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Ascension Borgess-Lee Hospital, Dowagiac

Fall Prevention Initiative

Project Team: Left to Right - Suzanne Suseland RN, Debra Stover CNA and Mandy McMeeken RN Manager of ED/Inpatient Services

BACKGROUND

Ascension Borgess-Lee noted significant increase in the total number of falls in FY18 compared to FY17.
Plan: Assemble a team of front line staff to review policy and processes surrounding falls to reduce fall rate.

OBJECTIVE

Reduction in the total fall rate to less than the Ascension Health Target of 2.76 by mid-year of FY19 (FYE18 Fall Rate 5.14).
Prevention of patient injury.

METHODS

April 2018 - Frontline Staff work group assembled. Group reviewed fall data and completed gap analysis.
May 2018 - Implemented the "No Pass Zone." Guidelines for "No Pass Zone" discussed at Hospital Wide Safety Huddle and Department Managers reviewed with staff.
June 2018 - Work group engaged in a phone education/interview with another peer Michigan CAH to learn about their successful Fall Program." Collaboration was inspiring, educational and instrumental in developing Ascension Borgess-Lee's Fall Initiative: "With Vigilance: All Falls ARE Preventable." Poster with guidelines developed to achieve goal of standardization of processes in fall prevention. Emphasis placed on being vigilant among all aspects of fall prevention (fall bundle).

- Know the Fall Prevention Policy
- Perform fall assessment upon admission, each shift and with any condition change
- Individualized plan of care
- Utilize standard fall prevention interventions for all patients
- Bed and chair alarms for all high-risk patients
- Purposeful hourly rounding utilizing the 7 P's
- Adhere to the "NO PASS ZONE"
- Gait belts provided for each patient
- Patient/Family/Caregiver education
- At a minimum of 1:1 caregiver to patient ratio with ambulation and toileting
- Post Fall Huddle Tool

The poster with guidelines presented to frontline associates at Medical Surgical/SCU Staff meeting in July.
Number of days since last fall posted on Medical Surgical/SCU floor huddle board and updated daily as a reminder to maintain vigilance.

RESULTS

Q1 FY19 Total Fall Rate (12 month rolling) has decreased to 4.36 from 5.14, which translates to NO FALLS in >100 days. Staff was presented with treats to celebrate on day 100 of being FALL FREE.

With Vigilance: ALL Falls ARE Preventable

Develop a Mindset Change!

- Mindset change: "Not all falls are preventable" to "All falls are preventable"
- Not making excuses: Remaining vigilant among **ALL** aspects of fall prevention/Fall Bundle
- Collaboration of ALL caregivers

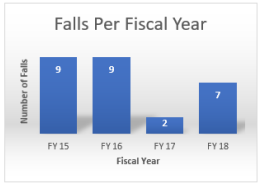
Zero is Real: How is this Possible?

- Focus on intra-professional education
- Evidence Based Practice: Standardization of processes and tools for patient safety (including Hand Off Communication & patient/family education)
- Celebrating successful outcomes

Interventions: Do them ALL or they will fall!

- Know the BLMH Falls Prevention Policy
- Perform the Hendrich II Assessment upon admission, each shift, and with any condition change
- Develop individualized care plan according to Hendrich II score and nursing judgement
- Utilize Standard Fall Prevention Interventions for all patients (see policy)
- Bed and chair alarms for all High-Risk Patients
- Hourly rounding during the day, every two hours at night
- Document under the 7 P's (ad hoc adult ADL's)
- Adhere to the No Pass Zones
- Gait belts are provided for each patient
- Patient/Family/Caregiver education
- At a minimum 1:1 caregiver to patient ratio with ambulation and toileting
- Post Fall Huddle Tool (Goal: Never to use)

Outcomes: Zero is real when you are vigilant about patient safety!



In FY 2017 BLMH
Went **278** Days Without a Fall!

CONCLUSION

After identifying an increase in the total fall rate, ABLH assembled a falls team consisting of frontline staff to assess and develop a plan to decrease the fall rate and facilitate improved patient safety. Fall Program information shared by a peer MI CAH proved to be inspiring. Guidelines developed for standardization of processes and education provided to staff. This initiative has increased staff awareness of fall prevention and has proven successful with reduction in fall rate. Continue FY19

For more information contact Doreen.Murphy@ascension.org

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Aspirus Iron River Hospital & Clinics

Fall Prevention – Use of Bed Alarms

Nursing leadership and front line staff reviewing capabilities of I-bed Awareness System.

