

ELEMENTS OF INNOVATIVE STRATEGIES: TEAM BASED APPROACH TO FALLS REDUCTION

CUSP PROJECT 2 SOUTH
ADVOCATE TRINITY HOSPITAL, CHICAGO, ILLINOIS

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ABSTRACT

- The Comprehensive Unit Based Safety Program (CUSP) was developed at John Hopkins Hospital as a program to involve interdisciplinary front line associates and physicians in identifying and resolving key patient safety concerns. It is described in the book *Safe Patients, Smart Hospitals* by Peter Pronovost, M.D. and Eric Vohr.

ABSTRACT cont.

- In 2010, Advocate Health Care adopted the CUSP model to improve patient safety among its 10 hospital sites. Previous patient safety efforts focused on the development of a Culture of Safety and implementation of safety behaviors, followed by a focus on infrastructure. Substantial improvements were made but efforts to reinforce and sustain change were needed.

ABSTRACT cont.

- Through utilization of the CUSP model, Advocate Trinity Hospital generated an innovative falls reduction strategy designed by a multidisciplinary team of front line associates. The falls rate on the pilot unit was decreased by 55% post-project implementation.
- The methodology successfully engaged front line associates (including clinical and non-clinical staff), ignited a passion toward patient safety, and created a results oriented culture on the unit.

PURPOSE

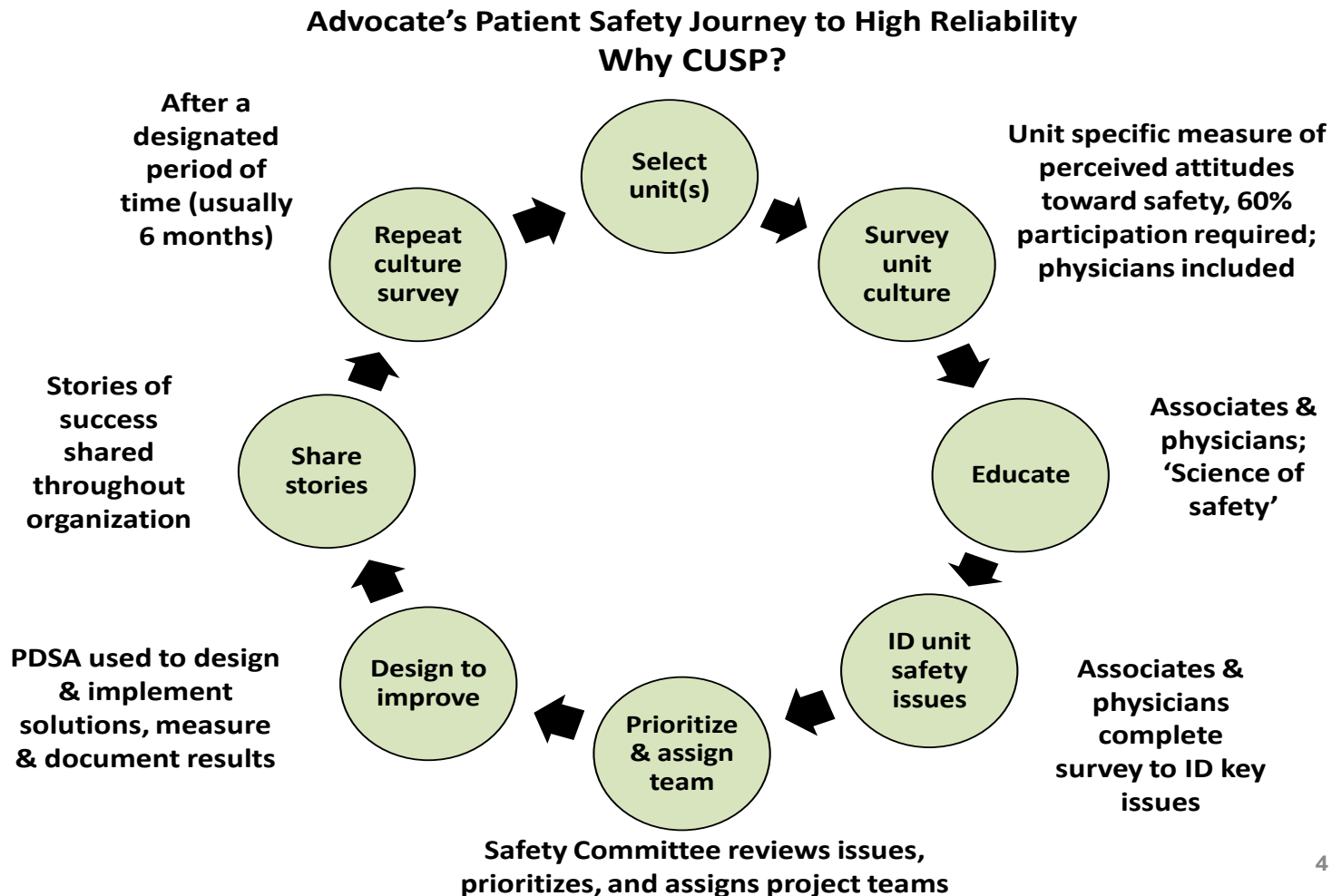
- Falls are one of the most common causes of morbidity and a leading cause of nonfatal injuries and trauma related to hospitalizations in the United States. At Advocate Trinity Hospital, falls consistently make up the largest single category of reported patient safety events.
- 2 South contributed to 29% of the falls at Advocate Trinity Hospital.

