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 Assessment Tool - Adult/Adolescent Complete and calculate Fall Risk Score If no box checked, score for category is 0.	Points Eve
Age (Single Select) ❑ 60-69 years (1 point) ❑ 70-79 years (2 points) ❑ ≥ 80 years (3 points)	
Fall History (Single Select) ❑ One fall within 6 months before admission (5 points)	
Elimination - Bowel and Urine (Single Select) ❑ Incontinence (2 points) ❑ Urgency or frequency (2 points) ❑ Urgency/frequency and incontinence (4 points)	
Medications: PCA/Opiates, anti-convulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropics (Single Select) ❑ On 1 high fall risk drug (3 points) ❑ On 2 or more high fall risk drugs (5 points) ❑ Sedated procedure within past 24 hours (7 points)	
Patient Care Equipment: Any equipment that tethers patient. ❑ One present (1 point) ❑ Two present (2 points) ❑ Three or more present (3 points)	
Mobility (Multi-Select, choose all that apply and add points together) ❑ Requires assistance or supervision for mobility, transfer, or ambulation (2 points) ❑ Unsteady gait (2 points) ❑ Visual or auditory impairment affecting mobility (2 points)	
Cognition (Multi-Select, choose all that apply and add points together) ❑ Altered awareness of immediate physical environment (1 point) ❑ Impulsive (2 points) ❑ Lack of understanding of one's physical and cognitive limitations (4 points)	
Total Points	

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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

Hourly Rounding

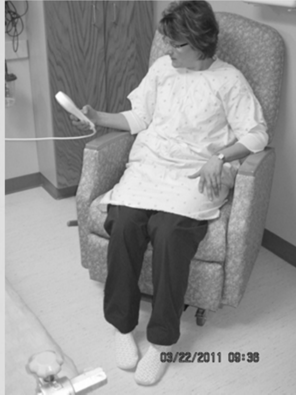
October of 2010: Roll out of hourly rounding using the model of the 3P's – address Pain, Potty, Position every hour along with a review of the environmental needs.

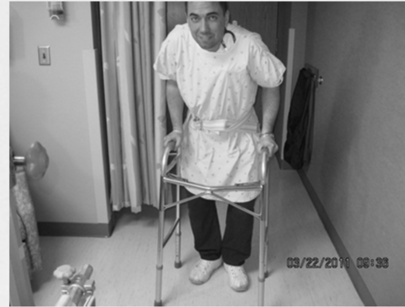
Fall Risk Identifiers

More Measures

Improved fall risk identifiers such as yellow slippers, yellow clips for patient ID band, and yellow magnets.

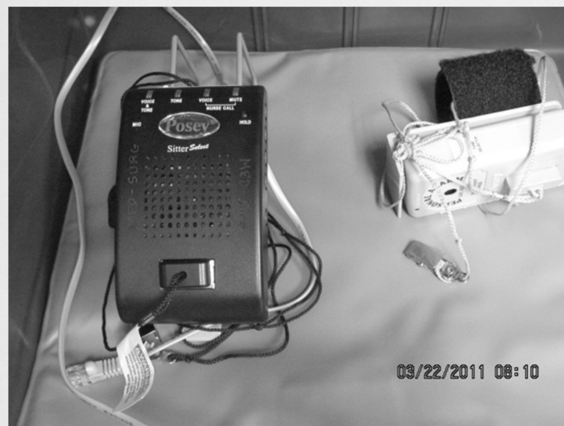
Patient with Gait Belt and Yellow Slippers





