact we developed the parameters gives staff ownership of the practice and can increase compliance.
-Danielle, RN

## Implementation


### PDSA Cycles of Change

The team started small with one patient, one PCA-RN partnership to launch the "Stay With Me" practice change and associated intervention on the pilot unit. The team seeks to perfect the process through identifying and correcting barriers through weekly PDSA (plan-do-study-act) team meetings.

### Use of Best Practice

The team did a thorough literature review and is participating in the Connecticut Hospital Association Fall Prevention Collaborative. We embraced the Institute for Healthcare Improvement *Transforming Care at the Bedsides Falls Initiative.*

### Use of Data in Decision Making

The team collects and uses data to evaluate progress and to target interventions to high risk populations. Weekly chart audits and post-fall causation data form the foundation for tests of change. A hospital wide working group was launched to improve collection and dissemination of fall causation data.

### Staff Education

Staff members received packets and attended an in-service on hourly rounding and the rationale for the "Stay Wth Me" intervention. Staff meetings and change of shift discussions place emphasis on pre-emptive toileting and staying with the patient.

### Roll Out of New Fall Prevention Equipment and Brochure

Chair alarms, walkers, and canes were rolled out hospital wide in June July and August. The new patient teaching brochure was rolled out in September.

## Evaluation

- In April the lead pilot unit went 24 days without a patient fall.
- The lead pilot unit reached its target in the 2nd half of FY 2009: reducing falls related to toileting by 50%.
- In October 2009 (FY 2010 first quarter) the lead pilot unit had a spike in falls, although half of them were assisted. 1 minor injury was reported. 4 of the 11 falls were related to toileting. 2 out of the 4 falls related to toileting were staff assisted falls. The unit has responded with a combination of interventions, including: PCA safety rounds, PCA/RN patient safety huddles, and a safe patient mobilization project in partnership with physical therapy.
- The 2nd strategic spread unit 5-5 reduced its fall rate consecutively three months in a row and in October went 31 days without a fall. The unit had one fall with assistance (no injury) in October. Results from the Medical Oncology Unit are being collected.
- 5-5 launched "Stay With Me" in addition to a combination of interventions: PCA/RN patient safety huddles, keeping high risk patients under observation at the front desk, and red leaf flags outside of rooms with a bed/chair alarm on.
- Lessons learned: combinations of creative interventions reduce fall rates. The full fall preventive measures bundle prevents falls. Balancing safe mobilization with fall prevention poses challenges for inpatient care units. Fall prevention requires teamwork and continuous process improvement.


Krauss M, et al., "Circumstances of Patient Falls and Injuries in 9 Hospitals in a Midwestern Healthcare System," *Infection Control and Hospital Epidemiology*, 2007, 28: 544-550

(based on Rizzo et al, adjusted to 2008) "Health Care Utilization Costs in a Medicare Population by Fall Status," *CMS Nursing Executive Center interview and analysis.*

Bouson B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. *Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls.* Cambridge, MA: Institute for Healthcare Improvement; 2008.



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