



# *Patients First* Webinar Fall Prevention: Sharing Strategies

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# Overview & Introductions

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# Strategies for Fall Prevention

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# Fall Factors

- *Patient falls are the leading cause of injury related death for patients over 65 years of age.*
- *Elderly patients often have health conditions that create physical inactivity, frailty, or balance problems.*
- *Institutional factors compound fall risk*
- *Most falls happen the first few days of admission*

# What did we find from our statewide survey?

- *30 Hospitals sent in fall risk policies and programs*
- *Each hospital had consistent fall prevention programs including:*
  - *Using a standardized fall assessment*
  - *Visually identifying patients at risk for fall*
  - *Instituting frequent toileting routines*
  - *Using bed and chair alarms*
  - *Using patient monitors for patients who are very high risk for falls*
  - *Conducting post fall investigations*

# What impacts fall rates?

- *Various techniques teaching fall prevention education and strategies to prevent falls in the home*
- *Screening patients at risks for fall and pairing their individual risk with specific interventions for their risk factor. (Salsbury Lyons, 2005)*

# Evidenced based risk fall assessments have the following elements:

- *history of falls*
- *difficulty in transferring*
- *assessment for dizziness and balance issues*
- *assessment for confusion*
- *assessment for visual impairment*
- *medication analysis*
- *assessment for incontinence and frequency*

# Prevention Strategies

*If all institutions are using the known fall prevention strategies for their risk for fall patients.....*

*The key may be looking at your data to diagnose how to improve your hospitals fall rates*

# There are several proven fall assessments

- *Morse Fall assessment*
- *Schmid fall assessment scale*
- *Hendrich II Model*

*What happens when the patients who are falling have not rated high risk for fall on your screening tool?*

# Examining Inter Rater Reliability of Your Assessment Tool

- *More research is needed in examining the ease of use of various fall assessments since the success of any institutional fall prevention program targets the patients who are assessed to be at high risk for fall.*
- *Correct interventions are applied to the correct patient and risk factors.*  
*(Papaioannou, 2004) (Salsbury Lyons, 2005)*

# On going assessment to identify the correct risk factor

- *Dietary Alterations*
- *Medication Alterations*
- *Exercise Alterations*
- *Specific dementia interventions*

# How do we foster critically thinking to achieve these outcomes?

- *Role of the Geriatric Resource Nurse*
- *Use reports generated by your documentation system to review your high risk patients*
- *Use case management rounds to identify risk factors and communicate strategies*
- *Use post fall investigations in order to discuss what could have been prevented*

# Unique interventions included:

- *“purposeful rounding” documentation of their rounding.*
- *comprehensive educational programs for the patient*
- *programs which made the patient and family more involved in developing strategies to reduce risk for themselves or loved ones*

# Communication of a patient's fall risk

- *Identifiers on the patient, room and chart*
- *Clinical audits examining the consistency of the applied interventions*
- *Post fall huddles*
  - Develop the critical thought process
  - Assist in completing the post fall investigation
  - Current fall data should be reported routinely to staff by unit so that they can trend their own fall rates. (McCarter-Bayer, 2005)

Only through thorough investigation of fall data can we respond to our own fall prevention opportunities.

# References

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- *Papaioannou, A. (2004). Prediction of falls using a risk assessment tool in the setting. BMC Medicine. January 21, 2004*
- *Eldridge, C. (2004). Evidenced-Based Falls Prevention. A Study Guide for Nurses. HcPro.*
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- *McCarter-Bayer. (2005). Preventing Fall in Acute Care. Journal of Gerontological Nursing. (3) 25-33*



# Patient Comfort Rounds

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# Background

- **Highest injury rate** among the surgical service

| <b>Neuroscience Falls Data</b> |             |                    |                 |                 |
|--------------------------------|-------------|--------------------|-----------------|-----------------|
| FY                             | Total Falls | Falls W/<br>Injury | Fall Rate       | Injury Rate     |
| 2005                           | 27          | 2                  | 5.5             | 0.41            |
| 2006                           | 30          | 11                 | <b>5.85</b>     | <b>2.14</b>     |
| Data Source: BSC               |             |                    | (6.4% increase) | (422% increase) |

- **Contributing factors** of falls with injuries: overestimation of ability, alteration in mental status, urinary incontinence, balance impairment, and inaccessible call light
- Most **common time intervals** when patients fall were: 4am, 10am, 6pm and 10pm
- **72.7%** (56/77) falls on Neuro Unit were related to **transfers/ambulation and toileting**



