Title of Entry: "I've fallen and I can't get up...Preventing Inpatient Falls"

Division: Small Organizations

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Problem Description: Patient falls are a challenge within many healthcare facilities. At our campus, during the year after our new hospital opened (October 2016) we noticed an increase in our inpatient fall rates. The 2017 baseline rate for the campus was 3.34 per 1000 patient days. Our senior level administration supported the formation of a campus team to address improvements for this patient safety care focus. We developed an aim statement of reducing inpatient falls to a rate lower than PA Patient Safety Authority Benchmark of 3.21 per 1000 patient days by June 2018.

Evidence: As noted, we opened a newly built hospital in October of 2016. As we on-boarded new staff and accepted patients, we quickly expanded from part of a medical surgical unit to a full unit and then to a second unit along with our intensive care unit. As our census grew, we started to notice a trend with increased falls. A large amount of research is available on patient falls in acute care facilities. Much of the evidence based practice has been incorporated into hospital policies and procedures to address falls and support fall prevention, but falls continue to happen. The PA Patient Safety Authority has focused on falls and falls prevention since 2004 (Pennsylvania Patient Safety Authority, 2020). The Joint Commission has supported addressing improvement for falls and patient safety for many years and has released two sentinel event reports related to the topic, the last being released in 2015 (The Joint Commission, 2020). According to the Agency for Healthcare Research and Quality (AHRQ) “each year, somewhere between 700,000 and 1,000,000 people in the United States fall in the hospital. A fall may result in fractures, lacerations, or internal bleeding, leading to increased health care utilization. Research shows that close to one-third of falls can be prevented” (AHRQ, 2018, para. 1). We wanted to address our elevated rate.

Baseline Data: Data review identified a rate of 3.34 per 1000 patient days for CY 2017. This was higher than state benchmark of 3.21 per 1000 patient days as defined by the PA Patient Safety Authority.

Interventions: Data review (retrospective and then concurrent) helped us focus on trends while input from bedside staff helped us focus on improvement actions. The team divided actions in ‘quick fixes’ and ‘more work fixes’, meaning things we could implement quickly with minimal process change or input from others and, then things that needed planning, education, or approval. Examples of quick fixes that we identified and addressed were adding appropriate departments to the team based on patient interactions, reinforced use of post fall huddle sheets to capture all risks, focused on bed placement for high risk patients on each unit, enforced safety huddle completion with review of high risk patients identification and, completed walking alarm check audits to ensure alarm use compliance. Examples of more work fixes that we identified and addressed included re-evaluation of signage to support identifying high risk patients, assessment of and attention to hourly rounding process to ensure properly completed, revisit of the patient & family education process and agreement signature, expanded use of the in room white board to capture fall risk, PCA knowledge level assessment related to experience and accountability for training needs, development of a one page education sheet (done in color) on how to correctly hook up the bed/Chair alarm connections and standardized the process for patient refusal of bed and chair alarm utilization. Additionally, we consistently reviewed best practice information from external sources (Joint Commission, PA Patient Safety Authority, and other best practice sources) to keep all possible fixes under consideration as a potential improvement at our facility. Other interventions completed were streamlined process to obtain yellow bands and socks for high risk patients, collaboration with the campus NICHE (Nurses Improving Care for Health system Elderly)
team for activity baskets with diversional activities, use of safety huddle boards in the care units that are updated daily with number of days the unit has been fall free, holding a “No Falls February” awareness month with fun activities and treats, and implementing a Blue Star awareness process to identify and flag patients with cognitive impairments who have an increased risk of falling related to this impairment.

Results:
• With consistent review in a rapid cycle format, our team was able to see a positive decrease in our fall rate and actually have an 8 month run of rates below the benchmark during 2018. (2018 rate decreased to 1.97 per 1000 patient days.) A challenge was noted in the start of 2019 as our rate increased (up to 2.79 per 1000 patient days for January-June) so the team rallied again and reinforced positive interventions, resulting in a second wave success of rates below benchmark for 8 months at this time (rate positively down to 1.47 per 1000 patient days for July-December).
2020 HAP Achievement Award Entry
"I've fallen and I can't get up... Preventing Inpatient Falls"

Project Started May 2017 with Full Implementation August 2018 and ongoing assessment at this time

Assessment and Background:
Describe the needs assessment process and/or research conducted prior to implementing the initiative and the results of that needs assessment/research, including evidence and baseline data.

- Patient falls are tracked and trended monthly within the patient safety process at our campus. We identified a spike in our fall rate in March and April of 2017 that lead to a campus PI team being formed in May 2017. (graph attached below)
- As a team:
  - We completed data drilldown on units, days of the week, time of day, patient ages and, reason for falls. Retrospective data was initially utilized and then we transitioned to concurrent monthly review. Trend was identified within unit of occurrence, MS3, and this is also our largest med surg unit. In attempting to define one root cause, we were unable to do so related to the multifactorial issues related to each patient care event and fall circumstances.
  - We reviewed the current "Patient Assistant Call Don't Fall Agreement" that was in place at that time along with our policy on falls with related interventions.
  - Please know our work was supported by our VP of Patient Care Services and our Director of Quality Management to enhance safe patient care.
  - Benchmarking was started by using PA Patient Safety Authority data, then pulling in the Joint Commission Sentinel Event Alert #55 on "Preventing Falls and Fall-related Injuries" to ensure we were addressing all of their recommendations. Additionally, Premier Best Practice educational offerings were investigated and we reviewed strategies that HIIN and QUEST found beneficial to see if there were new interventions we had not considered. (This was a past offering called "Head Over Heels for falls Prevention."

