Fall Prevention Program

St. Catherine Hospital
East Chicago, Indiana
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American Hospital Association

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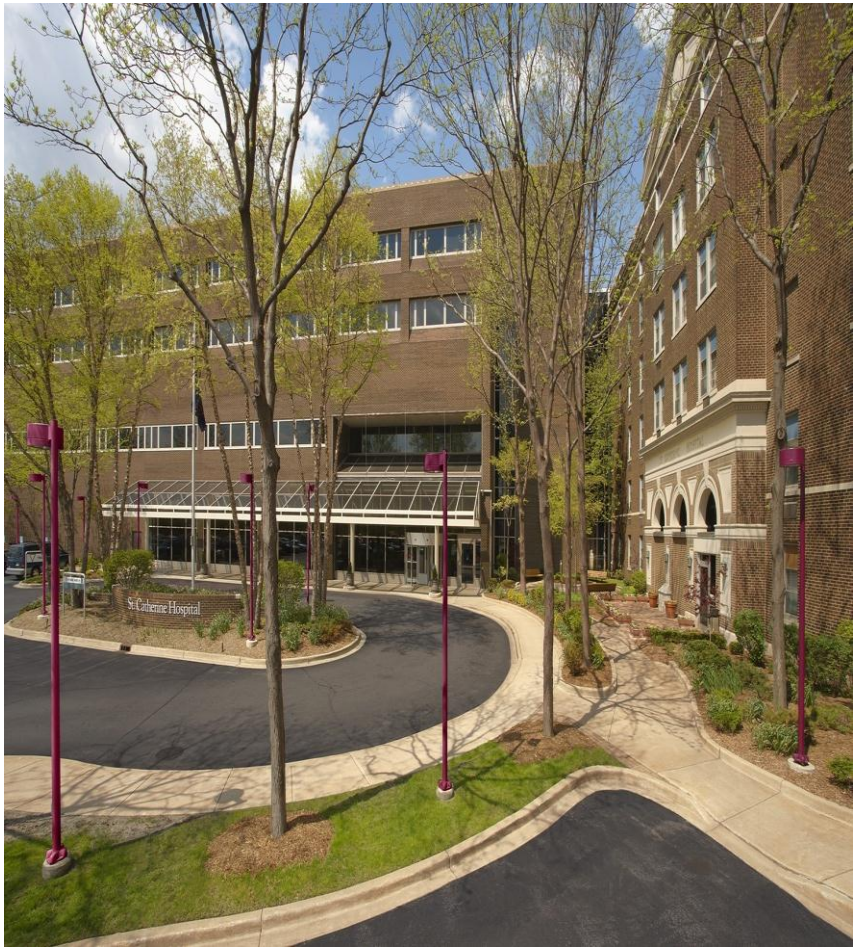
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

