Indiana Patient Safety Center
of the Indiana Hospital Association

Falls Rewind

Madeline Wilson, MSN, RN, CLSSBB

October 31, 2019

Objectives

Indiana Patient Safety Center
of the Indiana Hospital Association

- Review HIIN data
- Discuss targeted interventions for fall prevention
- Review resources to assist with harm reduction

Did you know?

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HRET/HIIN Goal

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20 percent reduction in patient falls by 2019.

- *Partnership for Patients (PfP) Goal*

State HIIN Improvement Data

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Current Rate: 0.54

Target Rate: 0.53

Harm Measure	Most recent Month Reported	Project to Date Relative Reduction	Monthly Baseline Numerator	Monthly Baseline Denominator	Project to Date Numerator	Project to Date Denominator
Falls with Injury	July	19%	151	226,153	2,594	4,797,865

Snapshot of State HIIN Data

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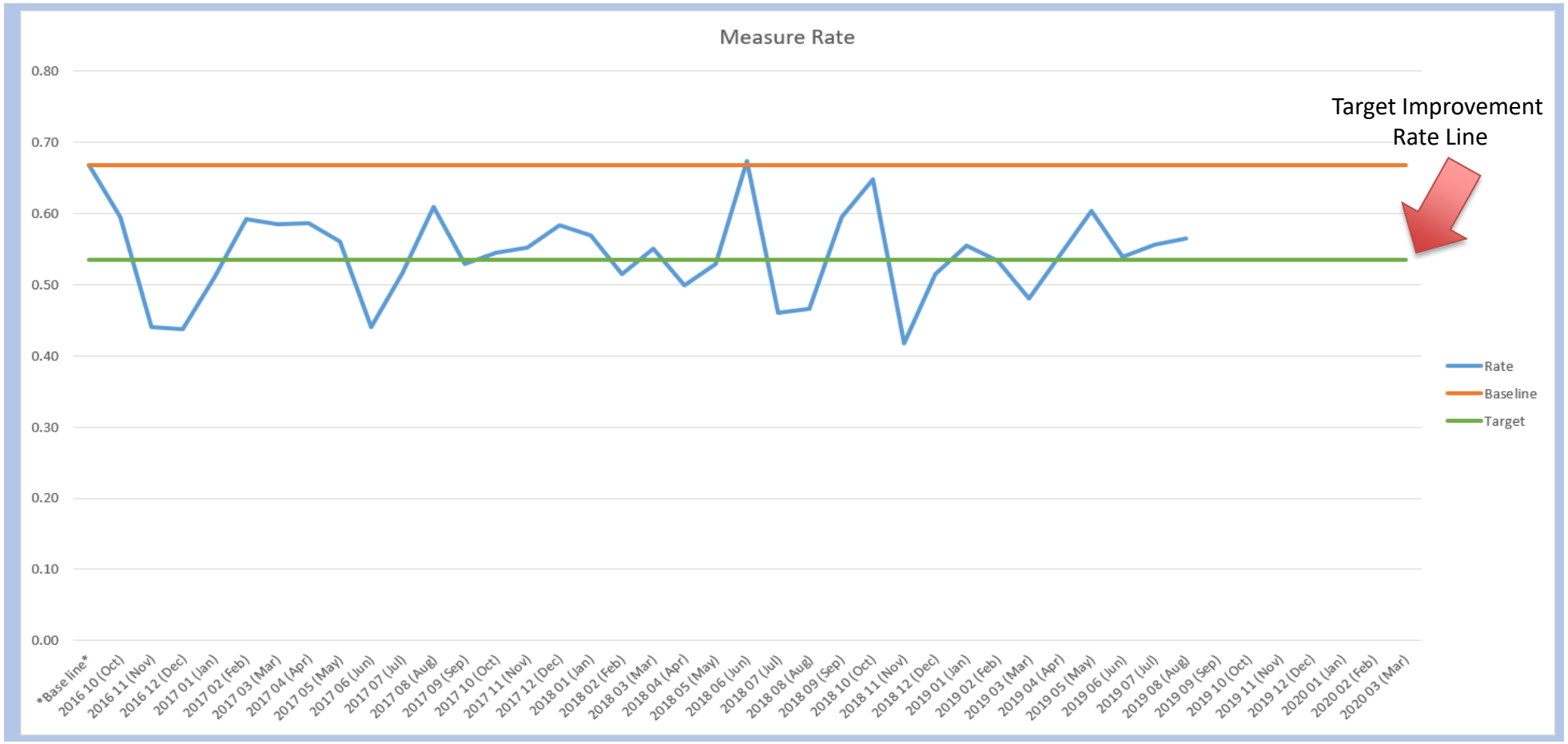
(All) (92 hospitals) for measure(s) selected with the slicer on the left, including Falls with Injury



The Numbers

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Of 92 HIIN participating hospitals-

- 14 hospitals have a combined total of 2,016 falls with harm
- Total falls with harm = 2,594

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What are you doing to reduce falls?

Impulsive Fallers?