Intervention and Plans:
Identify the steps taken to initiate your effort(s) including strategies, implementation plan, and the interventions

- The team brainstormed potential actions that could be implemented to assist with the issues. These were divided into quick fixes and fixes that required more work.
- Quick fixes that we identified and addressed were:
  - Adding Nutritional Services and Environmental Services staff to our team due to their interactions with our patients
  - Reinforced use of post fall huddle sheets to capture all risks
  - Focused on bed placement for high risk patients on each unit
  - Enforced safety huddle completion with review of high risk patients identification
  - Completed walking alarm check audits to ensure alarm use compliance
- More work fixes that we identified and addressed were:
  - Re-evaluation of signage to support identifying high risk patients
  - Assessment of and attention to hourly rounding process to ensure properly completed
  - Revisit of the patient & family education process and agreement signature
  - Expanded use of the in room white board to capture fall risk
  - PCA knowledge level assessment related to experience and accountability for training needs
  - Development of a one page education sheet (done in color) on how to correctly hook up the bed/chair alarm connections
  - Standardized the process for patient refusal of bed and chair alarm utilization
- Using a rapid cycle PDCA process at each meeting, we reviewed each action item from meeting to meeting. This allowed us to track what was working and what was not working, in addition to receiving status updates on the fixes that required more work.
- We added BioMed as an ad hoc member to address sound level alarms when this was identified as a concern.
- We added other interventions to our 'fix list' as issues came up - for example, handiness of yellow bands
and socks for patients was reported as a concern on a post fall huddle sheet. To quickly address, we changed our process to have them stocked within each room prior to each admission. If not needed, they could be removed. This may seem like a small item but each fix was a win along our improvement road.

- We also collaborated with our campus NICHE (Nurses Improving Care for Health system Elderly) Team to support use of diversional activities from the NICHE Activity baskets for elderly and confused patients. Diversion items available for use included adult word searches, adult coloring books, crafts (crocheting, simple wood projects, window hangers), card games, etc.

- We expanded what we learned and what we were doing with our inpatient care to our Emergency Department and also to our Surgical Services area to provide the same level of care across our care areas. This also allowed for new insight as we added additional team members.

- Building on each action implemented and on small wins, we started to see decreased falls ©

- We experienced a barrier in addressing signage for our high risk patients during this time. Our campus standard was to use door signage that is flat against the wall. This was aesthetically pleasing to the eye however; we determined it was hard for our staff to see when they looked down the length of the unit hallway. A decision as made to develop signage that could be used and removed and that would stick out from the doorway to identify these patients. We developed criteria for these supplemental signs. The signs were piloted on MS3 (our unit with the most raw number of falls) from February 5th 2018 to April 11th 2018. After success with them, we made the decision to expand to another care unit, MS2. This was done in June 2018. Full campus expansion was completed in August 2018 and remains in effect at this time. (sample attached below)

- To highlight improvement of not having falls, we asked each unit to implement capturing number of days without a patient fall on their safety huddle boards. Feedback on this was very positive with one PCA sharing "it's inspiring to see the number of days that our unit has been falls free!"

- In reaction to information learned from fall drilldown data during this time, we also ordered two sets per unit of fall mats for the campus in July 2017.

- Benchmarking was revisited in February 2018 when we again pulled out Joint Commission best practice information to see if new information was available and to reassess interventions we previously had not wanted to consider.

- As a team we decided to highlight falls with a "No Falls February" focus in February 2018. We did fun items such as a cookie handout day (cookies had yellow sprinkles and you were encouraged to be a 'smart cookie' about falls), a banana handout day to highlight 'no slipping and sliding' on our watch), a wear yellow day to highlight the color of fall awareness and, a "Room of Fall Risks" where staff could come and test their knowledge of risks, signage, and other challenges. This was well received by the staff who participated in any or all of the events offered. (flyer attached below)

Results:
Summarize the success of your initiative and provide evidence of sustained improvements.

- Fall rates are monitored monthly, and reported out at our team meetings, our campus Patient Safety Committee meeting and our Clinical Operations meeting. The graphic used for presentation is now color coded. When we have 3 months of positive results, the background is green, when we dip into concerning results the graph background is yellow, and when higher than benchmark results are noted for 3 consecutive months, the graphic goes red. This color coding provides a quick stoplight format to help us all know status when quickly reviewing the graph.

