It’s Not a Free-Fall
Leadership Counts!

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August 29, 2017
Objectives

• Identify key elements of an effective falls prevention program.
• Discuss implementation strategies for drivers of improvement in falls prevention.
• Identify barriers to improvement and suggested responses.
Why Falls With Injury

- Falls are the 3rd most likely cause of death for adults > 65 years old.¹
- Fall-related traumatic brain injuries (TBIs) account for 2.5 million emergency department (ED) visits per year.²
- Inpatient falls are estimated to add $4,200 to $27,000 per incident to an inpatient stay.³
- Public health issue—2015 rate of death from falls:⁴
  - CA 39 per 100,000
  - TX 47 per 100,000
  - AZ 82 per 100,000
  - OH 60 per 100,000
  - HI 53 per 100,000

1. National Center for Health Statistics 8/19/17
4. AARP USA Databank
Falls With Injury All Acute Care Units

Baseline (CY 2014) | Current (2017Q1)
--- | ---
Falls with Injury per 1,000 Patient Days | 0.51 | 0.50

Lower rate = better performance

Source(s): Collaborative Alliance for Nursing Outcomes (CALNOC) data and Hospital Self-Reporting data.
Note: Relative Improvement Rate equals baseline minus current evaluation period divided by baseline.
Falls With Injury All Acute Care Units (cont.)

**Source(s):** Collaborative Alliance for Nursing Outcomes (CALNOC) data and Hospital Self-Reporting data.

**Note:** Relative Improvement Rate equals baseline minus current evaluation period divided by baseline.
Protecting our Patients
Telling our Stories

Providence Holy Cross Medical Center
St. Joseph Health System Mission Hospitals
Palomar Health
PROVIDENCE HOLY CROSS MEDICAL CENTER

Kate Connolly, MSN, RN
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Director of Nursing Research, Magnet Program and Professional Role Development
Hospital Story of Improvement

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PROVIDENCE HOLY CROSS MEDICAL CENTER
MISSION HILLS, CALIFORNIA
About Us

• PHCMC has 377 beds and an average daily census: 216.
• PHCMC is nationally recognized for clinical performance and trauma care and is the only community hospital in the San Fernando Valley to receive ANCC Magnet® designation since 2007. It is one of only two 24/7 trauma centers in the San Fernando Valley with ED Visits: >110,000
• Services Include:
  • 24 hour Level 1 Trauma Center/Emergency Care
  • Cancer Center
  • Gastrointestinal Lab
  • Heart Center
  • Maternity Center with Baby Friendly Designation
  • CCS Designated NICU
  • Neurosciences and Rehabilitation with TJC Stroke Certification
  • Orthopedics
  • Surgery
  • Sub-Acute Unit
49 month Avg = 1.64 Falls/1000 Pt. days
Yearly Analysis 2016

Medication Class Associated with Fall/Slip 2016

- Antidiabetic: 1
- Anticoagulant: 1
- Anti-inflammatory: 1
- Antifungal/Antibiotic: 2
- Diuretic: 3
- Anticholinergic: 3
- Antiparkinsons: 3
- Muscle Relaxer: 3
- Antihistamine: 4
- Antipsychotic: 6
- Antidepressant: 6
- Other: 6
- Hypnotic: 9
- Anticonvulsant: 9
- Antihypertensive: 13
- Benzodiazepine: 19
- Opioid/Analgesic: 43
What We Did

• Changed signage 2 years ago
• Added bed alarms
• Revamped the falls council to include a community member, pharmacy, and environmental services (EVS)
• The community member left this spring and EVS never consistently came
• Pharmacy analyzed all falls for 1 year to see if they were medication related and gave us the top categories to watch for
Bed Alarms

• On all high-risk fall patients

• Challenges:
  – Bed alarms do not connect between North and South towers
  – Staff not turning them on
  – Alarm fatigue
  – Staff not in close proximity—don’t hear them
Red Socks

- For all patients indicated on Morse Fall as high risk

- Challenges
  - Poor roll out
  - Poor understanding of the purpose
  - Patients up walking independently with red socks on
  - Family wearing red socks
Telesitter

