AHRQ Fall Prevention Program Implementation Sharing Webinars

Webinar #4

November 18, 2015

Sponsored by:
Agency for Healthcare Research and Quality (AHRQ)

Hosted by:
The AFYA Team
(AFYA, Inc., ECRI Institute, and Stratis Health)
Today’s Topics

• Housekeeping

• Updates from the AFYA Team – Upcoming Webinar topics

• How two hospitals in the AHRQ Pressure Ulcer Prevention Cohort are engaging staff and senior leaders
  – Roswell Park Cancer Institute – Melissa Hiscock/Judith DelMonte
  – Broward Health North – David McMillan

• Round-robin sharing by the AHRQ Fall Prevention hospitals

• Questions and open discussion

• Wrap-up
Webinar Tools for Interaction

• Raise your “hand” to contribute to the discussion or ask a question.

OR

• Use the CHAT panel.
Webinar Tools - Muting

• Mute your audio to minimize background noise.

OR

• Mute your phone.
Updates from the AFYA Team

• **December Webinar**
  – Pat Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP
    • Presentation on best practices: bed alarms, bed rails, surveillance strategies, and patients with behavioral health conditions
    • Open questions – Hospitals to submit question(s) by November 30.

• **January Webinar**
  – Patricia Dykes, PhD, RN, FAAN, FACMI
    • Care planning for individual fall risks and the EHR.

• **February – April Webinars**
  – Hospital updates on implementation efforts
## Our Story – Involving our Hospital Board

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roswell Park contacted to be a part of AHRQ Project (May 2015)</td>
<td></td>
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<tr>
<td>Nursing includes AHRQ project into Board Report (June 2015)</td>
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<tr>
<td>CNO presents AHRQ project at Quarterly Board Meeting (July 2015)</td>
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<tr>
<td>Board Member contacts CNO to say he has a background in wound care</td>
<td></td>
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<tr>
<td>and is interested in the AHRQ Pressure Ulcer Project</td>
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<tr>
<td>CNO contacts WOC Team Leader with Board Member contact</td>
<td></td>
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<td></td>
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<tr>
<td>WOC Team Leader contacts Board Member to see if he would be interested</td>
<td></td>
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<tr>
<td>in joining our team and coming to our weekly meetings</td>
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<td></td>
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<tr>
<td>Board Member agrees and when we find out exactly who he is – we are</td>
<td></td>
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<tr>
<td>thrilled!</td>
<td></td>
</tr>
</tbody>
</table>
August 26, 2015 – Presentation to Institute Quality Committee:

- 5 Board Members
- CMO, COO, CNO
- 5 Physicians
- VP Quality, Managed Care, Clinical Research, Risk Management, Lab Medicine, Pharmacy
- Departmental Directors, Quality Staff, Patient Safety Officer
Project Charter

- Project Definition
- Critical Success Factors
- Team Members
- Analysis (SharePoint Site)
Roswell Park Cancer Institute is one of 11 U.S. hospitals to be chosen to participate in the AHRQ Pressure Ulcer Prevention Project. Pilot Units: ICU, 6W, 7E

By utilizing the toolkit provided by AHRQ (Agency for Healthcare Research & Quality) effective pressure ulcer prevention practices will be implemented. The toolkit’s content draws on literature on best practices in pressure ulcer prevention and includes both validated and newly developed tools that will be used by the Implementation Team charged with leading the effort to plan and put the new prevention strategies into practice.

**GOAL:** Decrease the overall rate of Hospital Acquired Pressure Ulcers Stage 2 or greater to 1.0 or less

**How do we know we are successful?**

- By Decreasing the # and rate of Stage 2 and above Hospital Acquired Pressure Ulcers
- By improved documentation within the EMR and provider notes (includes billing/coding)
- By improved comparative rates and standing within Leapfrog, NDNQI, and US World and News Report
- By developing guidelines, interventions, processes and tools that will assist staff in preventing & identifying skin issues earlier

**SHAREPOINT SITE**

AHRQ PRESSURE ULCER PREVENTION PROGRAM

Roswell Park is one of 11 Hospitals in the nation to be chosen to participate in the AHRQ Pressure Ulcer Prevention Program.

