It Takes a Village: Reducing Patient Falls in the Hospital Setting

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Martha Jefferson Hospital
A Member of Sentara Healthcare

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Objectives:

- Identify evidence-based strategies for reducing patient falls
- Demonstrate how interdisciplinary collaboration and creative problem solving can positively impact nurse sensitive clinical indicators.

Purpose:

The purpose of this presentation is to describe how a twice-designated Magnet, 176-bed community hospital used a comprehensive, multi-disciplinary approach to dramatically decrease patient falls, as demonstrated by fall rates that now outperform the mean for Magnet hospitals reporting to NDNQI.

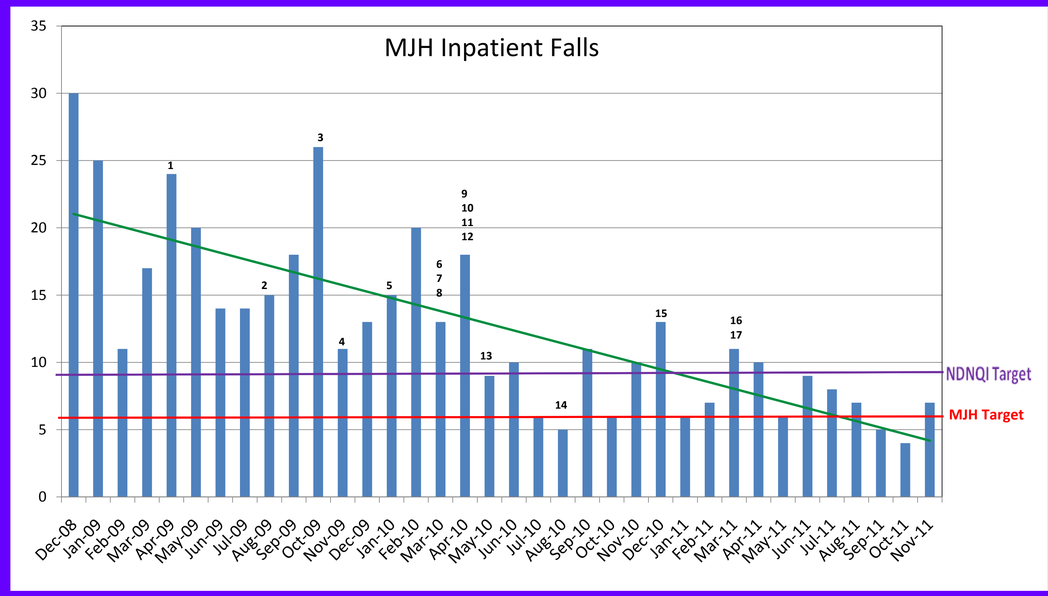
Background:

Preventing patient falls is an important safety focus for hospitals across the country. Identified as a "nurse sensitive" indicator of care quality and safety, patient falls can contribute to increased length-of-stay, complications due to injuries, or even death, in hospitalized patients. Patient falls can result in decreased quality ratings and reduced reimbursement for hospitals.

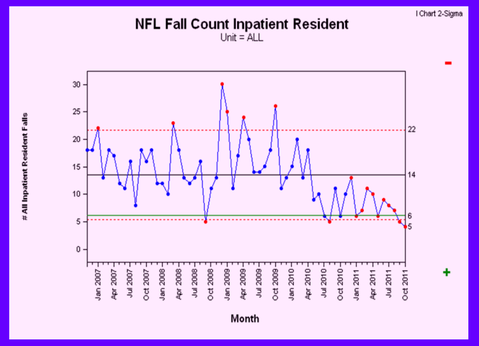
The chartered interdisciplinary NFL (No Fall Left Behind) Team included nurses, pharmacists, physical therapists, case managers, and other disciplines.

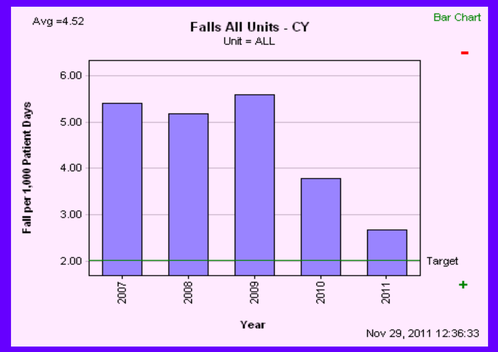
How we did it:

- Chartered interdisciplinary task force
- Thorough literature review of published research on fall prevention
- Analysis of current practice to identify gaps, compliance with current policies, and deviations from best practice
- Organization – wide adoption of 25 "best practice" recommendations
- Education and expectation for accountability across the organization - from the board room to the break room.