• Begun 2017
• Trained CNAs for this role

• Challenges:
  – Unexpected downtime
  – Oversight of staff and clear expectations
  – Determination of appropriate patients
  – Getting staff on board
Barriers and Challenges

- Clinical Institute Withdrawal Assessment (CIWA) patients
- Smokers
- When telesitter goes down
- CNA hours/balanced budget/one-to-one sitters
- Bed alarm issues
Current Data

49 month Avg = 1.64 Falls/1000 Pt. days
Where We Are

- Morse Fall Risk on every shift, after transfer and after a fall
- 2016 below 2015
- 2017 is above 2016
- Raw number in July: 19!
- Continued discussion on definitions
- Debriefing after falls
Advice for Others

UPSTREAM - DOWNSTREAM

• Very successful CAUTI reduction initiative
  • Indwelling catheters D/C sooner
    • Patients need to use the bathroom more frequently and faster!
    • Patients are up sooner and less steady
  • More falls!
Patient and Family Engagement

• Patient Education Agreement
  – Trialed in two units
  – Poor support for added work
  – Risk management nixed calling it a falls contract
  – Determine purpose
  – Repeat during patient transfer?
Thank You!

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Saint Joseph Health System Mission Hospital: Mission Viejo & Mission Laguna

June Melford RN-BC, MSN, CRRN
Gerontological Clinical Nurse Specialist
Fall Prevention Program at Mission Hospital: Evidenced-based Projects

June Melford MSN, RN-BC, CRRN
Gerontological Clinical Nurse Specialist
Mission Hospital
About Us

• Mission Hospital is a 495 bed, community, not-for-profit, Catholic, hospital with two campuses.
• Located in south Orange County, California.
• The hospital is part of the Providence Saint Joseph Health System
• Level II trauma center, ED visits 80+K
• Earned Magnet designation twice
Where We Were

- Fall Prevention taskforce re-engaged in 2011
  - Unit-based RN champions, meet monthly, CNS led
  - Review fall data
  - EBP projects
  - Role and responsibilities
    - PDF attached

- Unit level trended analysis
  - Post fall huddles and review EMR -> excel/graphs -> share with unit shared governance councils in order to develop unit level action plans
Fall Analysis

• Using performance improvement techniques, we began tracking the TOP contributing factors to Injury falls. Previously had decreased falls related to not using bed alarms.

• In Nov. 2016, 57% of injury falls were related to being left alone in the bathroom.

• Falls taskforce began an evidenced based project using the Johns Hopkins Nursing Evidenced-Based Practice Model on falls related to toileting in autumn 2016.
What We Did

In 2016, 57% of Mission Hospitals Falls with Injury were related to toileting. The Fall Prevention Taskforce reviewed the evidence and developed the S.A.F.E. Toileting Campaign.

S = Scheduled toileting

A = Do Not leave ALONE in the bathroom when patient has cognitive or balance problems

F = Fall Prevention Agreement with “Teach Back” – remind patients WHY they are at fall risk

E = Early mobility and use of safe patient handling Equipment

1. Patients identified as HIGH risk for falls will have Scheduled Toileting every 2 hour
   - Patient must be taken to the toilet not just offered toileting.
   - Sample scripting:
     √ “I have time now to take you to the toilet”
     √ “Would you like to go to the bathroom now or in a minute?”
     √ “It’s time for a bathroom break”
     √ “Let’s try to use the bathroom before you______” (i.e.: go for a walk, sit up in chair, go to therapy)

2. Do Not Leave Alone on the toilet - Must Stay within Arm’s Reach for patients who have Cognitive impairment or Balance problems.
   - Sample scripting
     √ “The most common place patient’s fall is in the bathroom because you have been identified at risk for falling. I will stay in the bathroom with you but will respect your privacy as much as possible.”

3. Patient Fall Prevention Agreement is to be completed with each patient on admission and put on the whiteboard for staff and family reference – you can use this to remind the patient WHY they are at risk for falling and to engage their cooperation.