BACKGROUND

Fall rates were higher than desired. A comprehensive review of fall prevention practices across the system was conducted, and it was found that there was various risk assessment tools in practice at each organization.

OBJECTIVE

Decrease number of inpatient falls by recognizing cause(s) for increase in number of inpatient falls in FY2018 and developing and implementing actions to eliminate causes.

METHODS

- The existing Fall Prevention Team reviewed the FY2018 fall data to determine causes of falls.
- Prior to this specific improvement project, the organization had implemented several methods to decrease inpatient falls including: completing a fall risk assessment on each patient upon admission and once during every shift, developing individualized care plans on all inpatients with the intent of decreasing falls , implementing purposeful hourly rounding, completing post-fall huddles, implementing the use of fall mats, utilizing bed and personal alarms, and implementing 1:1 monitoring when appropriate.
- Analysis of data indicated that nurses and ancillary staff were relying on the presence or absence of the I-bed alarm light to indicate if the bed alarm was activated. Unfortunately, our analysis revealed that the I-bed alarm light only indicates that the I-bed alarm is on, but it does not signify that the correct settings are set.
- To correct this issue, an educational blitz was developed and implemented to educate staff on the need to reset the bed alarm settings each time the bed alarm is restarted. The education blitz consisted of all clinical managers informing their staff of this initiative by discussing the initiative at daily safety huddles, emailing the information to staff, 1 on 1 discussions with staff members, and discussing the information at monthly department meetings.

Project Team: Deb Han, Director of Quality Management deb.han@aspirus.org; Nancy Ponozzo, VP of Patient Care Services; Kathy Sartorelli, Manager of Med-Surg; Sara Fischer, Manager of ICU and front-line staff.

RESULTS

Since implementation of this initiative, AIR's inpatient fall rate has decreased from 3.2 to 1.4. It is too early to determine sustainability of these results, so AIR continues to monitor and analyze its fall data on a monthly basis and following each fall.

CONCLUSION

It is important to track and trend data to determine if actions implemented are effective and sustainable. Not all actions produce expected results. It is important to be diligent in reviewing events and analyzing data to ensure expected outcomes are realized and sustained. Reviewing equipment manuals and speaking to vendors is an important part of utilizing equipment to its greatest potential.

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Aspirus Ironwood Hospital & Clinics, Inc.

Reduction of Inpatient Falls

Fall Kit

BACKGROUND

AIW's inpatient fall performance rate was double the national performance benchmark from NDNQI.
FY16 5.10% (18 inpatient falls)
FY17 4.1% (16 inpatient falls)

OBJECTIVE

Improve the safety of our inpatient population by reducing overall fall rate and falls with injury. Goal to reduce the rate of falls to reach the NDNQI top performing quartile in 3 years.

METHODS

July 2016
- Implementation of Fall Kits (gait belts, clip alarm, chair pad alarm, Patient & Family Education Sheet, nonskid socks), focused education with nursing staff.

December 2016
- Fall Improvement Team developed

February 2017
- Nurse education and training on Hester Davis Fall Risk Assessment, focused education on falls related to toileting, preventing bathroom falls.

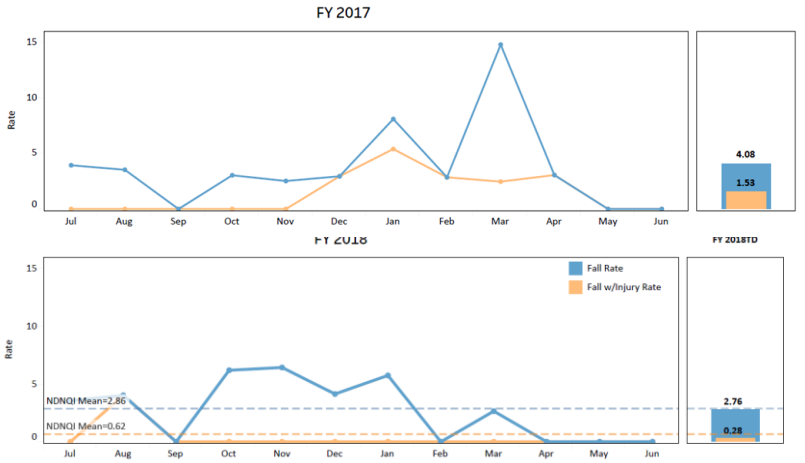
May 2017
- Go-live with new fall risk assessment, Hester Davis, and implementation of post-fall huddle process.