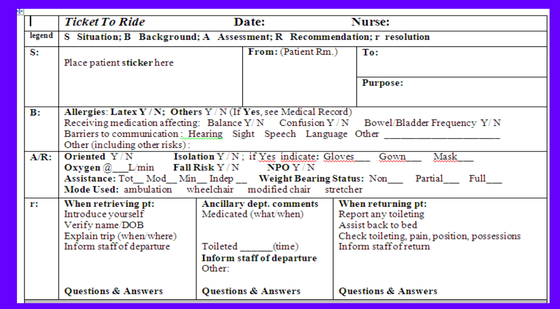
1. Stopped use of orange dots on doors to indicate fall risk
2. First NFL Meeting
3. Adopted use of yellow skid-proof socks and yellow arm bands
4. Revised event fall report to mimic generic and at -risk precautions
5. Creation of NFL Dashboard
6. CALL BEFORE YOU FALL signs implemented (trialed first on post-op TKR after block)
7. Posey motion detector supplies backordered w/no release date
8. *Pharmacy Quick Reference*
9. Must notify emergent contact post fall
10. *Volunteer Guidelines for Fall Prevention*
11. Ticket To Ride (TTR) [NO TICKET, NO RIDE]
12. Q2 Hour Rounding
13. Director Attends Fall Huddles either in person or virtually (at night)
14. Implemented Midas notification to Nursing of a *MJH Previous Fall* (retroactive to 2011)
15. Patient Mobility Policy per Standardized Guidelines for Levels of Assistance
16. Partnered with Pharmacists for medication assessment as part of post fall Huddle and part of criteria to request a contracted companion
17. Implemented contracted Companion Program





What worked for us:

- Purposeful "**TAB**" rounding every two hours:
  - **T**oilet patient
  - **A**ssess environment
  - **B**e back - remind patient that you will be back, if they need you they should "call before they fall"
- Use of bed and chair alarms on all at-risk patients. PAR levels of alarms placed in nurse server outside every patient room.
- Use of electronic medical record to generate daily fall risk assessment by RN; "traveling" documentation of fall risk; use of hand-off tool and "ticket to ride" to communicate fall risk to other disciplines



Ticket To Ride **Date:** **Nurse:**

legend	S Situation; B Background; A Assessment; R Recommendation; r resolution		
S:	Place patient **sticker** here	**From:** (Patient Rm.)	**To:**
			Purpose:
B:	**Allergies**: **Latex** Y / N; **Others** Y / N (**If Yes**, see Medical Record) Receiving medication affecting: Balance Y / N Confusion Y / N Bowel/Bladder Frequency Y / N Barriers to communication: Hearing Sight Speech Language Other _____ Other (including other risks):		
A/R:	**Oriented** Y / N **Isolation** Y / N ; if Yes indicate: Gloves___ Gown___ Mask___ **Oxygen** @___L/min **Fall Risk** Y / N **NPO** Y / N **Assistance:** Tot__ Mod__ Min__ Indep__ **Weight Bearing Status:** Non___ Partial___ Full___ **Mode Used:** ambulation wheelchair modified chair stretcher		
r:	**When retrieving pt:** Introduce yourself Verify name/DOB Explain trip (when/where) Inform staff of departure **Questions & Answers**	**Ancillary dept. comments** Medicated (what/when) Toileted _____(time) **Inform staff of departure** Other: **Questions & Answers**	**When returning pt:** Report any toileting Assist back to bed Check toileting, pain, position, possessions Inform staff of return **Questions & Answers**

- Multidisciplinary "huddles" immediately after every fall (day or night) to review compliance with prevention strategies and identify missed opportunities
- Paid "Companion" program when other avenues have been exhausted
- Daily updates ("days without a fall"), unit-level monthly reports via an electronic quality dashboard, quarterly reports to hospital board
- Thorough review and analysis of all falls by the Task Force to identify gaps in performance and champion organizational strategies for hardwiring success.

Conclusion:

- Falls can never fall off your radar screen – it must be an ongoing priority
- Everyone in the organization is responsible for being part of the solution to prevent patient falls
- Celebrate your accomplishments along the way
- Develop a culture of quality and safety such that fall prevention remains in the forefront every day.

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