4. Use safe patient handling Equipment for patient and your safety & encourage Early mobility to prevent patients from getting weaker while hospitalized.
Patient CareTech training in Nov 2016 with interactive scenarios done in small group in Skills Day, led by CNS

1. How often they would take this patient to the bathroom?
2. If they could leave this patient alone in the bathroom?

Example Scenarios:

- 83 yo/F POD 2 hip replacement surgery. Walks with walker min A, wears glasses. ID as high fall risk.
- 64 yo/M heart failure, taking meds that increase voiding. Walks with unsteady gait, when you took him to BR for a BM Identified at mod fall risk.
- 76 yo/M surgical patient demanding to be left alone in the BR, confused. Walks steady with walker, identified as high fall risk.
- 60 yo/F S/P mastectomy, on pain med and IV fluids. Walks on her own, Identified at mod fall risk.
### Fall Prevention Agreement

**Let's prevent falls together**

**Call, don't fall**
- If you fall while in the hospital, this could:
  - Increase your time in the hospital.
  - Increase the length of your recovery.
  - Be very painful or create new injuries.

**Do:**
- Call for help; we are here to assist you.
- Move slowly when changing position.
- Wear your glasses or hearing aids.
- Use handrails in bathrooms and hallways.
- Wear non-skid socks.

**Do not:**
- Climb over the bedside rails.
- Use the bedside table or IV pole for support.

#### What we may do to keep you safe:
- Keep your room tidy and uncluttered.
- Accompany you to the restroom, but provide you with as much privacy as possible.
- Use walkers or gait belts to help support you while walking.
- Use a bed or chair alarm.
- Make rounds every hour to ensure all of your needs are met.
- Review your medications.

#### Answer the questionnaire on the back of this form with your nurse to determine your risk of falling while in the hospital.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Why is this important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have had a fall in the past year.</td>
<td>☐</td>
<td>☑</td>
<td>People who have fallen recently are likely to fall again.</td>
</tr>
<tr>
<td>I am weaker than I normally am.</td>
<td>☐</td>
<td>☑</td>
<td>Not being as strong as you expect can increase your risk for falling.</td>
</tr>
<tr>
<td>Sometimes I need to rush to the toilet.</td>
<td>☐</td>
<td>☑</td>
<td>Rushing makes you unaware of your surroundings and can make you unsafe.</td>
</tr>
<tr>
<td>I have issues with pain.</td>
<td>☐</td>
<td>☑</td>
<td>Guarding against pain can affect balance.</td>
</tr>
<tr>
<td>I am not eating or drinking as much as I used to.</td>
<td>☐</td>
<td>☑</td>
<td>Dehydration and low blood sugar can make you weak or dizzy.</td>
</tr>
<tr>
<td>I have impaired vision or use eyeglasses.</td>
<td>☐</td>
<td>☑</td>
<td>You may have impaired visual judgment or difficulty finding stable footing.</td>
</tr>
<tr>
<td>I have lost feeling in my hands or feet.</td>
<td>☐</td>
<td>☑</td>
<td>This decreases your stability while standing and walking.</td>
</tr>
<tr>
<td>I am taking pain medications.</td>
<td>☐</td>
<td>☑</td>
<td>You can become dizzy or sedated with these types of medications.</td>
</tr>
<tr>
<td>I take medications for diabetes.</td>
<td>☐</td>
<td>☑</td>
<td>Fluctuations in blood sugar can make you tired or dizzy.</td>
</tr>
<tr>
<td>I take medications for my mood or to sleep.</td>
<td>☐</td>
<td>☑</td>
<td>You may become sedated, weak, or dizzy with these medications.</td>
</tr>
<tr>
<td>I am taking medications that can make me light headed or weak.</td>
<td>☐</td>
<td>☑</td>
<td>These symptoms increase your risk for falling. For example, new or change in dosage of many medications like heart medications or bowel preps.</td>
</tr>
<tr>
<td>I am in a new, unfamiliar environment.</td>
<td>☐</td>
<td>☑</td>
<td>Being in a new and unfamiliar environment increase risk of falling.</td>
</tr>
<tr>
<td>I steady myself by holding onto furniture.</td>
<td>☐</td>
<td>☑</td>
<td>Furniture support is not always reliable and may cause you to fall if it moves.</td>
</tr>
<tr>
<td>I have IV's or other devices attached to me.</td>
<td>☐</td>
<td>☑</td>
<td>You may trip over lines or wires. Being tethered to a device can affect your balance.</td>
</tr>
<tr>
<td>I have been asked to use a walker or cane to walk.</td>
<td>☐</td>
<td>☑</td>
<td>Not using these devices correctly increases risk for falls.</td>
</tr>
<tr>
<td>I don't want to bother the staff; I will do it myself.</td>
<td>☐</td>
<td>☑</td>
<td>The staff is here to help you and don't want you to get injured. Let us help. - Call, Do Not Fall!</td>
</tr>
</tbody>
</table>

