Reducing Falls with Injury

Indiana Harm Focus Areas
November 13, 2015

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Partnering with Communities to Achieve Zero Patient Harms

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Indiana Harm Priority Focus Areas

- Adverse Drug Events
- Care Transitions and Readmissions
- Catheter-Associated Urinary Tract Infections
- Prevention of Injurious Falls
- Sepsis

Underlying Assumptions:

- Selected topics determined by most need for improvement
- Call upon small group of engaged "experts" to collaborate on an Indiana plan
- Develop 3-5 recommendations based on validated research on best practices (don't reinvent the wheel)
- Identify up to 5 action items Indiana hospitals can take to improve performance on topic

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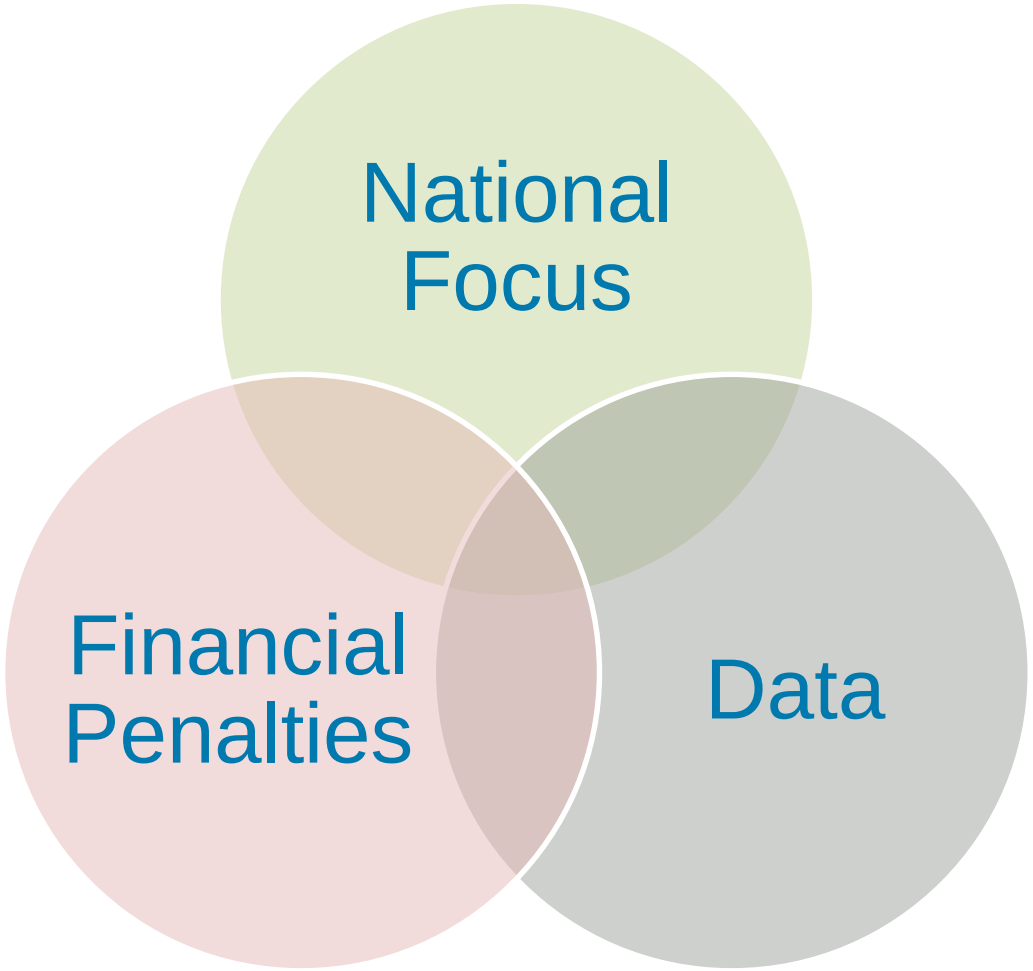
Why These Five?