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# Profile of Patient with Injury

- **Average age 70.2**
- **Fall risk assessment:** 64% indicated patient was at high risk for falls on admission & 71% were high risk day of fall
- No data available regarding the medication profile
- **63%** of falls occurred in the bathroom or in route to BR



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# Patient Comfort Rounds

6 week trial on Neuroscience Unit  
July 9<sup>th</sup> – August 17

All Patients

RN assesses  
Fall risk

## Comfort

- **Rotating rounds** (even/odd hours) by PCA/AA or PCA/RN completed on all patients with the use of a rounding card
- NIC to coordinate rounding schedule per shift during chart nurse report. In general, PCAs did the odd hour rounds & RNs did the even hours.

- Toileting
- Pain
- Positioning/comfort
- Personal needs
- Patient education, video/brochure

### Additional Roll out Notes

- All **bed alarms** checked prior to start
- **PCA & AA Inserviced** on:
  - how to set up the Falls video for viewing
  - give fall brochure
  - where to document
  - how to set up & use up the bed alarm system

## Medication Review

- Completed daily by pharmacy on those patients that score **greater than 45** on the Morse Fall Scale & with the **recommendation by the RN**
- Team collaboration to adjust med &/or education re: peak medication times

## Team Huddle/ Rounds

- NIC to facilitate with use of the huddle sheet
- Nsg/Pharmacy huddle M-F between 10-1030a
- Mini huddle with every charge report
- Nurse Mgr, Educator, Quality Program Mgr to attend nsg/pharmacy huddle to evaluate process



# Program Goals

- Reduce **fall/ fall with injury rate**
- Increase **patient satisfaction**
- Increase **staff satisfaction** related to patient flow and teamwork
- Reduce **call light use** during change of shift





# Implementation Plan

- Rounding cards developed for staff
- Huddle sheets & room check list created
- Pilot communicated to other disciplines
- Staff educated on the rounding process
- All beds and bed alarm functionality checked on before the pilot
- Rounding schedule established



# Rounding Protocol

| Rounding Protocol   |  |
|---|--|
| <b>Directions:</b> Upon entering the room, tell the patient you are there to do your rounds then please check & perform the following for each patient. |  |
| <b>PAIN</b>   | <input type="checkbox"/> Please ask the patient if she/he is in pain. If yes, please notify RN for medication administration.  |
| <b>POSITIONING</b>  | <input type="checkbox"/> Please ask if the patient is comfortable or needs to be repositioned.   |
| <b>TOILETING</b>  | <input type="checkbox"/> Offer toileting assistance. Assist to bathroom if patient has not voided in the last 3 hours.   |
| <b>PERSONAL NEEDS</b>   | Please make sure to check that the following items are within the patient's reach: <ul style="list-style-type: none"> <li><input type="checkbox"/> Nurse call light, TV control</li> <li><input type="checkbox"/> Urinal/commode</li> <li><input type="checkbox"/> Telephone</li> <li><input type="checkbox"/> Bedside table</li> <li><input type="checkbox"/> Kleenex box</li> <li><input type="checkbox"/> Plastic trash bag taped to the bedside table</li> <li><input type="checkbox"/> Set up meal tray, if applicable</li> </ul> |
| <b>SAFETY CHECK</b>   | Please check the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Bed is zeroed before placing new patient on bed and bed alarm is on (if needed)</li> <li><input type="checkbox"/> Bed alarm is on &amp; connected to the nurse call system (if needed)</li> <li><input type="checkbox"/> Bed in low position &amp; brakes are locked</li> <li><input type="checkbox"/> Chair alarm is on (if needed)</li> <li><input type="checkbox"/> No greater than 3 side rails up unless MD ordered</li> </ul>        |
| <b>PATIENT EDUCATION: Upon Admission:</b>   | <ul style="list-style-type: none"> <li><input type="checkbox"/> Offer to turn on fall prevention video</li> <li><input type="checkbox"/> Provide patient with fall prevention brochure</li> </ul>  |
| <b>MISCELLANEOUS</b>  | <ul style="list-style-type: none"> <li><input type="checkbox"/> Prior to leaving the room please ask, "Is there anything I can do for you before I leave?"</li> <li><input type="checkbox"/> Please tell patient that a member of the nsg staff (use names on white board) will be back in the room in about an hour to round again.</li> </ul>  |
| Once rounds are completed, initial on the Room Sheet. If toileting done, initial under appropriate time under "Toileted" column on the Room Sheet.      |  |
| <b>Note:</b> This will be posted on the EMAR COW as well as the patient room.   |  |
| The tracking of rounds will be documented on the tracking log in the patient room, next to the rounding protocol cards.                                 |  |

Rounding Protocol adapted from Meade et al. (2006). Effects of nursing rounds on patients call light use, satisfaction, and safety. *American Journal of Nursing* 106(9), p.58-71.



