FALL PREVENTION IMPROVEMENT PROJECT

Thayer County Health Services

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Leadership /Planning:

The mission of Thayer County Health Services (TCHS) is to improve the lives of those we serve by providing exceptional, patient-centered health care. Thayer County Health Services' vision is to be the region's provider and employer of choice for comprehensive health care and wellness. Thayer County Health Services' values of Respect, Integrity, Compassion, and Excellence align with our mission and vision. The Senior Leadership Team leads the facility by being an example to our staff daily by engaging with patients, family, and staff. One of the goals of the Senior Leadership Team is to engage all staff in quality improvement throughout the facility. Senior Leadership has stressed the importance of becoming a more quality focused facility with an emphasis on patient safety. The Thayer County Health Services Quality Assurance Improvement Plan (QAPI) for 2022 focused on patient safety and patient satisfaction. The goals included: "Improve HCAHP rating of likelihood to recommend the hospital from 77% to greater than 78%" and "Reduce the total number of inpatient falls by 20% by June 2022". These facility quality improvement initiatives show that the facility, including the Medical Staff, Senior Leadership, and the TCHS Board are committed to patient safety, satisfaction, and quality improvement.

The TCHS strategic plan aligns with the mission, vision, and values. The strategic plan focuses on "Improve Quality and Patient Safety Measures", "Strengthen Organizational Loyalty", "Promote Organizational Strengths", and "Enhance Services Available Close to Home." The TCHS Board approved the strategic plan in February of 2020. They are actively involved in the decisions of the hospital and fully support the strategic plan with the mission, vision, and values.

Process of Identifying Need:

TCHS had nine inpatient falls in 2019 and eight inpatient falls in 2020. This led to the initiation of our fall prevention project. In 2020, The CNO and Quality Coordinator began to focus on fall prevention with weekly emails and fall prevention education. Education was provided to the nursing staff on fall identification and criteria. At the time, nursing staff members were largely unaware that a patient-to-floor assist should count as a fall, per criteria. This new knowledge led to a subsequent increase in reporting of falls. Additionally, "*Call Don't Fall"* tiles were placed in patient rooms above the beds to provide a visual reminder to the patient to call for assistance. Although these steps were positive, it was clear that more interventions needed to be done.

Even with these interventions in place, the rate of patient falls was progressively rising as evidenced by the fall rate. Our fall rate is calculated using the number of falls per 1000 patient days. In 2019, the fall rate for TCHS inpatients was 8.96. In 2020, that number increased to 9.92. It was obvious that something needed to be done to prevent inpatient falls. At this point, the Quality Coordinator began performing a root-cause analysis (RCA) on each fall. In evidentiary discovery, it was noted that interventions to prevent a fall were not always in place until after the fall. When reviewing the RCA to determine further interventions for fall prevention, it was concluded that the Morse Fall Score was completed on admission and again after a fall. There was no evidence that the Morse Fall Score was utilized to prevent a fall or to recognize the potential of a fall occurring. It appeared as though staff were completing the task of the Morse Fall Score, but subsequent actions didn't indicate incorporation of the knowledge gained into the plan of care for fall prevention.

Process Improvement Methods:

With the increased rate of inpatient falls, we decided to form a fall team. In January of 2021, the Fall Prevention Team was created. The team consisted of representatives from the departments of Quality, Social Services, Nursing, Rehabilitation, Pharmacy, and a member of the Patient Family Advisory Council. The team objective was to reduce patient falls with a goal of zero falls in the facility and ensure the organization implemented a fall prevention program to reduce the risk of patient injury for all patient care areas. The first Fall Prevention Team meeting was held in February of 2021. In July of 2021, the facility Quality Initiative was solidified for the following specific and measurable goal: "Thayer County Health Services will reduce the number of falls by 20% (by 3 falls) by June of 2022". The first meeting of the Fall Prevention Team determined which patient population would be the initial focus. The team discussed implementation of a process for high fall risk patients, and development of a tracking/trending process for reporting results. Additionally, the team created a plan for communication to the Quality Committee and Leadership. This new process was initiated with swing bed patients and then later expanded to include acute and observation patients.

Utilizing the Institute for Healthcare Improvement (IHI) quality improvement model, the team developed a new process for fall prevention at admission. The Morse Fall Scale was to be completed on admission and during every shift throughout the hospital stay. The composite of the Morse Fall Scale was utilized to develop and implement interventions for patients at admission and throughout their stay that were previously not in place. Two different fall star signs were developed as a visual signal outside of the patient rooms (yellow or orange) so the staff were able to recognize that the patient has been identified as a medium or high fall risk. In

addition, a “cheat sheet” was developed and placed in every room for the nurse to determine what interventions were needed based on the Morse Fall Scale.