July 2017
- 1)Monitoring all inpatients admitted that had a Fall Risk Assessment completed within two hours of admission
- 2)Percentage of patients with completed patient/family education

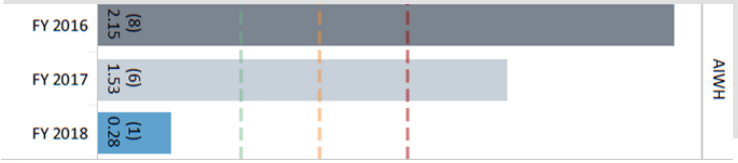
Project Team: Jenna Sharkey, Quality & Patient Safety Manager jenna.Sharkey@aspirus.org; Heather Pawlak, Nurse Education Manager; Julie Monville, CNO; Sandra Maki, Care Coordinator and Lisa Leppala, Manager of Patient Care.

RESULTS

FY17-FY18 | 37.50% fall reduction
FY17-FY18 | 83% reduction in falls with injury



Fall Rate & Fall with Injury Rate



CONCLUSION

We have created a culture in our organization where every employee's voice is important to the safety of our patients, staff, and visitors. This culture enhances our fall prevention work!

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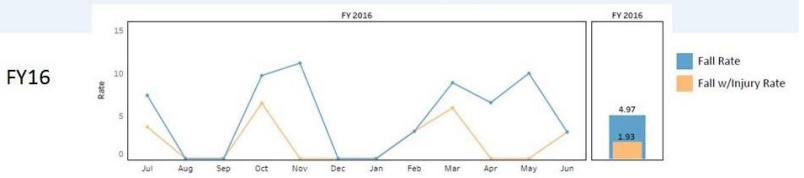
Aspirus Keweenaw Hospital, Laurium

Fall Prevention

Background

(Falls per 1,000 patient days)



FY2016 Fall Rates

BACKGROUND

Fall rates were higher than desired. A comprehensive review of fall prevention practices across the system was conducted, and it was found that there was various risk assessment tools in practice at each organization.

OBJECTIVE

Reduce the number of inpatient falls using a multidisciplinary approach to fall prevention.

METHODS

Aspirus Keweenaw Hospital implemented the HD Falls Program™ in May 2017. The program emphasized training, education, and competency for nursing and provided tools for achieving and maintaining compliance. An essential part of the HD Falls Program™ was introducing an extensive care planning model that maps specific interventions to individual risk factors that adjusts based on the patient's current condition.

Post-implementation, nursing leaders audited for compliance with the program and provided real-time feedback to nursing staff.

Discussion of patients that were high risk for falls was integrated into beginning-of-shift huddles on all nursing units so all staff would be aware of patients at risk.

August 2017: "Days without a fall" was tracked and shared at the daily Hospital Safety Huddle to bring awareness and top of mind to the initiative.

November and December 2017: Ancillary departments were educated on bed alarm activation.

January 2018: Audit results were integrated into the fall prevention discussions at monthly quality operations meetings to identify opportunities for improvement.

March 2018: CNAs began to stock gait belts in each bedside table for convenient use.

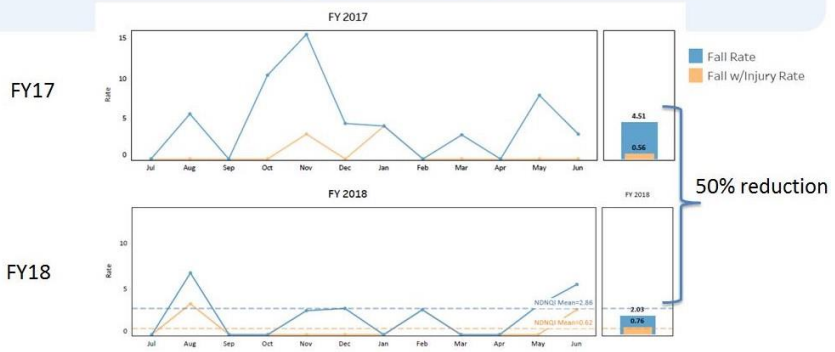
Project Team: Stacey Clisch, MS/OB Manager; Darcy Donnelly, Quality & Patient Safety Manager; Louise Kauppinen, ED/ICU Director; & Grace Tousignant, CNO.