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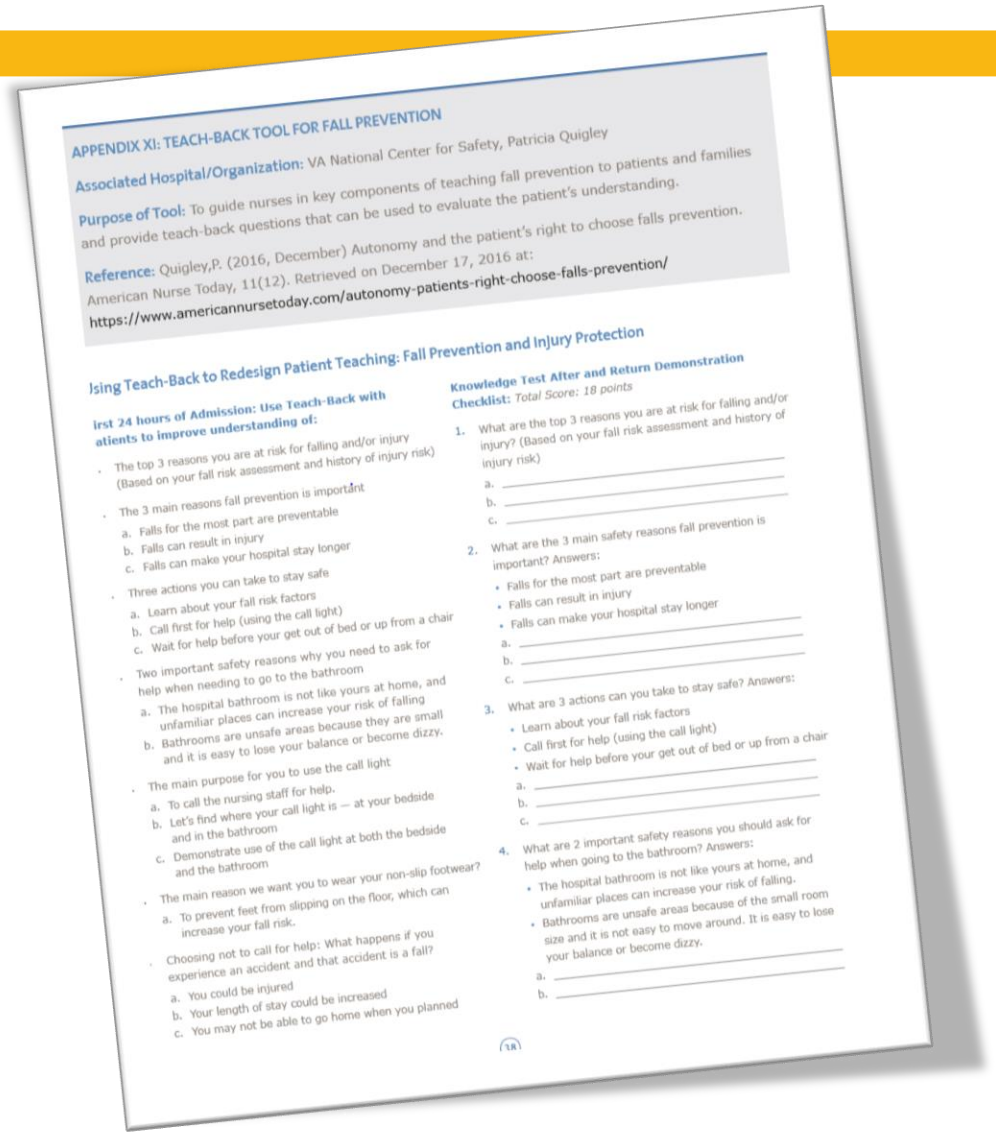

APPENDIX XI: TEACH-BACK TOOL FOR FALL PREVENTION

Associated Hospital/Organization: VA National Center for Safety, Patricia Quigley

Purpose of Tool: To guide nurses in key components of teaching fall prevention to patients and families and provide teach-back questions that can be used to evaluate the patient's understanding.

Reference: Quigley,P. (2016, December) Autonomy and the patient's right to choose falls prevention. American Nurse Today, 11(12). Retrieved on December 17, 2016 at: https://www.americannursetoday.com/autonomy-patients-right-choose-falls-prevention/

Using Teach-Back to Redesign Patient Teaching: Fall Prevention and Injury Protection

First 24 hours of Admission: Use Teach-Back with patients to improve understanding of:

- The top 3 reasons you are at risk for falling and/or injury (Based on your fall risk assessment and history of injury risk)
- The 3 main reasons fall prevention is important
  a. Falls for the most part are preventable
  b. Falls can result in injury
  c. Falls can make your hospital stay longer
- Three actions you can take to stay safe
  a. Learn about your fall risk factors
  b. Call first for help (using the call light)
  c. Wait for help before your get out of bed or up from a chair
- Two important safety reasons why you need to ask for help when needing to go to the bathroom
  a. The hospital bathroom is not like yours at home, and unfamiliar places can increase your risk of falling
  b. Bathrooms are unsafe areas because they are small and it is easy to lose your balance or become dizzy.
- The main purpose for you to use the call light
  a. To call the nursing staff for help.
  b. Let's find where your call light is — at your bedside and in the bathroom
  c. Demonstrate use of the call light at both the bedside and the bathroom
- The main reason we want you to wear your non-slip footwear?
  a. To prevent feet from slipping on the floor, which can increase your fall risk.
- Choosing not to call for help: What happens if you experience an accident and that accident is a fall?
  a. You could be injured
  b. Your length of stay could be increased
  c. You may not be able to go home when you planned

Knowledge Test After and Return Demonstration Checklist: *Total Score: 18 points*

1. What are the top 3 reasons you are at risk for falling and/or injury? (Based on your fall risk assessment and history of injury risk)
   a. _____
   b. _____
   c. _____
2. What are the 3 main safety reasons fall prevention is important? Answers:
   - Falls for the most part are preventable
   - Falls can result in injury
   - Falls can make your hospital stay longer
   a. _____
   b. _____
   c. _____
3. What are 3 actions can you take to stay safe? Answers:
   - Learn about your fall risk factors
   - Call first for help (using the call light)
   - Wait for help before your get out of bed or up from a chair
   a. _____
   b. _____
   c. _____
4. What are 2 important safety reasons you should ask for help when going to the bathroom? Answers:
   - The hospital bathroom is not like yours at home, and unfamiliar places can increase your risk of falling.
   - Bathrooms are unsafe areas because of the small room size and it is not easy to move around. It is easy to lose your balance or become dizzy.
   a. _____
   b. _____

18

Consider this teach-back tool from the HRET Change Package. Not only does it encourage patient/staff collaboration, but it also promotes "scripting" and helps staff to become more comfortable with conversations about falls.

