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Good Catch:

Fall Reduction Through an Interdisciplinary Approach in an Academic Medical Center

The University of Kansas Hospital
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Objectives

- Discuss the essential components of interdisciplinary fall prevention strategies
- Identify innovative methods to create an organizational culture of fall prevention

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Hospital Profile

- The University of Kansas Hospital is a Magnet designated academic medical center
- Nationally certified as a
  - Level I Trauma Center by American College of Surgeons
  - Primary Stroke Center by the Joint Commission
- 555 Staffed beds

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Hospital Profile

- In *U.S. News & World Report's* America's Best Hospitals list for 2009-2010, the hospital ranked:
  - 36th in the nation for ear, nose and throat programs
  - 39th for heart care and heart surgery
  - 48th for kidney disorders
- The University HealthSystem Consortium ranked the hospital second among the nation's academic medical centers in quality and safety

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What do we know?

- Falls are the 6th leading cause of sentinel events according to the Joint Commission
- The Joint Commission 2009 National Patient Safety Goal
  - Reduce the risk of patient harm resulting from fall
- Falls are 'Never Event' – Center for Medicare & Medicaid Service
  - Medicare no longer reimburses for fall related treatments

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What do we know?

- 20% – 30% of patients who fall suffer moderate to severe injuries such as hip fracture and head injuries
- As reported on the CMS website specific to Falls and Trauma:
  - 193,566 cases reported in 2007 (Medicare data)
  - Additional cost of $33,894/ hospital stay

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Time to Refocus on Falls

- Fall Prevention Program was stagnant and unable to sustain improvements in fall prevention
- Desire to establish effective and sustainable fall prevention program through instilling an organizational culture of fall prevention
- Overall, there were opportunities for improvement!

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Insanity is doing same thing over and over again and expecting different results.

Albert Einstein

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Our Journey

Commitment

- Leadership
- Allocating Resources

Interdisciplinary Approach

- Interdisciplinary fall task force
- New fall policy and organizational goals

Evidence into Practice

- Fall prevention bundle

Engaging Staff

- Mock Fall
- Practice Council
- Fall Campaign
- Post Fall Huddle
- Unit based score board

Good Catch

-Organizational culture 'fall prevention is everyone's responsibility'

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Commitment

- Leadership
  - Patient safety as number one priority
- Allocating Resources
  - Human Resource -Advance Practice Nurse
    - To manage fall prevention program
    - Drive new initiatives
    - Integrate evidence into practice
    - Clinical expert to the bedside
  - Material Resource
    - Attendance in National conferences
    - Educational Funds – Webinar and conference
    - Budget Allocation

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Interdisciplinary Approach
Mobilizing Resources

- Nursing task force transformed into interdisciplinary task force, led by Clinical Nurse Specialist
- Created standardized quality tools to determine potential issues and measure outcomes:
  - Fall Rate and NDNQI benchmark
  - Segmentation of data
  - Graphs and flow charts

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Interdisciplinary Approach

- Fall Prevention a Nursing Standard expanded to a Corporate policy
- Clearly stated expectations from all employees including physicians regarding fall prevention

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Interdisciplinary Approach
Examining Data

- Baseline analysis of the data revealed that
  - More than 40% of the falls were related to toileting
  - More than 50% falls were unwitnessed
    - Some of these unwitnessed falls were lead to moderate to severe injuries

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Interdisciplinary Approach

- Aiming High - Setting new goals
  - Eliminate unwitnessed and unassisted falls
  - Reduce falls related to toileting
  - Zero tolerance for major injuries related to fall

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Evidence into Practice
Bundling Works

- Fall Prevention Bundle
  - A care bundle is a group of evidence-based interventions that are more effective when implemented together rather than individually

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Evidence into Practice
Bundling Works

- Fall Prevention Bundle
  - Set of 6 interventions that are evidence based
    1. Identifier for high risk patient
    2. Communication between nurses and healthcare provider
    3. Remind patient to call for assistance
    4. Hourly rounds
    5. Toileting rounds
    6. Patient and family education

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Evidence into Practice
Seeking Attention

Before

After

- Old magnetic falling star sign was replaced with new yellow caution sign
- Falling star sign does not effectively communicate that patient has high risk for falls
- Staff did not replace the magnetic sign after patient discharge

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Evidence into Practice
Seeking Attention

New Fall Risk Identifier

- Signs, wristband, socks and patient education handout are packaged together and placed in one location to improve compliance