RESULTS

There was a reduction in falls in September 2017 with sustained fall rates through 2018. Post-fall huddles noted that with the earlier falls, bed alarms were not activated. More recent falls have been assisted falls with all fall prevention interventions in place. This trend highlights the adoption of the HD Falls Program consistently across all shifts and departments™.

Fall Rate

(Falls per 1,000 patient days)



FY2017 and FY2018 Fall Rates

CONCLUSION

The findings supported that focused, continuous efforts led by top leaders and supported by nursing and ancillary departments is needed for sustained performance improvement. Integration of monitoring and control of the process needs to be embedded into the quality reporting and performance improvement committee structure to avoid complacency. Next steps include shifting focus from fall risk assessment to fall injury assessment with emphasis on individualizing plans of care to minimize injury.

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Eaton Rapids Medical Center

Making Care Safer -Falls Prevention & Management

Team Celebration – nursing, rehab, clinical integration & leadership teams.

BACKGROUND

In March 2018, a patient fell leading to a formal complaint with DNV. This led to a complete review of our fall policy & protocols (or lack thereof). We found that we had little to nothing in place. Falls = priority #1!

OBJECTIVE

Our goal at ERMC is to identify patients at risk for falls, implement appropriate interventions to prevent falls and outline an evidence-based pre & post-fall management program to guide nursing care.

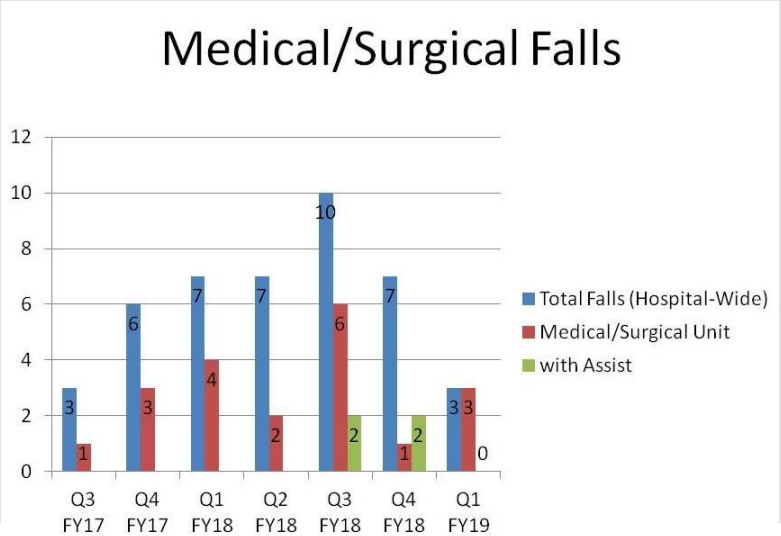
METHODS

- **Communication** - Improve at interdepartmental level, as well as facility level; Incorporate fall risk hand-off tool between units
- **Culture** - Change focus from "all falls" to preventable falls, falls w/injury, falls w/assist
- **Data Reviews** - Educate staff on falls; Benchmark against ERMC (national benchmarks are not unique to ERMC)
- **Education** - Education regarding falls & fall types
- **Environment** - Considering night lights in bathrooms; Pushing beds against wall based on patient needs
- **Equipment** - Considering purchasing floor mats, hip protectors and anti-tippers for wheelchairs
- **Falls Committee** - Infancy stages of Falls Committee creation, ensuring front-line staff membership
- **Falls Prevention** - Individualize each patient fall plan to meet specific needs; Each unit to create addendum/policy to meet their specific needs
- **Falls Reduction Efforts** - Set unit specific falls goals; Celebrate falls with assist
- **Post Fall Huddle** - Form post fall huddle to be performed after every fall and include patient, in addition to completion of newly created document; Gain knowledge and understanding of what happened and how to prevent from happening again
- **Purposeful Rounding** - Hardwire purposeful rounding utilizing 6 P's (Person, Plan, Position, Personal Hygiene, Pain, Presence)
- **Toilet and Bathroom Safety** - Currently in process of investigating options/pricing for additional grab bars on all units for safety

Project Team: Heather Schragg, Director, Patient Experience, Quality, Compliance, Risk Mgt. hschragg@ermchealth.org and Scott Piper, Manager, Med/Surg Department.