# Press Ganey Items

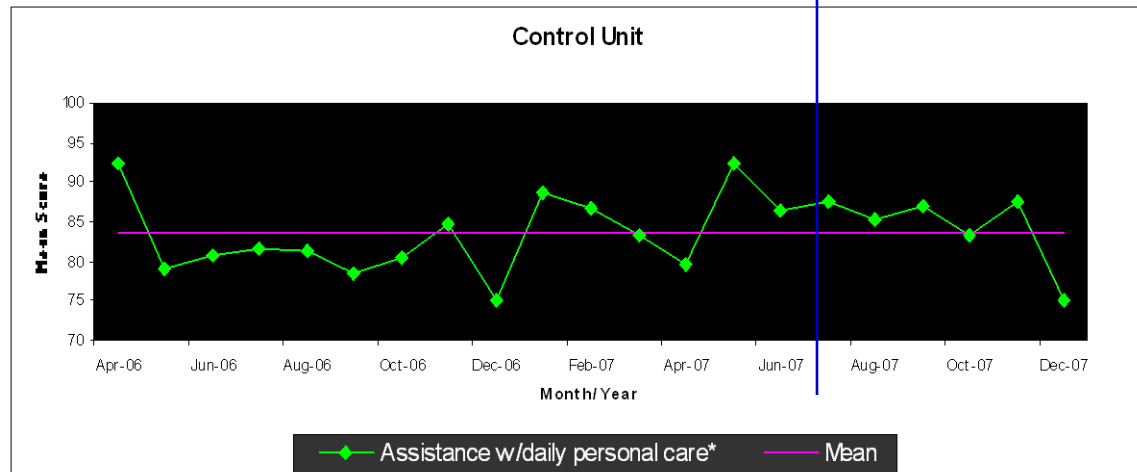
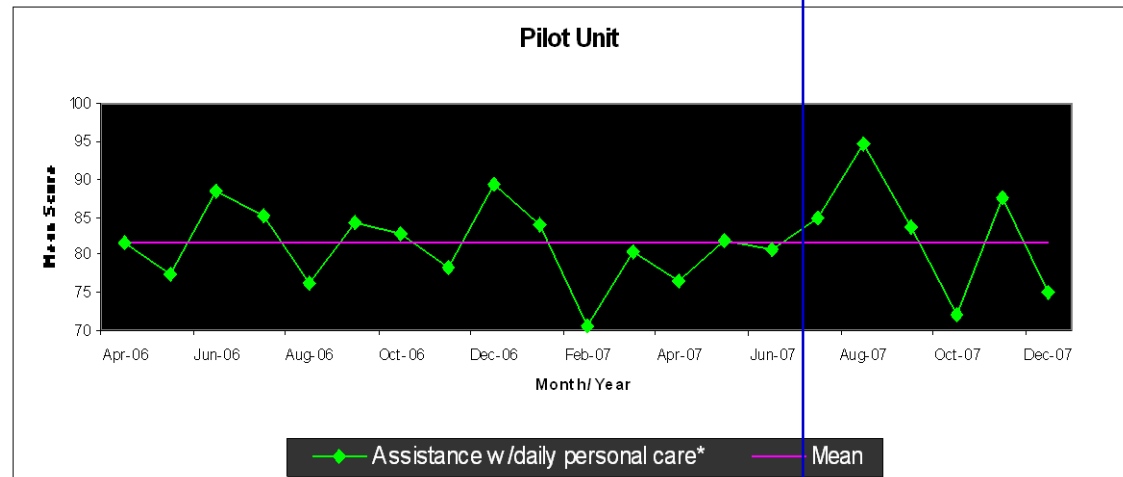
- How well was your pain controlled
- Response to concerns/complaints
- Promptness in responding to call button
- Nurses' attitude toward requests
- Attention to special/personal needs
- Assistance with daily personal care