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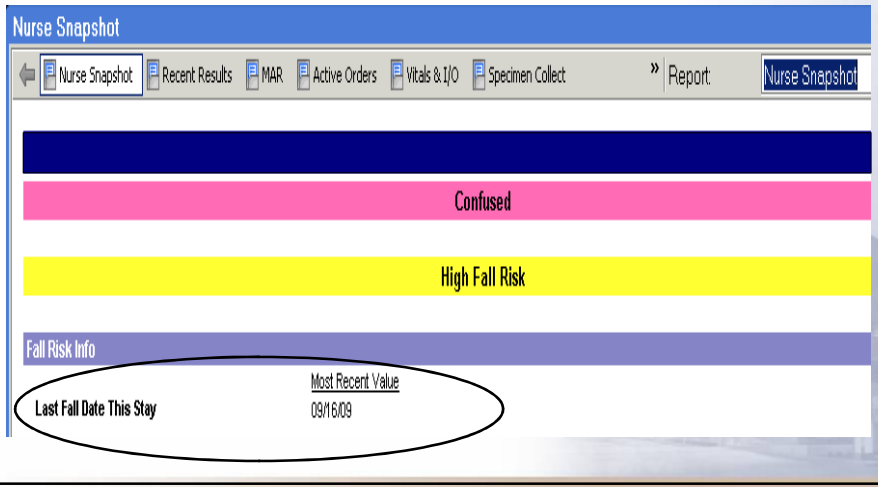
Evidence into Practice

Communication: Automatic high fall risk flag



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Evidence into Practice

Remind Patient to Call for Assistance

- Constant reminder to increase patient compliance to the use of call light
- Scripting helps to send out consistent message
  - For example “Mr Smith you are high fall risk and we are concerned that you may get hurt. Here is your call light so Please call me when you need to get out bed or use commode and wait for assistance”

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Evidence into Practice

Patient & Family Education

A Guide for Patients and Families

For High Fall Risk Patients

At The University of Kansas Hospital, we place our greatest emphasis on providing excellent care and achieving optimal outcomes for our patients. And we continually look for ways we can improve.

Each year, The Joint Commission, a national hospital accreditation agency, publishes National Patient Safety Goals to promote specific improvements in patient safety. One goal focuses on reducing the risk of patient harm resulting from falls.

Our care team evaluates each patient upon admission. You and your family are receiving this information because our Fall Risk Assessment shows you are at high risk for a fall. By making our staff and your family aware of your fall risk, we can work together to prevent a fall or injury during your stay with us.

What We Do To Prevent Falls

Our physicians, nurses, pharmacists, physical therapists and occupational therapists work together to prevent falls. Each day, our nurses use a risk assessment score to evaluate each patient's risk for falling. These are the safety precautions taken for patients who are at high risk for falls:

- You will wear a Yellow Fall Risk Wristband, which tells the staff to take special measures to prevent falls.
- High Fall Risk Signs will be placed outside your room to alert our staff that they should take special measures to keep you safe.
- We provide special "skid-proof" socks to prevent slips.
- Your nurse will assess the need for special equipment or beds for safety. Some examples are "high/low beds" that can be lowered closer to the floor or an enclosed bed.
- Your nurses and health care assistants will make frequent rounds to check on you. In between rounds, use your call light if you need to get out of bed. We have found many patients fall while going to the bathroom. During rounds, your nursing staff will ask if you need to use the bathroom, and will stay nearby if you become dizzy and to help you go back to bed.
- We may place a commode by your bedside, depending on your condition and needs.

What Can Increase The Risk of Falling?

- Medications. Different medications can make you dizzy, sleepy or confused, which can impair your judgment. Some medications may make you need to use the bathroom more often.
- IV lines, oxygen or other tubes. These can make getting around more difficult.
- Glasses or contacts. While in the hospital, you may not always be wearing your glasses or contact lenses.
- Surroundings. The hospital room and furniture are unfamiliar to you, especially when the room is dark. Our furniture has wheels, which may move and should not be used to steady you.
- Illness. You may just feel weaker because you're not feeling your best.
- Previous fall. If you've fallen before, you are at a greater risk of falling again. Please let your nurses know if you've had a fall in the last three months.

What You Can Do To Prevent Falls

- Use your call light. Please do not get up without assistance, even if you feel OK at the moment. Remember that medications can alter your judgment and make you unsteady on your feet.
- Move slowly. Remember, tubes and equipment can get tangled and you may be weak or dizzy. Tell your nurse if you feel light-headed.
- Never try to climb over a bed side rail or lean on it. They're not designed to support your weight.
- Our beds and tables have wheels to move around when we are providing your care. Don't grab furniture to support your weight. It may move and you'll be off balance.
- Let your nurse know if you use walking aids such as cane or walker at home. We can provide these during your stay with us.