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

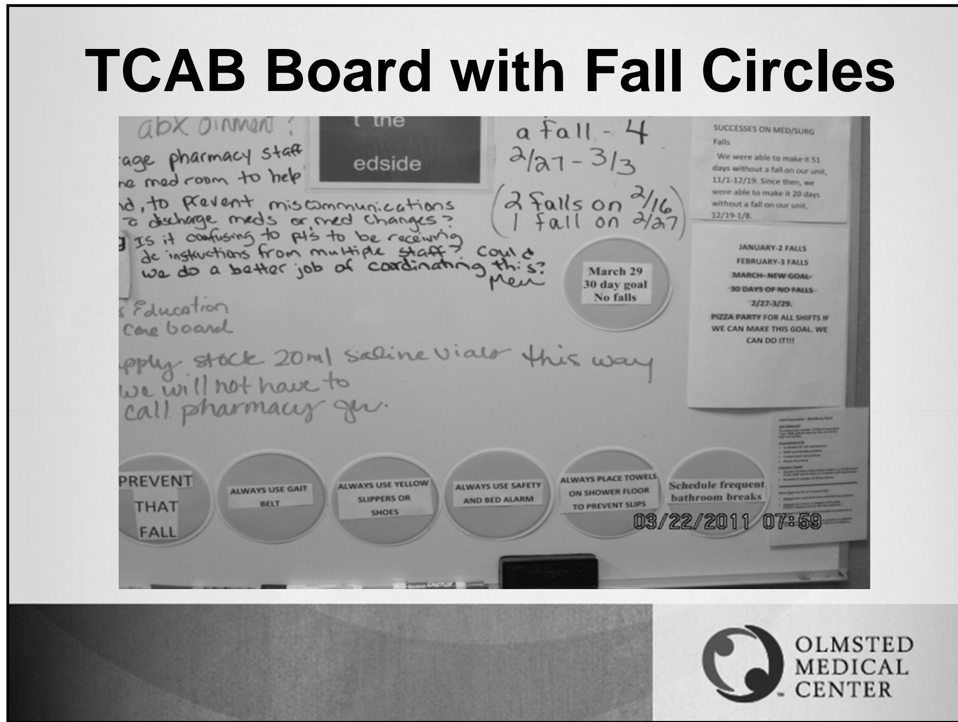
- Frontline staff are more willing to try new innovations to keep patients safe.
- Increased staff satisfaction as they feel they have a place to be heard.
- Changing monthly staff meetings to TCAB meetings…How might we?

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

TCAB Board with Fall Circles



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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.

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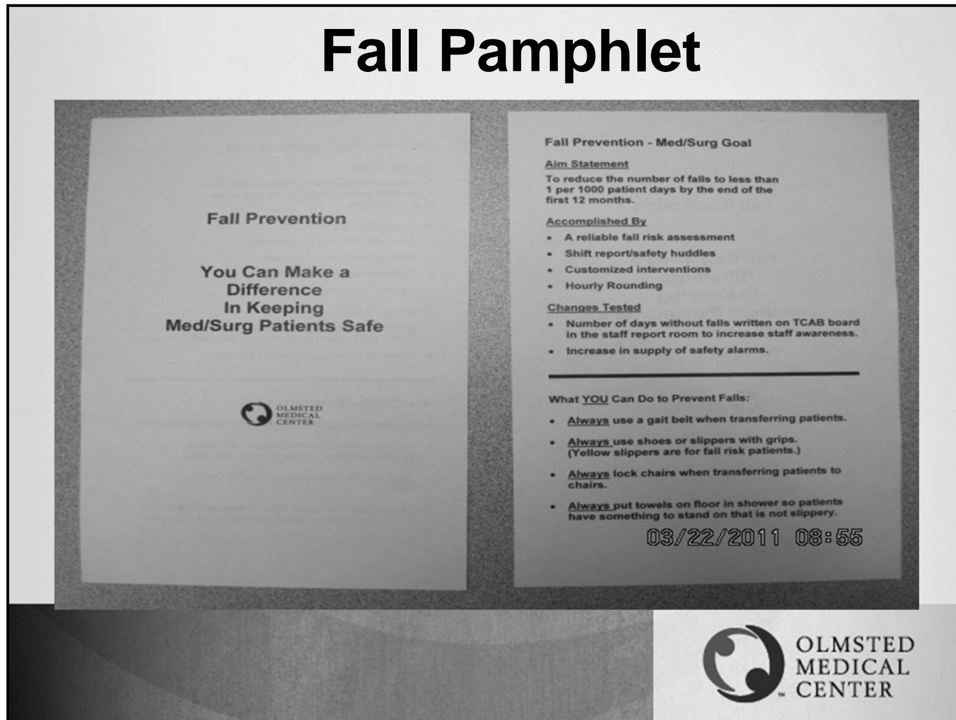
Fall Pamphlet



Fall Prevention

You Can Make a Difference In Keeping Med/Surg Patients Safe

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Fall Prevention - Med/Surg Goal

Aim Statement

To reduce the number of falls to less than 1 per 1000 patient days by the end of the first 12 months.

Accomplished By

- A reliable fall risk assessment
- Shift report/safety huddles
- Customized interventions
- Hourly Rounding

Changes Tested

- Number of days without falls written on TCAB board in the staff report room to increase staff awareness.
- Increase in supply of safety alarms.

What YOU Can Do to Prevent Falls:

- Always use a gait belt when transferring patients.
- Always use shoes or slippers with grips. (Yellow slippers are for fall risk patients.)
- Always lock chairs when transferring patients to chairs.
- Always put towels on floor in shower so patients have something to stand on that is not slippery.

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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.