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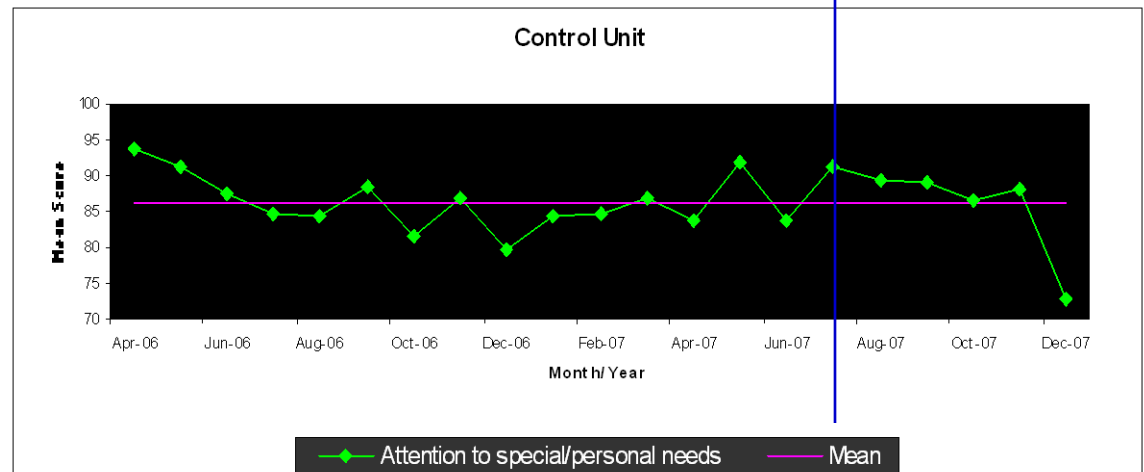
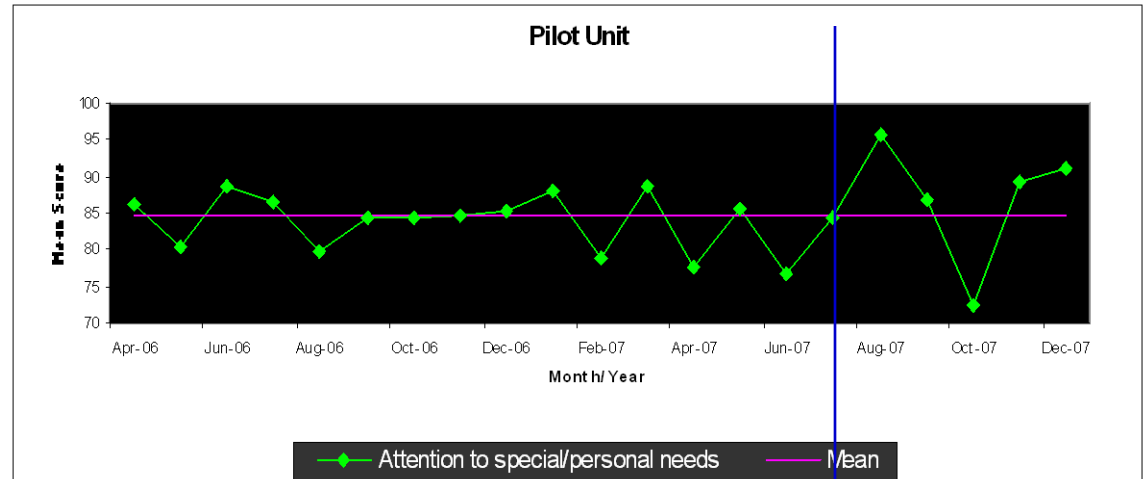
# Patient Satisfaction

Assistance with  
Daily Personal  
Care



# Patient Satisfaction

Attention to  
Special/personal  
needs





# Patient comments

- *“I wait for them to come instead of pushing the call bell because I know they’ll be here”*
- *“It makes me feel special”*
- *“It’s nice... someone is always checking up on me”*
- *Someone’s here every hour so I really don’t have to call for help”*
- *“My water pitcher gets filled & I don’t even have to ask, it’s a great program.”*



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# Staff Satisfaction Survey

36 staff surveys completed (24 pre-pilot and 12 post), findings included:

- **Less interruptions** by call light use during the pilot
- **PCR reduced call light use**
- **Staff worked together as a team**
- Rounds will help **keep patients safe** (unchanged)

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There were **2 questions added** to the post-pilot survey:

1. *The hourly rounding program improved the ability to meet the patients' personal needs (100% of staff agreed)*
2. *The medication review of patients at high risk for falls increased my awareness of the potential for medications to be a contributing factor to a fall (50% of staff agreed)*