What Your Family Members Can Do To Prevent Falls

- Remind the patient to use the call light. When a patient is forgetful or confused, a family member can make a real difference in safety.
- You know our patient best. Tell us what would be helpful to assist in preventing falls.
- We ask family members to tell the nurse when they are leaving the patient's bedside so our staff can resume more frequent safety rounds.

A fall could cause serious injury and prolong your stay in the hospital. We ask patients and families team up with us to prevent falls. Working together, we can help you feel safe when you're moving around.

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Evidence into Practice

Toileting Regimen

- 40% of falls were toileting related
- Offer toileting every 2 hours during daytime and every 4 hours during night-time
- **Don't leave patient alone on commode or in the shower**
- Shower only with shower chair and only with direct assistance/supervision

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Engaging Staff
Frontline Empowerment

Mock Fall Demonstration

- Innovative simulation learning
- 105 staff including nurses, physical therapist, dietitian and housekeeping staff reflected on fall prevention

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Engaging Staff

- Partnership with the Nursing Practice Council (PC)
  - One size does not fit all
  - Provide tools to review unit specific performance/issues
    - Focus on accountability for falls with all staff members across all disciplines
    - PC to evaluate if fall could have been prevented
  - Applying PDSA process in resolving issues

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Practice Council Fall Review Tools

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Practice Council
Fall Review Worksheet

Chair/Co-chair:_____ Unit: _____ Month: _____

Day of the week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1							
2							
3							
4							
5							
6							

Time of the fall	6a-8a	9a-1p	2p-5p	6p-8p	9p-1a	2a-5a
1						
2						
3						
4						
5						
6						

Activity at time of the fall	Toileting	Unassisted ambulation	Lying in the bed	Sitting in the chair	Other
1					
2					
3					
4					
5					
6					

Any medication prior to the falls that potentially caused fall	Yes	No	Medications
1			
2			
3			
4			
5			
6			

Hourly Rounds Conducted	Yes	No

If patient was high risk, were all the high risk interventions implemented at the time of the fall?	Yes	No	Not High Risk
1			
2			
3			
4			
5			
6			

Was Bed Alarm On?	Yes	No
1		
2		
3		
4		
5		
6		

Was call light on at the time of fall?	Yes	No	How long
1			
2			
3			
4			
5			
6			

Was fall **preventable?	Yes	No
1		
2		
3		
4		
5		
6		

** Preventable fall – high risk patient in which standards were not followed, for e.g. patient left on BSC unattended or call light was unanswered for more than 3 minutes

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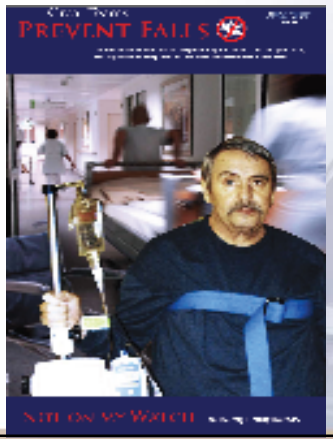
Engaging Staff
Campaigning Together

- Campaign - Great Teams Prevent Falls
  - It takes everyone on the team to eliminate falls



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Engaging Staff

- Post Fall Huddle
  - Modified form of root cause analysis
  - Conducted at the bedside immediately after a fall
  - Immediate assessment of events and sharing lessons learned

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Post Fall Huddle

POST FALL HUDDLE

Date/time _____ Day of Week_____ Room # ___
Demographics: Age ___ Male/Female

Type of Fall: Unassisted / Assisted and Unwitnessed / Witnessed
If unwitnessed, when staff was last in room _____
Injury Level: ☐ No ☐ Minor ☐ Moderate ☐ Major ☐ Death

Brief summary of fall:_____

_____

_____

- Was patient High Risk for fall? ☐ Yes ☐ No
  If yes, what interventions were implemented at the time of the fall?
  ☐ Sign outside the room ☐ Intervention poster in the room
  ☐ ID band ☐ Fall Patient / Family Guide given
  ☐ High Fall Risk Care Plan implemented/individualized
- Was the call light on at the time of the fall? ☐ Yes ☐ No
- Was fall related to Toileting? ☐ Yes ☐ No
  If yes, when was pt last assisted up to toilet? _____
- Had patient received any medication (within 30-60 min) with potential to impair judgment or lower blood pressure?
  If yes, specify what meds: _____
- Post-Fall interventions to prevent another fall?