http://www.hret-hiin.org/Resources/falls/18/falls-with-injury-change-package.pdf

Post Fall Huddle-Study from AHRQ

Indiana Patient Safety Center
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Jones et al. BMC Health Services Research (2019) 19:650
https://doi.org/10.1186/s12913-019-4453-y

BMC Health Services Research

RESEARCH ARTICLE — Open Access

The impact of post-fall huddles on repeat fall rates and perceptions of safety culture: a quasi-experimental evaluation of a patient safety demonstration project

Katherine J. Jones[1*], John Crowe[2], Joseph A. Allen[2], Anne M. Skinner[1], Robin High[3], Victoria Kennel[1] and Roni Reiter-Palmon[2]

Abstract

Background: Conducting post-fall huddles is considered an integral component of a fall-risk-reduction program. However, there is no evidence linking post-fall huddles to patient outcomes or perceptions of teamwork and safety culture. The purpose of this study is to determine associations between conducting post-fall huddles and repeat fall rates and between post-fall huddle participation and perceptions of teamwork and safety culture.

Methods: During a two-year demonstration project, we developed a system for 16 small rural hospitals to report, benchmark, and learn from fall events, and we trained them to conduct post-fall huddles. To calculate a hospital's repeat fall rate, we divided the total number of falls reported by the hospital by the number of unique medical record numbers associated with each fall. We used Spearman correlations with exact *P* values to determine the association between the proportion of falls followed by a huddle and the repeat fall rate. At study end, we used the TeamSTEPPS® Teamwork Perceptions Questionnaire (T-TPQ) to assess perceptions of teamwork support for fall-risk reduction and the Hospital Survey on Patient Safety Culture (HSOPS) to assess perceptions of safety culture. We added an item to the T-TPQ for respondents to indicate the number of post-fall huddles in which they had participated. We used a binary logistic regression with a logit link to examine the effect of participation in post-fall huddles on respondent-level percent positive T-TPQ and HSOPS scores. We accounted for clustering of respondents within hospitals with random effects using the GLIMMIX procedure in SAS/STAT.

Result: Repeat fall rates were negatively associated with the proportion of falls followed by a huddle. As compared to hospital staff who did not participate in huddles, those who participated in huddles had more positive perceptions of four domains of safety culture and how team structure, team leadership, and situation monitoring supported fall-risk reduction.

Conclusions: Post-fall huddles may reduce the risk of repeat falls. Staff who participate in post-fall huddles are likely to have positive perceptions of teamwork support for fall-risk reduction and safety culture because huddles are a team-based approach to reporting, adapting, and learning.

Keywords: Post-fall huddles, Teamwork, Safety culture

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Method: Used the TeamSTEPPS® Teamwork Perceptions Questionnaire (T-TPQ) to assess perceptions of teamwork support for fall-risk reduction and the Hospital Survey on Patient Safety Culture (HSOPS) to assess perceptions of safety culture.
https://www.ahrq.gov/teamstepps/instructor/reference/teampercept.html

Result: Repeat fall rates were negatively associated with the proportion of falls followed by a huddle. As compared to hospital staff who did not participate in huddles, those who participated in huddles had more positive perceptions of four domains of safety culture and how team structure, team leadership, and situation monitoring supported fall-risk reduction.

https://psnet.ahrq.gov/issue/impact-post-fall-huddles-repeat-fall-rates-and-perceptions-safety-culture-quasi-experimental

Findings from the study…

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"Patient falls are complex because they result from a combination of patient (e.g. lower extremity weakness), environmental (e.g. tripping hazards), and system factors. System factors that contribute to patient falls include the attitude that falls are inevitable, poor teamwork, and an inability to adequately learn from fall events."

https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y

University of Nebraska Med Center Huddle Pocket Guide and Form

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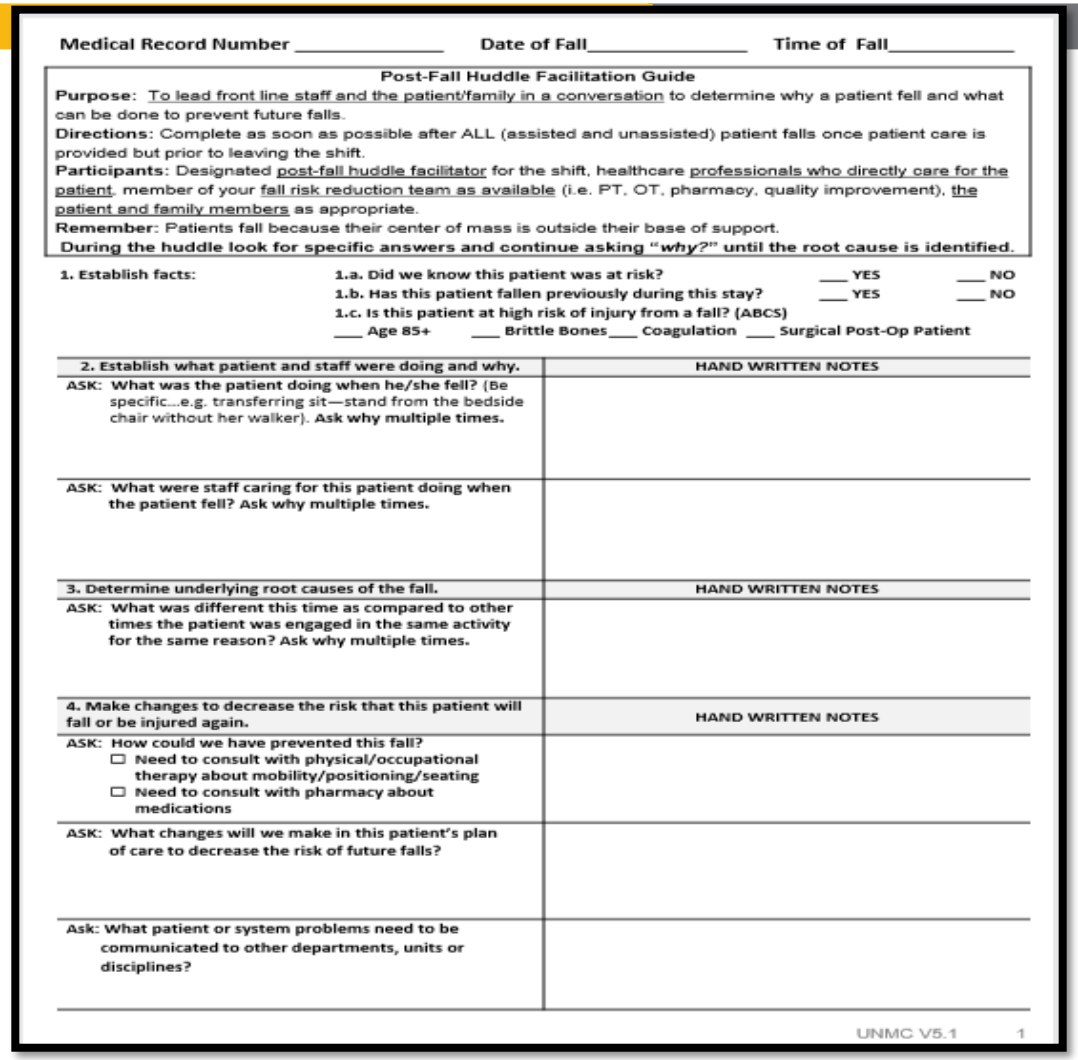
CAPTURE FALLS:
POST-FALL HUDDLE GUIDE