PURPOSE cont.

- The intention of our project was to educate and improve awareness about patient safety/falls reduction while empowering staff to take charge of improvements in their workplace.
- **Goal:** To decrease patient falls by 20% with a stretch goal of 50% compared to the same time frame in 2010.

METHODOLOGY

- The approach used to develop our CUSP project was as follows:



METHODOLOGY

- **Project Scope:** All patients admitted or transferred to 2 South, a cardiac unit.
- **CUSP Demonstration Period:** February 2, 2011 through May 31, 2011.
- **Methodology:** Participants for the multidisciplinary team were identified including an M.D., R.N.s, a Monitor Technician, C.N.A.s, a Unit Secretary, a Clinical Dietician, and Physical Therapist.

METHODOLOGY

- The team met monthly over the course of seven months.
- Staff completed the AHRQ Culture of Safety survey pre and post implementation of the CUSP project to measure changes in safety perception.
- Falls data for 2010 was analyzed to identify trends and common causes for patient falls.
- The team found that the predominant cause for falls was patients engaging in “risky behaviors”.
- An improvement plan was developed to address the common cause.

IMPROVEMENT PLAN

The following falls protocol was developed as part of the Improvement Plan:

- Complete interview of patients upon admission or transfer to 2 South for fall risk factors.
- Conduct Hendrich II Risk Score to measure falls risk.
- Assess ability to stand and ambulate through the “Get Up and Go Assessment”.
- Review and obtain patient/family signature and commitment to comply with “My Fall Safety Plan”.

IMPROVEMENT PLAN cont.

- Initiate falls interventions:
 - Yellow falls ID band
 - Yellow non-slip slippers
 - Falls signs posted in patient room and bathroom
 - Yellow “Is Your Bed Alarm On?” sign posted on patient door
- Ensure bed alarm on and set at correct parameter.

IMPROVEMENT PLAN cont.

- Monitor Technician records falls risk patients on the central monitor screen.
- Unit secretary documents falls risk patients on white board at Nursing station
- Rounding on patients by R.N. and C.N.A. is done hourly to assess the “4 P’s” (pain, potty, positioning and pump).
- Care team assists at risk patients to bathroom and remains with them to assist back to bed.
- Care team verifies bed alarms are on during hourly rounding.

“MY FALLS SAFETY PLAN” ADVOCATE TRINITY HOSPITAL

- PATIENT NAME:

At our hospital we care about you and your safety and want to partner with you to prevent falls. Falls can happen, especially in a new environment and when you are being treated for illness or injury. Falls prevention is a partnership between your caregivers, you, your family and your visitors.

Our staff receives training in falls prevention and will use their best efforts to prevent a fall by doing the following:

- Check on you hourly (we call this hourly rounding) to meet your needs
- Place your call light and personal items near you
- Keep your floor clean and free from clutter
- Assist when you get up, if needed
- Place a yellow band on your wrist to identify you are at risk for falls
- Use a bed exit alarm
- Assess the need for a gait belt to help you walk and move from a bed to a chair
- Encourage you to walk with assistance only
- **Your fall risk level is:** Standard High risk
- **We ask you to do the following to prevent you from falling:**
- Use your call light if you need to go to the bathroom or need other help
- Call for assistance when you:
 - Feel dizzy, feel Weak, feel sleepy, especially after you have taken medicine
 - Notice any spills in your room
 - Are attached to any equipment, such as IV pump
 - If your doctor or nurse asks you not to get up unless someone is there to assist you, follow their directions

- Visitors are asked to notify staff when they leave a patient’s room.

Always wear the yellow socks we have given you

- **You are at risk because:**

- Your bones are weak and you are at risk for broken bones
- Due to medications you may fall more easily
- You will bleed easily if you fall
- You have a history of falling

Other:

I have received this information & agree _____ Date _____

I do not agree with the above information _____ Date _____

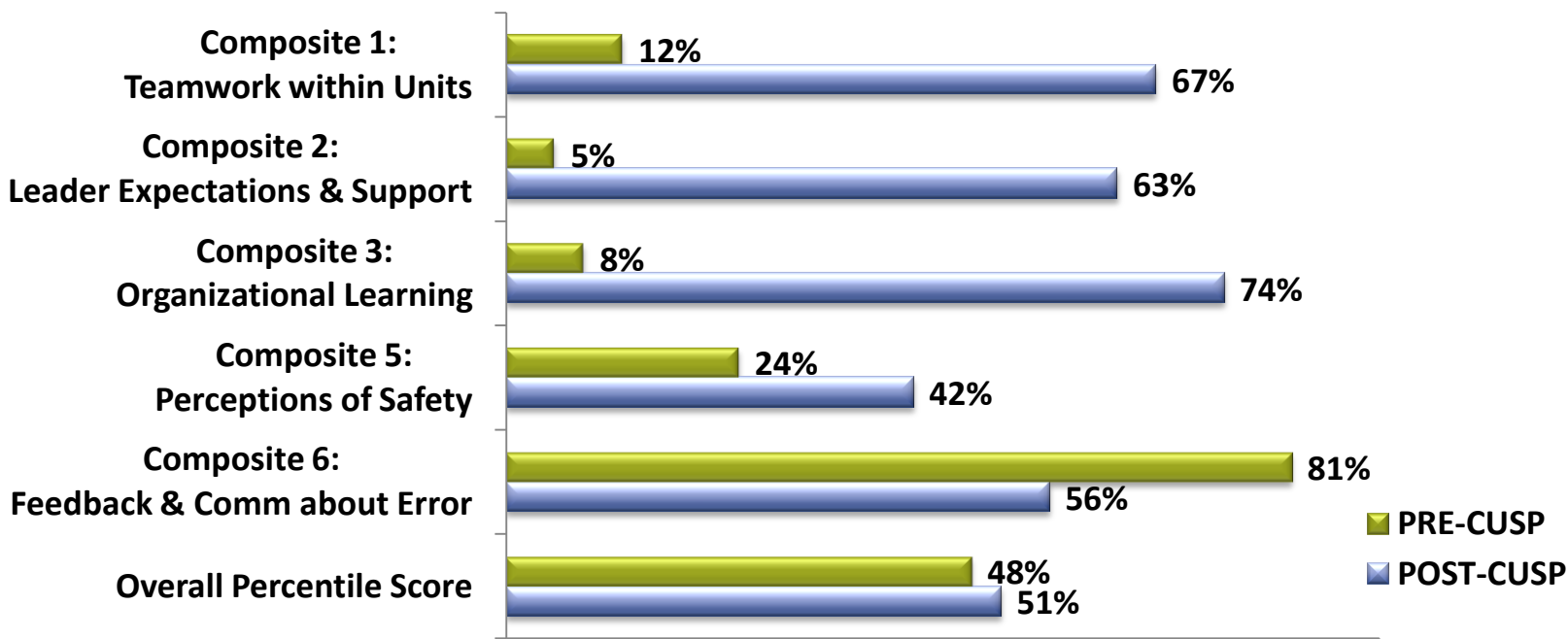
R.N. Signature _____ Date _____

RESULTS

- Based on successful implementation of the identified action items falls were reduced by 55% compared to the same time period in 2010.
- Pre and post AHRQ surveys were administered to staff to assess their perception of the culture of safety on 2 South.
- Post survey results demonstrated an 18% improvement in the staff's perception of safety.

CUSP AHRQ METRICS 2 SOUTH

Trinity ~ 2 South Telemetry CUSP AHRQ Metrics



CONCLUSIONS

- A Comprehensive Unit Based Safety Program (CUSP) driven by staff participation is effective in decreasing adverse patient safety events (falls) and increasing overall patient safety.
- **LESSONS LEARNED:**
 - The project facilitated teamwork amongst all disciplines on the patient care unit.
 - Built confidence and empowerment of associates on the unit to make decisions as drivers of the project.

CONCLUSIONS cont.

- Patient and family involvement in identifying risk factors for falls increased compliance with falls prevention plans.
- Staff ownership of the design, implementation and measurement of the project made the project meaningful and sustainable.
- The team based approach has encouraged multidisciplinary collaboration on other quality projects beyond the falls initiative.

2 SOUTH MULTIDISCIPLINARY CUSP TEAM

- Tomeisha O'Brien, R.N., B.S.N., CUSP Project Leader, Staff R.N.
- Elzbieta Osmelak, R.N., Staff RN
- Laurie Pate, Monitor Technician
- Jacqueline Douge, Certified Nursing Assistant
- Belinda Crocker, Unit Secretary
- Daniela Braucher, Physical Therapist II
- Ashley Holman, Clinical Dietician
- Harley Brooks, M.D., Physician Champion
- Diana K. Dudick, R.N., B.S.N., B.C., Manager Clinical Operations
- Sabrina Provine, R.N., M.A., Manager Performance Improvement & Patient Safety
- Donna Currie, M.S.N., Director Clinical Excellence, Oak Brook Support Services
- Alfred Bolden, M.P.A., Director Cardiac and Medical Services
- Michelle Gaskill, R.N., M.H.A., V.P. Nursing Services & Clinical Operations