St. Catherine Hospital

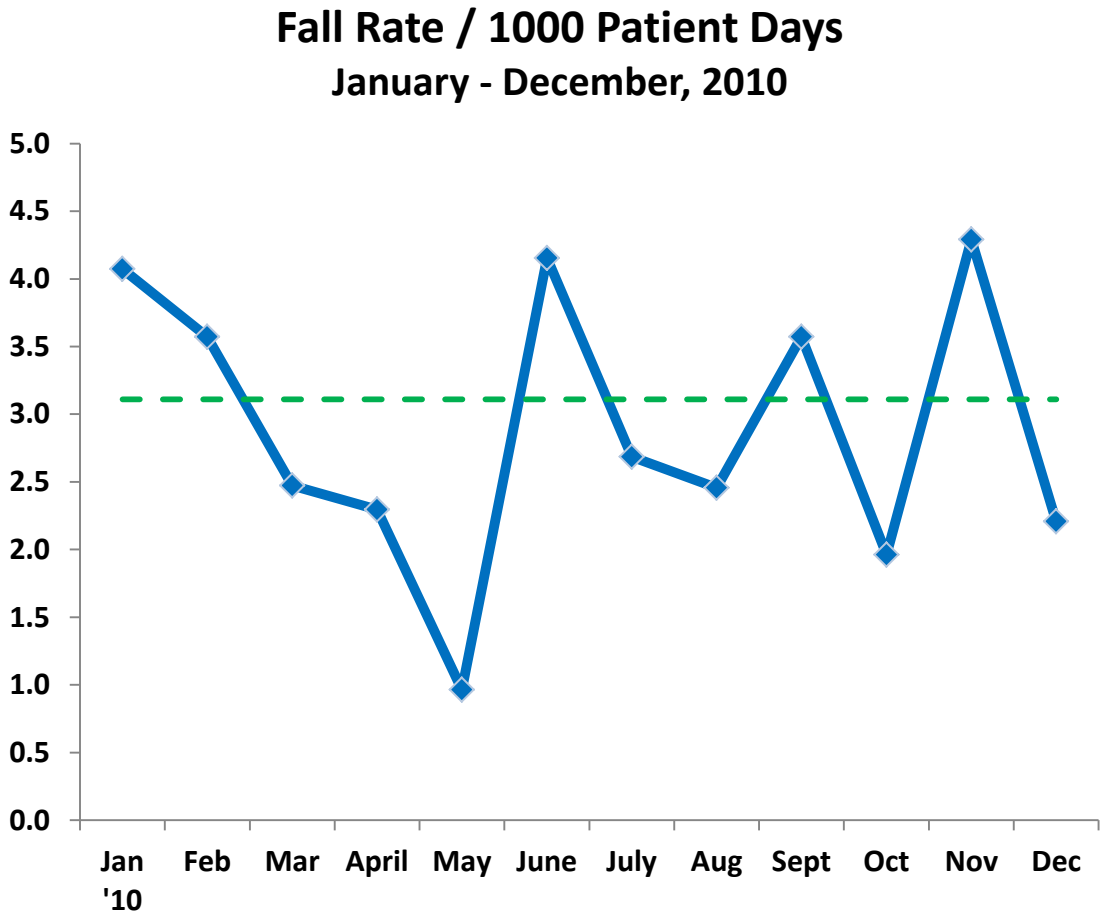


- 189 bed community hospital, located in East Chicago Indiana
- Member of – Community Healthcare System
- Licensed by the Indiana State Board of Health
- Fully accredited by Joint Commission
- Certified by Society of Chest Pain for the Chest Pain Clinic
- Certified by Joint Commission for the Stroke Disease Management

Objectives

- Describe our journey of our fall prevention program
- Share our successes, pains, and lessons
- Review our outcomes
- Discuss monitoring process to ensure improvement
- Share our goals for 2012

Where We Were in 2010?



- 126 Total Falls (excluding BHS)
- Overall Rate of 3.11 falls
- 2011 Goal to decrease falls by 20%
  - < 100 falls year end
  - Rate < 2.5/1000 patient days

Our Fall Program

- Developed and implemented “Home grown” fall risk assessment :
  - Comprehensive review of evidence
  - Identified common risk factors: Age, mental status, mobility, fall history, medications, alteration in elimination needs, use of ambulatory care devices
- Implemented Universal fall precautions for all patients
  - Use of visual/audible cues: yellow armband, bed alarms, non – skid footwear
  - Review of medications, beds in low position, call lights at bedside
  - Patient education and family involvement , orientation to surroundings
  - Environmental interventions: clutter free, no hazzards, etc
- Individualized interventions for high risk patients
  - Based on identified needs

