2020 Quest for Excellence Project Submission

Faith Regional Health Services

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Step by Step: A Journey to Fall Prevention

Criteria 1 – Leadership/Planning (10 points)

In one year, our hospital reduced the number of inpatient falls by 26% resulting in our lowest fall rate in the past ten-years by utilizing a multidisciplinary step by step approach that kept focus on alignment and consistency. The journey to reduce falls started with alignment at all levels of the organization, from senior leadership and the board to the providers, frontline care providers, and support staff. The consistency was achieved through application of our mission and values. There was an organizational urgency to improve the quality and safety of our patients. This vision of safety set the foundation for our success and aligned with our strategic plan of hardwiring excellence by providing the best possible care to our patients.

Our fall problem was complex with several issues. We lacked alignment and consistency as well as a link to our mission and values. Without the presence of a fall team there was not an organized approach to reducing falls. Education was needed and our policy and procedure did not support our practice. Our fall assessment tool was not completely understood, and the interventions were not being applied consistently. There was also an absence of leadership, ownership, and oversight. Using a multifaceted approach with a multidisciplinary fall prevention team was our goal for forming the framework for our team. This team was led by the Quality Project Manager and included frontline champions from all disciplines, unit leaders, and administration. The following was accomplished: policy and procedure review, education, and development of post fall huddles. Audits were performed to highlight our opportunities and trends. Lastly, fall validations were conducted to validate education and application of

interventions. Staff received timely individual feedback on both positives as well as opportunities for improvement. This feedback was linked to our mission and values. The CNO and Vice President of Quality and Performance Improvement provided administrative support and guidance. The goal was to decrease our overall fall rate. With this goal, 90-day incremental action plans were implemented with reporting and accountability at all levels.

Criteria 2 – Process of Identifying Need (15 points)

As an organization we knew we knew that we wanted to lower our fall rate to better protect our patients and this ignited a sense of urgency to implement change. This urgency led to a multifaceted approach beginning with the collection of baseline data through an audit process, followed by the formation of a multidisciplinary fall prevention team. With all disciplines represented we were able to better work together as an engaged team and focus on our number one priority, the safety of our patients.

One of the situations that we faced as an organization was the fact that no one team or individual owned falls. We basically had to start from square one in organizing a team and linking its purpose to the Mission of the hospital. Our hospital's patient engagement committee was also involved with the process changes. The fall team reported monthly to this committee on changes and improvements being made to better protect our patients. The committee offered valuable ideas that was shared at team meetings. We also recognized that if we appropriately implemented changes, we could have a potential to reduce costs. When a patient has a fall, this is considered a "no pay event" which means no federal reimbursement for hospital acute care post-injury. According to The Joint Commission and Institute for Healthcare, the average cost of a fall with injury is $14,000 to $27,000 which could put an organization at risk financially. In addition

to increased costs, falls result in many injuries and they may also affect direct-care staff. At the end of the day we want our staff going home knowing they did everything they could to keep their patients safe. The benchmark goal for falls with injury per 1000 patient days is 0.44, which is set by the national Database of Nursing Quality Indicators (NDNQI). With this benchmark in the back of our head we had a lot of improvements to make.

Criteria 3 – Process Improvement Methods (30 points)

We utilized a standardized fall prevention toolkit as a resource for establishing a fall prevention team along with a Plan Do Check Act approach to implementing change. The toolkit recommended that we establish a multidisciplinary team and that's exactly what we did. This toolkit was also very helpful in identifying how fall prevention meetings should be run and provided us with organized checklists. We also used a standardized rounding tool for conducting audits and validations. Bedside auditing was conducted by leaders who provided front line staff with immediate feedback. To ensure patient safety, initiation of fall prevention interventions was the focus of the audits. These audits provided us with valuable data that helped us identify trends and address barriers encountered by front line staff. This data ultimately allowed us to develop focused education and training activities for staff throughout the hospital. The last change that helped with fall reduction was the emphasis placed on the utilization of the Post Fall Huddle form. It was determined that this form was not consistently being filled out by all inpatient departments. Information about the importance of this form was included in the education to staff. Further, it was determined that the information being gathered was missing some essential information that would help identify appropriate individualized fall preventions for patients. The Post Fall Huddle Form was reviewed, and several revisions were made based on suggestions

