Criteria 1 – Leadership/Planning

Memorial Community Hospital and Health System (MCH&HS) is comprised of a Critical Access Hospital along with three Rural Health Medical Clinics, a Home Health Care Program and a Hospice Program. Through our mission we work together as an engaged team of Physicians, Medical Professionals and Support Staff, committed to delivery of state-of-the-art health care tailored to our unique community and second to none in the area. In doing so, we intuitively grow and evolve along with the needs of the community to deliver health services that measurably enrich the lives of families we serve through an exceptional commitment to quality and compassionate care. Consistent with this mission, our goal is to provide care that is:

- **Safe** – Prevent injuries and adverse events to patient from the care that is intended to help.
- **Effective** – Provide services based on scientific knowledge and evidence based practice standards.
- **Patient centered** – Provide care that is respectful of and responsive to individual preferences, needs, and values. Ensure that patient values guide clinical decisions.
- **Timely** – Reduce wait times and potentially harmful delays.
- **Efficient** – Avoid waste including waste of equipment, supplies, ideas, and energy.
- **Equitable** – Provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status.

MCH&HS Employees participate in ongoing and systematic quality improvement efforts as outlined in the Quality and Patient Safety Plan. These efforts use national patient safety and performance improvement standards as guides, and focus on direct patient care delivery and support processes that promote optimal patient outcomes. This is accomplished through medical quality peer review, clinical outcomes review, a systematic approach to performance improvement (PI), evaluation of patient grievances, aligned key performance indicators and annual employee reviews, annual employee engagement survey and action planning, and annual culture of patient safety survey and action planning.

The MCH&HS Board of Directors is ultimately responsible for assuring that high quality, safe and efficient care is provided to our patients by Medical Staff and as well by Professional and Support Staff. The Board ensures adequate resources are allocated for the provision of safe, optimal, quality care while acting as responsible stewards of the resources entrusted to them. The Board delegates the responsibility for implementing the Quality and Patient Safety Plan to the Medical Staff, the Quality Council, and Hospital Leadership.

Criteria 2 – Process of Identifying Need

In March of 2013, an elderly patient receiving care on our Medical Surgical (M/S) Unit suffered a fall resulting in a major and permanent injury. At the direction of Executive Leadership and Quality, a response team was organized to carry out a root cause analysis (RCA). Disciplines participating in this analysis included Hospital Leadership, Quality, Nursing Leadership, Nurses and Physicians who had cared for the patient, Radiology, Laboratory, Physical Therapy, and Respiratory Therapy. This team

met and reviewed the timeline for the event and determined immediate causal and risk factors to be mitigated. Further investigation of the fall itself revealed inconsistent practices around patient fall risk assessment and the timeliness of implementing appropriate prevention measures. As part of the resulting RCA action plan, members of Nursing and Quality set forth to redesign the organizational Fall Prevention Plan. The intent of this redesign was to solidify internal processes which would assure accurate patient assessment for fall risk and consistent implementation of prevention measures to reduce risk of falls. It was an opportunity to standardize our processes, promote interdisciplinary communication, and promote patient involvement to prevent patient falls.

Criteria 3 – Process Improvement Methods

Prior to the fall event described above, falls on the M/S Unit were tracked as part of the departmental Performance Improvement (PI) activity, reported quarterly to the Quality Council. Falls occurring outside of the M/S Unit were monitored but without a structured PI activity. The concept of completing a post fall huddle had been implemented on the M/S Unit, but the practice was inconsistent. We looked at our current Fall Prevention Policy to determine if changes were needed and whether our practices were consistent with national standards of care.

The policy was re-tooled to include clearer expectations surrounding utilization of the Morse Fall Risk Model when completing each patient's fall risk assessment (Attachment A). An assessment for risk for injury was also added to the policy. This secondary assessment targets patient conditions which if there was a fall, the patient would likely sustain injury (Attachment B). The policy was also streamlined in order to

assure consistency with manual and electronic documentation of assessments and selected prevention measures.

