Reducing Incidents of Patient Falls

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Rochester, MN
Olmsted Medical Center

• 61 Bed Level IV Trauma Hospital

• 22 Bed Medical/Surgical Unit

TCAB Themes and High Leverage Changes….the “what” of TCAB

• Safe and Reliable Care
• Vitality and Teamwork
• Transformational Leadership
• Patient-Centered Care
• Value Added Care Processes
Objective

Discuss strategies to prevent falls and injuries from falls.

Strategic Objectives for TCAB

To develop one or more models of care at the bedside on Medical/Surgical units that will result in:

- Improved quality of patient care
- Improved quality of patient service
- More effective care teams
- Improved staff satisfaction and retention
- Greater efficiency
Transforming Care at the Bedside

• OMC’s Med/Surg Unit TCAB core team attended a TCAB conference in August of 2010.

• OMC’s Med/Surg Unit became a part of the first AF4Q regional effort in the United States to implement TCAB.

Aim Statement

To reduce the number of patient falls on the Med/Surg Unit to less than 1 per 1,000 patient days by the end of the initial 12 months (by September 1, 2011).
Strategies for Fall Prevention

The aim will be accomplished using:

- a reliable fall risk assessment
- shift report/safety huddles
- hourly rounding
- customized interventions

John Hopkins Fall Assessment

Brief yet inclusive.
Fall risk assessment completed on admission for all patients and every 24 hours thereafter.

Safety Huddles/Bedside Reporting

December 2010 – Bedside report roll out
Identify at Every Shift the Patients Most at Risk of Falling

Assignment sheets have patients flagged that are at risk for falling so all staff are aware of the patient’s fall risk status.

Benefits of Bedside Report

• Increased direct nurse-patient contact at the beginning of the shift.

• On-coming nurse sees the patient instead of just hearing about the patient.

• On-coming nurse can assess patient risks at the start of the shift.
Hourly Rounding

October of 2010: Roll out of hourly rounding using the model of the 3P’s – address Pain, Potty, Position every hour along with a review of the environmental needs.
Fall Risk Identifiers

More Measures

Improved fall risk identifiers such as yellow slippers, yellow clips for patient ID band, and yellow magnets.
Patient with Gait Belt and Yellow Slippers

Changes Tested
Increase in number of available safety alarms
Staff Resistance on the Med/Surg Unit

- In December of 2010 staff was expressing dissatisfaction with bedside report.
- Staff posed the question as to how bedside report could be done differently.
- Suggestions for change were tested and adopted.

Staff Empowerment

- TCAB provided an avenue for improved communication.
- Staff voiced satisfaction as small tests of change were implemented with bedside report.
- Bedside report and hourly rounding have become part of the culture of OMC’s Med/Surg Unit.
Why TCAB Works

• Before TCAB change meant, “This is the way it will be now.”
• After TCAB change means, “We can do a small test of change and adjust as we need to.”

Culture Change

• Frontline staff are more willing to try new innovations to keep patients safe.
• Increased staff satisfaction as they feel they have a place to be heard.
• Changing monthly staff meetings to TCAB meetings…How might we?
Communicate Fall Risks to All Staff

• Increased staff awareness through the development of a TCAB communication board in the report room.

• Incentive for all staff to strive to work together to keep patients safe from falls.

• Incentive rewards..pizza parties for all shifts.

• Education posted on whiteboard including yellow circles with fall prevention education.

TCAB Board with Fall Prevention Goal
Development of Fall Prevention Pamphlet

• Increase in falls noted after students began their rotations.

• A fall prevention pamphlet was developed to educate students and staff new to the Med/Surg Unit on tips to prevent falls.

• Director of Medical-Surgical Services educated students.
More Safety Measures

• Signs posted in the patient bathrooms and by the patient beds to include patients on how to keep them safe from falls.

• Increased safety alarms purchased.

• Signs placed at the head of the patient’s bed if the patient has a safety or bed alarm.
Fall Prevention Tips

OMC is committed to working with our patients and their families to provide a safe and comfortable environment. Listed below are some general tips to prevent falls. Please consult your nurse if you have questions.

1. Always call for a nurse, no matter how busy we appear. “Call, don’t fall!”
2. Call for assistance when getting out of bed or going to the bathroom.
3. Keep a night light on.
4. Use the call light for any item that is out of your reach.
5. Get up slowly from a lying or sitting position. Dangle your feet before walking. Sit down immediately if you feel dizzy.
6. Report any spills to your health care team.

Are Safety and Bed Alarms Turned On?
# Results

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Days Without Falls</th>
<th>Number of Falls</th>
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</thead>
<tbody>
<tr>
<td>November-December 2010</td>
<td>51</td>
<td>0</td>
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<tr>
<td>December 10 – January 11</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>January 8 – January 15</td>
<td>7</td>
<td>1</td>
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<tr>
<td>January 15 – February 16</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>February 16 – February 27</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>February 27 – March 29</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>March 29 – April 8</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>April 8 – May 8</td>
<td>30</td>
<td>0</td>
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</tbody>
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October: Hourly rounding implemented  
December: Bedside reporting implemented  
February: Falls with students  
March: Student and patient education implemented
Reviewing Our Patient Falls

- What was missed on assessment that could have predicted and prevented this fall?
- What did we learn?
- What can we do differently?

PDSA Cycle

Testing changes in the real work setting.

- Plan it.
- Do it.
- Study it.
- Act on what is learned.

Don’t be afraid to try something and to move on if it doesn’t work or isn’t right for your setting or organizations.

Don’t worry about perfection – Adapt, Adopt, Abandon
Action Planning

Assessment - Risk of Injury

FALLS: ACTION PLANNING FORM

<table>
<thead>
<tr>
<th>Key Changes</th>
<th>Processes</th>
<th>Status of Change</th>
<th>Ideas for Testing &amp; Designing Reliable Processes</th>
<th>Process Measures</th>
<th>Who will lead?</th>
<th>Timeline?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Receive standardized fall risk assessment for all patients at admission and regularly update patients' clinical status changes.</td>
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<td>2. Identify all patients at risk of increased risk of serious injury from fall.</td>
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<td>3. Integrate use of ABCS tools for assessment; fall assessment processes.</td>
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Source: Reducing Patient Injuries from Falls, Chuck Meek, RN, BSN, MHA
Communication and Education

Standardized
As front line staff become more engaged in patient safety and prevention of falls, we ARE making a difference in keeping our patients safe.

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Transforming Care at the Bedside