1. Establish facts…a) was this patient at risk, b) a previous fall, c) ABCs?
2. What was the patient doing when he/she fell? Why?
3. What were staff caring for this patient doing when the patient fell? Why?
4. What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Why?
5. How could we have prevented this fall?
6. What changes will we make in this patient's plan of care to decrease the risk of future falls?
7. What patient or system problems need to be communicated to other departments, units, or disciplines?
8. Complete documentation
   a. Who attended
   b. Type of fall
   c. Type of error

UNMC

POST-FALL HUDDLE FACILITATOR TIPS

1. Create a safe, learning-focused environment (e.g., this is an opportunity for the *front line to learn* about why a patient fell – actively listen and be slow to judge)
2. Ask probing questions (e.g., ask "*why?*" until root causes are identified)
3. Encourage open and honest sharing of information from all huddle participants (e.g., encourage turn taking and recognize each person's contribution)
4. Give praise and acknowledge good work (e.g., say "thank you" and "nice job" when appropriate)
5. Identify mistakes made and focus on how staff can improve in the future (e.g., acknowledge the mistake but specifically mention an action staff can take to address this issue in the future)



Medical Record Number _____ Date of Fall_____ Time of Fall_____

Post-Fall Huddle Facilitation Guide

Purpose: To lead front line staff and the patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls.
Directions: Complete as soon as possible after ALL (assisted and unassisted) patient falls once patient care is provided but prior to leaving the shift.
Participants: Designated post-fall huddle facilitator for the shift, healthcare professionals who directly care for the patient, member of your fall risk reduction team as available (i.e. PT, OT, pharmacy, quality improvement), the patient and family members as appropriate.
Remember: Patients fall because their center of mass is outside their base of support.
During the huddle look for specific answers and continue asking "*why?*" until the root cause is identified.

1. Establish facts:
1.a. Did we know this patient was at risk? ___ YES ___ NO
1.b. Has this patient fallen previously during this stay? ___ YES ___ NO
1.c. Is this patient at high risk of injury from a fall? (ABCS)
___ Age 85+ ___ Brittle Bones ___ Coagulation ___ Surgical Post-Op Patient

2. Establish what patient and staff were doing and why.	HAND WRITTEN NOTES
ASK: What was the patient doing when he/she fell? (Be specific…e.g. transferring sit—stand from the bedside chair without her walker). Ask why multiple times.	
ASK: What were staff caring for this patient doing when the patient fell? Ask why multiple times.	
3. Determine underlying root causes of the fall.	**HAND WRITTEN NOTES**
ASK: What was different this time as compared to other times the patient was engaged in the same activity for the same reason? Ask why multiple times.	
4. Make changes to decrease the risk that this patient will fall or be injured again.	**HAND WRITTEN NOTES**
ASK: How could we have prevented this fall? ☐ Need to consult with physical/occupational therapy about mobility/positioning/seating ☐ Need to consult with pharmacy about medications	
ASK: What changes will we make in this patient's plan of care to decrease the risk of future falls?	
Ask: What patient or system problems need to be communicated to other departments, units or disciplines?	

UNMC V5.1 1

https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

Are you assessing mobility status and adding to the care plan?

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B.M.A.T. - Banner Mobility Assessment Tool for Nurses

Test	Task	Response	Fail = Choose Most Appropriate Equipment/Device(s)	Pass
Assessment Level 1 Assessment of: -Cognition -Trunk strength -Seated balance	**Sit and Shake**: From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at the side of the bed; *may use the bedrail.* Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	**Sit:** Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). **Shake:** Patient has significant upper body strength, awareness of body in space, and grasp strength.	**MOBILITY LEVEL 1** - Use total lift with sling and/or repositioning sheet and/or straps. - Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube), or air assisted device. **NOTE:** *If patient has **'strict bed rest'** or **bilateral 'non-weight bearing'** restrictions, **do not proceed** with the assessment; **patient is MOBILITY LEVEL 1.***	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of : -Lower extremity strength -Stability	**Stretch and Point**: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	Patient exhibits lower extremity stability, strength and control. **May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).**	**MOBILITY LEVEL 2** - Use total lift for patient unable to weight-bear on at least one leg. - Use sit-to-stand lift for patient who can weight-bear on at least one leg.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: -Lower extremity strength for standing	**Stand**: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	Patient exhibits upper and lower extremity stability and strength. **May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).** **If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.**	**MOBILITY LEVEL 3** - Use non-powered raising/stand aid; *default to powered sit-to-stand lift if no stand aid available.* - Use total lift with ambulation accessories. - Use assistive device (cane, walker, crutches). NOTE: Patient passes Assessment Level 3 **but requires assistive device** to ambulate or **cognitive assessment** indicates poor safety awareness; ***patient is MOBILITY LEVEL 3.***	Passed Assessment Level 3 **AND no assistive device needed** = Proceed with Assessment Level 4. ***Consult with Physical Therapist when needed and appropriate.***
Assessment Level 4 Assessment of: -Standing balance -Gait	**Walk:** Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	**MOBILITY LEVEL 3** If patient shows signs of unsteady gait or ***fails* Assessment Level 4,** refer back to **MOBILITY LEVEL 3; *patient is MOBILITY LEVEL 3.***	**MOBILITY LEVEL 4** MODIFIED INDEPENDENCE **Passed = No assistance needed to ambulate**; use your best clinical judgment to determine need for supervision during ambulation.

