Fall Protection and Prevention Program

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St. Elizabeth Healthcare

American Hospital Association

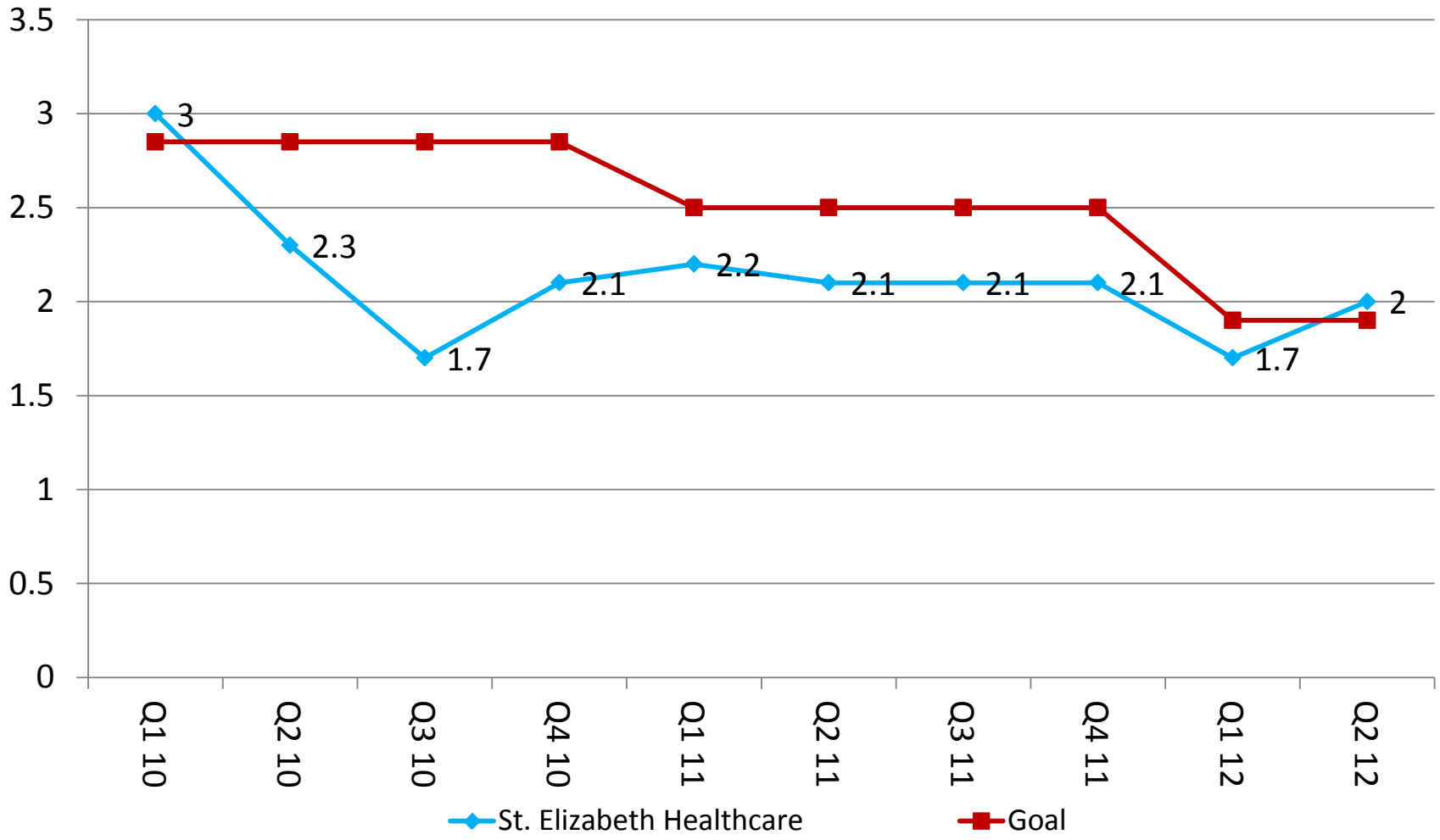
HRET
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

Objectives & About Us

- St. Elizabeth is a multi-facility Health Care System in Northern Kentucky – hospitals, diagnostic and treatment centers
- Multidisciplinary Council for oversight, review and recommendations
- System-wide roll out of new program May 19, 2010