**Let's prevent falls together.** This agreement is intended to educate you and your family about ways to prevent falls while in the hospital. By signing below, you are agreeing that you have answered the questionnaire on the reverse and understand the steps to take to prevent falls.

**Patient / Family Member**

**Date**

**Time**
Challenges

1. Lack of a unit fall prevention champion
2. Education delays
   • PCT Skills Day—Nov. 2016
   • RN education delayed till August 2017
3. Mission Hospital core value of “Dignity”
   • Very difficult for staff to not leave patients alone in the bathroom if they requested this.
   • Had to do a lot of coaching with scripting that patient safety wins over privacy.
4. Multifactorial problem so addressed with many interventions at the same time including
   • Bed alarms, pictograms, SPH training, remote monitoring.
Current Data for Mission Hospital

Measure: Injury Falls Per 1,000 Patient Days

Implementation Period

<table>
<thead>
<tr>
<th>Metrics</th>
<th>2015 Q2</th>
<th>2015 Q3</th>
<th>2015 Q4</th>
<th>2016 Q1</th>
<th>2016 Q2</th>
<th>2016 Q3</th>
<th>2016 Q4</th>
<th>2017 Q1</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-Standardized Score</td>
<td>-0.39</td>
<td>-0.37</td>
<td>-0.22</td>
<td>-0.27</td>
<td>-0.31</td>
<td>-0.03</td>
<td>-0.51</td>
<td>-0.34</td>
<td>-0.31</td>
</tr>
<tr>
<td>Mean</td>
<td>0.01</td>
<td>0.00</td>
<td>-0.00</td>
<td>-0.02</td>
<td>-0.02</td>
<td>0.01</td>
<td>0.02</td>
<td>0.02</td>
<td>0.00</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.52</td>
<td>0.48</td>
<td>0.41</td>
<td>0.44</td>
<td>0.43</td>
<td>0.43</td>
<td>0.45</td>
<td>0.45</td>
<td>0.45</td>
</tr>
</tbody>
</table>
Current Data

• 25% decrease in falls related to toileting—57%-> 42%.
• Improved patient engagement.
• Evidenced-based safe toileting interventions for which nursing expectations are identified.


Thank You!

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Palomar Health

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Director Quality, Patient Safety and Infection Control

Eva Bunny Krall APRN MSN ACNS-BC CDE
CNS Quality and Patient Safety
Creating a Culture of Safety: Fall Prevention, Sunflowers in Bloom

Valerie Martinez  RN BSN MHA CIC CPHQ NEA- BC
ACNS-BC CDE
Director Quality, Patient Safety and Infection Control

Eva Bunny Krall APRN MSN
CNS Quality and Patient Safety
Objectives

Upon completion of the presentation, participant will be able to:

1. Describe interventions taken at Palomar Health to support Fall Prevention
2. Discuss Code Sunflower and Associated Outcomes
Palomar Health

Mission
The mission of Palomar Health is to heal comfort and promote health in the communities we serve.