Pressure ulcer prevention requires an interdisciplinary approach to care. Some parts of pressure ulcer prevention care are highly routinized, but care must also be tailored to the specific risk profile of each patient. No individual clinician working alone, regardless of how talented, can prevent all pressure ulcers from developing. Rather, pressure ulcer prevention requires activities among many individuals, including the multiple disciplines and multiple teams involved in developing and implementing the care plan. To accomplish this coordination, high-quality prevention requires an organizational culture and operational practices that promote teamwork and communication, as well as individual expertise. Therefore, improvement in pressure ulcer prevention calls for a system focus to make needed changes.

**CRITICAL SUCCESS FACTORS**

**PROJECT DEFINITION**

**CRITICAL SUCCESS FACTORS**

**PROJECT LEADER:** Melissa Hiscock, RN, CWOCN, OCN

**UNIT LEADERS:** Jennifer Lindemann, RN, Christine Szafranzki, RN, Mary Williams, RN, LaShaun Suttles, HCA

**CORE TEAM:** Judy Del Monte, MS, CPHQ, Katie O’Hearn, RN, MSN, CWOCN, Wendy Kinsey, RN, BS, CWOCN

**Jessica French, RN, BSN**

**Anna Foster, RN, BSN**

**Barbara Benz, RN, MSN**

**Cheri Gajewski, RN, MSN, OCN**

**Thomas Stewart, PhD**

**Matt Piechnik, RN**
### Action Plan – AHRQ Project

**Roswell Park Cancer Institute - AHRQ Pressure Ulcer Prevention Program**

**ACTION PLAN: JUNE - OCTOBER 2015**

<table>
<thead>
<tr>
<th>KEY INTERVENTIONS/TASKS</th>
<th>STEPS TO COMPLETE TASK AND TOOLS TO USE</th>
<th>TEAM MEMBERS RESPONSIBLE</th>
<th>TARGET DATE FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analyze Current State of Pressure Ulcer Prevention Practices at Roswell Park Cancer Institute</strong></td>
<td>Create Policy - When to Call ET Services</td>
<td>Katie, Wendy, Melissa, JD</td>
<td>August 10, 2015</td>
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<td></td>
<td>Send Survey - Nursing Views on Pressure Ulcer Prevention</td>
<td>Melissa</td>
<td>June 12, 2015</td>
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<td>Send Survey - Pieper Knowledge Test</td>
<td>Melissa</td>
<td>August 6, 2015</td>
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<td></td>
<td>Data Review - Determine Target Goals</td>
<td>Judy</td>
<td>June 17, 2015</td>
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<td>Core Team to Review Webinars 3-8</td>
<td>CORE TEAM</td>
<td>August 10, 2015</td>
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<tr>
<td><strong>Identify the Bundle of Prevention Practices to be Used in Redesigned System</strong></td>
<td>Develop Pocket Pad with Body Outline</td>
<td>JL, CS, MW, LS staff review</td>
<td>July 3, 2015</td>
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<tr>
<td></td>
<td>Skin Assessment on Hand-Off Nurse Worksheet</td>
<td>Jen, Mary, Christine</td>
<td>July 31, 2015</td>
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<td></td>
<td>Project Screen Savers for Pilot Computers</td>
<td>Judy &amp; RNs</td>
<td>Sep 30, 2015</td>
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<td>Reorganize Pyxis for Pressure Ulcer Products</td>
<td>Unit RNs &amp; Central Supply</td>
<td>Sep 30, 2015</td>
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<td>Change in Condition - Create definition</td>
<td>Literature Review</td>
<td>HOLD</td>
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<td>Skin assessment documentation each shift</td>
<td>Pilot 6W, 7E - Real time documentation</td>
<td>July 31, 2015</td>
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<td></td>
<td>Process for Pressure Ulcer education pamphlet distribution to our Roswell patients</td>
<td>Jen to discuss with 6W staff for ideas</td>
<td>July 24, 2015</td>
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<td></td>
<td>Unit Champion Selection for Pilot Units</td>
<td>Jen, Christine, Mary</td>
<td>July 13, 2015</td>
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<td></td>
<td>Develop Intervention Guidelines from Braden Score - paper to trial before building in EMR</td>
<td>Jen, Christine, Mary to Review with staff</td>
<td>July 31, 2015</td>
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<tr>
<td></td>
<td>Create PU Note in EMR where MD and WOC documentation will be aligned w/ ICD-10</td>
<td>Melissa</td>
<td>October, 2015</td>
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<td></td>
<td>Decide on Information for Quality Board &amp; Post</td>
<td>CORE TEAM</td>
<td>June 26, 2015</td>
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<td></td>
<td>Develop SharePoint site for Team Members</td>
<td>Judy</td>
<td>June 22, 2015</td>
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<td></td>
<td>Decide on a Logo to use for Project</td>
<td>CORE TEAM</td>
<td>June 17, 2015</td>
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</table>
# Action Plan – AHRQ Project

