Q 2 to Protect U: Lessons Learned in Fall Prevention Practices

Michelle Kasprzak, BSN, RN, OCN®, Kim Slusser, MSN, RN, CHPN®, Deborah Allen, MSN, RN, CNS, FNP-BC, AOCNP®, Giselle Boward, RN, OCN®, Steve Power, MBA, & Darlene Wilkins, RN, OCN®

Duke University Hospital - Durham, North Carolina

Abstract

Objectives:

- Develop an understanding of the quality improvement process utilizing the Six Sigma DMAIC process
- Identify strategies to reduce patient falls through staff education and awareness and patient engagement.

Purpose:

When an inpatient medical oncology unit's fall rates, with and without injury, exceeded target goals for four consecutive quarters, it was essential to identify and develop strategies to decrease the number of falls.

Significance:

Oncology patients are at high risk for falls due to complex treatments and symptoms. Falls impact LOS, quality of life, discharge planning, and nurse-patient relationships. The institution's financial burden from treating injuries due to falls threatens ability to deliver quality care in the future.

Strategy and Implementation:

We analyzed twelve months of fall data identifying root causes and performed audits measuring compliance with policy. Findings showed staff did not perform safety checks 32% of the time, 32% of patient rooms had obstructive paths to the bathroom, staff performed safety checks with significant variance, and there was absence of shared team responsibilities and patient engagement. Literature was reviewed and 160 practices in fall prevention and reduction were ranked on feasibility and effectiveness. An evidence-based campaign was developed. It includes a slogan design, scripting, shared team responsibilities based on work flow, improved patient call and bed exit alarm systems, and patient engagement Staff completed an interactive education program. Slogan pins are worn increasing staff and patient awareness, scripting cards are worn with name badges promoting consistency in addressing the five elements of the safety checks, and a chart of accrued falls is displayed on the unit.

Evaluation:

Data collection is ongoing and first quarter analyses will be shared at the conference presentation. Reduction in falls and falls rate is the goal of successful implementation. Elimination of variance in practice and increased patient engagement will be measured by audits and patient interviews.

Implications for practice:

Root cause analysis led us to incorporate evidence-based strategies for the development of this project. These strategies can be utilized in other patient populations and organizations to ensure a safe environment for patients.

Statement of the Problem

1. Drift in performance since last focused fall education intervention in 2005 led to the need for a more sustainable intensive practice change, as seen in Figure 1

2. Performance below comparisons for falls per 1,000 inpatient days
   - As compared to other medical units within the facility
   - As compared to national average

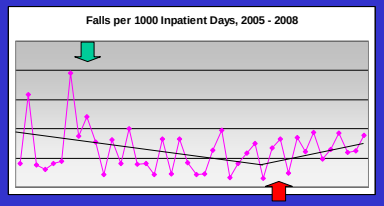
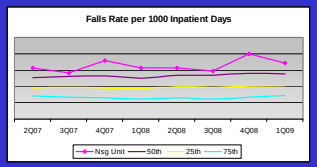
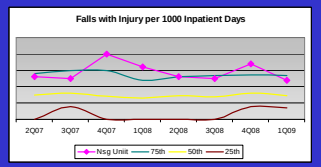


Figure 1. 2005 Falls Rate prior to and after implementing the Falls Education showing a sustained reduction over 18 months, followed by an increase in last months of 2008.





Figures 2 & 3. Overall Falls Rate with and without injury higher than the national average.

Intervention for Practice Change

Education Program

- Mandatory staff participation
- 45 minute program presenting:
  - CMS criteria & current unit performance
  - Physiology of cancer for patients at risk to fall
  - Variance in staff performance of Safety Checks
  - Videos showing correct Safety Check versus incorrect checks
  - Interactive discussions of how to overcome practice change barriers
- Use of TABS monitoring system for those at high risk
- Scripting for Q 2 to Protect U Safety Checks
  - Name tag cards with prompts for scripting
  - Pins with Logo for patient engagement
  - Assigned alternating times for NCA and RN staff to perform the safety checks

SCRIPTING for Q2 2 PROTECT U

- Hi, Mr./ Mrs. XX. I am here for your **Q2 2 Protect U**.
- While I am here can I help you use the bathroom/bedpan/urinal?
- I am placing your personal items (remote, phone, glasses, etc.) here at the bedside so you will not need to get up.
- Are you in pain? If so what is your pain score 1-10?
- Do you have any other concerns I can address for you? Can I get you anything else?
- We will be back in 2 hours for your **Q2 2 Protect U**.
- If you need something in the meantime or need to get up, please use the call bell (reposition the call bell near them).

Weekly updated Falling Freddie chart of patient fall incidence for actual falls with and without injury is posted in the nursing workroom as a reminder for practice change.

1 Month Data

Patient interviews showed that:

- 60% stated pain, restroom needs, and belongings were addressed
- 12% were not asked if they needed to use the restroom
- 20% stated personal belongings within reach was not addressed

Auditor's observations during patient interviews:

- 96% patients had personal belongings within reach
- 88% patients had a clear path to the bathroom

During the observations of staff performance:

- 40% staff interactions with patients did not include the statement that a staff member will return in 2 hours to perform a safety check
- Patients were being left in the bathroom unattended, resulting in 2 falls within 1 month since implementation of campaign

Chart Audits revealed:

- Change of shift documentation was more likely to be incomplete, specifically related to staff roles
  - For NCAs: at 0700 & 1900
  - For RNs: at 0500 & 1700

Conclusion:

The Education Rollout ALONE was unlikely to provide a sustained change in practice. Sustainable practice change takes time and focused endeavors.

Focused Intervention

- No one left unattended in bathrooms
- Targeted staff engagement in the Q2 2 PROTECT U campaign

Sustainment & Improvement Plan

- Engagement of leadership with staff
  - Engagement in staff meetings and shift safety huddles
    - Review of falls: cause, preventative measures for future risk assessment
    - Celebrate gains and recognize success
  - 1:1 Discussions with staff
    - Patient specific fall prevention plan of care for high risk patients
    - Post fall review for lessons learned and opportunities to modify patient's plan of care
- Further promote staff & patient partnerships
  - Q2 2 Protect U identification & purpose
- Continued documentation audits, patient interviews, and staff observations
  - Presentation to staff monthly and as a poster with biannual updates
- Ongoing educational booster through a hospital wide initiative, November 2009

Current 4 Month Data

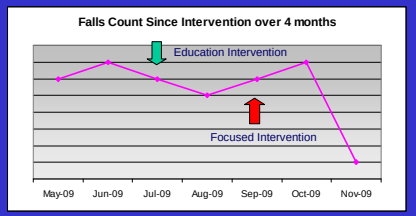


Figure 4. All falls, with and without injury, since initiation of intervention in July 2009. Intervention is ongoing.

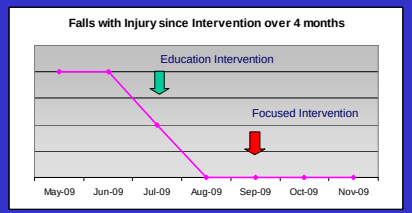


Figure 5. Falls without injury count since initiation of intervention in July 2009. Zero falls with injury since August 2009.