Once re-tooling was complete and the policy approved, we developed standard operating procedures (SOP's) for both fall risk assessment and for the post fall huddle. These SOP's provide staff with step by step instructions for completing fall risk assessment and implementation of prevention measures, but also assures the right people come together if a fall occurs. Additional tools were pushed out for use during the redesign of our processes. A "Fall and Risk for Injury Interventions" table (Attachment C) was created which is used as a trigger to define appropriate prevention measures for nurses to consider in order to prevent a patient fall. The "Patient Road Map" (Attachment D) was developed to serve as an education tool when teaching patients about their fall risk and what measures the Health Care Team will use to keep patients safe.

To assist with workflow of gathering supplies needed when a patient is deemed a fall risk, we planned, built, and implemented a "Fall Risk Kit" (Attachment E). This kit contains items that every patient scoring 50 or greater on their fall risk assessment will need implemented as a prevention measure. The kit includes yellow socks, yellow arm-band, yellow star, the "Patient Road Map", a gait belt, and a green arm band in case the patient is determined to be a high risk for injury.

Once our plan was finalized it was time to educate our staff. On May 1st, we rolled out the redesigned Fall Prevention Program which was showcased in a "Banana **Slips** Party". Nursing Leadership and Quality hosted the event. Employees and Providers from the entire organization were welcomed to participate in a three minute

poster board presentation (attachment E) about the new fall prevention program. After listening to the presentation, they were provided homemade banana splits with all the trimmings.

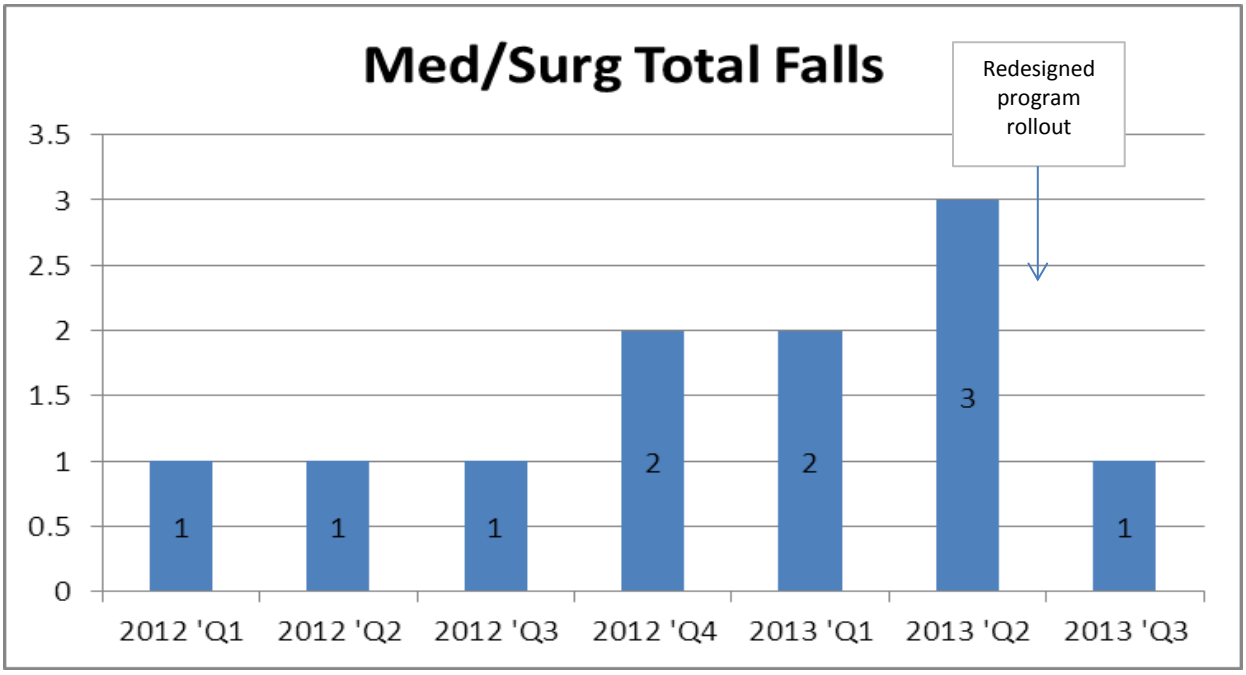
Additional education followed with formal presentations at the M/S department meeting and several ancillary department meetings (Radiology, Emergency Department, OB, Cardio-pulmonary). Furthermore, the PT/OT Department provided mandatory competency gait belt and transfer safety training for MS, OB, Radiology, and Cardiopulmonary.