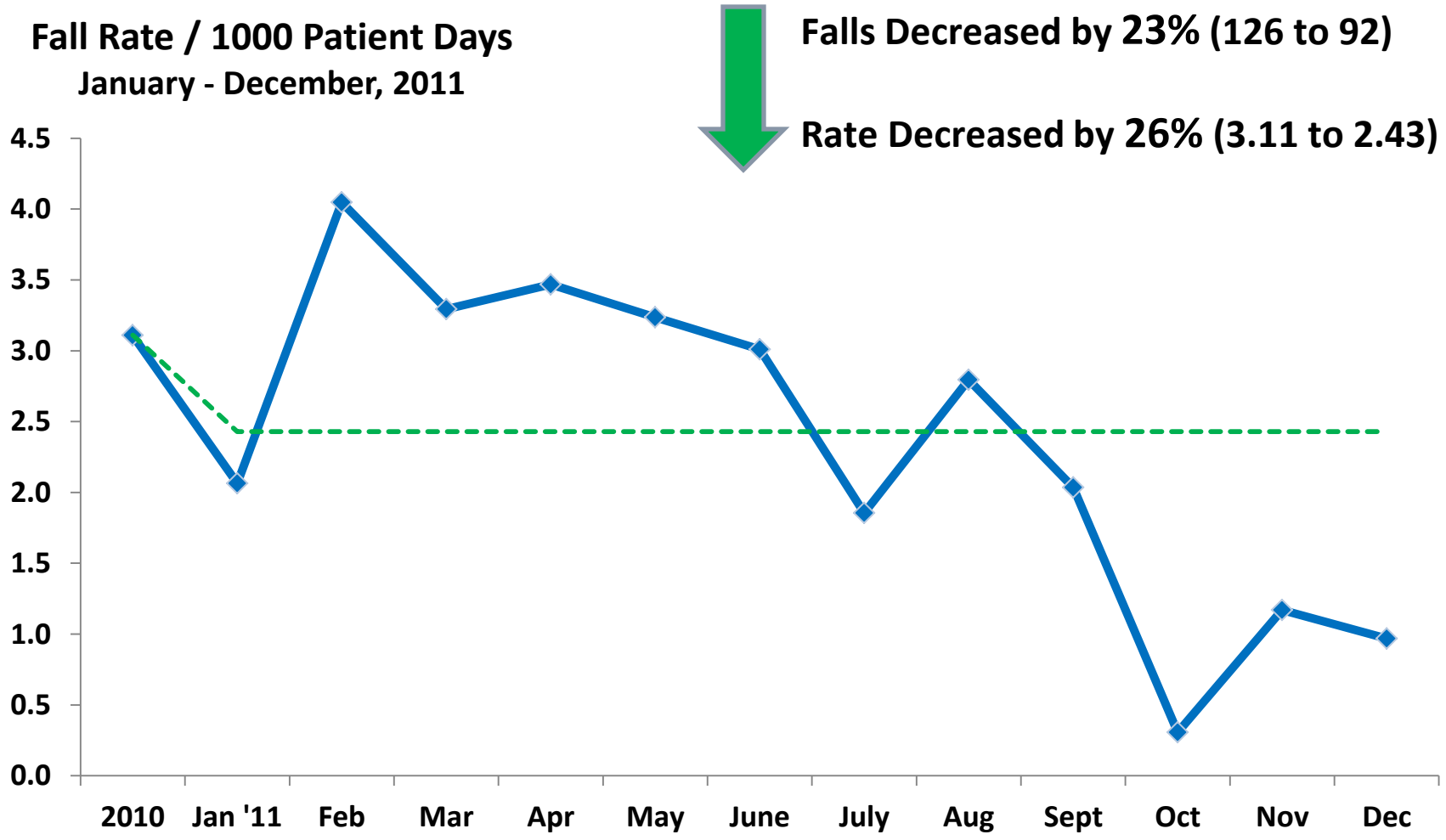
What Else Did We Do?

- Implemented hourly rounding with emphasis on addressing pain, position, and potty
- Implemented the “ No Passing Zone”
- Assessed falls for patterns
- Established a fall prevention guideline for radiology and other ancillary departments