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.

Originated: 2011; revised: 2/27/12, 3/02/12, 3/07/12, 3/19/12, 4/19/12, 5/01/12, 5/03/12, 05/20/2013

Pre-hospitalization Risk Assessment & Education-it matters!

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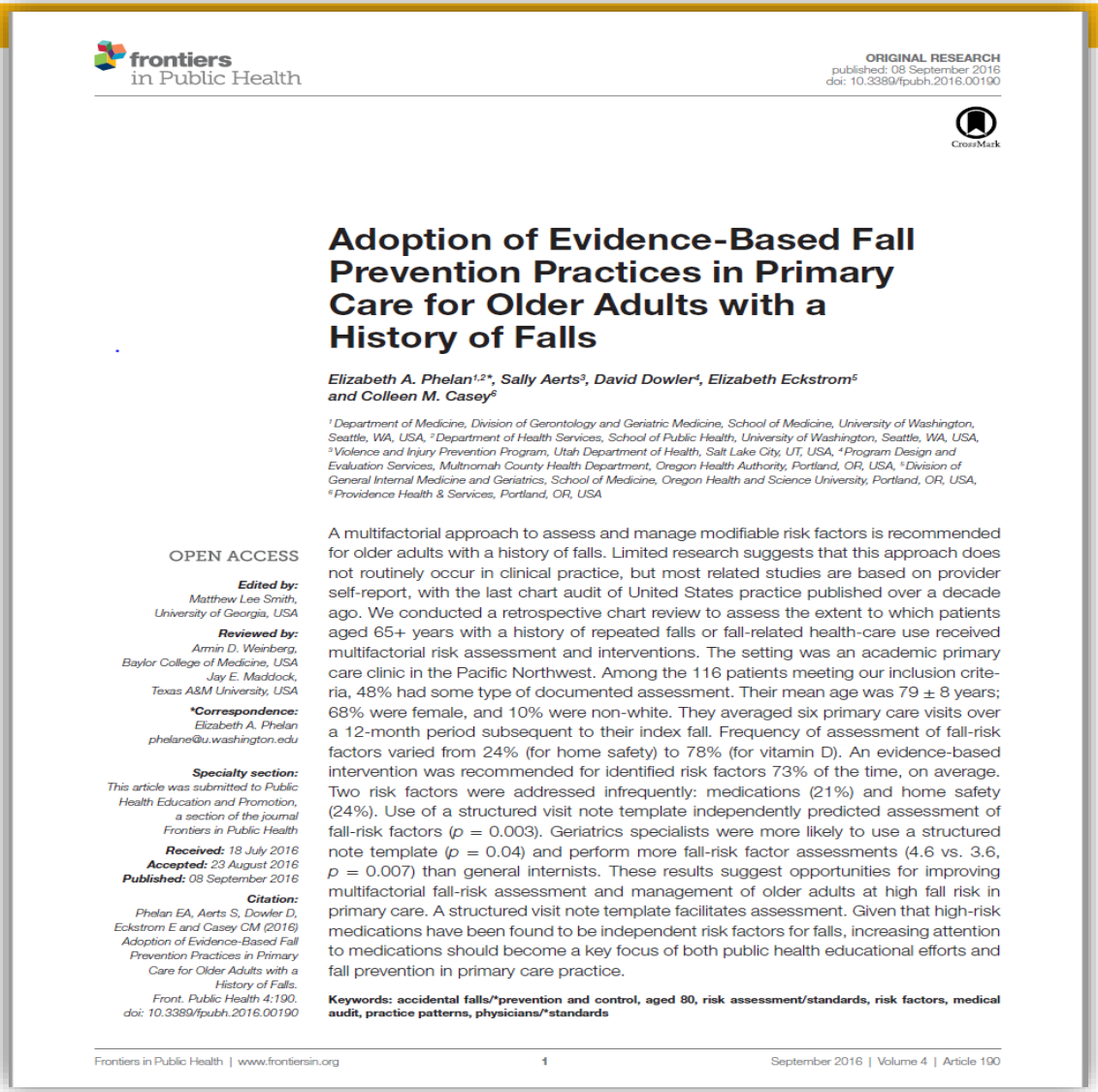

frontiers in Public Health

ORIGINAL RESEARCH
published: 08 September 2016
doi: 10.3389/fpubh.2016.00190

Adoption of Evidence-Based Fall Prevention Practices in Primary Care for Older Adults with a History of Falls

Elizabeth A. Phelan[1,2], Sally Aerts[3], David Dowler[4], Elizabeth Eckstrom[5] and Colleen M. Casey[6]*