A number of elements were implemented with success. An Ocuvera Camera system was installed in several rooms for staff to utilize for high risk patients. The process that was developed for utilization of the Ocuvera camera system included using the composite of the Morse Fall Scale to ensure that cameras were utilized appropriately. A score of 45-100 placed a patient into the high risk category which required the use of the camera system. New walkers were purchased for patients that were under 65 inches and over 70 inches that would adjust in height to provide safer mobility. Pharmacy conducted rounding with patients to discuss medications and evaluate medications to see if adjustments were needed to prevent falls. Hourly rounding was already required by the nursing staff, but was not consistently performed. Therefore, the staff were re-educated on the importance of routinely completing the hourly rounding and making sure to address any needs of the patients. TCHS initiated a bedside shift report. As part of the new process, arriving nurses received a group report at the beginning of shift. After the group report, the oncoming nurse was expected to visit the patient room with the outgoing nurse. During this time, nurses communicated with the patient and each other regarding alarms, fall risk, patient needs, clutter management and any other outstanding issues. The nursing supervisor completed audits to ensure the Morse Fall Scale was completed each shift, interventions implemented according to the score, and fall stars placed outside the room.

Additional interventions were identified with the completion of audits. One issue identified was that gait belts were inaccessible for staff, and therefore not being utilized consistently. This was mitigated by placement of hooks beside each patient bed. Additionally, a

new shower chair with a safety belt was purchased to reduce the risk of falls from the shower chair during showers.

Another process improvement method for the project included the implementation of a fall huddle. When a fall occurred, staff were asked to conduct a fall huddle with everyone on that shift to evaluate and investigate what happened. The fall huddle form was then given to the Quality Coordinator to review and conduct a root-cause analysis. The Quality Coordinator met with the staff, Nursing Supervisor, and the CNO within 2-3 days of the fall to discuss the root cause possibilities. Later, the group examined positive actions and opportunities for improvement. The staff were informed that this process was designed to encourage a learning environment and not intended to be disciplinary or punitive. We encouraged staff to share ideas on future fall prevention, including feedback on current interventions and courses of action as well as suggestions for new processes and equipment.

Afterward, the Fall Prevention Team also met within a week of the fall. At this time, RCA information was shared along with the fall huddle form, and the staff member feedback. The Fall Prevention Team also had a chance to provide feedback and give suggestions on how to potentially prevent falls in the future. The Plan, Do, Study, Act (PDSA) framework was utilized throughout this process to improve and ensure implementation of interventions. During the fall prevention initiative, the team met after every fall to review the root-cause analysis and interventions that were in place. Discussions regarding process improvement, audit results, and change management led to improved fall interventions and fall reduction with increased patient safety. The fall rate consistently decreased each month due to no falls.

In August of 2021, a Fall Cohort was developed with Hospital Quality Improvement Contract (HQIC) utilizing CAPTURE FALLS with University of Nebraska Medical Center (UNMC). In the course of the new engagement with CAPTURE FALLS, the focus shifted to creating a broader culture of patient safety. Through consistent education of staff and providing staff with equipment that was needed to keep patients safe, the culture of the staff changed to focus on proactive interventions versus reactive interventions. For instance, one staff member stated that the positive support of leadership in providing needed equipment helped the staff be confident in taking ownership of patient safety. Staff continued to complete the Morse Fall Scale every shift to ensure that interventions were in place. As a result, staff members now often ask for assistance with transfers to safeguard patients against falls. Staff continue to bring new ideas for patient safety to the team via multiple channels, including direct feedback and huddle communication.

Results:

TCHS has demonstrated significant patient safety improvement and fall rate reduction. Fall rates have decreased from 12.50 for January of 2021 to 1.13 at the end of June 2022. The last inpatient fall was July 19, 2021, which puts TCHS at over 360 days fall free!

As discussed previously, multiple new processes were developed and started due to the Fall Prevention Team and the post-fall huddles. For example, the Morse Fall Scale is now used to evaluate high risk patients and interventions are implemented based on the score. Fall risk awareness has increased with all staff, as evidenced by staff participation in all interventions developed during this project. Staff are more engaged in proactive interventions for patient safety. The process change of completing the Morse Fall Scale at admission and on every shift in

order to implement appropriate fall prevention interventions immediately has led to better patient outcomes with preventing falls. This has also led to more focus on safe mobility to keep the patient moving while continuing to reduce the risk of falls.

