STOP OUR PATIENT FALLS Strategies for Implementation of an Effective Fall Prevention Program

January 30, 2013
STOP Our Patient Falls

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It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.  Florence Nightingale
Objectives

1. Describe each component of the effectiveness formula in attaining outcomes.
2. Identify two frameworks that can be applied within the effectiveness formula to achieve sustainable outcomes.
3. Describe components of an effective fall prevention program.
Background

- The beginning
- The vision – Sharp Experience
- The action plan – Structure & Process
Structure

Effectiveness Formula

\[ Q \times A^2 = E \]

**Quality of the solution**

**Acceptance & Accountability**

**Effective results**
Quality of Solution

Performance Improvement Framework

1. **Define**
   - Who are our customers and what are their requirements?
   - How is our process currently performing in meeting customer requirements?

2. **Measure**
   - What is causing us to not meet customer requirements?

3. **Analyze**
   - What is our strategy to meet customer requirements and does it work?

4. **Improve**
   - What is the plan to consistently meet customer requirements?

5. **Control**
Quality of Solution

- Define
  - Decrease patient falls
- Measure
  - Fall rate 3.12, Benchmark 2.82
- Analyze
  - Root cause: complicated & inconsistent
Quality of Solution

- Improve
  - Simplify
  - Standardize
  - Simulate

- Control
  - Changing systems/structures
Quality of Solution
Patient Assessment

Prior State

• Schmid

Improved State

• Schmid
• Mobility Assessment
• Risk for Injury Assessment (the ABCs)
• Patient Self-Assessment
Quality of Solution
Identification and Communication of Fall Risk

Prior State
• Red Maple Leaf

Improved State
• Red Maple Leaf
• Fall Risk Kit
• STOP Sign
• Handoff Tools
Quality of Solution
Plan of Care

Prior State
• Written Plan of Care

Improved State
• Written Plan of Care
• Verbal Plan of Care
• Bedside Report
• Visual Plan of Care
Quality of Solution
Preventive Interventions

Toileting Schedule
- Hourly
- Even Hr
- Odd Hr

Mobility Aid

Fall Risk

- Total Lift
- Sit-Stand Lift
- Gait Belt
- Supervision
- Minimum
- Moderate
- Maximum

Bed Pan Urinal
Bedside Commode
Bathroom

- Remain within arms' reach while toileting
- Reactivate alarm after care

Pt Initials: ____
Today's Date: ____
Quality of Solution
Preventive Interventions

Prior State
• Universal Fall Precautions
• Generalized Interventions

Improved State
• Universal Fall Precautions
• Individualized Interventions
• Targeted Interventions Focused on Toileting
Quality of Solution
Patient Education

Prior State
• Verbal Instruction

Improved State
• Verbal Instruction
• Written Instruction
• Care Partner Education
• Safety Video
• Fall Prevention Video
Quality of Solution

Interactive Patient Care System

• Safety video
• Fall risk assessment
• Fall prevention video

Based on your answers, you are at risk for falling! We would like for you to watch a short video on fall prevention. This education is important and will give you tips on how to help prevent unnecessary injury throughout your hospital stay.

[Options: Watch Video Now, Remind Me Later, No, Thank You]
Structure

Effectiveness Formula

\[ Q \times A^2 = E \]

Quality of the solution
Acceptance & Accountability
Effective results
Acceptance of Solution

Change Acceleration Process

**Leading Change**

- Creating A Shared Need
- Shaping A Vision
- Mobilizing Commitment
- Making Change Last
- Monitoring Progress

**Changing Systems & Structures**
Acceptance of Solution

- Leading Change
  - Chief Nursing Officer
  - Directors
  - Safe Patient Mobilization Committee
Acceptance of Solution