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A multifactorial approach to assess and manage modifiable risk factors is recommended for older adults with a history of falls. Limited research suggests that this approach does not routinely occur in clinical practice, but most related studies are based on provider self-report, with the last chart audit of United States practice published over a decade ago. We conducted a retrospective chart review to assess the extent to which patients aged 65+ years with a history of repeated falls or fall-related health-care use received multifactorial risk assessment and interventions. The setting was an academic primary care clinic in the Pacific Northwest. Among the 116 patients meeting our inclusion criteria, 48% had some type of documented assessment. Their mean age was 79 ± 8 years; 68% were female, and 10% were non-white. They averaged six primary care visits over a 12-month period subsequent to their index fall. Frequency of assessment of fall-risk factors varied from 24% (for home safety) to 78% (for vitamin D). An evidence-based intervention was recommended for identified risk factors 73% of the time, on average. Two risk factors were addressed infrequently: medications (21%) and home safety (24%). Use of a structured visit note template independently predicted assessment of fall-risk factors ($p = 0.003$). Geriatrics specialists were more likely to use a structured note template ($p = 0.04$) and perform more fall-risk factor assessments (4.6 vs. 3.6, $p = 0.007$) than general internists. These results suggest opportunities for improving multifactorial fall-risk assessment and management of older adults at high fall risk in primary care. A structured visit note template facilitates assessment. Given that high-risk medications have been found to be independent risk factors for falls, increasing attention to medications should become a key focus of both public health educational efforts and fall prevention in primary care practice.

Keywords: accidental falls/*prevention and control, aged 80, risk assessment/standards, risk factors, medical audit, practice patterns, physicians/*standards

OPEN ACCESS

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Specialty section:
This article was submitted to Public Health Education and Promotion, a section of the journal Frontiers in Public Health

Received: *18 July 2016*
Accepted: *23 August 2016*
Published: *08 September 2016*

Citation:
Phelan EA, Aerts S, Dowler D, Eckstrom E and Casey CM (2016) Adoption of Evidence-Based Fall Prevention Practices in Primary Care for Older Adults with a History of Falls. Front. Public Health 4:190. doi: 10.3389/fpubh.2016.00190

https://www.frontiersin.org/articles/10.3389/fpubh.2016.00190/full#T2

IHAconnect.org/Quality-Patient-Safety

Patient & Family Engagement

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- **Recommendations for Practice: Use the STEADI Materials**
- STEADI is a comprehensive set of materials that provides a foundation to systematically evaluate and address fall risk.
- STEADI includes an algorithm to assess fall risk, tips for integrating fall risk management into clinical practice, assessment tools for modifiable fall-risk factors, descriptions of interventions, and patient education materials.
- It is a systematic, evidence-based, accessible, and free resource for PCPs and their practice teams to evaluate and manage their patients' fall risk.

https://www.cdc.gov/steadi/patient.html

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Resources

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Falls PI Tool

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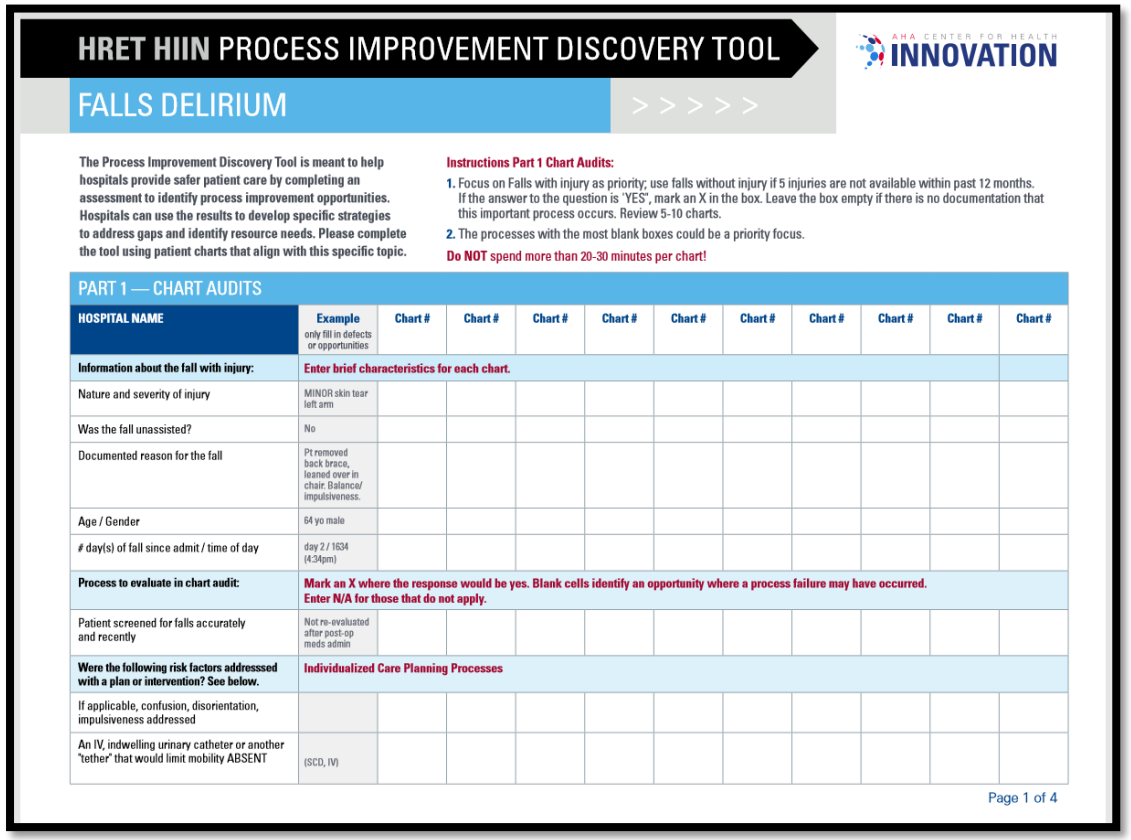

HRET HIIN PROCESS IMPROVEMENT DISCOVERY TOOL

AHA CENTER FOR HEALTH INNOVATION

FALLS DELIRIUM

The Process Improvement Discovery Tool is meant to help hospitals provide safer patient care by completing an assessment to identify process improvement opportunities. Hospitals can use the results to develop specific strategies to address gaps and identify resource needs. Please complete the tool using patient charts that align with this specific topic.

