IHI Expedition
Protecting Your Patients from Injurious Falls
Session 4

March 13, 2013
These presenters have nothing to disclose

Pat Quigley, PhD, ARNP, CRRN, FAAN, FAANP
Kathy Duncan, RN

Expedition Coordinator

Kayla DeVincentis, CHES, Project Coordinator, has worked at IHI since 2009, starting as an intern in the Event Planning department. Since then, Kayla has contributed to the STAAR Initiative, the IHI Summer Immersion Program, and the Expeditions. Kayla obtained her Bachelor’s in Health Science from Northeastern University and brings her interest in health education and wellness to IHI’s Work-Life Wellness Team.
WebEx Quick Reference

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
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- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to
All Participants
Expedition Director

Kathy D. Duncan, RN, Faculty, Institute for Healthcare Improvement (IHI), co-leads IHI’s National Learning Network and manages the 24 IHI Improvement Map support care processes. Ms. Duncan also directs IHI Expeditions, manages IHI’s work in rural settings, and provides spread expertise to Project JOINTS. Previously, she co-led the 5 Million Lives Campaign National Field Team and was faculty for the Improving Outcomes for High Risk and Critically Ill Patients Innovation Community. She also served as the content lead for the Campaign’s Prevention of Pressure Ulcers and Deployment of Rapid Response Teams areas. She is a member of the Scientific Advisory Board for the AHA NRCPR, NQF’s Coordination of Care Advisory Panel, and NDNQI’s Pressure Ulcer Advisory Committee. Prior to joining IHI, Ms. Duncan led initiatives to decrease ICU mortality and morbidity as the director of critical care for a large community hospital.

Today’s Agenda

- Introductions
- Debrief Session 3 Assignment
- Interventions to Reduce Falls and Falls Harm Part II
  - Intentional Rounding
  - Pre-shift Safety Huddle
  - Post Fall Huddles
- Homework for Session 5
Expedition Objectives

At the end of the Expedition each participant will be able to:
- Differentiate types of falls as a basis for analysis of program effectiveness
- Integrate injury prevention into existing fall prevention programs
- Inventory tests of change in fall and injury prevention interventions
- Summarize successes ready for adoption and spread
- Plan small tests of change they can test throughout the Expedition

Faculty

Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Associate Director, VISN 8 Patient Safety Center of Inquiry, is both a Clinical Nurse Specialist and a Nurse Practitioner in Rehabilitation. As Associate Chief of Nursing for Research, she is also a funded researcher with the Research Center of Excellence: Maximizing Rehabilitation Outcomes, jointly funded by HSR&D and RR&D. Her contributions to patient safety, nursing and rehabilitation are evident at a national level – with emphasis on clinical practice innovations designed to promote elders’ independence and safety. She is nationally known for her program of research in patient safety, particularly in fall prevention. The falls program research agenda continues to drive research efforts across health services and rehabilitation researchers.
Assignments for Today

- Test one new intervention
- Attempt to acquire one new piece of equipment for integration into your patient care environment
- Explore at least 2 patient education resources about new safety equipment that you just learned about
- Assess compliance with injury risk assessment on 3-5 admissions

Interventions to Reduce Falls and Falls Harm, Part 2

Special Recognition: Robert Wood Johnson Foundation Funding
This material is the result of work supported with resources and the use of facilities at the James A. Haley Veterans' Hospital.
At the end of this Session:

- The attendees will be able to:
  - Differentiate the difference between standard rounding and intentional rounding
  - Test strategies for pre-shift huddles
  - Apply post fall huddle process to a fall event
  - Examine outcomes specific to post fall huddles

Chat Question

- Has anyone “cracked the code” on hardwiring intentional hourly rounding?
Intentional Rounding

Clinical Rounds with specific intention:
- Strategy to improve communication between the nurse and patient
- Strategy to improve patient satisfaction with care
- Innovation in patient safety
- Increase patient participation as active partner is care
Beginnings

- Developed by the Studer Group, another way to organize existing work
- Purpose: To anticipate and meet patient needs routinely and ensure patient safety (Shaner & McRae, 2007)
- Allow information to be gathered in a structured way, addressing problems as they occur (Studer Group, 2005)
- Addresses patient needs proactively

Performing Intentional Rounding

- Specific scripts for consistency and reliability of the content
- Defined methods to hardwire implementation
- During Hand-off, explain to the patient who would be checking on them hourly (or frequency) to enhance their safety and address personal needs
- Schedule tasks during the rounds
- Before leaving the room, address the 4 “P's”
The 4 “P’s”

- Pain
- Personal Needs (toileting)
- Positioning
- Placement

Immediately before leaving the room, ask the patient if anything else was needed, emphasizing the nurse has the time to address any needs.

Lastly, inform the patient when the nurse would return.