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Falls with Injury

Falls: CMS HEN Evaluation Measure (NQF 0202)	
All Documented Patient Falls with an Injury Level of Minor or Greater	
Measure type	Outcome
Numerator	Total number of patient falls of injury level minor or greater (whether or not assisted by a staff member) by eligible hospital unit during the measurement period[6]
Denominator	Patient days by in eligible units during the measurement period[3]
Rate calculation	$\frac{Numerator}{Denominator}$ x1,000
Specifications/definitions Sources/Recommendations	Available from NQF 0202

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Indiana's HRET HEN Results

Measure Name	% Reduction (Positive Number Indicates Improvement)
Excessive anticoagulation with warfarin - Inpatients	25.87
ADEs due to opioids	0.2
Hypoglycemia in inpatients receiving insulin	4.27
Catheter-Associated Urinary Tract Infections Rate - All Tracked Units (CDC NHSN)	12.08
Catheter-Associated Urinary Tract Infections Rate in ICU (CDC NHSN)	-54.74
CLABSI Rate - All Units (by Device Days) (CDC NHSN)	5.43
CLABSI Rate - ICU (by Device Days) (CDC NHSN)	20.42
Falls With Injury (minor or greater) (NSC-5)	-3.97
Birth Trauma - Injury to Neonate (AHRQ PSI-17)	40.88
Patients with at least One Stage II or Greater Nosocomial Pressure Ulcers (NSC-2)	18.68
Surgical Site Infection Rate (within 30 days after procedure) (CDC NHSN)	3.53
Potentially Preventable VTE (VTE-6)	54.01
Possible/Probable VAP Rate-All Units (CDC NHSN)	-77.38
Readmission within 30 days (All Cause)	2.61
Elective Deliveries at >= 37 Weeks and < 39 Weeks (JC PC-1)	69.24

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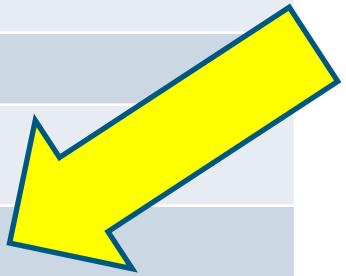
Indiana Harm Snapshot

(from HRET HEN 1.0 data)

		Indiana Harms (9/2013 – 8/2014)
ADE	Warfarin	1640
	Hypoglycemia	7455
	Opioids	4132
CAUTI Rate All Tracked Units		448
Falls with Injury		1381
Readmissions (All Cause)		43707
Sepsis Mortality		1076
Total		59,839



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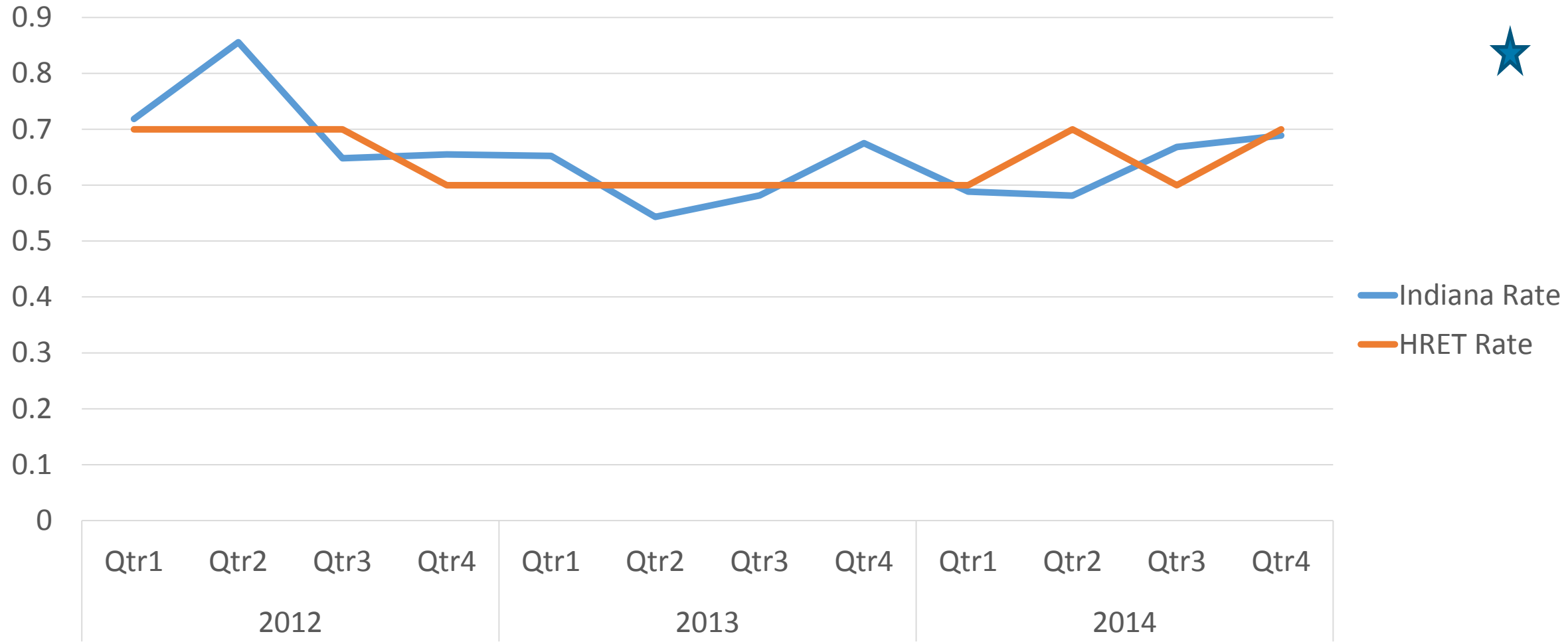
Falls with Injury



