Fall Prevention

Our Journey To Improvement

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HSHS St. Mary's Hospital
Decatur, Illinois

HSHS
St. Mary's
Hospital

Hospital Sisters Health System (HSHS)

St. Mary's at a Glance

HSHS St. Mary's Hospital

HSHS St. Mary's Hospital, Decatur

SENATE DISTRICT 48 HOUSE DISTRICT 96

PATIENT SAFETY

Reducing falls for high-risk patients

Multidisciplinary teams implemented several interventions including:

- Purposeful hourly rounding
- Multidisciplinary rounding
- Addressing pain management needs
- Patient safety and environmental inspection
- Plan of care focused on patients needs

Patient, Family & Community Impact

- Improves patient safety
- Improves patient outcomes
- Reduces mortality

Saving Lives, Saving Dollars

INVESTMENT
$6.1k
EDUCATION & TRAINING

SAVINGS
$241k
FALL-RELATED INJURIES

Launch date: January 2016

Where we started…

So what did we do….

Assessment upon admission

- Hendrich II fall risk model scoring
- >5 = high risk
- Care Plan
- Socks, arm band, light outside room, bed alarm
- Assessment for sitter need

Guide for House Supervisor

GENERAL:

Date:	**Time:**
Patient Name:	**Dept:**
Requested by:	**Estimated Sitter time (hours):**

INDICATION:

- ☐ **Suicidal Patient** ☐ **Homicidal Patient**
- ☐ **Cognitive Impairment**
  - o **1:1 Observation**
  - o **Direct Observation**

PATIENT SAFETY ALTERNATIVES ATTEMPTED:

☐ Bed/chair exit alarm	☐ Hourly rounding
☐ Personal alarm device	☐ Move patient closer to desk if appr
☐ Offer family option to stay with patient	☐ Supportive interaction with staff
☐ Pain management – Review medications	☐ Relaxation: music, reading, drawin
☐ Decrease simulation	☐ Snack, cold or hot drink
☐ Patient reminders	☐ Bath/shower, cool washcloth
☐ Low bed	☐ Repeated redirection
☐ Side rails up while in bed	☐ Set clear behavioral expectations
☐ Increase day activity to tire patient for sleep	☐ Diversion activities (crafts, cards,
	☐ Consider if medical restraint is app

Comments:

Must be completed at minimum frequency of four (4) hours by Staffing Facilitator/House Supervisor

REASESSMENT	**Date:**	**Time:**	**Covered by:**
	Date:	**Time:**	**Covered by:**
	Date:	**Time:**	**Covered by:**
	Date:	**Time:**	**Covered by:**
	Date:	**Time:**	**Covered by:**

DISCONTINUATION Date: **Time:**

NOT PART OF PERMANENT RECORD

Sitter SBAR

Patient Name: _____

Reason for sitter: _____

Nurse name & phone number: _____

Nurse station phone number: _____

Medical equipment in place:

- ☐ Oxygen
- ☐ Foley Catheter
- ☐ NG tube
- ☐ Telemetry
- ☐ IV location _____
- ☐ Dressing locations _____

Meals:

- ☐ Need assistance ordering
- ☐ Need assistance eating
- ☐ Independent
- ☐ Diet Restrictions_____
- ☐ Check meal tray for hazardous items
- ☐ Other _____

Mobility:

- ☐ Must stay in bed
- ☐ May get out of bed with assistance
- ☐ May get out of bed independently
- ☐ May walk in the hallway
- ☐ May not leave the room
- ☐ Bed alarm activated

Toileting:

- ☐ Sitter must maintain visual observation
- ☐ Nurse or aide must assist
- ☐ Independent

Documentation:

- ☐ ADL's as provided
- ☐ Close Observation every 15 minutes
- ☐ 1:1 Observation every 15 minutes

Special Instructions:_____

Daily Safety Huddles

- New approach- 2019
- Includes **all** team members
- Each shift change
- Not optional
- 5-8 minutes
- Staff led

Date:_____ Shift: 6A 6P

On coming RN/LPNs _____ PCTs_____

Unit Clerk_____/_____

1. **Start with a bright spot (e.g. positive comment about team member, recognition of progress, metrics, "connect to purpose" reflection)**

ELEVATED SHIFT HUDDLE AGENDA

SAFETY RISKS

Who is at risk to fall? What are we going to do to prevent?	ROOM #s and Additional Interventions:	
What safety issue are we at risk for today? Wounds/Q2H/High skin risks	RISK:	INTERVENTIONS- What are we going to do to reduce risk?