Evidence Reviews

- **HOURLY ROUNDS: WHAT DOES THE EVIDENCE INDICATE?**

- **THE LATEST EVIDENCE ON HOURLY ROUNding AND RAPID RESPONSE TEAMS IN DECREASING ADVERSE EVENTS IN HOSPITALS.**
  Melnyk BM; Worldviews on Evidence-Based Nursing, 2007 Dec; 4 (4): 220-3 (Journal Article - Abstract) ISSN: 1545-102X PMID: 18076465 CINAHL AN: 2009863793
Results

- Reduction in call light use
- Decrease in falls
- Decrease in pressure ulcers
- Improved patient satisfaction and likelihood of recommending the hospital
- Improved nursing satisfaction: care is more efficient and less stressful
- Positive results exceed expectations

Evidence Reviews

- **EVIDENCE-BASED PRACTICE CENTER: MADISON WISC VA: DR. BEVERLY PREIFER**
- Since the publication of the Meade article, there have been other studies examining hourly rounding and fall prevention.
- Additional Researchers found
  - no difference in fall rates after one year of hourly rounding.
  - decrease in call light use but no difference in falls after implementing hourly rounding.
- Hourly rounding presents no harm to patients,
- Nurses / Teams need to clearly understand why they are implementing hourly rounding: what are the expected outcomes, and decide on your have the capacity for implementation.
Additional Actions

- Toilet before giving pain medication
- Test patient knowledge (and skill) about fall and injury prevention
- If prescribed hip protectors and/or helmet, inspect to ensure they are on
- If floor mats required and patient in bed, observe for floor mat
- Observe height of the bed (relevant to patient activity: if patient resting, is it in low position; if patient out of bed, is the bed raised-up)

Other Outcomes

- What Type of Falls would be sensitive to intentional rounding? Your choices are:
  - Accidental Falls
  - Anticipated physiological Falls
  - Unanticipated physiological Falls
  - Intentional Falls
Answers

- Accidental Falls
- Anticipated physiological Falls
- Unanticipated physiological Falls
- Intentional Falls

Is your approach likely to be successful?
Challenges

- Use of formal scripting
- Hardwiring
- Sustainability
- Accepting rounds are value added

Poll Question

- Do you include discussion of patients who are at risk of injury from falls in your pre-shift huddles?
Pre-Shift Huddles

Pre-shift Huddles
Standardize Safety Communication

- High Fall Risk communication in hand-offs:
  - Nurse-to-nurse hand-off (including unit-to-unit)
  - Charge-nurse-to-charge-nurse hand-off
  - Purple hand-off form (Ticket to Ride) for off-unit movement

- Best Practice: Safety Huddles (at shift change or on rounds) verbally tell the whole team who is vulnerable, at greater risk for falls and Injury and WHY
The Proactive Safety Huddle

Goals:
- To make entire staff aware of which patients are at risk for fall and injury and WHY
- To create awareness of specific prevention measures in place for each patient
- To create team vigilance for all unit patients at risk
- To reduce anticipated physiologic falls

Pre-shift Huddles

- Redesign Practice for Prevention and Protection
- Unit-wide Communication about Vulnerable Patients
Standardize Safety Communication

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Method: Test Unit One

- On 5 South: After nurse-to-nurse hand-off, the entire unit comes together for a brief (10-15 minute) shift huddle. Each patient who is at risk for falls is discussed: what is their fall risk level? Reason for risk level (age, condition, meds, history of falls, mental status, etc). Also shared in the huddle is any other change or event that wasn’t already identified in the shift report (e.g., patients were fine all day but then get Sundowners, or if they are striking out at specific people).

Method: Test Unit Two

- On 6 South: An hour into the tour, the charge nurse conducts a huddle of all the unit staff to discuss patients who are high risk for falls/injury and other safety issues (restraints, name-alerts). The charge nurse asks: “What makes this patient a high fall / injury risk?” (previous fall, confusion, anemia, syncope, etc)? What is our plan to keep the patient safe?
Safety Huddles

- See handout

Poll Question

- Do you involve the patient in post fall huddles?
Post Fall Huddles

*Model: After Action Reviews*

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After Action Review/Post-Fall Huddle

- Nurse Reviewer: ___________ Date: ___________
- Patient Name/ID: ______________

**Instructions:**
- Hold AAR as soon as possible after the patient fall occurred.
- Keep the AAR meetings brief; 15 minutes.
- Involve the patient if possible.
- Forward completed review to Nurse Manager, then to Patient Safety Manager.(11E)
### AAR/Post-Fall Huddle