RESULTS

We realized that we had to change the way that we thought about falls. FALLS HAPPEN and not all falls are preventable! We added the "Number of Days Since Last Fall with ASSIST" to our Daily Safety Huddle report out. In addition, we CELEBRATE falls with assistance, as this is considered a "win" due to staff being there to reduce or eliminate harm/injury to a patient!



CONCLUSION

Since implementing our Fall Prevention and Management Policy and Program, we have seen a decrease in falls not only in our Inpatient Unit, but also hospital-wide. This has been very rewarding! We are not done yet! Although we have seen an overall positive trend, our falls intervention program MUST be initiated hospital-wide, as this is not just an inpatient initiative. Further, our culture of safety and Fall Prevention and Management Program MUST come from the top down.
Care! Serve! Inspire!

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Mackinac Straits Hospital, St. Ignace

Managing Falls and Preventing Injury

BACKGROUND

Mackinac Straits Hospital receives many high fall-risk patients. In Winter 2018, we admitted a patient who fell 7 times in 40 days. Nurse care planning and education failed to correct the patient's unsafe behavior.

OBJECTIVE

Through a Fall Task Force Committee, Mackinac Straits Hospital will: (1) Reduce the average falls, per quarter, on the inpatient unit; (2) reduce the extent of injury from falls, per quarter, on the inpatient unit.

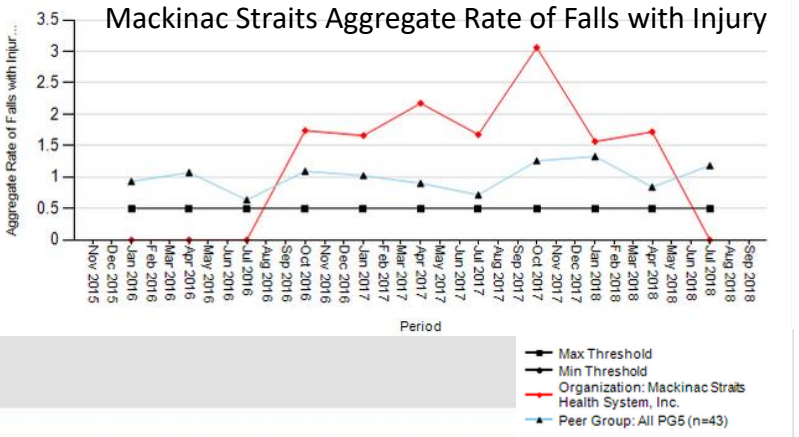
Project Team: James Shannon, Chief Nursing and Quality Officer jshannon@mshosp.org; Cindy Donajkowski, Nurse Executive; Jamie Lester, Case Manager; Sharon Macdonald, Patient Advocate and Sam LaVake, Quality Coordinator.

METHODS

- Mackinac Straits Hospital secured a visit from a national falls expert, to review Mackinac Straits Hospital's patient care environment as well as the methods it uses to reduce falls and prevent injury from falls. The national expert provided a gap analysis and tools to help Mackinac Straits Hospital identify opportunities to improve its fall management processes.
- Mackinac Straits Hospital organized a Falls Task Force Committee based on the expert's recommendations. The committee meets on a quarterly basis. The committee is responsible for overseeing fall prevention and facilitating process improvements to reduce the risk of injury from falls in the inpatient unit.
- The Falls Task Force Committee is a multidisciplinary team. The Nurse Executive or the Case Manager act as chair, while the Chief Nursing and Quality Officer serves as an advisor. The Quality Coordinator acts as project manager and data coordinator, and the Patient Advocate serves as safety coach for clinical staff and assists with policy and procedure development. The committee also utilizes ad hoc members from outpatient therapy, pharmacy, and facilities.
- The Fall Task Force Committee's responsibilities include monitoring trends of fall rates, and investigating fall sentinel events. The committee is also responsible for recommending and evaluating improvement initiatives for fall prevention. Additionally, the committee will evaluate patient equipment and supplies used for fall management and injury reduction from falls.

RESULTS

The results are not ripe enough to report. The committee's first meeting occurred September 2018. The committee updated Mackinac Straits Hospital's inpatient post-fall processes to reflect best practice. Management audits RN documentation of care associated with post-fall processes and the Falls Task Force Committee reviews audits to identify opportunities to improve clinical services.