Patient Experience/Quality

Last Fall on unit:

Patient Experience Measure	Goal:	Result:	Strategy for the shift:
[Insert one Quality Metric]	Goal:	Result	Strategy for the shift:
Nurse Leader Rounding Results	Positives: Opportunities:	Recognized: Focus:	Notes:

UNIT OPERATIONS

PICC/CENTRAL LINES	RM #s	TO BE DC'D/REASON
FOLEY CATHETERS	RM #s	TO BE DC'D/REASON
LOOSE STOOLS (tick sheets done?)		
EXPECTED ADMISSIONS- Surgical		
PATIENTS HOLDING FOR BEDS		
EXPECTED DISCHARGES/TRANSFER OUT		
ISOLATION PATIENTS	RM #s and Reason	
CONFUSED/NEED FOR SITTER		
VTE/Flu shot needs		
STROKE PATIENTS		

SPECIFIC PATIENT POPULATION CHECKS

Dialysis	
Confidential/Suicide Patients	
Drips	
Ventilators	

2. **End on a positive note (e.g. "shout out" to a team member; identify value of the month and who has exhibited; etc.)- Example- Team work – someone working extra today…**
3. **Additional huddle notes to review**

Purposeful hourly rounding

- Ensure patient's needs are met
- Studer partners
- Validation
- Support-Coach-Support

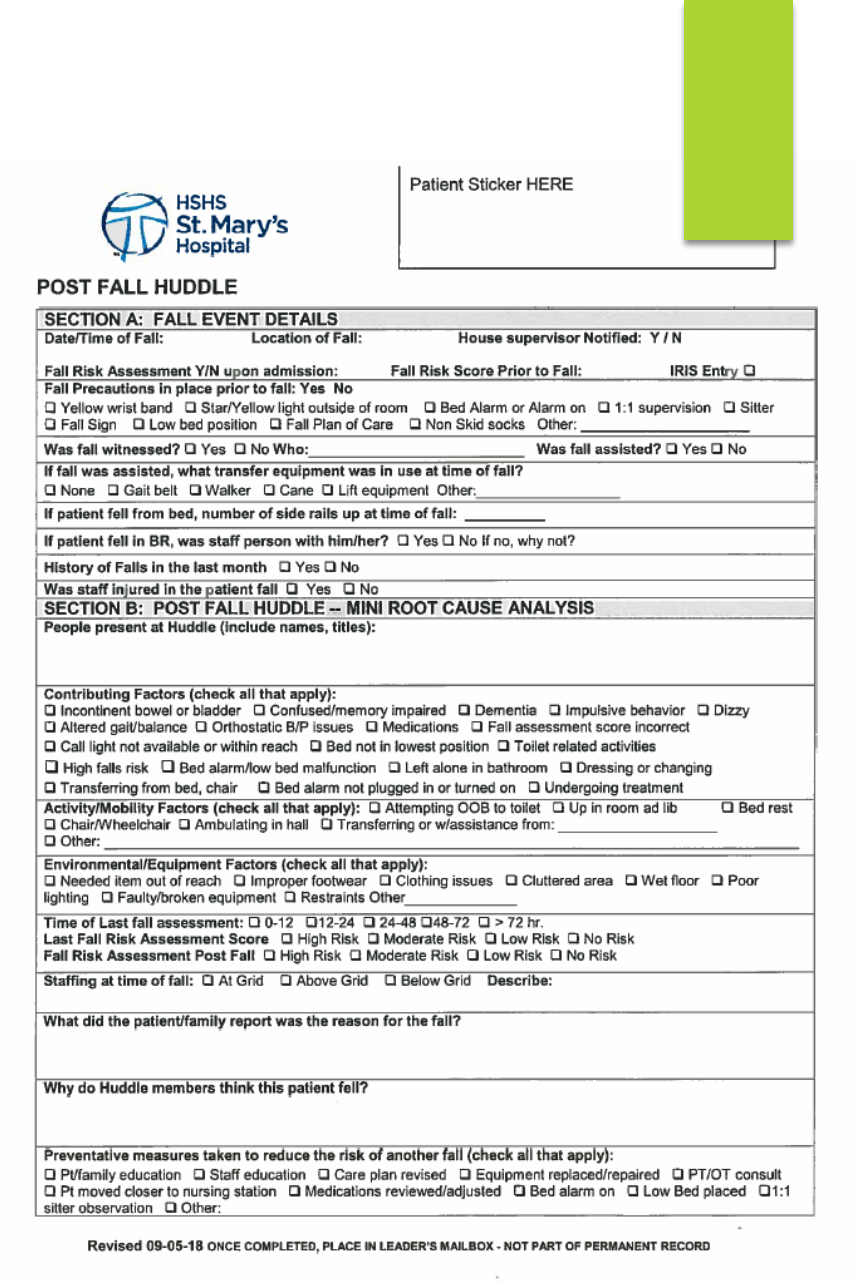
LAPS- Leaders accountable for patient safety