Source: AHA/HRET Comprehensive Data System

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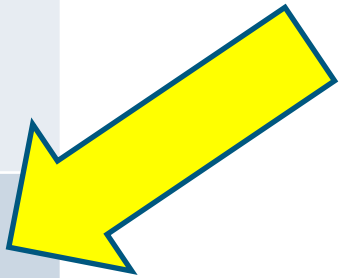
Most Frequently Reported Medical Error Events

Event	2006	2007	2008	2009	2010	2011	2012	2013	2014
Stage 3 or 4 pressure ulcers	26	27	33	22	34	41	30	45	44
Retained foreign object	23	24	30	29	33	17	19	27	27
Surgery on the wrong body part	11	23	16	17	14	18	15	18	21
Death or serious disability assoc with medication error	6	8	7	3	0	3	0	0	4
Death /Serious disability assoc with a fall	4	5	8	8	17	12	14	12	10



*ISDH added “serious disability” to definition effective in January 2009

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HEN 2.0 Core Focus Areas

Goal: Reduce Harm by 40% and Preventable Readmissions by 20% by Sept. 23, 2016

Must report on all applicable	
• Adverse Drug Events (ADE)	• Pressure Ulcers (PrU)
• Catheter-Associated Urinary Tract Infection (CAUTI)	• Readmissions
• Central Line-Associated Blood Stream Infections (CLABSI)	• Surgical Site Infections
• Injuries from Falls and Immobility	• Venous Thromboembolism (VTE)
• Obstetrical (OB) Harm and Early Elective Deliveries (EED)	• Ventilator Associated Events (VAE)

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Prevention of Injurious Falls

Faculty

Fayette Regional Health System	Jessica Couch
Franciscan St. Anthony Michigan City	Bobbi Herron-Foster
Hancock Regional Hospital	Vicki Fletcher
Indiana University Health Bloomington	Lavanya Pashikanti
Indiana University Health Bloomington	Barb Haley
Johnson Memorial Hospital	Robert Hattabaugh
St. Vincent Anderson Hospital	Audra Pierce
Terre Haute Regional Hospital	Sonja Rebeck

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Falls Faculty Recommendations

To reduce injurious falls with injury, it is recommended that all Indiana hospitals do the following:

- **Utilize a multidisciplinary falls team, which may include physician, physical therapist and pharmacy champions**
- **Screen/assess all patients for fall and injury risk factors**
- **Identify individualized risk factors, such as inpatients on anticoagulants, and link interventions to specific risk factors and incorporate into daily huddles, rounding and changeover processes**
- **Learn from falls events by conducting post fall huddles and monitoring data**
- **Execute a plan to hardwire results, such as planning annual staff development opportunities and routine audits**

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Today's Webinar Speaker

Jackie Conrad RN, BSN, MBA
Improvement Advisor

Cynosure HEALTH

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Goals for Our Time Together

- Engage in a conversation about learnings from HEN 1.0 that will be carried forward to accelerate success in reducing injuries from falls in HEN 2.0.
- Explore how to turn data into information that can be used to set goals or a focus for fall injury prevention.
- Review solutions for specific contributing factors for falls.
- Learn from each other.

- What else do you want from this webinar?

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How Do We Get to the 40% Reduction Goal?

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It takes a team PLUS
Will, Ideas and Execution

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Conversation with the Faculty

- What are the key learnings from HEN 1.0 that you want to bring forward in HEN 2.0?
- Which recommendation will present the most challenge and what are your ideas to promote success?

