

# California Hospital Engagement Network

Working to reduce patient harm by 40 percent and readmissions by 20 percent by the end of 2013.



## Falls with Injury Rate Reduction Dameron Hospital – Stockton, CA

### Aim Statement

Decrease Inpatient Fall with Injury Rate by 40% from 2011 baseline by December 31, 2013:

- Reduce Rate from 0.72 to 0.43 Falls per 1000 Patient Days.

**CMS Injury Benchmark: 0.50**

Why is this project important?

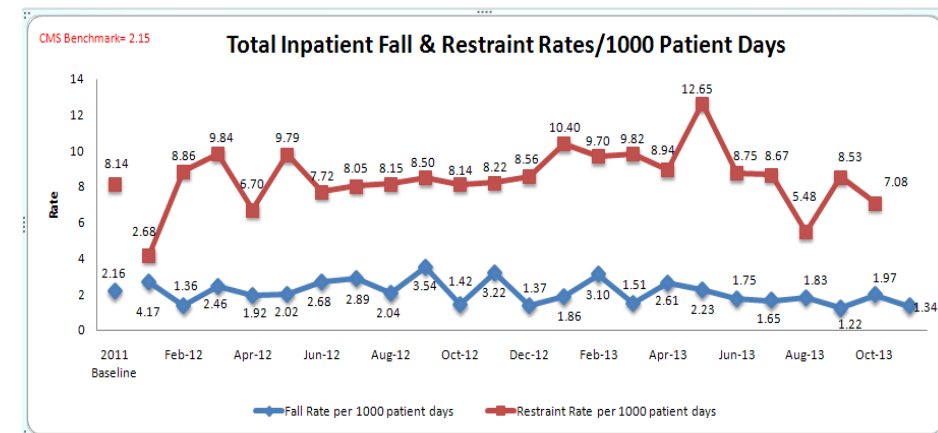
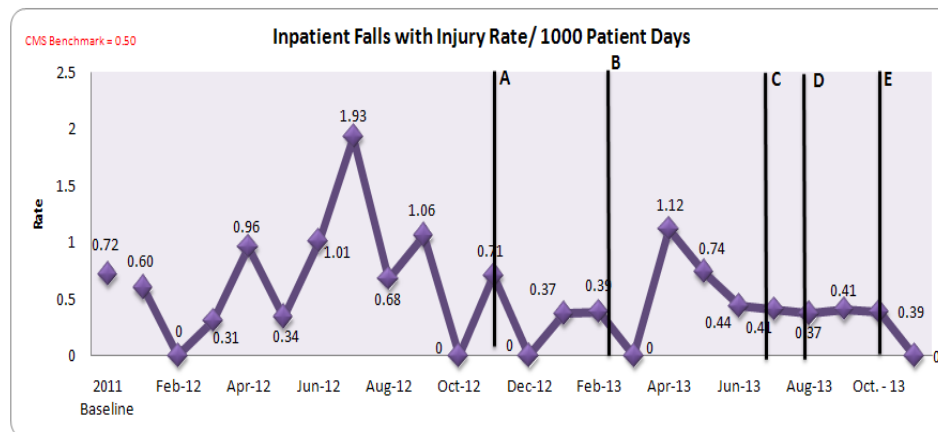
The Partnership for Patients estimates that 25% of fall injuries are preventable. Preventing injury will improve patient safety and satisfaction. Falls are the leading cause in inpatient injuries, increasing length of stay and health care costs.

### Changes Being Tested, Implemented or Spread

- A) -Initiated blue & yellow star system to Med/Surg, Telemetry, ICU/CCU (I)
- B) -Education rolled out to 4M on using Fall Risk Tool (T)
  - Post fall huddle to gather ~ 15 minutes after a fall on 4 Main (T)
- C) -Fall Risk Stop Sign Tests begin
- D) -Updated Morse Fall Scale
- E) -Patient Safety Contract/Transitioning Home Handouts begin, along with Fall Risk Stop Sign to use as visual cue for pts and hospital staff

### Run Charts

**Rate= Total Inpatient Falls or Restraints/Total Patient Days x 1000**



- Continuous audits for correct risk assessment and compliance with required High risk interventions and tests.
- Continuous audits of safety handouts, stop sign & patient understanding (teach-back).

### Lessons Learned

- Written instructions needed for patient education.
- Additions to shift change checklist for stop sign was helpful.
- Staff education reinforcement needed.

### Recommendations and Next Steps

- Educate & involve patient & family on fall risk assessment and their responsibility, using handouts & education.
- Enforce Hourly Rounding.
- Initiate Chair or Leg Alarms.
- Consider Enclosure Beds.
- Complete s/p fall huddle teaching to all part-time & per diem pharmacists and their role in huddle.
- Spread handouts and Stop Sign to Critical Care, Med/Surg/Telemetry units.
- Initiate teaching of the process for appropriately assessing patients at risk for falls with Versant students and new hires.

### Team Members

- Susan Hooper RN, Ortho
- Danae Sharp, Quality Analyst
- Matt Mitchell, RPh
- Abby Adesanya, Ass't Director Pharm
- Mary Lopez RN, Admin. Director
- Maria Mendez, EVS
- Chris Joyner, ED Director
- Jesse Loera, PT
- Stephani Walton RN, Staff Development
- Marsha Bridges, Critical Care Manager