- An IHA initiative
- Every weekday
- Review EPIC dashboards
- Discuss high risk patients

A Fall still happened: Then what

Post fall huddle- Debrief

- House supervisor
- Charge nurse
- Provider if available (or notification occurs)
- All team members for patient
- Enter event in IRIS
- Addition of TEAMSTEPPS (2018-2019)



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Patient Sticker HERE

POST FALL HUDDLE

SECTION A: FALL EVENT DETAILS

Date/Time of Fall: **Location of Fall:** **House supervisor Notified: Y / N**

Fall Risk Assessment Y/N upon admission: **Fall Risk Score Prior to Fall:** **IRIS Entry ☐**

Fall Precautions in place prior to fall: Yes No
☐ Yellow wrist band ☐ Star/Yellow light outside of room ☐ Bed Alarm or Alarm on ☐ 1:1 supervision ☐ Sitter
☐ Fall Sign ☐ Low bed position ☐ Fall Plan of Care ☐ Non Skid socks Other: _____

Was fall witnessed? ☐ Yes ☐ No **Who:**_____ **Was fall assisted?** ☐ Yes ☐ No

If fall was assisted, what transfer equipment was in use at time of fall?
☐ None ☐ Gait belt ☐ Walker ☐ Cane ☐ Lift equipment Other:_____

If patient fell from bed, number of side rails up at time of fall: _____

If patient fell in BR, was staff person with him/her? ☐ Yes ☐ No If no, why not?

History of Falls in the last month ☐ Yes ☐ No

Was staff injured in the patient fall ☐ Yes ☐ No

SECTION B: POST FALL HUDDLE -- MINI ROOT CAUSE ANALYSIS

People present at Huddle (include names, titles):

Contributing Factors (check all that apply):
☐ Incontinent bowel or bladder ☐ Confused/memory impaired ☐ Dementia ☐ Impulsive behavior ☐ Dizzy
☐ Altered gait/balance ☐ Orthostatic B/P issues ☐ Medications ☐ Fall assessment score incorrect
☐ Call light not available or within reach ☐ Bed not in lowest position ☐ Toilet related activities
☐ High falls risk ☐ Bed alarm/low bed malfunction ☐ Left alone in bathroom ☐ Dressing or changing
☐ Transferring from bed, chair ☐ Bed alarm not plugged in or turned on ☐ Undergoing treatment

Activity/Mobility Factors (check all that apply): ☐ Attempting OOB to toilet ☐ Up in room ad lib ☐ Bed rest
☐ Chair/Wheelchair ☐ Ambulating in hall ☐ Transferring or w/assistance from: _____
☐ Other: _____

Environmental/Equipment Factors (check all that apply):
☐ Needed item out of reach ☐ Improper footwear ☐ Clothing issues ☐ Cluttered area ☐ Wet floor ☐ Poor lighting ☐ Faulty/broken equipment ☐ Restraints Other_____

Time of Last fall assessment: ☐ 0-12 ☐12-24 ☐ 24-48 ☐48-72 ☐ > 72 hr.
Last Fall Risk Assessment Score ☐ High Risk ☐ Moderate Risk ☐ Low Risk ☐ No Risk
Fall Risk Assessment Post Fall ☐ High Risk ☐ Moderate Risk ☐ Low Risk ☐ No Risk

Staffing at time of fall: ☐ At Grid ☐ Above Grid ☐ Below Grid **Describe:**

What did the patient/family report was the reason for the fall?

Why do Huddle members think this patient fell?

Preventative measures taken to reduce the risk of another fall (check all that apply):
☐ Pt/family education ☐ Staff education ☐ Care plan revised ☐ Equipment replaced/repaired ☐ PT/OT consult
☐ Pt moved closer to nursing station ☐ Medications reviewed/adjusted ☐ Bed alarm on ☐ Low Bed placed ☐1:1 sitter observation ☐ Other:

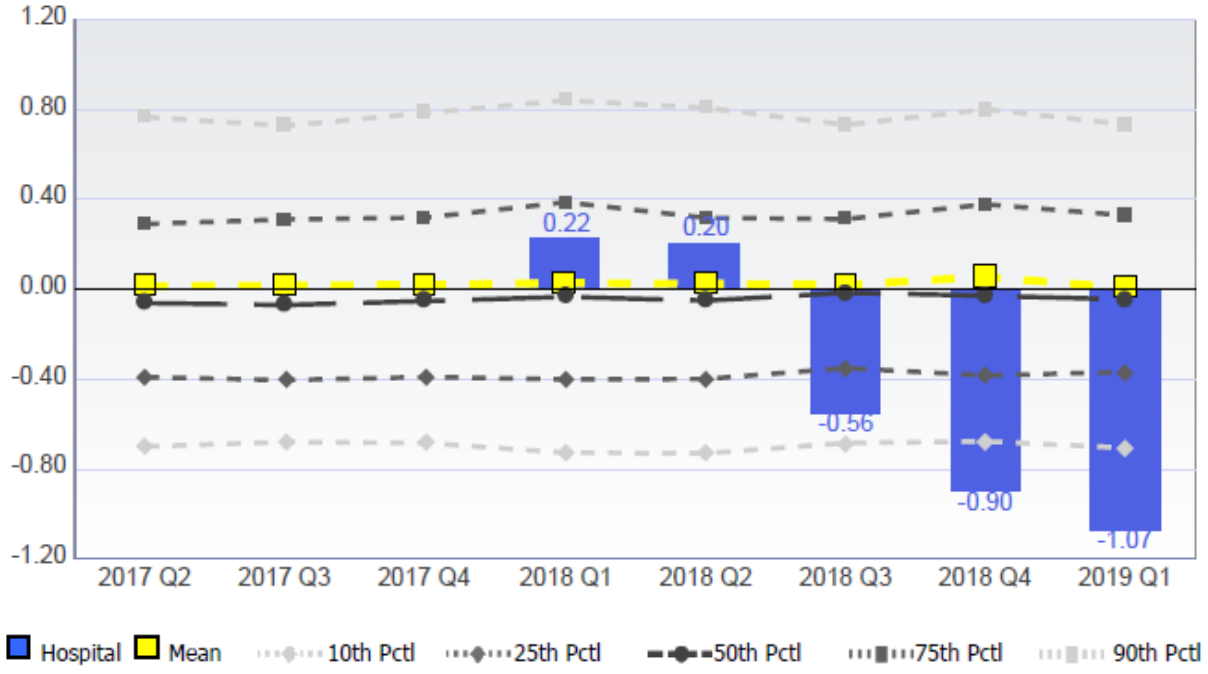
Revised 09-05-18 ONCE COMPLETED, PLACE IN LEADER'S MAILBOX - NOT PART OF PERMANENT RECORD

Harm events

- IRIS/Falls with harm, no harm
- Notification
- Safety huddle (transparent)
- If it happens here/happen other units
- 24 hour review by leader

NDNQI

Falls per 1000 patient days



Metrics	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Average
Hospital-Standardized Score	No Data	No Data	No Data	0.22	0.20	-0.56	-0.90	-1.07	**-0.42**

Where do we go now?

- Stay with me
- Multidisciplinary training
  - RN, LPN
  - Care techs
  - Therapy
  - Health Clerks
- System approach
- 65% reduction in other ministries

Fall Prevention Agreement

Fall Prevention Agreement

1. I have been educated by my nurse that many of the following factors may put me at high risk for falls:
   - Medicines that make me weak and dizzy (such as medication for pain, nausea, or sleep)
   - Weakness due to bed rest
   - Being in an unfamiliar environment
   - Use of bulky patient care equipment (IV poles, lines, or pumps, monitor wires, oxygen tubing, surgical tubes)
   - Potential loss of control of urine or stool, as well as a need to go to the bathroom suddenly and/or frequently due to IV fluid or medication.
   - Recent Surgery/procedure

2. **I understand that falling can cause serious injuries, including but not limited to death, fractured bones, head injury, wounds, or a prolonged hospital stay.**

- Use my call light to request help when I need to get up.
- Wait for help before getting up from the bed, commode, toilet, or chair.
- Report feelings of dizziness or weakness to my caregiver immediately.
- Keep my room free of clutter with unnecessary items.
- Avoid use of moving objects to help steady myself (such as my IV pole, bedside tray table, wheelchair or other moving objects).
- Always wear shoes or nonskid slippers/socks when I get out up.
- Keep important items within reach.

Help us keep you SAFE!
Remember: **CALL DON'T FALL!!!**

I will speak up when I don't understand something. I have a right to ask questions about my healthcare.

Patient Signature _____ Family member signature: _____

Nurse signature: _____ Date/time: _____

Questions

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