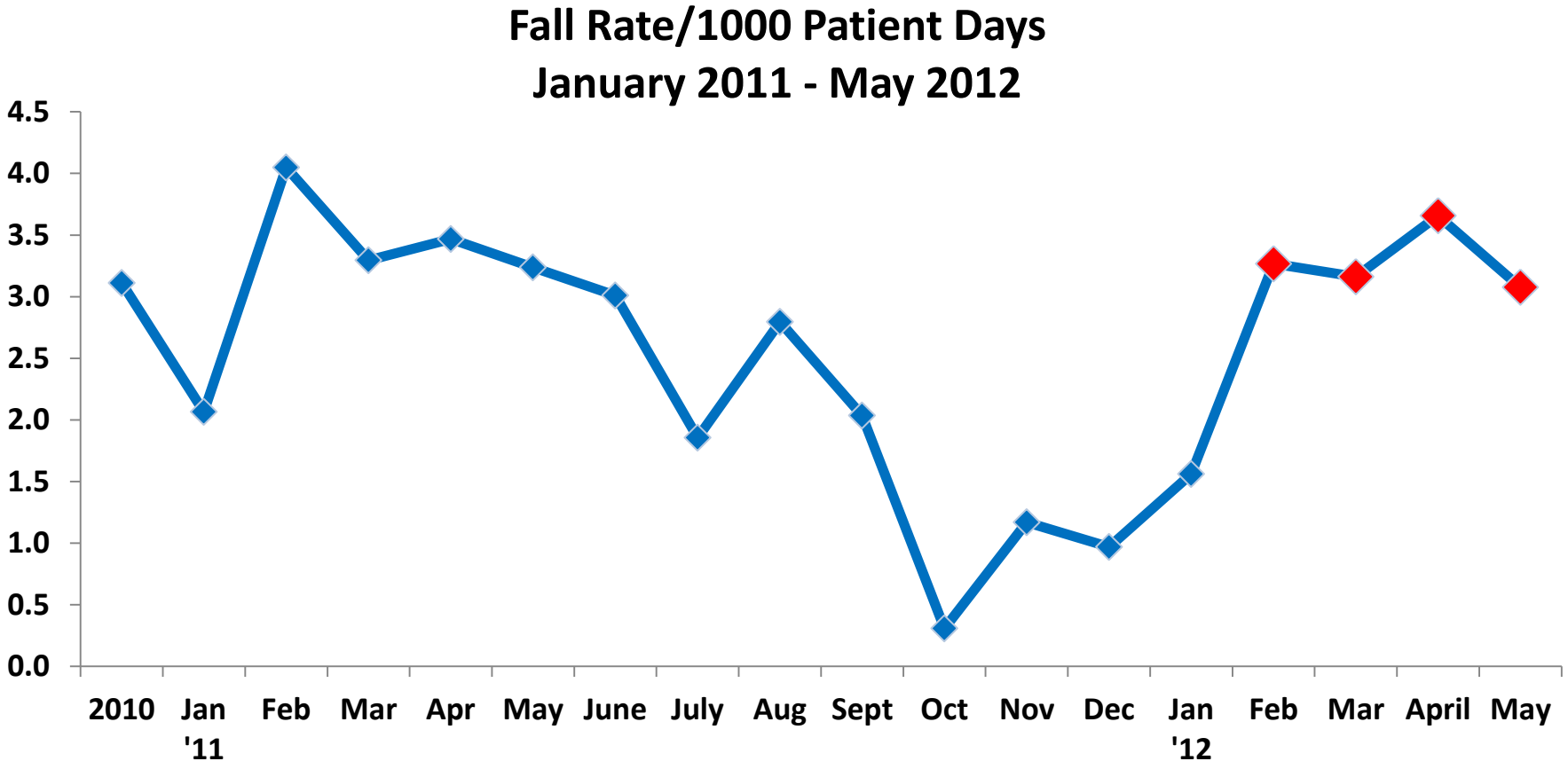
What Else Did We Do?

- Increased availability and use of bed alarms
- Improved hand – off communication to include patients who are high risk for fall
- Implemented “Root Cause Analysis” for every fall with managers and staff
  - What can we learn to prevent future occurrence?
  - Action plan developed based on based on analysis

Did it work?


Fall Rate / 1000 Patient Days
January - December, 2011
Falls Decreased by 23% (126 to 92)
Rate Decreased by 26% (3.11 to 2.43)
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2010
Jan '11
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec

But Then ……..


Fall Rate/1000 Patient Days
January 2011 - May 2012
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2010
Jan '11
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan '12
Feb
Mar
April
May

What Happenned?

- We went live on EPIC computerized clinical system in August of 2011
- Switched from the “home grown” fall risk assessment to Morse scale
  - Interventions for high risk for fall is the same for every body, not individualized
- Saw an increase in falls with our younger, more alert patients
- Did not include patients and families on our post fall analysis
  - Post fall analysis need to be done immediately after the fall

What are we doing now?