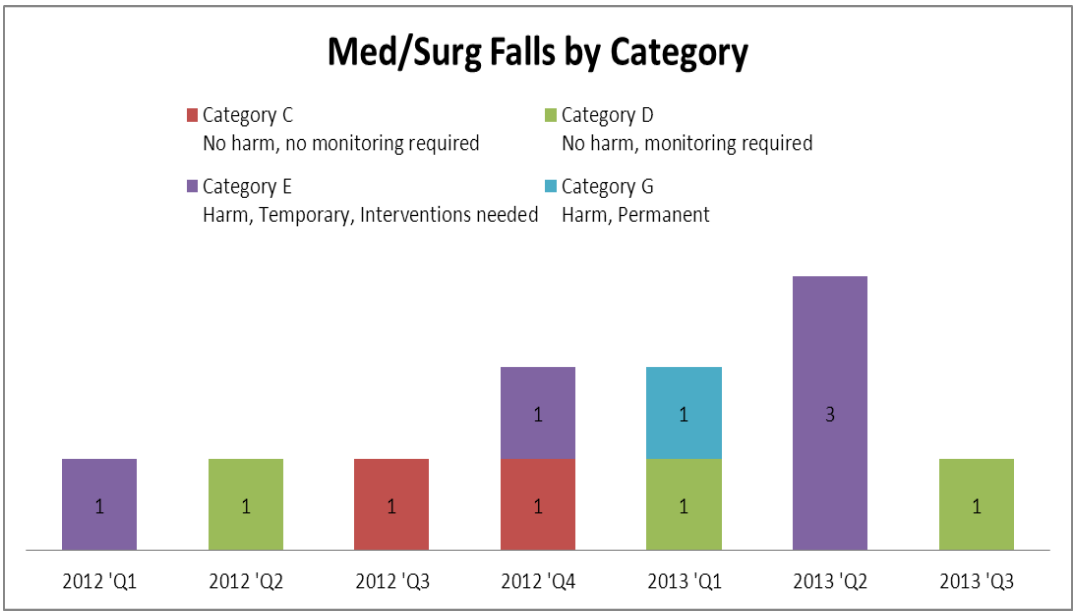
Post fall huddles have since been fully implement throughout organization. If a patient falls anywhere, the huddle occurs and is documented on the post fall huddle form. These forms are then forwarded to the Quality Department where information pertinent to the fall is maintained in a fall log for the purposes of trending.

While not directly related the March fall event, MCH&HS has since implemented a “Daily Safety Huddle”. This huddle brings together members of the Leadership team to review departmental safety issues, concerns and events for the previous 24 hours. Information is logged in a daily report which is then sent to all departments following the huddle. Feedback from departments and individual staff members has been extremely positive. In addition, huddle addresses the number of days since the last patient fall anywhere within our organization, keeping falls as a focus for every staff member each day. This summer, we have been able to take that same fall information and develop a scrolling banner on our organization’s intranet home page. This enables every employee who visits the home page to see how many days have passed since the last patient fall.