The Fall Prevention Team member from the Patient Family Advisory Council provided insight from the patient and family perspective. This allowed the team a better understanding of how to support the patient and family when designing patient safety interventions. This member was able to take new ideas from the Patient Family Advisory Council to the Fall Prevention Team and vice versa.

The TCHS Senior Leadership team has demonstrated a heightened awareness of patient safety since project inception. Several senior leader members are standing members of the Quality Committee and involved in safety discussions. The Nursing Supervisor takes information regarding patient safety to the standing bi-monthly Operations Team Committee meeting and makes needed requests for equipment to the CNO. The CNO is often involved in discussions regarding patient safety. Overall, the leadership team has been actively engaged in the quality improvement process.

Lessons Learned, Replicability, Sustainability:

Lessons learned from this project had broad implications and the potential to transition to future projects. Staff education, team engagement, care transitions, and discharge planning were a few of the areas that we learned that can affect fall prevention. Certainly, these multifocal concepts could be applied to additional quality and patient safety improvements. Of note, interdepartmental staff engagement amplified the connections within the organization needed to carry out large scale improvement projects. For instance, the staff were more engaged in being

proactive with fall prevention interventions to ensure the best outcome for the patients. In addition, staff members demonstrated more engagement in quality and safety initiatives. They expressed appreciation for overall support, including new equipment needed to care for the patient and acknowledgement of the hard work dedicated to patient safety. For example, discharge planning has been revamped to focus on the safety of the patient by ensuring the needed equipment and support resources are available at home to succeed. The care transition nurse calls patients after discharge to answer any questions they might have, verifies that the patient feels safe at home and has the equipment needed.

In terms of lessons learned, it was determined that a nurse champion would have been helpful to have on the fall prevention team. Education deficits might have been better addressed through use of the nurse champion role. It was recognized that there was a need to provide more education to the staff regarding fall huddles prior to implementation. Unfortunately at first, staff felt that they were being blamed or reprimanded when called in for the huddle. When in actuality, the idea was to learn more about the process and utilize their ideas to assist in fall prevention. Staff were able to provide useful information in identifying both the root causes and trends that were occurring with the falls.

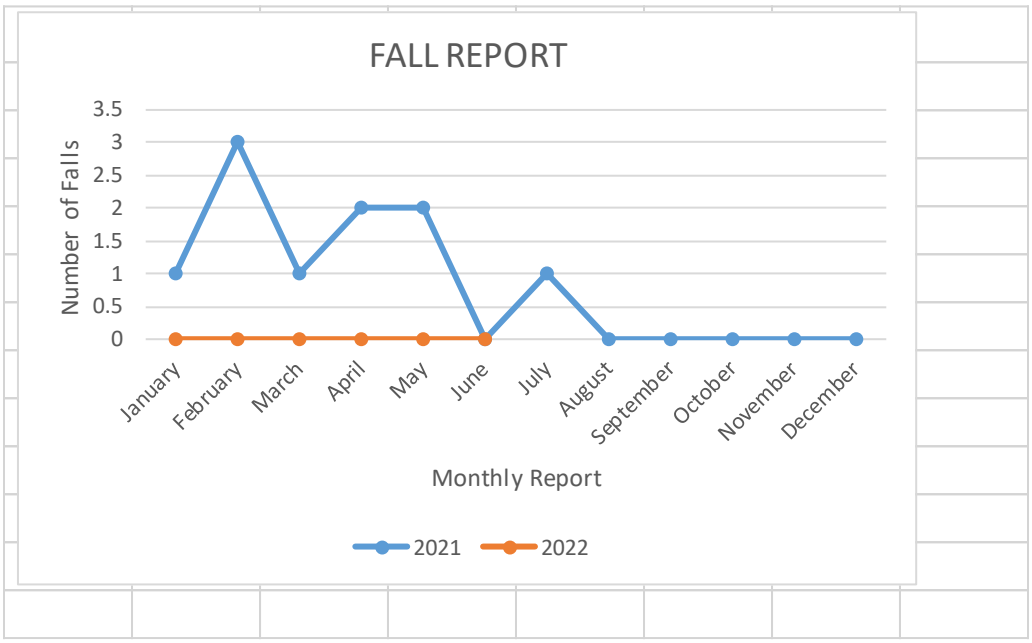
The outstanding results, including 365 days fall free speak to the level of sustainable practice achieved by TCHS staff. We continue to randomly audit fall interventions, educate and have discussions with staff in regards to fall prevention, and recognize the hard work and dedication of the staff in patient safety. Staff are more proactive in placement of interventions, ensuring proper equipment is available to the patient, and educating the patient regarding fall prevention interventions.