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# Medication Review

5 instances where medications were reviewed and pharmacy noted a potential change:

- 2 involved a **dose adjustment** (haldol and seroquel)
- 2 involved **changing administration time** (diuretic from 6am to 8am and enalapril from QD to BID)
- 1 involved **changing route** to po from IV (lopressor)





# Pilot Unit Findings

1. **24% reduction** in the fall rate and **100% reduction** in the injury rate (compared to control unit which had a slight reduction in their fall and injury rates (8% and 13% respectively))
2. **Patient satisfaction** data (anecdotal feedback from patients is **overwhelmingly positive**)
3. **Staff reported increased work satisfaction** (less interruptions by call light, felt patients needs were being met, teamwork, patient safety)
4. **61.4% reduction in call light activation** during the evening change of shift on the pilot unit



# Challenges

- Educating float staff to the Rounding Protocol
- Periods of decreased support staff (Patient Care Assistants &/or Activity Assistants)
- Periods of very high patient acuity



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# Next Steps

1. Ongoing reinforcement of PCR on 10CD
2. PCR rolled out on 6D Jan. 2008
3. Establish a **systematic process** to routinely check functionality of **beds and bed alarms**
4. **Identify other units** that would benefit from **PCR**
5. Collaborate with pharmacy re **medication fall risk assessment**
6. Communicating **fall risk** during **hand-off**



# Neuroscience Patient Comfort Rounds Team

- Mary Antonelli, RN, MPH Quality Program Manager
- Teresa Buchanan, RN, MBA Quality Program Manager
- Steven Baroletti, Pharm D
- Karen Fiumara, Pharm D
- Barbara Grady, RN, BSN, Quality Assistant
- Margaret Gulley, RN, BSN, Nurse In Charge 10C
- John Hauck, Lead Quality Data Analyst, Center for Clinical Excellence
- Patricia Krause, Pharm D
- Diane Lancaster, Director Quality Measurement & Improvement
- Julianne Mazzawi, RN, MSN Quality Program Manager
- Mary Katherine O'Brien, RN, MSN Nurse Manager 10CD
- Heidi Smith, RN, CNRN
- Escel Stanghellini, RN, MSN Quality Program Manager
- Colleen Zidik, RN, BSN, MBA Quality Program Manager



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# Falls Prevention in a Small Community Hospital

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Process and outcomes achieved through multidisciplinary collaboration

Lorraine Aldrich, RN MS CCRN CNAA

Director, Professional Development

Baystate Franklin Medical Center



# What was happening?

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- ❑ Medical surgical unit- 24 beds with medical behavioral/geriatric/pediatric patients- undergoing physical renovations
- ❑ During monthly meetings, several staff members identified increased falls
- ❑ A review of falls data was conducted
- ❑ Literature search was facilitated by the CNS with CNPC
- ❑ Other disciplines were invited to participate

# What was found?

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- ❑ Elderly patients
- ❑ Predominately Male
- ❑ Activity most frequently listed prior to fall-toileting
- ❑ Patient location near nurse's station not a variable
- ❑ 2006 – 5.65 falls/1000 patients days

# Next Steps/Outcomes

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- Brainstorm sessions with staff
- Initial Phase:
  - revised falls assessment sheet for patients identified at risk
    - Instituted every 2 hour checks on high risk patients
    - CIS reassessment every 12 hours
  - Trial and selection of footwear with more secure footing/grip
  - Trial and purchase of alarm system for chair and bed use ( audible and visual)- temporary plan

# Next Steps/Outcomes

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- Use of “Falling Leaves” for easier ID
- Intense review of medication times such as diuretics, beta blockers etc
- Approved change in diuretic times from 0800 and 2000 ( bid ) to 1000 and 1800
  - Greater staff/ family member interaction
  - Minimized late night ambulation

# Next Steps/Outcomes

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- Evaluation of bed alarm system in collaboration with Master Facility Plan
- Choice of new nurse call system incorporating visual and audible notification
- Benchmark with NDNQI for trends
  - Analysis with staff after each fall
- Education of ancillary staff re: falls risk

# Current Status

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- ❑ Formal education plan with transport staff
- ❑ Share results with ancillary departments
- ❑ Consider development of interdisciplinary falls team
- ❑ Literature search and plan for patient safety – not measured at risk for falls but clinical risk for injury ( i.e. anticoagulation)
- ❑ 2008- .7 falls/1000 patient days



# Sharing Strategies Session



**Thank you for your  
participation.**



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