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

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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
Common Medical Diagnoses
- Diabetes
- COPD
- Hypertension
- GERD
- Asthma

Treatment
- Individual (1:1) Counseling
- Group Therapy
- Recreation Therapy
- Medication Management
• 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.
• 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
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.
Patients are mobile— we encourage patients to be out of their rooms, attending groups, and interacting with peers.

Platform style beds
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).
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.
• **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
• 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.
• 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.
- Education Continued…..

• Implementation (hospital wide) of the Charge Nurse Fall Follow-Up Form.

• Mandatory fall prevention competency that included reviewing the “Fall Binder”.

• 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).
Bed alarms/Chair alarms

The green bed or chair pad connects to the Posey Sitter Select control box via what looks like a telephone cord. The pad must be placed under something such as the bottom sheet of the bed. The box has a sensor that is placed under a chair. To stop the alarm push the "hold" button. When transferring from a bed to a chair you may leave the bed pad in place and just move the control box. When the bed alarm is on and working a light will shine constantly on the box.

Remember to wipe down the box and pad with disinfectant or a damp cloth between patients. The pad must be stored flat and the control box returned to the box.

Also, it is suggested that you keep the bed/chair alarm set prior to the patient using. Set up the bed and then when set stand by one of it alarms.

These MUST be used for a level 2 fall risk.

Universal Fall Precautions

- Stethoscope
- Chair safe
- Non-slip socks
- Room lights work
- Q10 minute checks

Level One Fall Precautions All of above +

- Yellow bed
- Patient family notified
- Personal alarm magnet (9 p.m.)
- Lid bath
- Bedside commode
- PT PT cannot

Level Two Fall Precautions All of above +

- Bed alarm mode
- Bariatric bed
- Patient family notified
• **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
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.
• 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.
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.
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
Results

UPMC Northwest
Behavioral Health
NUMBER OF FALLS

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Results

UPMC Northwest
Behavioral Health
FALL RATE
Results

UPMC Northwest
BEHAVIORAL HEALTH
INJURY RATE

FALL RATE

.66
.49

Jan 10
Aug 10
Sep 10
Oct 10
Nov 10
Dec 10
Jan 11
Feb 11
Mar 11
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Apr 12
May 12
Jun 12
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?