from the fall prevention team. Historically the form was delivered to the unit's Director for review. The team recommended that additional staff review the form and make input as needed. With the team's recommendation a Post Fall Huddle email group was established. Included in the group were Directors, Managers, Quality staff, Risk Management staff, Nursing Supervisors, and the VP/Chief Nursing Officer. Once the form was complete the Nursing Supervisor would email it to the email group for review.

Criteria 4 – Results (30 points)

While conducting audits we quickly recognized that changes to the current Fall Prevention Policy were needed. The team worked with front line staff to research best practices and implement changes. Auditing at the bedside proved to be worth the time. On our Medical Surgical unit, we increased compliance of bed and chair alarm usage from 44% to 90%, compliance of placing the yellow fall risk wristband from 67% to 95%, placement of yellow falling star magnet from 56% to 98%, and compliance of updating the patient care board from 67% to 88%. All these improvements were accomplished in two months. We continue to do random audits on these interventions to ensure staff compliance. The fall team had its first meeting in April after a disheartening first quarter which resulted in 23 patient falls. This was also when the baseline data collection was occurring through audits which showed that our compliance with fall prevention techniques was not up to par. After establishment of the team, a robust audit process, and implementation of improvements, falls were reduced to 12 in the second quarter, 19 in the third, and only 10 in the fourth. A substantial reduction of falls with injury was also noted throughout the year. During the first quarter there were 8, 4 in the second, 4 in the third, and only 3 in the fourth. Also, the hospital enjoyed a 137 day stretch with zero

falls with injury in the Acute Care Area. Prior to this, such a feat had not been accomplished since FRHS began tracking fall rates in 2011. In October of 2019 our organization implemented a new Electronic Health Record, Fall Prevention Screening tool, and a new Fall Prevention Policy. FRHS plans to continue auditing fall prevention interventions and hold monthly fall prevention meetings. These meetings will allow us to address barriers as they arise, and allow us to continue working through issues so that FRHS is able to provide the safest environment for our patients.

Criteria 5 – Lessons Learned, Replicability, Sustainability (15 points)

This project has been unique in that there have been very few projects at our organization that have included hands on training for the executive team. When we introduced the goal of reducing patient falls in our inpatient setting, the Board of the hospital felt it was essential to engage all staff within the organization. Throughout our project the engagement of staff focused not only on frontline nursing positions, rather it included everyone from the executive team to housekeeping and plant services. Anyone that could/would walk into or past a patient room was included in this safety initiative. While the frontline nursing staff played a larger role, we still wanted all ancillary staff to be able to identify ways they could help improve patient safety. With nursing involvement this was also one of the first time that our organization increased the responsibilities of our charge nurses. To increase engagement charge nurses in addition to directors and managers were trained to audit falls. By delegating these fall audits to charge nurses there was a sense of empowerment that encourage staff engagement which ultimately made our project successful. In addition to staff engagement through their involvement in auditing, the auditing techniques used were vital to the success of this project. Through auditing,

leaders were able to provide immediate feedback to staff. This feedback allowed for real time corrections on issues that could be compromising patient safety. This project not only allowed us to increase the safety of patients within the organization, but also gave us the tools to build our staff to be stronger, more confident leaders. With the success of this project in 2019 there were also many lessons learned. As we all know 2020 provided us with many obstacles with the biggest being the COVID-19 pandemic. During this time, it was noted that non-clinical staff were rounding less on patient's due to the strict PPE requirements and shortages which we believe had an impact on patient falls. We learned that to maintain sustained results it is important to be consistent with auditing and validating any new process.