  _____
- Reviewed & updated High Risk Care Plan post fall ☐ Yes ☐ No
- PSN Report Completed ☐ Yes ☐ No

2009 Falls Prevention Goals: Eliminate Unwitnessed and Unassisted falls (esp. Toileting r/t falls), Zero Injuries r/t falls

GREAT TEAMS PREVENT FALL

*To be completed by charge nurse with involved staff immediately after falls. Place on Fall bulletin board for staff awareness & PC follow-up.

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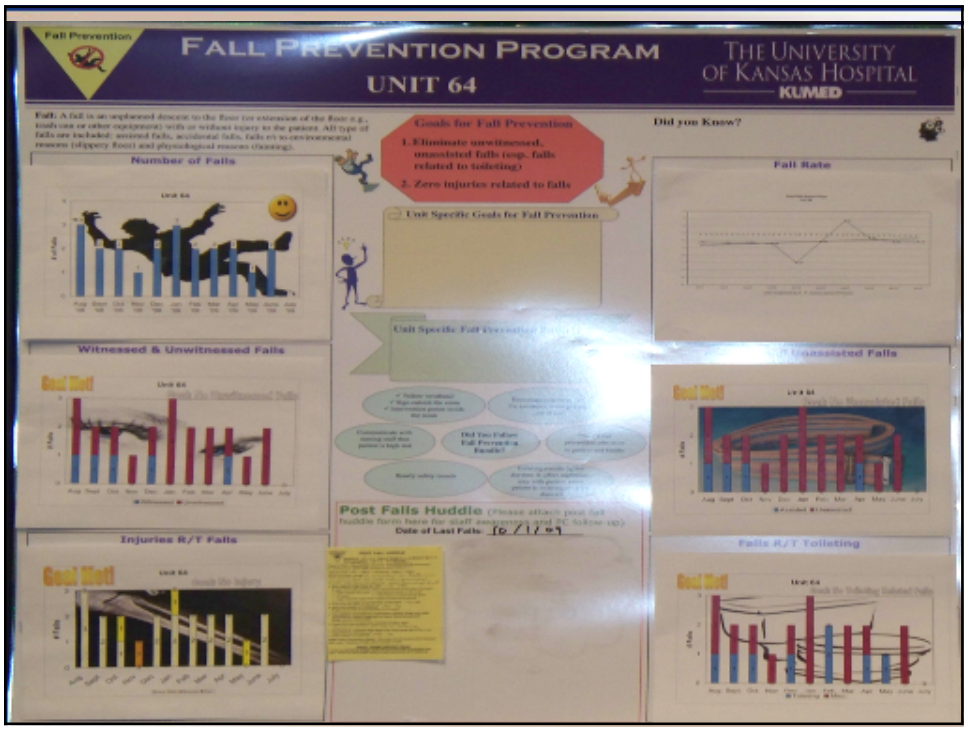
Engaging Staff
Keeping Staff Informed

- Unit Based Score Board
  - Maintain communication on unit specific performance
  - Allow bedside nurses to monitor and evaluate performance



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Good Catch
Recognizing and Celebrating

- Good Catch Award
  - Positive Reinforcement
  - Recognize staff across all disciplines who make an extraordinary effort to prevent falls
  - Engage staff at all levels

Good Catch Award Button

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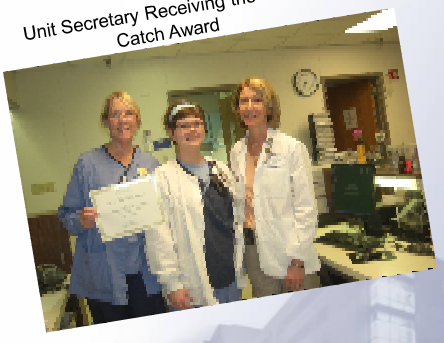
Good Catch
Recognizing and Celebrating

Student Nurse Receiving the Good Catch Award

Unit Secretary Receiving the Good Catch Award



Success Story: Housekeeping staff was leaving Unit 42 and saw high fall risk patient with yellow socks in hallway outside her room. She stayed there and summoned the sta keeping the patient safe and prevented the falls. The patient had an orthopedic Halo an could have been severely injured

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Technology Helps

- Bed and chair alarms
- New Hill Rom bed with Nevicare technology
  - Software designed to automatically monitor compliance to fall safety protocol
  - alerts caregiver via wireless device

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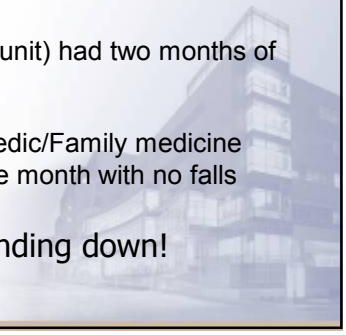
Outcomes

- Medical surgical units reduced falls by 15%
- NDNQI data for 2nd quarter 2009 showed 4 units with a 16% – 56% reduction in falls
- Five units have achieved a first zero falls month
  - Unit 51 (Surgical unit) & Unit 66 (Medical unit) had two months of zero falls
  - Unit 64 (Transplant unit), Unit 43 (Orthopedic/Family medicine unit) & Unit 46 (Medical/Tele unit) had one month with no falls
- Overall falls across most units are trending down!