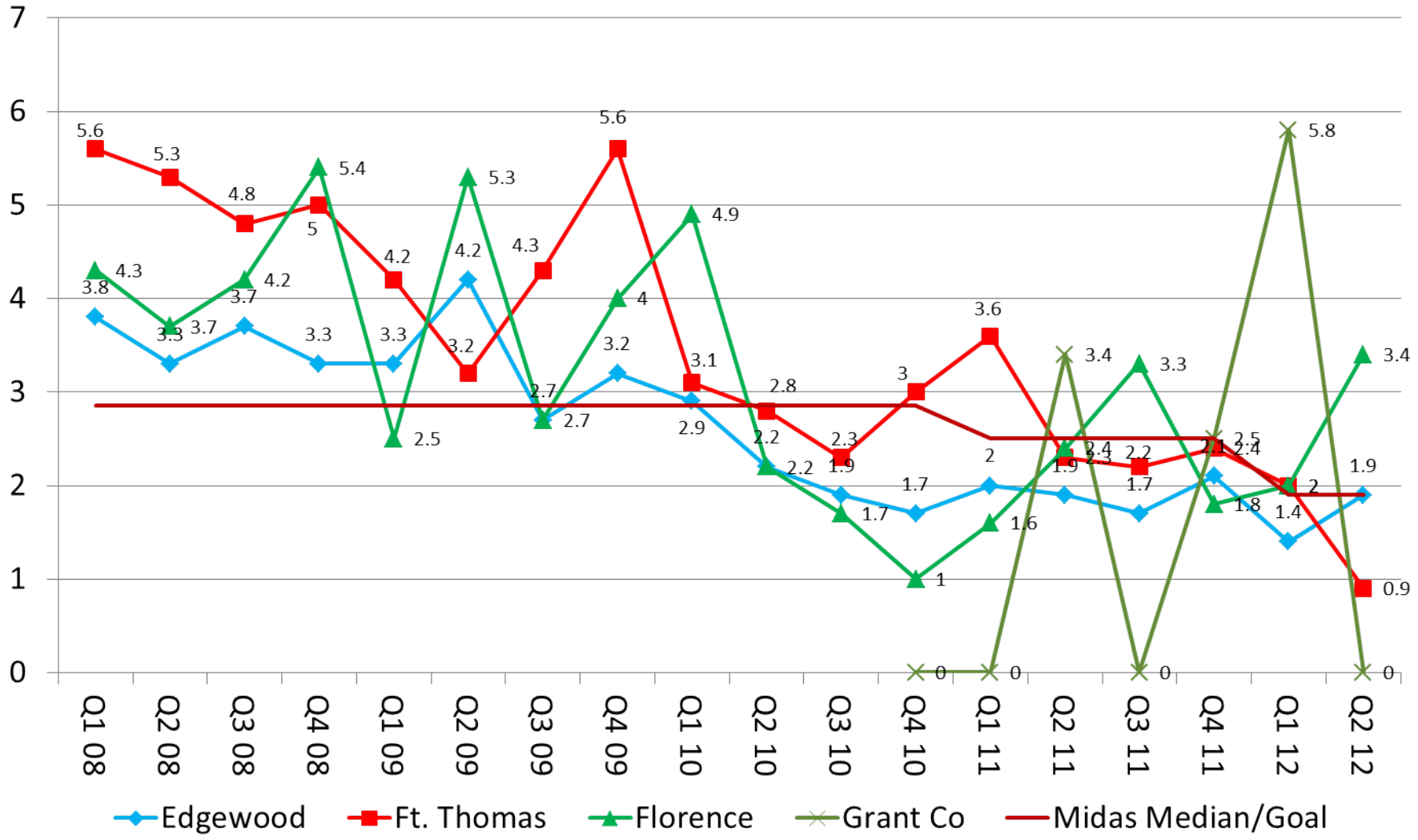
- **To create a system –wide Fall prevention program**
  - **To engage all associates in fall prevention**
- **To recognize that all patients are at risk at the time of admission**

St. Elizabeth Health Care
Acute Care Falls Per 1000/Pt. Days
All Facilities Combined



2ND Q 12 Data incomplete at time of report

St. Elizabeth Health Care
Acute Care Falls Per 1000/Pt. Days



What We Tested

- Everyone is responsible for an awareness of the environment, potential risks, answering lights and resolving issues [I Stop for Lights]
- Educational/marketing materials targeting direct care areas, ancillary departments, common areas, patients and visitors for the purpose of engaging everyone
- Tool kits for nursing and ancillary departments for staff education and ongoing monitoring
- **Bi-weekly meetings to review all falls/with a presentation of fall and action taken by the department in which the fall occurred**
- Color code fall risk in EMR/triggered by fall risk assessment

What We Learned

- Communications between shifts regarding “at risk” patients needed to occur [Safety Huddle]
- Each fall incident needed to be looked at when it occurred to identify the cause and what actions should be taken to reduce the risk of another fall [Fall Huddle]
- Patients and families needed ongoing education to better understand individual fall risk [Teach Back]
- A bi-weekly meeting of department leaders enhanced accountability and understanding and generated new approaches, i.e. diuretic time change
- **Hourly rounding was the most effective intervention when it consistently included the 3 Ps [toileting primary]**

Barriers & How we Resolved

- **Engaging all disciplines within the "system"**
  - Education sessions with all departments
  - Tool kits for all departments direct interactions with patients
  - Marketing displays directed at staff, patients, and visitors
  - Presentation monthly at system management meeting
  - Tied to "Gain Sharing"
- Better data collection and review
  - Revision of Midas – classification of falls
  - Audit tools for nursing managers
  - Monthly PI submitted for review to Quality – PDSA methodology

Barriers & How We Resolved

- Ongoing emphasis on fall prevention
  - Distribution of revised marketing materials for year 2
  - Brochure – patient/family education reviewed/distributed on admission
  - Bi-weekly meeting
  - Required annual education on Fall Prevention for all associates

- Encouraging independent functioning while ensuring safety
  - Increase involvement of therapy pre/post fall
  - **Remains an ongoing issue**

Ongoing Tests

- Yellow arm band to identify patients with recent fall history or when a fall occurs during hospitalization
- Color coding for moderate and high risk for fall on the EMR
- Trialing/purchase of fall prevention tools, i.e. “Potty Alarms”
- Brochure for patients/families on admission
- Educating visitors
- Medication dosage or administration time changes
- Scripting for hourly rounding

Advice for others

- System-wide program where everyone is responsible
- Explore Best Practice interventions
- Develop review/reporting process
- Review all falls:
  - Involve units/department where fall occurred
  - Involve ancillary departments as resource, i.e. pharmacy, maintenance
  - Communicate findings to units/departments
- Education/focus on prevention must be ongoing for staff, patient and visitors - revisit/revise
- Take the time to educate the patient about his/her risk factors/ involve the families and visitors

Wrap Up & Next Steps

- Next steps/goals:
  - Incorporate the patient in the post fall huddle
  - Falls frequently occurred when patients were left unattended in the BR [“Safety Trumps Privacy”]
  - Goal: fall rate of 1.7/1000 patient days 2012
  - Continue to look for best practices and approaches to enhance program