• Creating a shared need

<table>
<thead>
<tr>
<th>THREATS (Ineffective)</th>
<th>OPPORTUNITIES (Effective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leave patient in bathroom - alone</td>
<td>1. Remain within arms reach of patient while toileting</td>
</tr>
<tr>
<td>2. Conduct shift report on unit or outside room</td>
<td>2. Conduct shift report in patient’s room at bedside</td>
</tr>
<tr>
<td>3. Communicate patient’s fall risk using visual symbols</td>
<td>3. Communicate patient’s fall risk visually and verbally to patient, family and all members of team</td>
</tr>
<tr>
<td>4. Follow physician’s activity order to determine toileting mode</td>
<td>4. Use MAT results to determine toileting mode, needed equipment and/or personnel</td>
</tr>
<tr>
<td>5. Create IPOC to meet documentation requirements</td>
<td>5. Create individualized patient IPOCs based on patient’s risk factors and reviewing at shift change</td>
</tr>
</tbody>
</table>

http://www.youtube.com/watch?v=BGltsVLbI1Q
Acceptance of Solution

• Shaping a vision
• Individual and collective vision
Acceptance of Solution

• Mobilizing Commitment

STOP Our Patients From Falling
Name: Shannon Steele
Unit: PT
1 thing I commit to start/stop/continue doing to prevent patient falls:
I will have a "post huddle" after my session with the patient's RN to communicate about their mobility and risk of falls.

STOP Our Patients From Falling
Name: Lauren Carter
Unit: 3W
1 thing I commit to start/stop/continue doing to prevent patient falls:
call light within reach. Always be within arms reach when in restroom or shower.

STOP Our Patients From Falling
Name: Ashley Santisteban
Unit: SWU
1 thing I commit to start/stop/continue doing to prevent patient falls:
ENGAGING IN PATIENT PARTICIPATION. HAVING THOSE AWKWARD CONVERSATIONS AND ENSURING SAFETY
Acceptance of Solution

- Making change last
  - Individual (Checklist)
  - Peer (Huddles, debriefs)
  - Charge/resource nurse (Rounding)
Acceptance of Solution

• Education - Simulation

Desire for Independence

Confused, Elimination Needs

Environment Scan

Oriented, Impaired Mobility
Accountability for Solution

- Set expectations for all care providers
- Teach to meet expectations
- Hold team members accountable
  - Leader rounding
  - Just Culture
Structure

Effectiveness Formula

\[ Q \times A^2 = E \]

Quality of the solution
Acceptance & Accountability
Effective results

DMAIC
CAP
Effective Results

• Monitoring Progress
  – SPM Committee oversight
  – Event debriefing/action plan/communication
  – Weekly fall report with recognition

• Changing Systems & Structures (Control)
  – Orientation and competency programs
Effective Results

- Reflective Learning

Reflective Learning Model (Adjusted for Debriefing)

1. What happened?
2. What was observed of affected staff?
3. How does their actions relate to standards/expectations?
4. What can be done differently?
Effective Results

• Rounding for quality

### Fall Risk/SPM Risk Report

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>&quot;Fall&quot;</th>
<th>Orientaion</th>
<th>Behavior</th>
<th>MINT</th>
<th>MRT</th>
<th>WT (kg)</th>
<th>SBP (mmHg)</th>
<th>TTD</th>
<th>MoBility</th>
<th>ManiFestation</th>
<th>Elimination</th>
<th>Pads Plx</th>
<th>Mod</th>
<th>PPC</th>
<th>EHR</th>
<th>WSH</th>
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<tr>
<td>MN4A - M NORTH ORTHO/NEURO-4A</td>
<td>Oriented x 4</td>
<td>-</td>
<td>Fall</td>
<td>Assisted, Assit balance</td>
<td>-</td>
<td>101</td>
<td>3</td>
<td>Assisted 1</td>
<td>Alert 0</td>
<td>Assisted 1</td>
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<td>0</td>
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<td>-</td>
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<td>-</td>
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<td>72</td>
<td>2</td>
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</tbody>
</table>

***** END OF REPORT *****
Effective Results

![Graph showing falls per 1000 patient days from 3Q10 to 4Q12 with a downward trend after training]
Effective Results

Patient Focused Always Events

- Those aspects of the patient and family experience that should always occur when patients interact with healthcare professional and the delivery system
Questions