Additionally, sustainability of the project is demonstrated by integration into daily workflow. Utilizing the Morse Fall Scale to determine the interventions needed allows the patient to be as independent as possible while remaining safe. By completing the Morse Fall Scale every shift and utilizing the intervention "cheat sheet", staff retain the autonomy to add/remove interventions as needed at any given time if the patient has a status change.

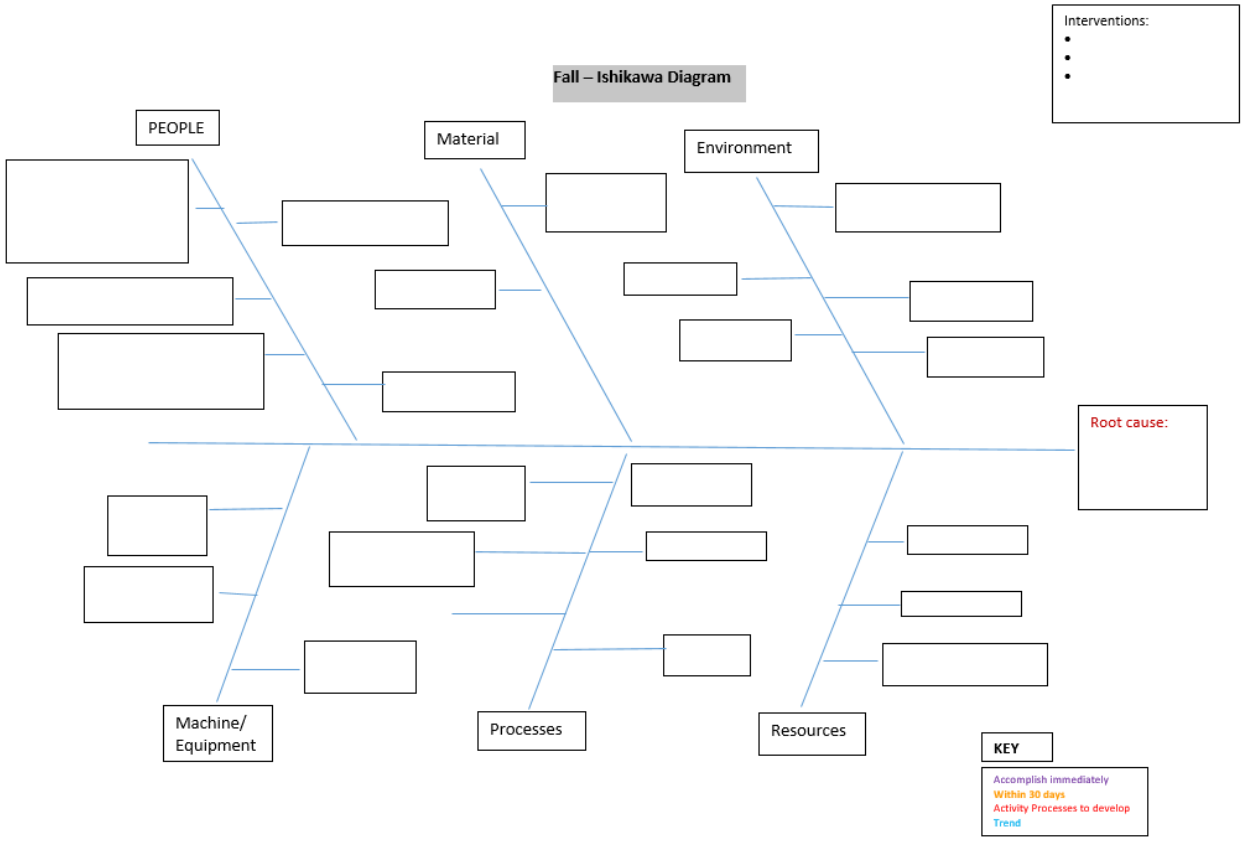
As a result of this project, new ideas for patient safety have emerged. For instance, a project on discharge planning and transition of care was initiated to ensure patient safety when returning home. Our amplified focus on patient safety has led to further projects, such as medication reconciliation improvement, patient medication counseling, and safe mobility for the high fall risk patient. We are currently starting a new Age Friendly Initiative utilizing the 4M (Matters, Mobility, Mentation, and Medication) framework to continue expansion of patient safety. Thayer County Health Services continues to strive for excellence in quality of care and patient safety.

BASELINE DATA ANALYSIS:

CURRENT DATA ANALYSIS:



ROOT CAUSE ANALYSIS:



This is the diagram that is utilized for root cause analysis to identify areas of improvement or trends from one fall to another.