<table>
<thead>
<tr>
<th>Questions</th>
<th>Lessons learned</th>
</tr>
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<tbody>
<tr>
<td>Why did this patient fall? (Ask 3 times)</td>
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<tr>
<td>Was patient at correct fall/injury risk level?</td>
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<td>Were the appropriate interventions in place?</td>
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<td>What accounted for the difference?</td>
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<td>How could the same outcome be avoided the next time?</td>
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<tr>
<td>What is the follow up plan?</td>
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<td>Patient’s account (if able to share)</td>
<td></td>
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<tr>
<td>Contract with the patient for safety (Promise to use call bell; return demo how to use call bell)</td>
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</tbody>
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Nurse Manager Review: Signature Date

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### The Post-Fall Huddle

**SCENARIO:**

- EMS staff reports to nursing staff that the patient in room 123 (semi-private room), near the window, is on the floor at the foot of to his bed. The nurse finds the patient, Mr. Morse, sitting on the floor in a puddle of urine with one leg under the other. The patient has SCD sleeves on. Mr. Morse is classified as being at “high risk” for falls.
PATIENT’S ACCOUNT

- I had to go real bad to take a leak. I put my light on but no one came quick enough. I didn’t see a urinal so I got up to go by myself. I couldn’t hold it and I felt a little dizzy as I began to urinate on the floor. I couldn’t stop myself from falling. I didn’t hit my head or anything. My leg is a little sore. I landed on my butt for the most part.

WHY DID THE PATIENT FALL?
(Ask 3 times)

- **First time:** the obvious – what you actually see.
- “He was trying to go to the rest room”.
- “He urinated and slipped and fell”.


**Second time:** environmental factors and preventive measures

- The SCD cords were hanging over the foot of the bed and onto the floor. This could have caused the patient trip and fall.
- The urinal was not in reach.

**Third time:** things not so obvious (pathological factors)

- The patient has a history of hypertension and diabetes.
- He had his Lopressor dose adjusted the day prior.
- His blood sugar was not checked but may have been at either extreme.
**HOW COULD THE SAME OUTCOME BE AVOIDED THE NEXT TIME?**

- Educate patient and reinforce with each contact or frequently; establish intervals of times that patients at high risk will be reeducated; document education.
- All SCD cords will be safely tucked under the mattress if not being used.
- Ask patients at each interaction about toileting.
- Check orthostatic BP and blood sugar.
- Contract with patient for safety.

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**AAR Part 2: Types of Falls**

**Part 1. Fall Type**
Select which type of fall occurred. Select only one of the first four types of falls.

- **Accidental Fall**: Fall due to extrinsic environmental risk factors: spill on the floor, clutter, tubing / cords on the floor, etc.
  - OR
- **Anticipated Physiological Fall**: Factors associated with known fall risks as indicated on the Morse Fall Scale: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur to the patients’ existing physiological status, history of falls, and decreased mobility upon assessment.
  - OR
- **Unanticipated Physiological Fall**: Factors associated with unknown fall risks that were not predicted on a fall risk scale: unexpected orthostasis; extreme hypoglycemia; stroke; heart attack.
  - OR
- **Intentional Fall**: Patient who voluntarily positions his/her body from a higher level to a lower level.

**Part 2. Additional Fall Information**
Select the following items if the fall was assisted by staff or a repeat fall for this patient:

- **Assisted Fall**: Patient was physically assisted to the floor by a staff member.
- **Repeat Fall**: A fall has already occurred for this patient.

Benefits of Proactive Safety Huddle

- Better customization of care for vulnerable patients
- Enhanced staff learning about fall contributing and prevention factors
- Improving “systems thinking” among the staff
- Better sense of “community”; everyone is involved in keeping all the patients safe, not just “theirs”
- Building upon one another’s knowledge of the patients individual needs and issues
- Decrease in anticipated physiological falls

Outcomes of Post Fall Huddles

- Specify root cause(s) of the fall
- Select protective barriers to prevent recurrence of fall under same conditions and same type of fall
- Complete changed care plan
- Define type of fall that occurred
- Educate patient (and family) about causes of fall and prevention, protection strategies
Outcomes

- Intentional Rounds: Reduce accidental and anticipated physiological falls
- Pre-shift Huddles: Reduced anticipated physiological falls
- Post-fall Huddles: Eliminate repeat falls (same type and root causes), Changed Plan of Care, Reduce Accidental and Anticipated Physiological Falls

Questions?

Raise your hand
Use the Chat
Assignments for Session 5

- Review your fall program evaluation plan and determine if intentional rounding is linked to Type of Fall: accidental and anticipated physiological falls.
- Observe 2-3 pre-shift huddles for identification and planning of vulnerable fall and fall-injury populations.
- Conduct follow-up of 2-3 post fall huddles for creation of changed plan of care, implementation of post fall interventions, and involvement of the patient.

Sample PDSA Form
Volunteers?

Expedition Communications

- Listserv for session communications: FallsExpedition@ls.ihi.org
  - To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes
Next Session

Wednesday, March 27, 1:00 PM – 2:00 PM ET
Session 5 – Preventing Falls with Injury
Assessment Tool and Patient Education
Resources