CONCLUSION

Our first post-implementation meeting is scheduled for January 2019. At this meeting we plan to discuss trends in falls and falls with injury, nursing documentation concerns, challenging scenarios and frequent fallers. In the future, we hope our findings demonstrate lower rates of falls and falls with injury, as well as less serious injuries from falls. Also, we hope our findings demonstrate improved clinical nursing behaviors, as evidenced by better clinical documentation and decision-making.

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MidMichigan Health, Clare

Reduction of Falls within the Inpatient Unit

BACKGROUND

MidMichigan Health-Clare recognized the need to reduce falls on the Inpatient Unit as our FY 2016 baseline indicated 3.06 fall/1000 patient days.

OBJECTIVE

To reduce inpatient falls by 15% in FY17 and then by 15% in at least one quarter in FY18. Baseline FY16 was 3.06 falls/1000 patient days. FY17 resulted in 1.65 falls/1000 patient days with 46% reduction.

Project Team:
Kellie Warner, CDI/QNS, kellie.warner@midmichigan.org; Jenn Walsh, Unit Manager; Wendy Bicknell, Director of Operations; Katie Salman, QNS; and Jill Thorington, Unit Manager.

METHODS

- Implemented Inpatient Executive Adopt-A-Unit (2017) interdisciplinary team with executive sponsor that met monthly. All team members were required to complete an A3 or PI 101 class
- NDNQI fall participation (ongoing) with certificates presented by Quality Council to units who meet benchmark 2 consecutive quarters
- Harms Committee system-wide (2017)
- Initiation of No Pass Zone within the facility-no employee is to ignore a call light; education given to all departments within hospital (2017)
- Hester Davis initiated within EPIC with staff education regarding scores along with wall signs to match patient's fall risk score (2017)
- Yellow wrist bands applied to all high fall risk patients according to Hester Davis scale-education pamphlets given to patients and families regarding use of yellow bands and their visual purpose (2017)
- Post-fall huddles performed immediately after patient fall (2017)
- High fall risk patients identified during shift huddles per nursing (2017)
- Monthly unscheduled fall audits performed by Quality-real time discussion with staff regarding any issues found during audit if deviation was observed
- Good Catch program for "near misses/near falls with recognition at DSB (daily safety briefings) (2018)
- MHA site visit by Patricia Quigley (May 2018)
- Purposeful rounding tool built within EPIC-education with staff regarding necessity to help reduce falls (July 2018)
- Implementation of Daily Excellence Huddles on each shift with discussion of last fall and high risk patient identified

RESULTS

FY 2017 goal met with 46% reduction in baseline from FY16. FY18 had 2 quarters without a fall with injury. The inpatient unit celebrated 250 days without a patient fall by making a video for the health system to view on the Quality dashboard. They also received 2 certificates of recognition from the Quality Council for meeting benchmark for 2 consecutive quarters.

CONCLUSION

Findings indicate that fall reduction is a team effort from executive leadership to frontline staff. Ongoing and daily education is necessary to create a culture of safety for our patients. We continue to strive for zero patient falls with injury on a daily basis.

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MidMichigan Medical Center-Gladwin

Fall Reduction

BACKGROUND

MidMichigan Medical Center-Gladwin was performing below the 50% percentile for IP falls.

Project Team: Carolyn VanWert, QNS Carolyn.vanwert@midmichigan.org; Julia Reid, Campus Manager; Glenn King, VP/CNO; and Katie Salman, QNS.

OBJECTIVE

To reduce our inpatient falls by 15%

Baseline CY 2017:
4.1 falls / 1000 patient days

Target: 3.49 falls / 1000 patient days
Re-measurement FY 2018

METHODS

Gladwin implemented the IP Executive Adopt-A- Unit (2017) utilizing A3 plan that included MDT members and executive leadership. Team members were required to complete PI 101 or Managing to Learn Session (review of PDCA and/or A3 process)

Gladwin Specific A3 Countermeasures:

- Root Cause Analysis on 100% falls with injury
- Focus on use of bed/chair alarms with fall risk patients
- Working on transition to bed alarm connection with intercom system
- Care Plan individualization

Other Strategies:

