Strategies for engagement: One organization's path to decreasing fall rates

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Objectives

- Participants will be able to significance of falls on patients and nurses
- Participants will be able to identify components of fall prevention plan
- Participants will be able to discuss the strategies created and implemented to decrease falls
- Participants will be able to identify tools used to identify efficacy of falls program

Where did we start?

- For the final quarter of 2009 oncology contributed 32 out of 125 falls
- 2009 institutional fall rate of 3.21/1000 patient days
- 2010 goal 2.81 falls /patient day

Review of the Literature

- Major academic medical center reported a rate of 4.88 falls per thousand patient days with a goal of 3.2 falls/thousand patient days
- Injury Rate reported as "good"

Miller and Limbaugh,2008

Impact of Falls on Patients

- Injury
- Loss of confidence in care givers
- Loss of confidence in physical abilities

Impact of Falls on Nurses

- Loss of time
- Distraction
- Job Dissatisfaction

Institutional Impact of Falls

- Cost
- Decreased patient satisfaction
- Decreased reimbursement

- Falls need to be viewed like a medication error! Avoidable and preventable with appropriate level of diligence

First Steps

- Identification and education of vested parties
- Identification of barriers to goals
- Identification of structures and processes already in place
- Identification of our opportunities for improvement

Pilot Units

- Inpatient adult oncology units
  - Four Units
    - Surgical Oncology
    - Medical Oncology
    - Hematology Oncology Unit
    - Bone Marrow Transplant Unit

Who are the Vested Parties?

- Nurses
- Ancillary personnel
- Patients
- Families
- Physicians/LIPs
- Anyone the patient may come into contact with!

Nursing Education

- How are rates report
- Importance of all aspects of the falls plan
- Validation of rounding
- Call director or designee with every fall

Clinical Care Technicians

- Role as Fall Champions
- Role in Safety Huddles
- “First line of defense”

Unit Secretaries

- Role in Safety Huddle
- Facilitation of communication

Patients and Families

- Falls education upon admission
- Family role in fall prevention
- Consistent re-enforcement

Physicians and LIP

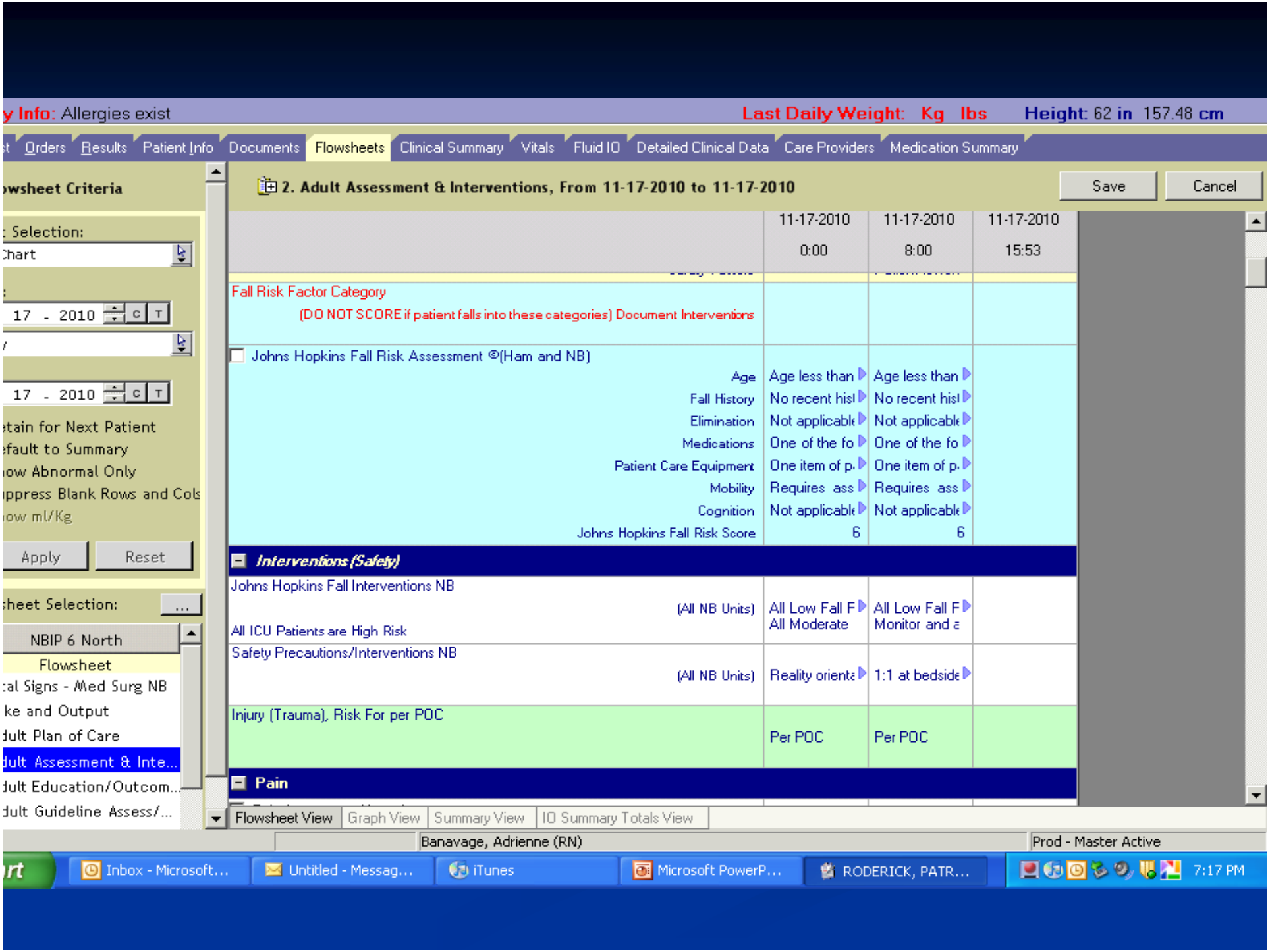
- “state of the union”
- Use of sitters/ one to ones