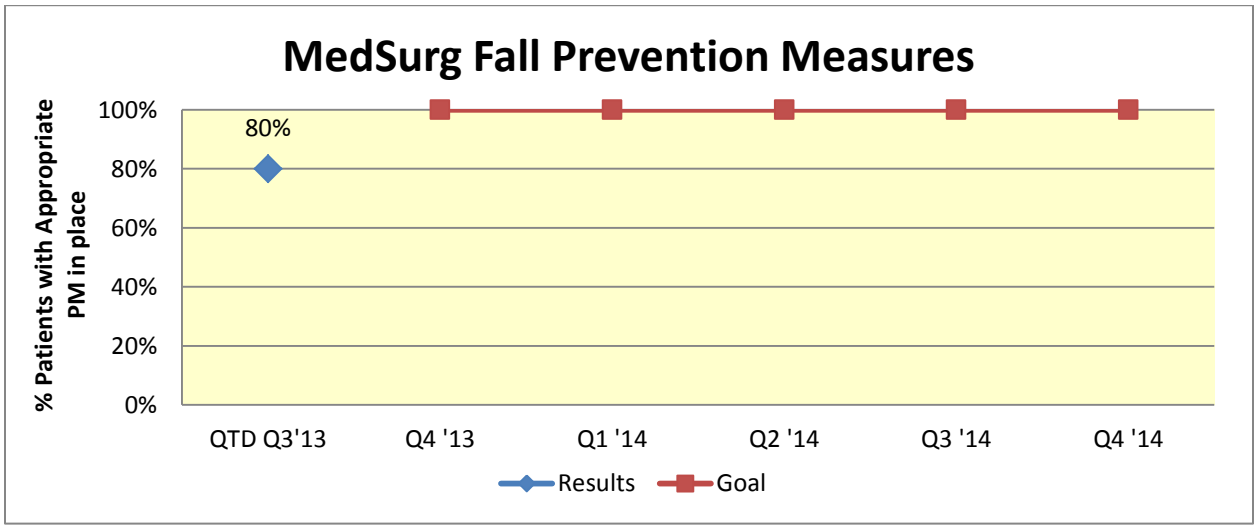
Criteria 4 - Results

Overall, we have not seen falls completely eliminated (see following graph). However, fall risk assessment, prevention measures, and circumstances of falls have become an open and transparent topic for discussion at department meetings, medical staff meetings, and these items are addressed daily by Leadership in our Safety Huddles.





Work also occurred to redesign of the M/S PI activity that previously measured number of patient falls. The department project now tracks compliancy of staff implementation of appropriate fall prevention measures for all patients on the unit identified as being at risk for fall. Data collection for this activity began in July (see following graph).



Initial analysis and drilldown of cases revealed gaps directly related to use of the Fall Risk Kits. Interventions which were missing included the yellow star, yellow socks and availability of gait belts in the patient rooms. Ongoing education with staff members is taking place monthly at scheduled Department meetings to target these items and the need for staff to access a Fall Risk Kit at the time of admission or when the patient is deemed at risk for fall.

Criteria 5 – Lessons Learned, Replicability, Sustainability

There were several additional opportunities that surfaced during development and implementation of our redesigned Fall Prevention Plan. One area involved our gait belts and the fact that in order to use the belts effectively, we needed to have more than one size available. Today, we have extra-large belts available on the M/S unit and adequate supply available in the purchasing department in the event that the standard belt is not functional for obese patients.

We also identified the need for making sure our clinical staff members were deemed competent using a gait belt and to assure that appropriate transfer methods were being used consistently with patients. The PT/OT department, being experts in the area of patient transfers, were able to contribute their services to complete competency training for staff members providing care to acute and skilled patients. We also identified that best practice literature encourages use of “low beds” for certain patients as a way to keep them safe. Following this significant event, Leadership will be looking at the financial feasibility of having access to “low beds”.

Another area identified as being essential in making our process effective was patient and family involvement in the fall risk assessment. Analysis of the event that

occurred in March indicated that when the patient was assessed for having falls at home the response was “no”. After the fall when discussing the event with family, those family members were not surprised since according to them, the patient had been falling at home. This brought to light the need for making sure both the patient and the family is included in assessing risk for fall and that both are provided information on fall prevention measures in place during the patient’s stay.

Next, we revealed that processes can be problematic if staff members become complacent in their actions. Today, our Fall Risk Assessment is a “hard stop” in the electronic medical record. This assures that the assessment will be completed and prevention measures addressed before the Nurse will be able to complete the required admission or shift assessment.

Finally, our work on this safety event acknowledged the need for two key criteria Quality improvement activities: 1. Involve all disciplines potentially impacted by a process. This assures that each and every angle of the process is addressed and will promote a smooth and efficient implementation of process changes.
2. Without clear communication on what is expected, staff will perform based on processes they have used in the past. Therefore, clear, concise, open communication is essential to keep our patients safe.