



A Successful Patient Fall Reduction Program in an Inpatient Behavioral Health Unit

Trisha Rimpa, RN, BSN, MA
Barbara Jordan, DNP, RN, NEA-NC
Susan Bialo

UPMC Northwest



UPMC Northwest

- Built in 2004 as part of the University of Pittsburgh Medical Center (UPMC)– one of the leading nonprofit health systems in the United States.
- 180-bed hospital in a rural region which services Venango County and other neighboring counties in northwestern Pennsylvania. Located in Venango County.
- Committed to providing patients with compassionate care while offering a wide range of technologically advanced services, including a nationally recognized stroke program and cancer center.



Welcome to the Behavioral Health Unit



Description of the Behavioral Health Unit

- 28 bed general adult and geriatric combined unit
- Staffing ratio of 4:1
 - RNs
 - Milieu Therapists
 - PCAs
- Common Psychiatric Diagnoses
 - Major Depression
 - Bipolar Disorder
 - Schizophrenia
 - Anxiety Disorders
 - Borderline Personality Disorders



Description of the Behavioral Health Unit

- Common Medical Diagnoses
 - Diabetes
 - COPD
 - Hypertension
 - GERD
 - Asthma
- Treatment
 - Individual (1:1) Counseling
 - Group Therapy
 - Recreation Therapy
 - Medication Management



Why work on decreasing falls?

- Needed a QI project! 😊
- The inpatient behavioral health unit's (BHU) fall rate was more than three times the fall rate of the other units combined.
- This fact was of great concern to the hospital's Patient Safety Committee, the Fall Committee, UPMC Northwest Administration, and the BHU itself.

7

UPMC LIFE CHANGING MEDICINE

How bad was it???

- From July 2010 to June 2011 the number of patient falls on the BHU was 76 with a fall rate of **14.84/1000** patient days.

Compared to:

- The number of patient falls on all other inpatient units combined was 132 with a fall rate of **3.72/1000** patient days.
 - Medical/Surgical
 - Oncology
 - Emergency Department
 - AICU
 - Cardiac
 - TCU/Rehab

8

UPMC LIFE CHANGING MEDICINE

Now what to do about it?

- The problem was discussed in most every meeting including Management Team, Nursing Leadership, and during Administrative Rounding.
- Staff of the BHU felt the pressure to improve the number of falls and to keep the patients safe.

9

UPMC LIFE CHANGING MEDICINE

Identified Obstacles

- Patients are mobile- we encourage patients to be out of their rooms, attending groups, and interacting with peers.
- Platform style beds



10

UPMC LIFE CHANGING MEDICINE

Identified Obstacles

- Bathroom call lights are on the wall opposite the toilet.
- Call lights are not near the beds in patient rooms, we rely on "tap bells".
- Unit culture change- changing the culture to one of "falls/injury can be prevented".
 - Improvement is possible!
- Lack of equipment (ineffective fall mats, only two bed alarms total).

11

UPMC LIFE CHANGING MEDICINE

Identified Obstacles

- Lack of education as unit transitioned from an adult/adolescent unit to an adult/geriatric unit
- Hallways did not have handrails.
- Older adults who take several types of psychotropic medications, such as antidepressants or sedatives are more likely to experience falls.

12

UPMC LIFE CHANGING MEDICINE

Action

• Staff Education

- On unit posting of the monthly fall data
 - Data compares the BHU to the rest of the hospital
- Discussion at unit meetings
 - Days Without Falls (posted daily)
 - How to use fall prevention equipment
 - How to correctly assess and identify high risk patients
 - What to do about it?
 - » PT consults
 - » Fall prevention equipment

13

Action

• Education Continued.....

- Fall prevention posters created and displayed on the unit for staff and patients- "Falling Leaves- Don't Let our Leaves Fall".
- Began using bright yellow leaves outside patient doors for all level 2 fall risk patients.
- Fall Champion identified on each shift and this was added to their annual performance appraisal as a goal.
- Environmental rounds re-designed to include ensuring that all fall prevention interventions are in place.
 - Done each shift by direct care staff.

14

Action

• Education Continued.....

