STRATEGIES TO PREVENT INJURIES FROM FALLS

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Learning Outcomes

Identify the four components of a successful fall/injury prevention program.

Develop strategies to synthesize new tools into your local fall prevention program.
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

Model for Improvement

![Model for Improvement Diagram](image-url)
What are we trying to accomplish?

- What is your injury rate?
- What do you know about the distribution of the types of injuries
  - Minor: band aid, ice pack or less
  - Moderate: steri-strips or sutures
  - Major: fracture, reduction, traction
  - Death

TARGET

Incidents of serious injuries from falls are reduced to 1 or less per 10,000 patient days.

* IHI Transforming Care at the Bedside
How will we know that a change is an improvement?

Establishing Measures

- Tells whether changes actually lead to improvement
  - Seek usefulness, Not perfection
- Multiple Balanced Set of Measures
  - Process, satisfaction, value
  - Use sampling
  - Integrate measurement into daily routine
Measures

Outcome Measures:
How is system performing?
What are results?

Process Measures:
Are system parts/steps performing as planned?

Balancing Measures:
Do changes designed to improve one part cause problems in another?

Family of Measures

- Moderate and higher injury rate
- Minor injury rate
- Falls rate
- Process measures like: Teach back, rounding, reliability, assessments, huddles to id today’s pts at highest injury risk
## RISK OF INJURY FROM FALL

<table>
<thead>
<tr>
<th>+ RISK FALL/- RISK INJURY</th>
<th>+ RISK FALL/+ RISK INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional approach</strong></td>
<td><strong>New area of focus</strong></td>
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</tbody>
</table>
| 1. Use existing protocols to prevent falls  | 1. Use existing protocols to prevent falls  
| 2. Problem solve every fall | 2. Add injury reduction interventions  |
| **New area of focus**     | **New area of focus**    |
| Identify, communicate, and intervene when injury risk changes. | Identify, communicate, and intervene when fall risk changes. 
|                              | 2. Implement injury reduction strategies  |
|                              | 3. Enhance communication about risk of injury  |
|                              | 4. Problem solve every fall               |

### Strategies: the Vital Few

- **Assess Risk of Falling and Risk for Injury from a Fall (All Patients)**
- **Communicate and Educate (Patients Assessed to be at Risk of Fall or Injury)**
- **Standardize Interventions (Patients at Risk for Falling)**
- **Customize Interventions (Patients at Risk for Injury)**

*IHI’s TCAB How to Guide: Reducing Patient Injuries from Falls*
Strategies: the Vital Few

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Fall Risk Assessment Tool

• Morse
• Schmidt
• Conley
• Hendrich II

Fall Injury Assessment Tool: ABCS

• A: Age- >85

• B: Bones: History of fractures- Hip (although multiple fx could be a sign); Certain Diagnoses- (osteoporosis, bone metastasis); Treatments or medications that cause bone to be weak

• C: Coagulation: Blood Thinners(Coumadin, heparin gtt); Coagulopathy

• S: Risk of surgical complications post surgery (Recent Abdominal, thoracic surgery, lower limb amputation)

Assessment For High Risk to Injury: Falls Algorithm

- Assess Risk of Falling and Risk for Injury from a Fall (All Patients)
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Strategies: the Vital Few

Communicate and Educate (Patients Assessed to be at Risk of Fall or Injury)

- Communicate to all staff information regarding patients who are at risk of falling or sustaining a fall-related injury
- Communicate risks and associated interventions at every shift change
- Educate the patient and family members about risk of fall's injury on admission and throughout hospital stay using health literacy strategies

Communication

- **Visual Indicators**: Wrist band, room identifiers, socks, stickers, etc.
Pre Shift Huddle

Communicate information about our patients identified as the “Vital Few”...

- those who are a high risk for injury if they fall
- those at risk for skin breakdown (HAPUs)
- those who are receiving high alert medications
- the next potential medical response team call

- At the beginning of every shift (shift change) for 5 minutes
- All clinical staff
- Identify safety interventions

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Handoff Tool-
Every Patient, Every Time

- Patient’s risk assessment score
- Patient’s risk to Injury
- Interventions in place
- Walking rounds

Bedside Communication

- Is the patient at high risk to injury?
- How do I know that?
- What interventions are in place to keep the patient safe?
  - Visual cues
  - Low bed suite
  - Patient teach back
White Boards

Post Fall Huddles

- As soon after the event as possible, set up a meeting to debrief with everyone involved.
- Have a key point person to lead these at each shift
- Review within the same shift for most powerful learning
- Include patient and family whenever possible
A3 Problem Solving

• Structured Problem Solving

• Find the Why’s

• Forces Us to Think Critically, Creatively, and Collaboratively

• Gets to the Root Cause of the Problem

Strategies: the Vital Few

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• Educate the patient and family members about risk of fall’s injury on admission and throughout hospital stay using health literacy strategies.
Enhanced Teaching and Learning

“Teach Back”

- Explain needed information to the patient or family caregiver
- Ask in a non-shaming way for the individual to explain in his or her own words what was understood
- Once a gap in understanding is identified, offer additional teaching or explanation followed by a second request for Teach Back

Fall Prevention Tips

Sentara is committed to work with our patients and their families to provide a safe and comfortable environment. Here are some general tips to prevent falls. Please consult your nurse if you have any questions.