Instructions Part 1 Chart Audits:

1. Focus on Falls with injury as priority; use falls without injury if 5 injuries are not available within past 12 months. If the answer to the question is 'YES", mark an X in the box. Leave the box empty if there is no documentation that this important process occurs. Review 5-10 charts.
2. The processes with the most blank boxes could be a priority focus.

Do NOT spend more than 20-30 minutes per chart!

PART 1 — CHART AUDITS

HOSPITAL NAME	Example only fill in defects or opportunities	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #	Chart #
Information about the fall with injury:	**Enter brief characteristics for each chart.**										
Nature and severity of injury	MINOR skin tear left arm										
Was the fall unassisted?	No										
Documented reason for the fall	Pt removed back brace, leaned over in chair. Balance/ impulsiveness.										
Age / Gender	64 yo male										
# day(s) of fall since admit / time of day	day 2 / 1634 (4:34pm)										
Process to evaluate in chart audit:	**Mark an X where the response would be yes. Blank cells identify an opportunity where a process failure may have occurred. Enter N/A for those that do not apply.**										
Patient screened for falls accurately and recently	Not re-evaluated after post-op meds admin										
Were the following risk factors addresssed with a plan or intervention? See below.	**Individualized Care Planning Processes**										
If applicable, confusion, disorientation, impulsiveness addressed											
An IV, indwelling urinary catheter or another "tether" that would limit mobility ABSENT	(SCD, IV)										

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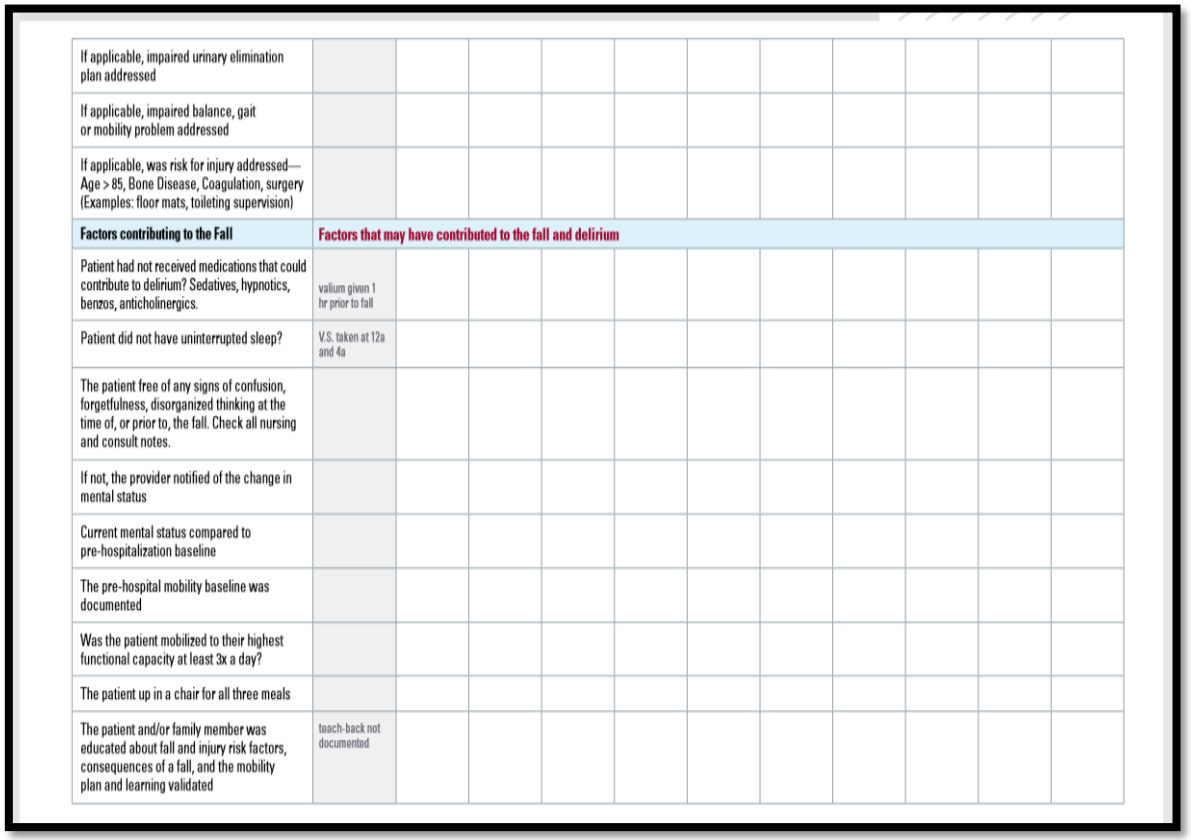

If applicable, impaired urinary elimination plan addressed											
If applicable, impaired balance, gait or mobility problem addressed											
If applicable, was risk for injury addressed—Age > 85, Bone Disease, Coagulation, surgery (Examples: floor mats, toileting supervision)											
Factors contributing to the Fall	**Factors that may have contributed to the fall and delirium**										
Patient had not received medications that could contribute to delirium? Sedatives, hypnotics, benzos, anticholinergics.	valium given 1 hr prior to fall										
Patient did not have uninterrupted sleep?	V.S. taken at 12a and 4a										
The patient free of any signs of confusion, forgetfulness, disorganized thinking at the time of, or prior to, the fall. Check all nursing and consult notes.											
If not, the provider notified of the change in mental status											
Current mental status compared to pre-hospitalization baseline											
The pre-hospital mobility baseline was documented											
Was the patient mobilized to their highest functional capacity at least 3x a day?											
The patient up in a chair for all three meals											
The patient and/or family member was educated about fall and injury risk factors, consequences of a fall, and the mobility plan and learning validated	teach-back not documented										

http://www.hret-hiin.org/Resources/falls/19/discovery-tools-falls-final-enabled.pdf

