PATIENT FALLS DOWN!

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DEFINE

Opportunity/Problem Statement

• When a patient falls in the hospital, there is potential for injury of minor, moderate or severe degrees. While injury level falls have declined over the recent past, our total number of falls has continued to increase. Not only can the patient experience complications and an extended length of stay, but the hospital system is at risk for lowered reimbursement as a result of regulatory changes.

• With a total of 715 patient falls in 2008 and 721 in 2009, it was time to take action. To address these patient falls concerns, the System Nurse Quality Council initiated the "Patient Falls Task Force" a Six Sigma project in March 2009. The two areas of opportunity were to decrease total falls as well as falls with injuries, and educate the organization about why a patient falls and how to implement fall prevention strategies.
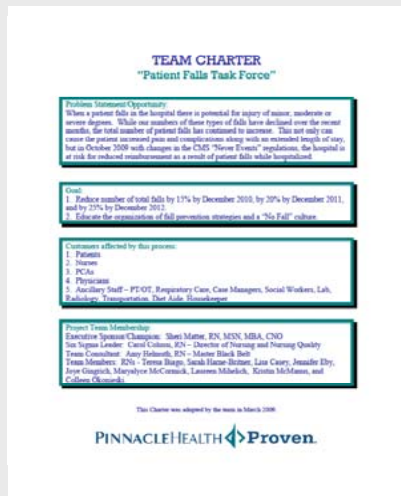

GOALS

• Reduction of total falls by 60% over the next sequential three year period. Reduce by 15% by December 2010, by another 20% by December 2011, and an additional 25% by December 2012.

• Educate the entire organization about fall prevention strategies.

• To achieve this goal the DMAIC (Define, Measure Analyze, Implement/Improve, Control) methodology of Six Sigma was applied.

MEASURE/ANALYZE

• We examined fall data from our two most recent years, and quickly learned which units were having the most number of patient falls, as well as the identifiers for the types of falls.
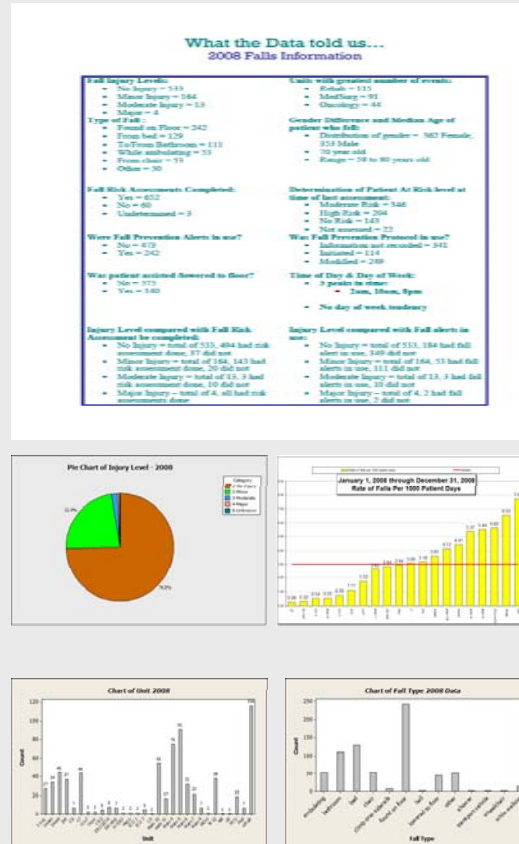
Patient Falls Task Force Membership

Executive Sponsor/Champion: Sheri Matter, RN, MSN, MBA, CNO
Team Consultant: Amy Helmuth, MSN, BSN, RN – Master Black Belt
Nurse Quality Council RN Members: Teresa Biagio RN MS, Jennifer Eby BSN RN, Laureen Mihelich RN, Kristin McManus RN, Colleen Okonieski RN.
Nurse Research Council RN Members: Sarah Harne-Britner, RN, MSN, CNS Erica Leber-Burnham BSN MSN RN, and Maryalyce McMcCormick RN.
Nurse Manager Members: Lisa Casey BSN RN, Joye Gingrich BSN RN, and Theresa Sellers BSN MHA RN.
Nursing Informatics Team: Jenny Miller-Morris RN, Sharon Fleck, MBA
Six Sigma Team Leader: Carol Colussi BSN, MHA,RN

IMPLEMENT

DECREASE VARIATION OF FALL PREVENTION STRATEGIES
Working with our Patient Care Value Analysis Team in Supply Chain Management, the Falls Task Force reviewed and selected a bedside/chair-side fall alert indicator pad. The pressure sensitive pad has a voice activated alarm that is individualized for the patient – including at times use of a recorded family member – reminding the patient to sit down and wait for help from the nursing staff. Additionally, the Falls Task Force team constructed a Fall Prevention Package which contains all of the necessary items for staff to implement the fall prevention program.