- After a few months of ups and downs in the fall/winter of 2017, we were able to have 8 consistent months of patient fall rates under the PA Patient Safety Authority benchmark (May 2018 through December 2018)! But we weren't done... continued tracking identified a spike up in the start of 2019.

- We saw this increased rate in January 2019 but with rapid review and attention and re-education of bedside staff, saw a decrease again over the following months. At this time, we continue to meet every two months to keep momentum going and not stop focusing on our work and intervention needs.

- In November 2019, we started a "Blue Star" pilot on MS3 in reaction to identifying that we had patients with cognitive impairments that might not be easily identified but put our patients at a higher fall risk. Education and posters explaining this process were defined and education was completed (see poster info attached). Results were positive when the pilot was assessed in January 2020. To assess the pilot, we completed a patient care services survey and reviewed fall rates for the specific unit. Survey results
indicated that the majority of nurses and PCAs on the unit supported that they had used the blue stars to identify patients and changed their practice on how they interacted with these patients and their families. The unit fall rate decreased from 1.48 per 1000 patient days for the 4 months before the pilot, to 0 for the two months of the pilot! The pilot has now been expanded to a second MS unit to assess for continued success.

• As we link falls to financial implications, we focus on falls that involve harm, as these have financial impact on the system. Cost savings are present when falls with harm do not occur. We have had minimal events with harm. (graph attached below)

**Adaptability:**
Describe the potential ability to replicate your initiative in other organizations that provide the same service or serve the same type of population. Also, describe how to maintain the initiative and/or its results, any negative outcomes, areas of improvement or lessons learned.

• Information is shared within our network and the ability to replicate education and awareness is high. Population for med surg units can be consistently compared based on care needs within the units' scope of service.
• We have been able to maintain momentum as we share positive outcomes and have incorporated the reporting out of our number of days falls free within each unit huddle and at our daily campus level patient safety huddle.

**Supporting Appendices:**
You may include clearly labeled pictures, data tables, or graphs as appendices if needed.
As below:
- Fall rates trended over time
- Door signage
- Informational Flyer for “No Falls February”
- Educational poster for Blue Stars pilots
- Falls with harm rates trended over time

Graphic Display of Fall Rates Trended Over Time:

Door signage:
With the help of our internal Print Shop, our supplemental door signage is printed on yellow card stock, done two sided and laminated. A magnet is glued to one end so it can be applied to the metal door frame of the appropriately defined high risk patient and be seen down the hallway. At time of discharge, EVS removes the sign and appropriately cleans it with a disinfection wipe. They then provide it back to the nursing staff for re-use.

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Campus Name & Logo

— Achieving Patient Safety
Call, Don’t Fall, Prevention
Informational Flyer:
This is the informational flyer we used for our “No Falls February” fun in February 2018.

"No Falls February"

• Do you think we have a lot of patient falls?
  • Do you know that our fall rate is higher than the Patient Safety Authority benchmark?
    • Do you want to help us do something about it?
    • Then join us as we support “No Falls February” 😊

What does that mean?

• Be a “Smart Cookie” & help us kick off the month! Free cookies with yellow sprinkles available in the cafeteria February 1st from 11am to 1pm & 5pm to closing.

• Enjoy a free banana in the cafeteria on “No Slipping & Sliding” day on Friday February 9th

• Have some fun with Infection Control on Valentine’s Day... See what Tammy has going on in the cafeteria at lunchtime...

• Participate in “Room of Fall Risks” & “Wear Yellow” day (Friday February 23rd). Room location will be MS4 (Room 410) from 6am until 8pm. Stop in and test your knowledge, learn how to make sure bed & chair alarms are on, assess for correct signage and a few other twists...

• Let’s hope to be “On a Roll” on Monday February 26th with no falls and celebrate with tootsie rolls (available in the cafeteria)
Blue Star Pilot:
This is the informational poster we used for our pilot on our first MS unit in November 2019.

MS3 Pilot using CAM Score & Blue Star Signage
Starting Monday November 11th 2019

Nurses role....

★ Complete the CAM assessment in EPIC (CAM – Confusion Assessment Method).
★ If patient is positive (+) for delirium, dementia, and/or Alzheimer’s, initiate appropriate interventions
  ○ Notify the SLIM attending of finding.
  ○ Use pharmacologic agents only when non-pharmacologic interventions are ineffective.
  ○ Add as problem on plan of care – Intervention to include ensuring medical information communication should also be with family members as appropriate.
★ Continue to monitor CAM every 12 hours (at 0900 and 2100)
★ Place a Blue Star on whiteboard in the patient room. (This notifies all staff caring for the patient that there is baseline confusion.)

Other Care providers...

★ Be aware that Cognitively Impaired Patients will be identified with a blue star on the whiteboards in the room.
★ Please take note to any of the “unit stars” when providing care or services to our patients.
★ Ensure communication of medical information is also done with family members as appropriate.

BLUE STAR AWARENESS
**Graphic Display of Falls With Harm Rates Trended Over Time:**
Our graphic trending indicates positive results of no falls with harm from July 2017 through October 2018.