Tapping into the Power of Benchmarking:
Using NDNQI Data to Reduce Falls on an Inpatient Rehabilitation Unit

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Problem

In 2004 the fall rate on our hospital-based, 18 bed acute inpatient rehabilitation facility (IRF) was 13.4/1000 pt days. It was not unusual to have a quarterly fall rate at 16/1000 patient days. The unit culture accepted that falls were a normal occurrence for rehabilitation patients. Falls data was sporadically shared with staff. When it was shared, we compared ourselves only to ourselves and our fall rate was always about the same. Because we had no one else to compare to, we had a unit culture of normalized deviance around patient falls.

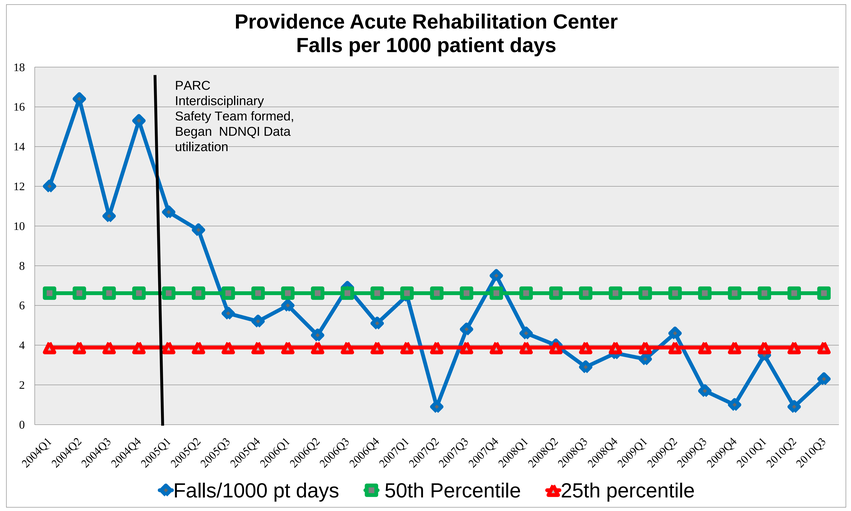
In 2005 our hospital applied for Magnet status, and so began to utilize NDNQI data. We saw that the average fall rate for units like ours was half of our unit's usual fall rate. The ability to benchmark against other like units opened our eyes. We realized best practice departments do not just meet national benchmarks, they exceed them.

Process

We began our quest to exceed the benchmarks by calling together an interdisciplinary team (the 'Safety Team') to look at the problem of falls on our IRF. We realized that fall prevention is not just within nursing purview. According to research on falls, the best practice has only been achieved when there is significant organizational support for fall reduction across departments and disciplines (Agency for Health, 2008). The team evaluated the unit's falls, looked for trends and implemented new protocols, new equipment , and education. The team concentrated on individualizing fall prevention interventions to fit patient intrinsic risk factors. They have worked with the safe patient handling team to ensure all disciplines who transfer patients are "speaking the same language". We began to involve and educate the family as well as the patient.

Because the safety team was made up of unit staff, they were able to hold their peers accountable as the unit tried new ideas or equipment. As our fall rate declined, the culture on the unit changed from "rehab patients are bound to fall" to "the rehab unit is the safest place in the hospital to be a patient." Falls data was shared regularly in staff meetings and posted on the unit. The Safety Team continues to meet and identify areas for improvement. With our initial work our fall rate declined from twice as high to average. In order to reduce our fall rate even further we have diligently debriefed any falls and applied what we learn to unit practice and protocols.

Results



Future work

We have become zealots in our quest to keep our patients safe, and have seen a steady decline in falls. Our fall rate for 2009 was 2.9/1000 patient days, which is below the 25th percentile. We are on track to best that for 2010.

We are now focusing on expanding the use of best practices from our unit to hospital-wide best practices. Many of the keys to success that we have put into practice are being used hospital wide. The overall hospital rate has significantly declined by using some of the same key points, and the hospitals fall rate is significantly improved.

References

Agency for Health Care Research and Quality National Guidelines Clearinghouse, (2008). *Prevention of falls (acute care). health care protocol* Retrieved from http://www.guidelines.gov

Keys to Success

NDNQI DATA! Display it, share in meetings, compare yourself to like units.

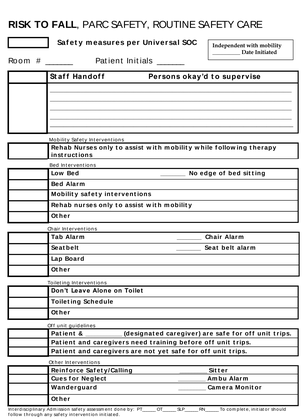
Involve the interdisciplinary team: (research has shown that best practice results when there is a full organizational, interdisciplinary approach to fall prevention).

New equipment (low beds, alarms, tab alarms, seat belts)

New processes and protocols (interdisciplinary documentation on the Plan of Care, staff handoff protocols, Rounding)

Consistent message to patients/family

Consistent signage: the entire fall prevention plan is visible to all staff members at all times


RISK TO FALL, PARC SAFETY, ROUTINE SAFETY CARE

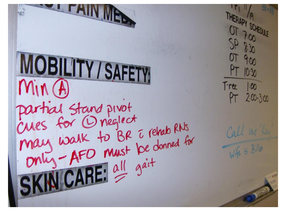
Safety measures per Universal SOC — Independent with mobility _____ Date Initiated

Room # _____ Patient Initials _____

	Staff Handoff — Persons okay'd to supervise
	Mobility Safety Interventions
	Rehab Nurses only to assist with mobility while following therapy instructions
	Bed Interventions
	Low Bed _____ No edge of bed sitting
	Bed Alarm
	Mobility safety interventions
	Rehab nurses only to assist with mobility
	Other
	Chair Interventions
	Tab Alarm _____ Chair Alarm
	Seatbelt _____ Seat belt alarm
	Lap Board
	Other
	Toileting Interventions
	Don't Leave Alone on Toilet
	Toileting Schedule
	Other
	Off unit guidelines
	Patient & _____ (designated caregiver) are safe for off unit trips.
	Patient and caregivers need training before off unit trips.
	Patient and caregivers are not yet safe for off unit trips.
	Other Interventions
	Reinforce Safety/Calling _____ Sitter
	Cues for Neglect _____ Ambu Alarm
	Wanderguard _____ Camera Monitor
	Other

Interdisciplinary Admission safety assessment done by: PT____ OT____ SLP____ RN____ To complete, initialer should follow through any safety intervention initiated.

Consistent risk assessment and adherence to identified interventions



Consistent language and transfer techniques between therapists and nurses

Education (staff, patients, family members) . Patients and family members are considered a part of the falls prevention plan. We provide education to family members on safe mobility techniques, or let them know if it is unsafe to help their family member.