Reducing Patient Injuries from Falls

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Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

ACT  PLAN  DO  STUDY
The PDSA Cycle for Learning and Improvement

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data
The Sequence for Improvement

Develop a change

Test a change

Test under a variety of conditions

Make part of routine operations

Implement a change

Spread a change to other locations

Theory and Prediction

Act

Plan

Study

Do
What are we trying to accomplish?

- To decrease inpatient falls?
- What is the fall rate?
- What’s the benchmark?
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
How will we know change is an improvement?

TARGET

Incidents of patient harm from falls are reduced to 1 or less per 10,000 patient days.
Mr. Gaskin’s Story
Review Data and Cases

Review, analyze the last 20 falls associated with injury

- What are the trends among patients (e.g., age, gender, diagnosis, type of medications)?
- What were patients doing when they fell?
- Why did patients fall or incur injury from a fall despite efforts to keep them safe?
- Were fall risk assessments used, and if so, how reliably?
- Did the risk assessments identify patients at risk?
- Were interventions implemented based on the results of risk assessments?
- Why did a fall-related injury occur despite these interventions?
Review of Last 20 Falls With Harm

• What patterns emerged?
• Why do you think the patient was injured in spite of best efforts to prevent the fall?
• What was missed on assessment that could have predicted and prevented the harm?
• What did you learn?
• What will you do differently?
Data Review

<table>
<thead>
<tr>
<th>Date of Fall</th>
<th>Time of Day</th>
<th>Location of Fall</th>
<th>Patient Demographics (age and sex)</th>
<th>Medication List</th>
<th>Environmental Issues (lighting, floor surfaces, etc.)</th>
<th>Patient Condition (e.g., fatigue, dizziness)</th>
<th>Procedure (e.g., blood draw)</th>
<th>Patient Activity (e.g., walking, standing)</th>
<th>Injuries Sustained</th>
<th>Severity of Fall</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/12/2023</td>
<td>23:50</td>
<td>med surg</td>
<td>22M</td>
<td>weak</td>
<td>IV tubing cap on foot, change of shift</td>
<td>AAQt13</td>
<td>no</td>
<td>yes</td>
<td>hip, leg</td>
<td>minor</td>
<td>pancreatic cancer with metastases to the liver</td>
</tr>
</tbody>
</table>

HARM FROM FALLS DATA COLLECTION FORM

Analysis: Why do you think the patient fell in spite of all the prevention efforts in place?
Percent of Previous 20 Falls Associated with Injury by Risk Factor for 108 Charts Reviewed

% of Falls with harm with the following criteria

Percent

- Age 85+: 16.7%
- Bones (osteoporosis): 22.2%
- Psychotropic meds: 49.1%
- Anticonvulsants: 28.7%
- Antihypertensives: 8.3%
- Toileting issues: 42.6%
- Mobility ("get-up-and-go" test): 54.6%
- History of previous fall: 68.5%
- Blood (anticoagulants or bleeding disorder): 24.1%
What changes can we make that will result in improvement?

THE VITAL FEW
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)
Strategies: the Vital Few

Assess Risk of Falling and Risk for Injury from a Fall (All Patients)

• Perform standardized fall risk assessment on admission and when the patient’s clinical status changes
• Assess patients most at risk of moderate to severe injury from a fall every shift
Fall Risk Assessment Tools

• Morse
• Schmidt
• Heindrich II
• Conley
Defining Data

- **A**: Age >85
- **B**: Bones- History of fractures- Hip (although multiple fx could be a sign); Certain Diagnoses- (osteoporosis, bone metastasis)
- **C**: Coagulation- Blood Thinners (coumadin, ASA, heparin gtt); Coagulopathies
- **S**: Risk of Surgical complications post surgery
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

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

• Communicate risks and associated interventions at every shift change
Establishing Fall Prevention Program Visual

![No Fall Icon]
“Ask Me 3”

• Encourages patients to ask 3 questions in every health care encounter:
  — What is my main problem?
  — What do I need to do?
  — Why is it important for me to do this?

• Providers’ “teach to the test”
  — “…it changes the way I talk to parents…”

• http://www.npsf.org/askme3/
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
What does Teach Back Look Like?

• Provide an explanation why it is important to use the call light
• Provide a visual demonstration on how the call light works
• Request a return demonstration on how and why it is important to use the call light
• Follow-up assessment of understand of the how's and why's of using the call light
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.
Pre Shift Huddle

Communication of patients identified as the “vital few”: those that are at high risk to harm from falls, skin breakdown, medication error or the next medical response team call

- At the beginning of every shift change for 5 minutes
- All clinical staff
- Identify safety interventions
Handoff Information-
Every Patient, Every Time

• Patient’s risk assessment score
• Patient’s risk to Injury
• Interventions in place
• Walking rounds
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 focused rounding to assess and address patient needs for pain relief, toileting and positioning
Focused Rounding

• P= Pain
• P= Potty
• P= Position
• P= Personal items nearby
• P= Pathway safe exit to bathroom
• “Someone will be back in about _____ minutes. Is there anything else I can do for you now? I have the time.”
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
MANDATORY INTERVENTIONS-
High Risk to Injury

• Identification (armband, blanket, room sign)
• Teachback on HRTI
• Focused rounding every one hour
Customized Interventions

Bones
- Height adjustable bed
- Mat on floor
- Safe exit
- Hip protectors
- CONSIDER: Bedside commode

Coagulation
- Height adjustable bed
- Mat on floor
- Safe exit
- Teachback on anticoagulation safety
- CONSIDER: 1. Bedside commode

Surgery
- Height adjustable bed
- Mat on floor
- Safe exit
- CONSIDER: 1. Bedside commode
Leadership Support Culture of Safety

We will provide the *best outcome for every patient every time*