- Still use Morse scale, but only for screening
- Developed a fall risk assessment/re – assessment to be done every shift
  - Action plan is based on identified risk factors which is individualized
- Developed a risk for injury assessment using the ABC concept
- Changed from a post fall analysis to a post fall "huddle" to be performed immediately after a patient fall with input from patient/family

What are we doing now?

- Piloted new risk assessment/re – assessment process in July
  - Two nurses in Medical – Surgical floor for two days
- Initial feedback:
  - Nurses love the new form because it specifically targets the risk factors and what needs to be done
  - Minor tweaking of the forms per nurses recommendations
  - Buy in is better since this is their “baby”
- Staff re-enforcement of fundamentals of fall prevention

What's our next steps

- Inservice the staff on the newly developed tools
  - Risk assessment/re – assessment
  - Assessment for risk of injury
- Educate staff on the post fall huddle
- Housewide implementation after the inservice
- Increased patient education to "Please Call, Don't Fall"

Patient/Family Information

You Are Not Bothering Us!

We are here to help you get well and stay safe. Please remember:

- Use your call light. Your care and safety are our top priority!
- **A**lways **B**e **C**areful!

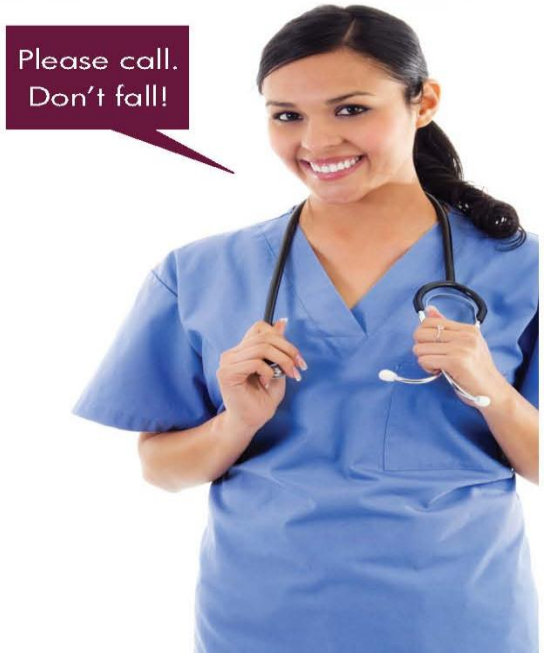
Remember Your ABC's!

ALWAYS
BE
CAREFUL!

Community Healthcare System® www.comhs.org

Community Hospital	St. Catherine Hospital	St. Mary Medical Center
Munster, Indiana	East Chicago, Indiana	Hobart, Indiana

Your Safety Comes First!



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Help Our Staff Members Prevent You from Falling!

Patient/Family Information

Please Call, Don't Fall!

Falls occur in health care settings for many reasons. There are several ways for patients to help staff prevent falls from occurring:

- Tell the nurse and/or physician of your physical limitations.
- Always use the call light before getting out of bed.
- Use your non-skid footwear when walking.
- Do not reach for items. Call for help!
- Family and friends are not qualified to help you walk. Call for help!

Who is at risk for Falling?

Everyone!

Community Healthcare System has discovered that some patients at risk for falling are alert-oriented adult patients of all ages.

Patients in the health care setting are at a higher risk for falling for a variety of reasons. Some of these reasons include previous falls, mental status changes, illness, side effects from medications, problems with balance and weakness as well as poor eyesight.

Safety and the patient's well-being are the highest priority for staff at Community Healthcare System.

Education

As health care professionals, we take pride in answering any questions or concerns that you may have. Please feel free to ask us any questions. The more you know about your care and safety in the health care setting, the safer you will be.

Please Call Poster

For Your Safety,
Please Call, Don't Fall.

Measures – What & How

- Continue to monitor and report by unit on a monthly basis:
  - Number of Falls
  - Number of Falls with Injuries
  - Fall Rate / 1000 patient days
- Units will add compliance to the new forms to their monthly QI data monitoring
- Analyze the result of the post – fall huddle to get to the root of the problem and implement action plan accordingly
- New goal is to have no major injury due to falls by end of 2013.
- Concentrate on the preventable falls
  - In addition to tracking severity of falls will begin classifying falls as preventable or non-preventable

Questions?

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