- Staff Involvement
 - Two staff members became members of the hospital fall committee (one MT and one PCA).
 - Clinical Nurse Manager became co-chair and then chair of the hospital fall committee.
- Milieu Therapist Information Sheet introduced to all staff. This sheet includes a section on safety and lists all level 2 fall risk patients.

15

Action

- Education Continued.....

- Implementation (hospital wide) of the Charge Nurse Fall Follow-Up Form.
- Mandatory fall prevention competency that included reviewing the "Fall Binder".

16

Action

• Creation of the Fall Binder

- Photos taken and printed out of all fall prevention equipment.
- Detailed instructions on how to use each item.
- Location of where the item is located.
- Fall Risk Level that the intervention would be appropriate for (Universal, 1, 2).

17

Fall Binder



18

Action

• Equipment Acquisition

- Bed alarms
- Chair alarms
- Self-releasing belts
- Fall mats with glow in the dark beveled edges
- Wheelchair positioners
- Wheelchair wedge cushions
- Activity aprons
- Handrails for the hallways
- BHU designated wheelchair
- Installation of additional call bells and zone lighting

19



Results

- Fall prevention initiative throughout the hospital
 - Creation of Fall Binders for each inpatient unit, including specific interventions that relate to that particular floor.
 - Fall Equipment Cart created on the cardiac unit and then other units adopted this as well.



20



Results

• Renewed interest in fall education and awareness

- Reinvigorated Fall Committee
 - Improved attendance.
 - Representatives from all disciplines.
 - Participation in the system Fall Call.
 - Review of monthly fall data completed in a more meaningful way with feedback provided to unit directors.

21



Results

- Education Day
 - Educated over 300 front line staff regarding fall prevention interventions and proper patient education.
- Orientation
 - All new hires are educated on fall prevention at orientation.
 - Patient safety officer presents a PowerPoint geared toward all disciplines with general information about fall education and common interventions.

22



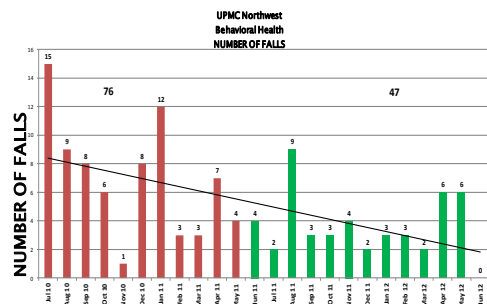
Results

- There was a 38% decrease in falls on the BHU from July 2010 to June 2012
- The injury rate decreased from .66 to .49
- For Fiscal Year 2012 there were 10 months of zero injury related to falls on the Behavioral Health Unit

23



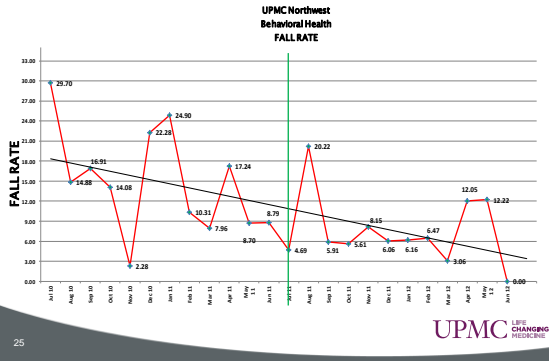
Results



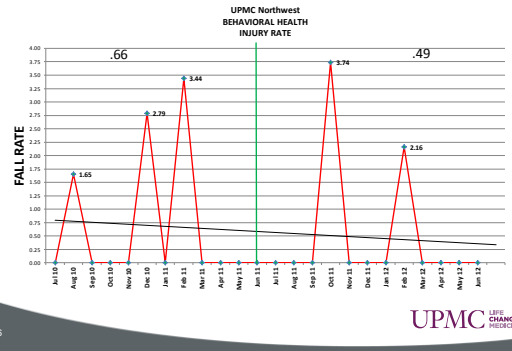
24



Results



Results



Conclusions

- It is possible to decrease falls and injury rates on patients in a Behavioral Health Unit.
- Change does not have to be financially prohibitive.
- Staff buy-in makes all the difference.

Questions?