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HEN 1.0 Strategies that Led to Success

- Post Fall Huddles at the bedside
- Patient contracts
- No one toilets alone
- Engaging rehabilitation services in unit ambulation and progressive mobility
- Fall and Injury Risk Assessment conversation at change of shift

Common denominator: Data was used to determine the focus

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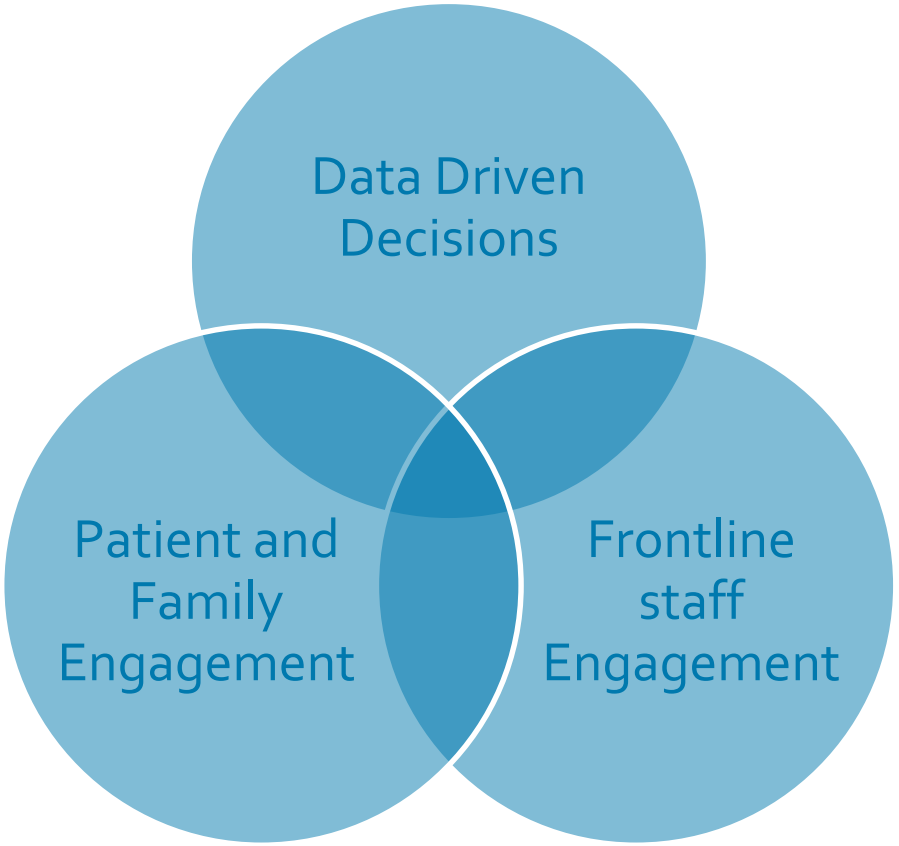
Success is in the Approach Not the Interventions



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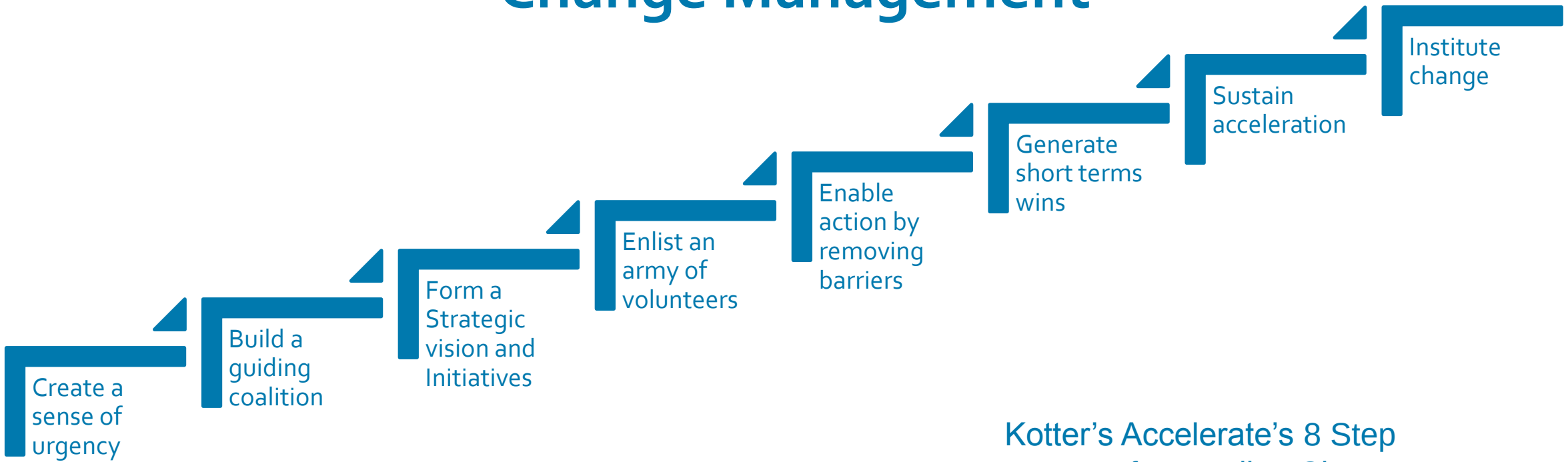
Change Management