- Call for assistance when getting out of bed or going to the bathroom. Use bathroom emergency light if needed.
- Keep the night light on.
- Walk close to the wall and use handrails for support.
- Wear slippers/shoes with rubber soled bottoms.
- Report spills or unsafe conditions to your healthcare team.
- Use the call bell for any item beyond your reach.
- Rise slowly from lying or sitting position. Dangle your feet before walking and sit down immediately if you feel dizzy.
- View Patient Safety Video.
Fall Precautions

Please help us keep our patients safe

• Please use the call light for help
• Your loved one is on fall precautions. Please let us know when you leave the room for any reason
• Remind your loved one not to get up on their own

IOWA HEALTH SYSTEM
Best Outcomes for Every Patient Every Time
Strategies: the Vital Few

Communicate and Educate (Patients Assessed to be at Risk of Fall or Injury)

- Educate ALL staff about fall reduction/injury prevention program.

Your role in preventing falls at Grundy County Memorial Hospital
Staff Education

- Monthly storyboards
- Quality bulletin boards
- Safety Fairs
- Fall prevention related conferences

Strategies: the Vital Few

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High Risk to Fall Interventions

- Purposeful rounds every two hours
- Call bell in reach
- Teach back on call bell use
- Toileting prior to pain medication
- Safety huddle prior to each shift
- Post fall huddle
- Bed in low position
- Brakes locked on bed, chair, commode
- Appropriate lighting including night light in bathroom.
- Non slip footwear
- Bedpan/urinal in reach

High Risk to Fall Interventions

- Alarm devices as needed
- Assistive devices as needed
- Gait belts
- Bedside commode
- Positioning devices
- PT/OT review
- Pharmacy review
- Clutter elimination
- Family or patient attendant with patient
- Height adjustable beds with mats
- Rearrange furniture to provide a safe exit
Strategies: the Vital Few

Standardize Interventions (Patients at Risk for Falling)
• Implement both hospital-wide and patient-level improvements to the patient care environment to prevent falls
• Perform purposeful rounding

Places That Falls Occur
• Patient’s room – 79.5%
• Bathrooms – 11%
• Hallways /treatment rooms – 9.5%

The Patient’s Bedroom

• Single patient concept
• Height adjustable beds
• Handrails
• Bed alarms/chair alarms/motion sensors
• Equipment placement
• Bundling equipment cords

The Patient’s Bedroom

• Night light
• Glowstrips on floor to illuminate route to bathroom
• Non slippery floors
• Bedside chairs that are easy to get in and out of
• Support family presence
The Patient’s Bathroom

• Night light
• Motion sensored lighting
• Raised toilets- Fixed, raised toilet seats
• Safety railings on either side of toilet
• Replace doorknobs with levers

The Patient’s Bathroom

• Showers
• Non-slippery floors
• Appropriate door openings
Environmental Fall Risk Rounding Checklist: Patient Room

- All wall light switches working properly (also check for burned out bulbs)
- All patient light controls working properly.
- If nightlights present (under bed, in bathroom), do they work properly.
- Call bell functions properly
- Flooring free of tripping hazards such as uneven surface or doorway thresholds.

Environmental Fall Risk Rounding Checklist: Patient Room

- If bed exit alarm present, it operates properly.
- Door openings to bathroom wide enough (36 in) for assistive device to fit through (ex. walker, IV pole)
- Grab bars located next to toilet.
- Portable equipment pushed by patient moves freely & in good repair.
Strategies: the Vital Few

**Standardize Interventions (Patients at Risk for Falling)**

- Implement both hospital-wide and patient-level improvements to the patient care environment to prevent falls
- Perform purposeful rounding

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**Why Rounding?**

- Studer Group’s Alliance for Health Care Strategy (AHCS) research showed Hourly Rounding:
  - Reduces call lights by 37.8%
  - Reduces miles walked by nurses by 1.6
  - Reduces falls by 50%
  - Reduces decubiti by 14%
  - Improves patient satisfaction scores by 10 points
Basics of Purposeful Rounding

- 5 Ps
  - Pain
  - Potty
  - Position
  - Personal belongings
  - Pathway – Safe exit

Examples – Key Words

- “I have time to spend with you right now”
- “Someone will be in to check on you about every hour”
- “It is time to….try to go the bathroom, let me help you”
- “It is time to…change your position, let me help you”
- “Someone will be back to check on you in about one hour. Is there anything you need before I leave?”
Strategies: the Vital Few

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Strategies: the Vital Few

Customize Interventions for Patients at Highest Risk of a Serious/Major Fall-Related Injury

- Increase the intensity and frequency of observation
- Make environmental adaptations and provide personal devices to reduce risk of fall-related injury
- Target interventions to reduce side effects of medications or treatments
Quick Checks in LTC

WHO

- History of 2 or more falls within 1 month.
- Upon admission for 72 hours.
- Upon readmission from hospitalization for 24 hours.
- For acute illness or medical condition.
- Upon CNA or nurse referral because of changed resident behavior.