From HRET

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Go to this website to access these resources:

http://www.hret-hiin.org/Resources/falls/19/hot-topic-falls-73119.pdf

Mobility Resources to Get You Started

Mobility Assessments

- Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool
- Timed Get up and Go Test
- Get Up and Go Test

Staff Training

- CAPTURE Falls mobility training videos, mobility tools

Mobility Change Package

- Project HELP Mobility Change Package – Staff training and competency checklists

Mobility Protocols and Resources

- Med Surg Mobility Protocol
- ICU Mobility Protocol
- Beach Chair Positoning Article

Patient and Family Engagement Resources

- Staying Active in Hospital - handout
- Teach Back Tool for Fall Prevention
- Lutheran Fall Questionnaire

Mobility Tracking Tools

- Mobility is Medicine Bedside Tracker
- Daily Mobility Patient Goal sign
- Let's Get Moving Bedside Mobility Tracker
- Walk of Fame Mobility Board – hallway board to make mobility visible

Environmental Safety

- Guide: Creating a Safe Environment to Prevent Toileting Related Injuries

Developing a Business Case for Mobility

Financial modeling for mobility program: Pub med link

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American Hospital Association™ Advancing Health in America

HRET Change Package

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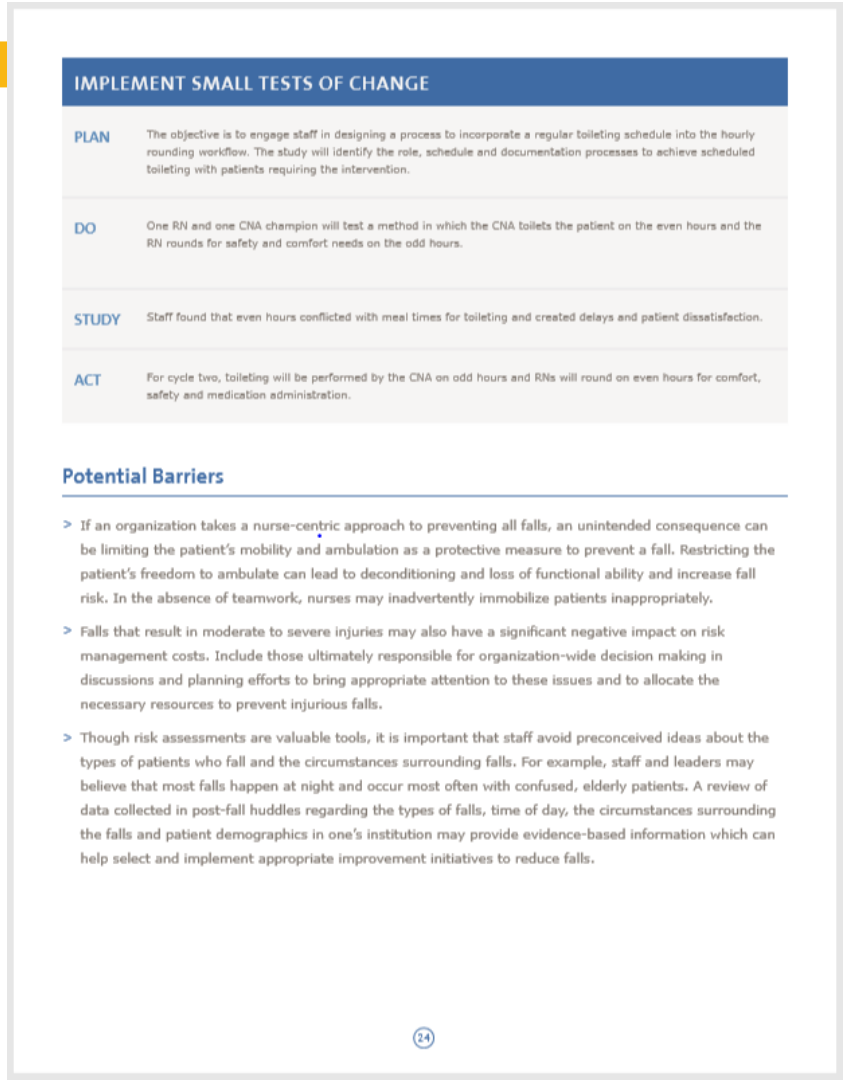

IMPLEMENT SMALL TESTS OF CHANGE

PLAN	The objective is to engage staff in designing a process to incorporate a regular toileting schedule into the hourly rounding workflow. The study will identify the role, schedule and documentation processes to achieve scheduled toileting with patients requiring the intervention.
DO	One RN and one CNA champion will test a method in which the CNA toilets the patient on the even hours and the RN rounds for safety and comfort needs on the odd hours.
STUDY	Staff found that even hours conflicted with meal times for toileting and created delays and patient dissatisfaction.
ACT	For cycle two, toileting will be performed by the CNA on odd hours and RNs will round on even hours for comfort, safety and medication administration.

Potential Barriers

- If an organization takes a nurse-centric approach to preventing all falls, an unintended consequence can be limiting the patient's mobility and ambulation as a protective measure to prevent a fall. Restricting the patient's freedom to ambulate can lead to deconditioning and loss of functional ability and increase fall risk. In the absence of teamwork, nurses may inadvertently immobilize patients inappropriately.
- Falls that result in moderate to severe injuries may also have a significant negative impact on risk management costs. Include those ultimately responsible for organization-wide decision making in discussions and planning efforts to bring appropriate attention to these issues and to allocate the necessary resources to prevent injurious falls.
- Though risk assessments are valuable tools, it is important that staff avoid preconceived ideas about the types of patients who fall and the circumstances surrounding falls. For example, staff and leaders may believe that most falls happen at night and occur most often with confused, elderly patients. A review of data collected in post-fall huddles regarding the types of falls, time of day, the circumstances surrounding the falls and patient demographics in one's institution may provide evidence-based information which can help select and implement appropriate improvement initiatives to reduce falls.

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http://www.hret-hiin.org/Resources/falls/18/falls-with-injury-change-package.pdf

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