## Roswell Park Cancer Institute - AHRQ Pressure Ulcer Prevention Program

### ACTION PLAN: JUNE - OCTOBER 2015

<table>
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<tr>
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<th><strong>TEAM MEMBERS RESPONSIBLE</strong></th>
<th><strong>TARGET DATE FOR COMPLETION</strong></th>
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<tbody>
<tr>
<td><strong>Patient and Staff Education</strong></td>
<td>Staff pocket booklet on Prevention</td>
<td>CORE TEAM</td>
<td>August 14, 2015</td>
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<tr>
<td></td>
<td>Patient Education on Pressure Ulcers</td>
<td>CORE TEAM</td>
<td>August 8, 2015</td>
</tr>
<tr>
<td></td>
<td>Pressure Ulcer Prevention Algorithm</td>
<td>Jenn, Katie, Melissa, Judy</td>
<td>August 14, 2015</td>
</tr>
<tr>
<td></td>
<td>Reliability for Braden Score between nurses</td>
<td>Melissa, Katie, Wendy</td>
<td>October, 2015</td>
</tr>
<tr>
<td></td>
<td>Learning from Pressure Ulcer Case Reviews</td>
<td>Post in Breakroom</td>
<td>August 8, 2015</td>
</tr>
<tr>
<td></td>
<td>Understanding Prevalence &amp; Incidence Rates</td>
<td>CORE TEAM</td>
<td>October, 2015</td>
</tr>
</tbody>
</table>

**Identify the Changes to the Electronic Medical Record of Prevention Practices to be Used in Redesigned System**

| | Add body diagram to EMR admission note (this is only able to be added to a structured note) | Marlene | After September, 2015 |
| | Add question to Admission Note - Have you ever had a pressure ulcer/bedsore in the past? | Marlene | After September, 2015 |
| | Create a pop up alert when a change in mental or physical status is checked that RN must reassess patient Braden score | Marlene | After September, 2015 |
| | Add descriptors to the Braden Scale to give more details | Marlene | After September, 2015 |
| | Add more free text space in the Skin assessment observation | Marlene | After September, 2015 |
| | Standard order set for Pressure Ulcer | Marion Skipper | After September, 2015 |
| | Change Braden Subscale Score to Numeric | Marlene | After September, 2015 |
| | Create MLM that would pull problems identified on the Braden Scale into the nursing care plan | Joanne & Marlene | After September, 2015 |
Hospital Acquired Pressure Ulcers
ICU, 6 WEST, 7 EAST

Hospital Acquired Pressure Ulcers Stage 2+
ICU, 6 West, 7 East 2013 - 2015

Hospital Acquired Pressure Ulcers Stage 2+
Rate per # of Admissions to Unit 2013-2015
## Approximate Cost of HAPU to RPCI
### Stage 3, 4, Unstageable and DTI

#### Hospital Acquired Pressure Ulcers
January – December 2014

<table>
<thead>
<tr>
<th>STAGE</th>
<th># HAPU</th>
<th>~ COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 2</td>
<td>14</td>
<td>N/A</td>
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<tr>
<td>Stage 3</td>
<td>7</td>
<td>$302,260</td>
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<tr>
<td>Stage 4</td>
<td>0</td>
<td>$0</td>
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<tr>
<td>Unstageable</td>
<td>5</td>
<td>$215,900</td>
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<tr>
<td>Deep Tissue Injury</td>
<td>15</td>
<td>$647,700</td>
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<tr>
<td><strong>TOTAL – Stages</strong></td>
<td><strong>27</strong></td>
<td><strong>$1,165,860</strong></td>
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<tr>
<td><strong>TOTAL – Stages 3,4,UNS,DTI</strong></td>
<td><strong>27</strong></td>
<td><strong>$1,165,860</strong></td>
</tr>
</tbody>
</table>