Vision
Palomar Health will be the health system of choice for patients, physicians, and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services.
Where We Were

- Fall rates escalating and fall with death: 2016
- Lack of standardization of fall prevention practices across the health system
What we did

Revitalize the fall team (Included Patient Family Advisory Member)
  – Review the literature
  – Incorporate the latest evidence-based interventions into practice
  – Standardize practice

Behavior expectations for all

Bring additional support to the bedside post fall: Code Sunflower (Rapid Response Nurse RRN)
Identifying Fall Risk Patients

1. FALL RISK wristband
2. Yellow No-Slip Socks
3. Slip-resistant floor mat
LEAF Behaviors Expectations

L  LOOK into the room

E  Evaluate/Enter

A  Alert the Nurse

F  Follow through
Code Sunflower

- Post Fall
- Rapid Response Nurse (RRN)
- Additional support to the bedside (Assessment)
- Post Fall Huddle WHY
3 month pilot July–October 2016

• Identified one patient with new stroke symptoms – stroke code; Rec’d TPA, Positive Outcome

• Reinforcement of bedside staff to call Code Sunflower

• Implement across Health System
Barriers and Challenges

Standardization
• Address a lot of variation in practice
• Recommend changes to staff on Safety Team, approval at patient safety

LEAF Behavior Expectations
• Reinforce, educate all (hard to reach all providers)

Code Sunflower
• Philosophy of quiet environment
• RRNs are a great resource: Motivate about Fall Prevention
• Additional Training for the RRN
  Already trained in trauma
  Getting to the “WHY” of the fall
• Staff not wanting to call a code sunflower
• Updated electronic RRN documentation in April 2017—DOCUMENT
RRN Documentation

Also have documentation screen for interventions/outcomes

Document Code Sunflower
Data: Inpatient overall

Patient Falls per 1000 Patient Days

- Palomar Health
- 25th Pctl
- 50th Pctl

Sunflowers Blooming

<table>
<thead>
<tr>
<th>Quarter</th>
<th>CY15Q1</th>
<th>CY15Q2</th>
<th>CY15Q3</th>
<th>CY15Q4</th>
<th>CY16Q1</th>
<th>CY16Q2</th>
<th>CY16Q3</th>
<th>CY16Q4</th>
<th>CY17Q1</th>
<th>CY17Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>1.83</td>
<td>2.11</td>
<td>1.46</td>
<td>1.73</td>
<td>1.62</td>
<td>2.28</td>
<td>1.22</td>
<td>1.54</td>
<td>1.94</td>
<td>1.25</td>
</tr>
</tbody>
</table>
### Current Data RRN (4/01/2017 to 7/31/2017)

<table>
<thead>
<tr>
<th>FALLS Month*</th>
<th>Total Falls</th>
<th>Escondido Campus</th>
<th>Poway Campus</th>
<th>No Injury</th>
<th>Minor</th>
<th>Major</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>11</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>*1</td>
</tr>
<tr>
<td>June</td>
<td>14</td>
<td>11</td>
<td>3</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>31</td>
<td>11</td>
<td>35</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Campus Code Call Summary

<table>
<thead>
<tr>
<th>Campus</th>
<th>Total number Code Sunflowers/Total Falls</th>
<th>% call Code Sunflower</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escondido Campus</td>
<td>21/31</td>
<td>67.7%</td>
</tr>
<tr>
<td>Poway Campus</td>
<td>9/11</td>
<td>81.8%</td>
</tr>
<tr>
<td>Inpatient System</td>
<td>30/42</td>
<td>71.4%</td>
</tr>
</tbody>
</table>
RRN Data of 30 Code Sunflowers

OUTCOMES of CODE SUNFLOWER
• 28/30 Remained on the unit
• 1/30 Transferred to Critical Care
• 1/30 Home

INTERVENTIONS
• Education of Staff and Family (10)
• CT Head (2) Orthostatic VS (3) 1 fluid
• POC Glucose (5) Sitter (1)
• C Collar (2) Discontinue lines (2)
• Rehab consult (2)
Advice

• Keep everyone energized and excited about falls
• Provide feedback about documentation, interventions, behaviors to sustain the change
• Electronic documentation early so able to pull data
Next Steps

RRNs

- Work with POWAY campus to document Code Sunflower
- On-going education of RRN
- Work w/safe patient handling for lift plan post fall
- Re-energize on Fall Prevention Day
- Opportunity to highlight your team wearing yellow
Thank You

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- Bunny Krall
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- 442-281-4268
Questions?
Key Take Aways

• Medication Analysis
• Balancing Measures
• SAFE Toileting Campaign
• Patient Family Engagement
• Behavioral Expectations
• Code Sunflower
What are you going to do differently

• Tomorrow?
• Next week?
• In the community?
Thank you!

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