- Participation in system Harms Committee
- NDNQI Fall participation (ongoing). Certificates to nursing units meeting benchmarks consecutive quarters (2017)
- Hester Davis implementation and staff education
- Gait belts (2017) and Hester Davis Fall Risk Signs (2018) for each patient in room
- Initiated NO PASS ZONE (no employees pass a call light)
- Yellow wrist bands for @ risk patients and fall brochure for patient/family (2017)
- Initiating Daily Excellence Huddles (August 2018) including fall discussion
- Education on accurate variance reporting for tracking and post fall huddle assessments
- Purposeful rounding tool built into EMR addressing 5 P's (live July 2018)
- Monthly Fall Risk Intervention Audits implemented (June 2018)
- Good Catch Program for "near misses/near falls" / recognized at DSB and drawings (2018)
- MHA Site Visit by Patricia Quigley (May 2018)

RESULTS

Goal met with a 50% decrease in IP falls with 2.07 falls / 1000 patient days from baseline of 4.1 falls / 1000 patient days.

Our unit received 2 certificates of recognition from the Nursing Quality Council for meeting NDNQI benchmarks for 2 consecutive quarters.

We have had 2 periods of 100 days with ZERO falls and now 145 days with zero falls and 192 days since a fall with an injury.

Held celebration for 150 days with no IP falls with staff search for $150 of "funny money" on the unit and gift drawings.

CONCLUSION

The findings indicated that with employee and leadership engagement, focused improvement efforts we can help reduce the number of falls and impact injury reduction to our patients. Injury prevention is a focus of our day to day work and now imbedded in our unit culture. We continue to strive for zero patient harm.

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McLaren Thumb Region, Bad Axe

Improving Safety through Communication

BACKGROUND

For 2017 our rural hospital had 10 falls with injury- a dramatic increase from 3 total falls the previous year. Through many discussions it was determined that improved communication was the key to safety.

OBJECTIVE

Decrease falls. Increased awareness of potential safety issues. Take a proactive (rather than reactive) approach to patient safety.

Project Team: Kim Rhode, Dir. MS, MB, OB, Cardiac Rehab;
Jane Christner, Chief Nursing Officer
Michael Johnson, CEO
Jeanine Starcher, Dir., ED, ICU, EP & Trauma
jstarcher@huronmedicalcenter.org

METHODS

Starting in Oct 2017 nursing staff began bedside reporting, including patients who were interested in the discussions. Rounding clocks were researched and staff educated on their purpose.

- Nov 2017: Initiated use of rounding clocks in inpatient rooms on Med-Surg.
- Dec 2017: Results of hourly rounding and patient safety concerns were shared in monthly department meetings. Leaders realized this was not frequent enough to have a significant impact on safety.
- Feb 2018: Each patient care unit began having daily safety huddles followed by a safety huddle by nursing directors to share safety concerns. This daily safety huddle of the nursing leadership expanded to include all hospital directors.
- April 2018: the leadership group recognized a lack of follow up for safety concerns that were identified. The daily safety huddles in each nursing department has continued to evolve to include asking about fall risks, actual safety incidents and near misses.

In May the leadership huddle began to include a more formal format that ensures follow up of all safety concerns that have been brought forward as well as discussion among the group about ways to change processes to prevent such incidents from occurring again. The number of leadership individuals joining the daily huddle continues to grow, and any staff member interested in joining can do so at any time.

RESULTS

There has been a total of 3 falls so far for 2018. Safety is a known priority among staff and safety issues are more openly discussed. Staff have become engaged in the process of daily safety huddles and thinking about potential safety issues. The number of near misses reported has increased. A more proactive approach to safety is the new culture.

CONCLUSION

We will continue to update the daily safety huddles to meet the needs of the staff and the patients. We will continue to focus on maintaining a proactive approach. The safety huddle process will remain very fluid to meet newly identified needs. In the near future, we will be implementing the use of a more objective fall risk assessment tool and the use of color coded socks/wrist bands to identify patients at risk of falls. Hospital administration supports efforts toward safety improvement.

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Munson Healthcare Manistee Hospital

Inpatient Fall Reduction

BACKGROUND

Our overall fall rate increased to 5.9 and by 182% between our fiscal years 2016-2017. Our fall with injury rate (NDNQI specifications) increased by 64% to 1.6 within the same time period. Benchmarks include 3.56 and .92 respectively.

OBJECTIVE

By November, 2018 our goal is decrease our fall rate by 25% to 4.4. By June, 2019 our goal is a decrease to < 3.56. falls and < 0.92 falls with injury (TJC). Our ultimate goal is zero falls with patient injury.

