Hospital Story

Stephanie Strohl, RN
System Manager – Quality Management
Union Hospital, Terre Haute, IN
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
• Critical Success Factor
  – Falls reduction goal for organization

• AIM
  – Reduce patient fall rate to =/< 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.