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Fall Prevention Tips

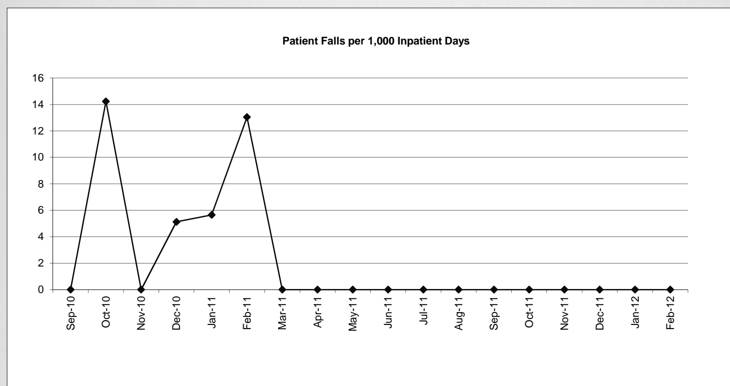
OMC is committed to working with our patients and their families to provide a safe and comfortable environment.
Listed below are some general tips to prevent falls.
Please consult your nurse if you have questions.

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

Time Period	Days Without Falls	Number of Falls
November-December 2010	51	0
December 10 – January 11	20	1
January 8 – January 15	7	1
January 15 – February 16	32	1
February 16 – February 27	11	2
February 27 – March 29	30	0
March 29 – April 8	10	2
April 8 – May 8	30	0



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

Hospital: ______________________ Pilot Unit: ____________ FALLS: ACTION PLANNING FORM

Aim Statement: ____

Key Changes	Processes	Status of Change	Ideas for Testing & Designing Reliable Processes	Process Measures	Who will lead? Timeline?
I. Asses Risk of Falling and Risk to Reduce Serious Injury from Falls	a. Perform standardized fall risk assessment for all patients on admission and whenever patients' clinical status changes.				
	b. Identify at every shift the patients most at risk of moderate to serious injury from fall.				
	c. Integrate use of ABCS harm risk assessment into fall assessment processes				
	d.				

Preparing to Test: Your team is collecting baseline data; meeting with key informants or team members and constituents; flowcharting or observing the process.
Testing: Your team is trying a change to see if the change results in improvement; there is no assumption that the change tested is permanent yet. A test of change involves complete Plan-Do-Study-Act cycles*:
Implementing: Your team is making a successful change permanent. Implementation will often require changing documentation, written policy, hiring, training, and organizational infrastructure – activities usually not required in the testing phase. Implementation, like testing, will requires the use of multiple Plan-Do-Study-Act cycles for continued learning.
Standard Work in Place (with > 90% reliability): Your team has developed a highly specified process which is currently in use; documentation exists that indicates the process is followed at least 90% of the time.

Source: Reducing Patient Injuries from Falls, Chuck Meek, RN, BSN, MHA

Communication and Education

Hospital: ____________________ Pilot Unit: ____________ FALLS: ACTION PLANNING FORM

Aim Statement: ____

Key Changes	Processes	Status of Change	Ideas for Testing & Designing Reliable Processes	Process Measures	Who will lead? Timeline?
II. Communicate and Educate About Patients' Fall Risk	a. Communicate to all staff information regarding patients who are at risk of falling and at risk of sustaining a fall-related injury.				
	b. Educate the patient and family members about risk of injury from a fall on admission and throughout the hospital stay, and about what they can do to help prevent a fall.				
	c.				
	d.				

Source: Reducing Patient Injuries from Falls, Chuck Meek, RN, BSN, MHA

Standardized

Hospital: ____________________ Pilot Unit: ____________ FALLS: ACTION PLANNING FORM

Aim Statement: ____

Key Changes	Processes	Status of Change	Ideas for Testing & Designing Reliable Processes	Process Measures	Who will lead? Timeline?
III. Standardize Interventions for Patients at Risk for Falling	a. Implement both hospital-wide and patient-level improvements to patient care environment to prevent falls and reduce severity of injury from falls.				
	b. Perform hourly (or every 2 hours) intentional rounding to assess and address patient needs for pain relief, toileting, positioning, personal items, and pathway (safe exit).				
	c..				
	d.				

Source: Reducing Patient Injuries from Falls, Chuck Meek, RN, BSN, MHA

Customized

Hospital: ____________ Pilot Unit: ____________ FALLS: ACTION PLANNING FORM

Aim Statement: ____________

Key Changes	Processes	Status of Change	Ideas for Testing & Designing Reliable Processes	Process Measures	Who will lead? Timeline?
IV. Customize Interventions for Patients at Highest Risk of a Serious or Major Fall-Related Injury	a. Increase the intensity and frequency of observation.				
	b. Make environmental adaptations and provide personal devices to reduce risk of fall-related injury.				
	c. Target interventions to reduce the side effects of medications.				
	d.				
	e.				

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

Transforming Care at the Bedside