Project Team: Eva DeLaGarza, Medical/Surgical Unit Manager; Alexi Callaway, Performance Improvement Manager; Esther Sigurdardottir, Director of Rehab Services; Lacey Makowski, Charge Nurse and Sharon Massie, Patient Care Tech.

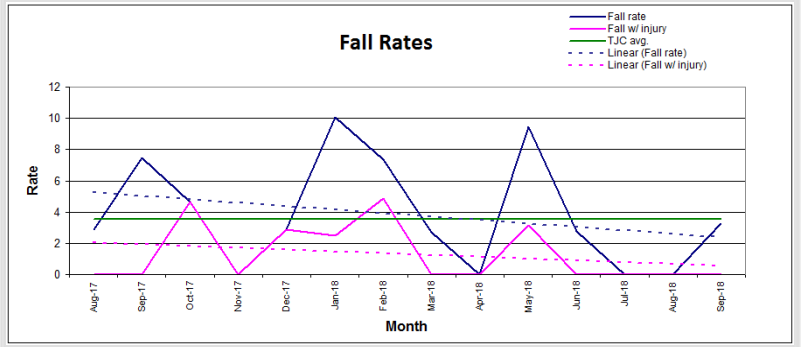
METHODS

MHMH began analyzing fall events in late 2016. In the fall of 2017 an improvement team was established. The team mapped out the fall prevention process from admission through discharge. A root cause analysis including frontline staff identified opportunities in equipment availability and additional training; a revision of our fall risk assessment to provide a more inclusive and accurate fall risk; visual management for the health care team to identify fall risk patients; the need for additional patient assistance while using the restroom; and education for patients and families about fall risks and prevention. All of the components were fully implemented by April of 2018.

Fall risk gown (easy identification for our entire health care team)

RESULTS

In the seven months prior to implementation, the overall fall rate was 5.27 and decreased in the seven months after implementation to 2.58 reflecting a 51% decrease. Our fall with injury rate has decreased from 2.26 to 0.43 by 81%.



Fall rate pre and post implementation

CONCLUSION

Our MHMH interdisciplinary team used A3 problem solving to make improvements in patient safety surrounding fall risk. We addressed root causes by making changes including our assessment, visual management options, and enhanced equipment and education for patients, families and staff. We will continue to monitor and investigate any potential opportunities in our pursuit of zero patient harm.

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UP Health System Portage, Hancock

Reducing Patient Falls

BACKGROUND

Falls are a devastating problem amongst a fragile patient population increasing morbidity, mortality and increased use of health care resources.

OBJECTIVE

In January 2013, The hospital created the Falls Team. This interdisciplinary team of individuals meets quarterly in order to discuss all aspects of fall incidence and prevention across all care areas in the health system

Project Team: Ryan Heinonen, Director of Acute Care; Kevin Keranen, Nurse Educator and Deb Young, CNO.

METHODS

Some of their most notable accomplishments include:

2013

Early Ambulation policy implemented:
Implemented balance assessment to be completed on admission.
Created fall risk education plan for staff and patients to increase falls awareness
The "yellow initiative": Patients identified as a high risk for falls wear yellow gowns, socks and wrist bands.
Implemented post-fall huddle and evaluation

2014

RN to RN bedside shift report started
Identified and implemented a standardized falls screening tool across care areas – The Morse Fall Scale

2015

ABC Risk for Injury assessment implemented to identify individuals at risk for injury if they fall.

2016

'Safety Trumps Privacy' initiative – Staff to remain with patient while in the bathroom
Pharmacy reviewing all inpatient charts to identify medications that put patients at risk for falls
Met mastery level in bedside shift report
Implemented Nursing Supervisor Admission Checklist:
Supervisor assures all newly admitted patients have all Fall Risk interventions in place

2017

Hardwire best practice and drive positive results through support and accountability of staff and front line leaders.

RESULTS

In early 2016, The team refocused on hardwiring best practices and pushing out accountability around the falls program to front line staff and leaders.

Overall Staff compliance with falls safety measure improved from 83% in 2015 to 98% in 2018.

Rate of falls/1000 patient days improved from 0.533 in 2015 to 0.1554 in 2018.

CONCLUSION

In order to sustain these improvements and maintain resilience, Portage has the following processes in place:
Nursing Preceptor Program:
Continued quarterly meetings of the interdisciplinary Falls Team
Annual Nursing competencies
Continued Process Improvement completed monthly by Falls Champions in all areas.
Inclusion of high fall risk population in shift briefs.