Additional Staff

- Therapists: Physical, occupational, speech
- Unlicensed personnel
- Visitors
- Volunteers
- Who else?

Falls Plan

- Fall Risk Assessment
  - Johns Hopkins Fall Assessment
  - Humpty Dumpty Falls scale
- Products
  - Bed exit alarms
  - Socks with treads
- Rounding
  - 4Ps: Position ,personal needs, pain and potty


y Info: Allergies exist
Last Daily Weight: Kg lbs
Height: 62 in 157.48 cm
Orders
Results
Patient Info
Documents
Flowsheets
Clinical Summary
Vitals
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Detailed Clinical Data
Care Providers
Medication Summary
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Selection:
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dult Plan of Care
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2. Adult Assessment & Interventions, From 11-17-2010 to 11-17-2010
Save
Cancel
11-17-2010 0:00
11-17-2010 8:00
11-17-2010 15:53
Fall Risk Factor Category
(DO NOT SCORE if patient falls into these categories) Document Interventions
Johns Hopkins Fall Risk Assessment ©(Ham and NB)
Age
Fall History
Elimination
Medications
Patient Care Equipment
Mobility
Cognition
Johns Hopkins Fall Risk Score
Age less than
No recent hist
Not applicable
One of the fo
One item of p.
Requires ass
Not applicable
6
Age less than
No recent hist
Not applicable
One of the fo
One item of p.
Requires ass
Not applicable
6
Interventions (Safety)
Johns Hopkins Fall Interventions NB
(All NB Units)
All ICU Patients are High Risk
All Low Fall F
All Moderate
All Low Fall F
Monitor and a
Safety Precautions/Interventions NB
(All NB Units)
Reality orienta
1:1 at bedside
Injury (Trauma), Risk For per POC
Per POC
Per POC
Pain
Flowsheet View
Graph View
Summary View
IO Summary Totals View
Banavage, Adrienne (RN)
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Inbox - Microsoft...
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RODERICK, PATR...
7:17 PM

- Recommendations for families related to age appropriate safety initiatives and cautions
- Specific information about the inpatient environment

New Additions

- Falls Champions
- Safety Huddles
- Post Falls Huddles
- Falls web site
- Adjuncts to bed exit alarms
- Toilet rails
- Falls drills
- Falls agreement

Falls Champions

- Empowering for both professional and ancillary staff
- Additional Education
- Accountability
- Shared leadership
- A form of peer review

Safety Huddle

- Short focused discussion of patients at risk for falling
- Beginning of every shift
- Entire staff participates

Post-Falls Huddle

- Immediate focused discussion after a fall
  - Participants include all personnel including leadership
  - Brief questionnaire
- Goal: What do the nurse and the patient feel contributed to the fall?

New Products

- Toilet Rails
- Adjuncts to bed exit alarms
- Low bed
- Visibility Aids

Falls Web Site

- Aggregates all fall info on one place on the intranet including:
  - Falls Huddles
  - Product Information
  - Educational Content

Falls drills

- Mock Fall
  - Staff stages a fall
  - Staff to respond as they would for a “real” fall
    - Fun
    - Allows lively discussion
    - Dialogue about what may and or may not be working

Falls Agreement

- Completed upon admission
- Facilitates conversation between patient, family and nurses
- Provides cues for key points for nurses to discuss

Measures of Success

- Falls Rates
- Review of qualitative data from post falls huddles
- Patient validation
- Staff feedback

Future Plans

- Educational Offerings
- Qualitative research