CREATE HIGH VISIBILITY OF ALL FALL ALERT PATIENTS
Our hospital participated in a voluntary system in the Commonwealth of Pennsylvania to standardize colored alerts for patients at risk for falls. Our chosen color "Yellow" has become the "signal" throughout the organization for any patient who is at risk for falling. A yellow armband, as well as yellow socks, and a bright yellow blanket covering the patient during transport or over the end of the bed when in their room – alerts all staff to the special needs of preventing falls for each patient.

### MODIFYING OUR COMPUTER SYSTEM AND USE OF THE MORSE SCALE
The staff RNs on the team felt the computer system was not user friendly, so working with our IT and Nursing Informatics specialists was a key step in order to document assessments and interventions every shift, while also communicating at risk patient information to the interdisciplinary team. We use the Morse scale for fall risk assessment, but added an additional criteria of RN Clinical Judgment, so that even if the patient is not scored at risk on the Morse Scale, but the RN feels the patient should be placed on fall precautions, a check of the clinical judgment screening kicks off the necessary electronic record and alerts.

Additionally, the team reviewed original intervention sets for the various types of fall risk (minor, moderate, high risk) and determined that a change to No Risk or At Risk would be best. This allows the team to educate all staff about At Risk patient types and the associated interventions for preventing falls.

CREATING A "NO FALL" ORGANIZATIONAL CULTURE
Through education and hands-on teaching, the Falls Task Force has implemented an "All Hands On Deck" program to bring about a change in our culture, emphasizing how no patient should ever fall. This has increased awareness across the organization about the importance of patient safety and environmental checks, regardless of who encounters the patient in any location.

IMPROVE
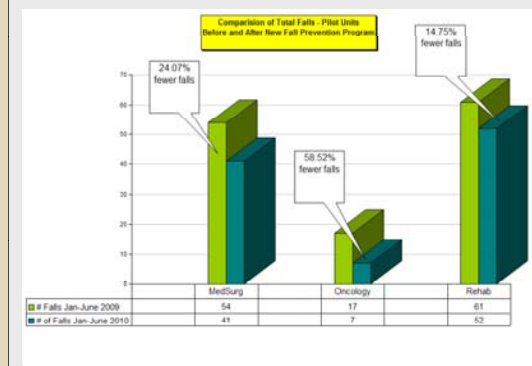
The three units with the most number of patient falls were selected as pilot units to monitor the outcomes of the hospital wide implementation of the new Fall Prevention Program. These three pilot units have seen tremendous success and decreased patient falls. From January to June these three units had a combined decrease in total falls of 24%. Additionally, 76% of these falls resulted in no injuries to the patient.
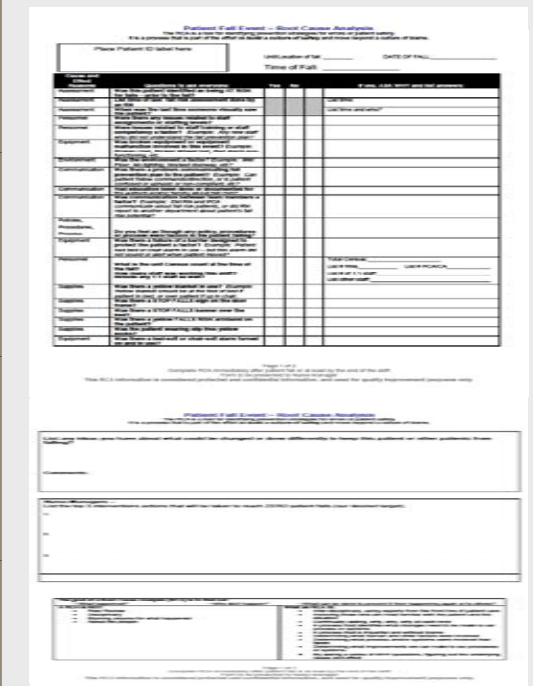
IMPROVE - continued

Fall Prevention Kit

CONTROL

Along with the standardized prevention kit, the team developed a Root Cause Analysis tool the staff utilize after any fall to help identify other strategies or roadblocks to fall-free care for our patients.

SUMMARY

Utilizing Lean Six Sigma performance methodology to identify our process problem zones has allowed us to develop a focused approach to managing the care of at risk patients more effectively in order to reduce falls and falls with injuries.