Kotter's Accelerate's 8 Step Process for Leading Change

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Conversation

What is your greatest challenge in leading change?

What have you learned that has worked to overcome this challenge?

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Data Driven Decision Making

- **Understand your organizations or units falls profile**
  - Types of patient that are falling – age, diagnosis, co-morbidities
  - Circumstances associated with the fall
    - Location
    - Time of day
    - Patient Activity
  - Contributing factors
    - Environmental
    - Equipment
    - Assessment
    - Communication
    - Medications

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Conversation

How are you analyzing Falls Data?

What have you learned?

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Turn Data into Information

- **Engage front line staff in analyzing the data and formulating hypotheses on solutions**
  - Identify the trends: Top Contributors to Falls
  - Link evidence based strategies to address the trends

- **Pick one to two change ideas to implement**
  - Staff designed work flow
  - Use PDSA cycles to test small changes

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New Tool: JC Falls TST Targeted Solution Tool

- **Journal of Nursing Care Quality in 2014**
  - 7 hospitals analyzed falls data to determine the top 5 contributing factors to falls
  - Information used to identify targeted solutions
  - Resulted in a 62 percent reduction in fall injury rates over an 18 month period.
  - This study demonstrates the benefits of understanding why patients are falling before an interventions or tool kit is selected for testing or implementation

- **Product just released by TJC in Oct 2015**

http://journals.lww.com/jncqjournal/Fulltext/2014/04000/A_New_Approach_to_Preventing_Falls_With_Injuries.1.aspx

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TJC Falls TST Today

- 70 hospitals currently using the tool to collect data for next publication.
- Free to JC accredited hospitals
- Hospitals enter data into JC data base monthly on all falls
- After 3 months with a N of 20-30, Top 5 factors are determined and targeted solutions are recommended
- The project incorporates Change Management and Robust Process Improvement methodology.
- Fall data collected in post fall huddles in participating organizations

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JC Falls TST Project

Contributing Factors	Targeted Solutions
Patient fell while toileting	• Implement hourly rounding with proactive toileting for all patients • Implement scheduled toileting for high risk patients: get patient up for toileting on a regular schedule
Medications that increase the risk of falls combined with toileting	• Educate patients on medication side effects and increased risk for falls • Schedule medication administration for at least 2 hours prior to "bedtime"
Patient did not know, forgot or chose not to use call light	• Educate patient on how to use and the need for using the call light for assistance at all times, especially when getting into/out of bed
Fall prevention education to patient/family not used or inconsistent	• Revise patient/family fall precaution education packet and process. Education should be targeted and individualized to patient specific fall risks
Patient awareness and acknowledgement of their own risk for falls	• Implement a patient agreement form to use call light for all ambulation. Emphasize risk factors during education and signing of patient agreement
Risk assessment tool is not a valid predictor of actual fall risk	• Implement a "validated" fall risk assessment tool • Implement a standardized cognitive assessment tool • Integrate cognitive assessment tool results with fall risk assessment tool
Inconsistency in ratings by different caregivers	• Standardize assessment tools used between nursing staff and physical therapy/ occupational therapy/rehab staff; allow both service areas to access each other's charting detail in the Electronic Medical Record (EMR)
Inconsistent or incomplete communication of patient risk for falls between caregivers	• Utilize white boards to communicate patient fall risks to all staff • Incorporate alerts into EMR that alert staff to patients who are at risk for fall and effectively translates fall risk information into useful tasks, reports and prompts • Initiate bedside shift report with patient that includes focus on fall risk concerns
Standardization of practice and application of interventions	• Implement house wide culture messaging around fall safety for all patients

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Conversation

Given what we have learned up to this point, what are your next steps?

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Thank you!

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