Quick Check in LTC

WHEN TO REMOVE

- The resident is no longer at risk related to a decline in mobility or increase in ability.
- Acute illness or medical condition is resolved.
- A change in behavior indicating an understanding of call light use and the need to call for help.
Strategies: the Vital Few

Customize Interventions for Patients at Highest Risk of a Serious/Major Fall-Related Injury

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- Make environmental adaptations and provide personal devices to reduce risk of fall-related injury
- Target interventions to reduce side effects of medications or treatments

Safe Exit

Safe Exit Side

R L
### Strategies – The Vital Few

<table>
<thead>
<tr>
<th>Age &gt; 85</th>
<th>ALL patients that meet at least ONE criterion receive:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Armband/ room sign</td>
</tr>
<tr>
<td></td>
<td>Teach back on high risk to injury</td>
</tr>
<tr>
<td></td>
<td>Safe exit</td>
</tr>
<tr>
<td></td>
<td>Purposeful rounds every one hour</td>
</tr>
<tr>
<td>Bones</td>
<td>1. Height adjustable bed</td>
</tr>
<tr>
<td></td>
<td>2. Mat on floor</td>
</tr>
<tr>
<td></td>
<td>3. Hip protectors</td>
</tr>
<tr>
<td>Coagulation</td>
<td>1. Height adjustable bed</td>
</tr>
<tr>
<td></td>
<td>2. Mat on floor</td>
</tr>
<tr>
<td></td>
<td>3. Helmet</td>
</tr>
<tr>
<td></td>
<td>4. Education on anticoagulation safety</td>
</tr>
<tr>
<td>Surgery</td>
<td>1. Height adjustable bed</td>
</tr>
<tr>
<td></td>
<td>2. Mat on floor</td>
</tr>
</tbody>
</table>

### Next Steps: Safe Transitions

- Correct assistive device
- Home safety assessment
- Patient and family education on safe home set up
- Community resources
Model for Improvement

ACTION PLANNING
## Preventing Falls with Injury: Team Assessment

Instructions: Please answer with either a “Y” for yes or an “N” for no.

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>Have tested this change</th>
<th>Have implemented this change</th>
<th>Tested and abandoned the change</th>
<th>Not yet tested this change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess patient for fall risk.</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>2. Assess patient for risk of injury associate with a fall</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>3. Communication the risk of injury amongst the care team</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>4. Communicate the risk of falling or the potential for injury from a fall amongst ancillary departments</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>5. Educate patients/families on risk for falling/injury</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>6. Repeat back - use of call light</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>7. Video/pamphlets for patients and/or families about the risk for falling/injury while hospitalized</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>8. Discharge instructions</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Standardize Interventions (Patients at Risk for Falling)

| 9. Visual cues                                                               | Y                       | N                             | N                               | Y                         |
| 10. Low bed and/or floor mat                                                | Y                       | N                             | N                               | Y                         |
| 11. Safe exit                                                                | Y                       | N                             | N                               | Y                         |
| 12. Patient teaching on anticoagulants                                       | Y                       | N                             | N                               | Y                         |
| 13. Environmental risk reduction                                            | Y                       | N                             | N                               | Y                         |
| 14. Focused rounding                                                         | Y                       | N                             | N                               | Y                         |

### Customize Interventions (Patients at Risk for Injury)

| 15. More frequent rounding                                                   | Y                       | N                             | N                               | Y                         |
| 16. Hip protections                                                         | Y                       | N                             | N                               | Y                         |

## WORK OUT

- Create the Plan for a small test of change
- Work Session = 10 minutes
- Report out = 5 minutes
- Share & Critique
**WORKSHEET FOR A SMALL TEST OF CHANGE**

**Team:** __________

**Date:** __________

**Aim:** What are you trying to accomplish with this test? The aim includes a measurable goal, timelines, and patient population and system to be improved. Every aim will require multiple smaller tests of change. Enter your aim.

**Measure:** How will you know that a change is an improvement? Enter your measure here.

**Plan**

<table>
<thead>
<tr>
<th>Describe your first (or next) test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>List the tasks needed to set up this test of change</th>
<th>Person Responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Predict what will happen as a result of this test</th>
<th>What measures will help you determine if the prediction succeeds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
</tbody>
</table>

...at this point. You have planned your test and will not be able to complete the Do-Study-Acct portion until you run the test.

**Do:** Describe what actually happened when you ran the test

**Study:** Describe the measured results and how they compared to the predictions and what you learned from the cycle

**Act:** Describe modifications for the next cycle based on what you learned

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**THANK YOU**

Suzanne Rita

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**Iowa Health System**

Best Outcomes for Every Patient Every Time