#### Hospital Acquired Pressure Ulcers
January – June 2015

<table>
<thead>
<tr>
<th>STAGE</th>
<th># HAPU</th>
<th>~ COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 2</td>
<td>6</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 3</td>
<td>4</td>
<td>$172,720</td>
</tr>
<tr>
<td>Stage 4</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Unstageable</td>
<td>4</td>
<td>$172,720</td>
</tr>
<tr>
<td>Deep Tissue Injury</td>
<td>8</td>
<td>$345,440</td>
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<tr>
<td><strong>TOTAL – Stages</strong></td>
<td><strong>16</strong></td>
<td><strong>$690,880</strong></td>
</tr>
<tr>
<td><strong>TOTAL – Stages 3,4,UNS,DTI</strong></td>
<td><strong>16</strong></td>
<td><strong>$690,880</strong></td>
</tr>
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</table>
Unit Quality Boards
• Use your internal intranet to organize information on the project so everyone has up-to-date information.

• Add a finance person to your team to help with financial information so you can put costs and outcomes together.

• Engage your Board and Senior Leaders in the project by showing ongoing progress and improvements.
Broward Health North
AHRQ Project Implementation TEAM

Deerfield Beach, FL
Bedsize: 409 Beds
NeuroMedical ICU
Engaging Upper Level Management

- Commenced with monthly meetings with CNO to update on AHRQ requirements.
- Updated CNO on pre-assessment tool and the opportunities for our facility.
- We used the same assessment tool for CAUTI, SSI, and speak-up campaign to trend for similar issues.
- These items were then presented at Quality Council to The C suite with a plan to correct.
Making it Stick

• The plan was to hold a yearly safety fair to address every department within the building to ensure a consistent message.
• The AHRQ initiatives will be reported to management and C suite, and at every quality meeting to ensure we are standardized in all of our committees.
• We started a quick meeting (rapid cycle improvement) that reports weekly at the Thursday management huddle. C suite attends this and implements immediate interventions.
HOW TO KEEP OUR PATIENTS FROM GETTING PRESSURE ULCERS/BED SORES

1. PREVENTION
   - Patients who cannot turn themselves must be turned every hour.
   - Do not raise or change the position of the head of the patient’s bed without checking with the nurse.

2. REDUCE FRICITION & SHEAR
   - When moving a patient up in bed, make sure to use a lift sheet and slide patient up in bed, no dragging.

3. BED CONDITION
   - Do not add linen underneath patient. Patient should have a fitted sheet on bed, lift sheet & absorbent pad.
   - No devices or tubes should be left underneath patient.

HOW TO KEEP OUR PATIENTS FROM FALLING

There must be hand-off communication (SBAR) between nursing, staff and other departments before a patient is taken from their room. When a patient is returned to their room, hand-off communication must be done with nursing staff before leaving the patient’s room/unit.

- Patients must never be left alone. Never leave a patient alone in the bathroom, on a stretcher, etc.
- Treat all patients as if they could fall until you know they are not (when you are told by the nurse).
- ALWAYS use bed or chair alarms.
- Everyone MUST respond when they hear an alarm sounding. Stay with the patient until help arrives.

All patients who need to hold onto the bed, people, use canes & walkers could possibly fall.

SPEAK UP & PASS IT ON - FOR PATIENT SAFETY

Why do YOU need to SPEAK UP & PASS IT ON?
Poor or lack of communication is the #1 root cause leading to patient harm events throughout the nation!

SBAR? is a technique to communicate critical information that requires immediate attention & action.

SBAR? is especially important during ‘handoff’.

Situation • Background • Assessment • Recommendation/Request • Questions?

The use of ‘CUS’ words is one way to ‘stop the line’ and alert other team members about your concerns:

I am Concerned • I am Uncomfortable
This is a Safety issue or I don’t feel like this is Safe!

REGULATORY

1. Be warm, confident & friendly.
2. Slow down & listen to the question – ask for clarification if you need it.
3. Only answer the question being asked, do not volunteer extra info.
4. If you see a team member struggle to answer, please help them.
5. SAFETY: Our ‘Robust process improvement’ is that we are all working continuously to reduce patient harm (falls, pressure ulcers, infections, errors).
6. SERVICE: We are all working to improve patient perceptions of care HCAHPS-communication, pain management, discharge planning & responsiveness.
Feedback

• C suite:
  – Glad we were educating hospital as a whole; found it educational for all.