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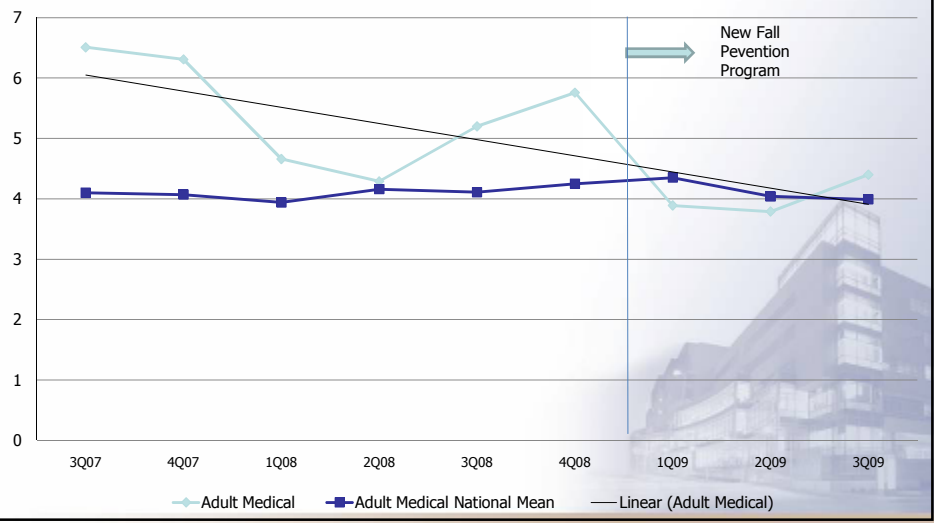
Data

Adult Medical Fall Rate (per 1000 patient days)



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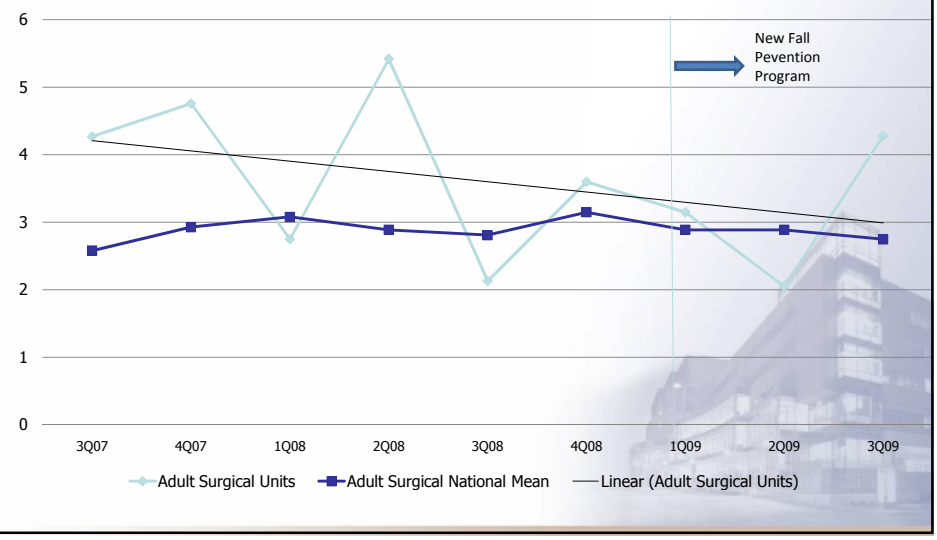
Data

Surgical Unit Fall Rate (per 1000 patient days)



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Future Directions

- Ongoing evaluation of initiatives
- Individual unit practice councils responsible for analyzing fall trends/impacting results
- Research study of prospective review of medication by pharmacist
- Population based risk stratification
  - Anticipated participation in research study on 'Impulsivity as a risk factor in patient fall'

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Keys to Success

- Significant support and dedication from senior leadership
- Engaging staff at all levels across all disciplines
- Empowerment and partnership with front line staff to enhance compliance and accountability
- Standardize and bundle high fall risk interventions
- Recognition and celebration encourage more success
- New initiative based on continuous data feedback
- Interdisciplinary and evidence based practice yields improve outcomes

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Thank you!

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