



Hospital Story

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Objectives and About Us

- Objective – Share Patient Fall Prevention Activities, Barriers and Successes
- Union Hospital, Terre Haute, IN
 - 380 bed acute care facility
 - Largest hospital between St. Louis and Indianapolis
 - 2010 New Facility Addition



Team Formation

- Clinical Fall Team –Reinitiated March 2012
 - Front Line Staff
 - Therapy
 - Pharmacy
 - Addressed as a system- CAH
- Collaboration with University
 - Research Students
- Senior Leader Support



AIM and Measure Selection

- Critical Success Factor
 - Falls reduction goal for organization
- AIM
 - Reduce patient fall rate to \leq 2 per 1000 patient days by end of fiscal year 2012
 - Reduce severity of patient injury as a result of falling



Tests of Change

- Yellow- the official color of falls
- Equipment
 - Chair alarms for every room
 - Bed Alarms and zone assignment
 - Gait belts
 - Double sided slippers
- Staff
 - Hourly Rounding & Patient Handoff
 - Fall Huddles/ Team Huddles
 - Education Rounding- cost of falls
 - Monthly fall data distribution- by Overall Rate & Unit Rate
 - Surveyed on understanding of fall assessment & prevention
 - High risk fall patients attended while in bathroom



Tests of Change

- Technology
 - Bed/Chair alarms linked to staff members wireless communication devices
 - Yellow Corridor Lights
 - Yellow Magnets
- Sitters
- Fall Assessment Tool
- Patient Education
 - Education channel & in patient packet upon admission
- Team reviews fall data detail monthly
 - Peer Review
- Daily Check In



Barriers, and How We Resolved those Barriers

- Equipment
 - Bed and Chair Alarms
 - Beds- Zone Re-Education
 - Maintenance notification of check if fall occurs
 - Chair- unable to locate in room, battery life
- Fall Assessment Tool
 - Selection of new tool
- Assessment of monthly fall data include medication
 - Vice President of Medical Affairs
 - Look at Pharmacy Interns



Advice for Fellows

- Front line staff to lead change
 - Senior Leader Support
- Present education to staff- consider including cost of a fall.
- Increase frequency & visibility of fall data
 - Competitive
 - Creative
- Be ever mindful of re-education needs



Wrap Up and Next Steps

- In summary- Work to Continue
 - Improvements in numbers:
 - 15% decrease in number of falls
 - 50% reduction in our fall injury rate
- Next Steps
 - Finalize fall and risk for injury assessment tools.