• Staff:
  – EVS said they could help with Foley maintenance by informing nurse that Foley bag should be drained.
  – Many other non-clinical people found it informational and felt they were more empowered to help the patients.
Definitely a huge win for BHN Patients!

Thank you.
Round Robin - Participating Falls Hospitals
Good Samaritan Hospital

San Jose, CA
Bedsize: 474
Pilot Units: Medical, Rehab
Leadership Engagement

- TeamSTEPPS
- Executive and Director Leadership

1. Fall Prevention standing agenda item on Patient Safety Committee

2. Transparency with prior events
Madonna Rehabilitation Hospital

Lincoln, NE
Acute Rehab Beds: 48-50
Pilot Unit: Acute Rehab
Engaging staff/leaders

Goal Setting

• **RN, LPN, NA Annual Evaluation Goal**: Total number of patient falls that occurred due to failure to follow proper procedures as a result of employee disregard for risks, based on the most recent 12 month period to date.

• **Nurse Therapist/Supervisor Annual Evaluation Goal**: Decrease patient falls with greater than minor injury to 5.0% or less as measured by the Acute Rehab Quality Score Card.
Engagement:

• Senior Leaders:
  – Quarterly Presentation to Quality Council
  – Quality Council includes Board Members; Senior Leadership; Physicians; Department Leaders
  – Present fall data and project initiatives
  – Allows opportunities to address barriers

• Staff
  – “Days Since Last Fall” Programs
  – Rewards for obtaining goals.

Longview, TX
Bedsize: 425
Pilot Units: Rehab, Medical, Cardiac IMC
Broadlawns Medical Center

• Engagement strategy: shared governance
• Involve and empower frontline staff in most levels of decision-making including workgroups, committees, and councils
• Fall prevention team primarily composed of frontline staff - they drive most of the discussion and changes; leadership has more of a facilitator role
  – Success: fall prevention team worked seamlessly while leader was on leave
  – Success: staff compliance and ability to embrace change more effective when presented by their peers, with leadership support
Mayo Clinic Health System – Franciscan Healthcare

LaCrosse, WI
Bedsize: 150
Pilot Unit: Medical
Strategy from MCHS – Franciscan Healthcare:

Standardization of Performance Board Documents for Falls
Run Chart – updated quarterly

SWWI Falls Data

Goal: to reduce falls with injury by reducing falls to less than 2.06 falls per 1000 patient days

Inpatient Falls per 1,000 Patient Days-NDNQI (SWWI)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate</th>
<th>Target</th>
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<tbody>
<tr>
<td>Q3-2015</td>
<td>28</td>
<td>12,067</td>
<td>2.322</td>
<td>2.060</td>
</tr>
<tr>
<td>Q2-2015</td>
<td>29</td>
<td>10,720</td>
<td>2.705</td>
<td>2.060</td>
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<tr>
<td>Q1-2015</td>
<td>28</td>
<td>10,258</td>
<td>2.730</td>
<td>2.060</td>
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<tr>
<td>Q4-2014</td>
<td>32</td>
<td>10,510</td>
<td>3.045</td>
<td>2.060</td>
</tr>
<tr>
<td>Q3-2014</td>
<td>22</td>
<td>10,577</td>
<td>2.089</td>
<td>2.060</td>
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</table>

Inpatient Falls with Injury per 1,000 Patient Days-NDNQI (SWWI)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate</th>
<th>Goal</th>
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<tbody>
<tr>
<td>G2-2015</td>
<td>7</td>
<td>10,219</td>
<td>0.685</td>
<td>0.68</td>
</tr>
<tr>
<td>G1-2015</td>
<td>6</td>
<td>9,703</td>
<td>0.611</td>
<td>0.61</td>
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<tr>
<td>G4-2014</td>
<td>14</td>
<td>10,510</td>
<td>1.332</td>
<td>0.804</td>
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<tr>
<td>G3-2014</td>
<td>3</td>
<td>10,577</td>
<td>0.284</td>
<td>0.28</td>
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Lagging Indicator
ICU FALLS ACTION PLAN

OCTOBER 2015

Goal: To increase everyone’s awareness of Fall Prevention in ICU.

Action: ICU Charge RNs will update the falls calendar at the end of each D12/N12 shift by placing a green or red “X” in their shift slot and hand-off this information in huddle, i.e. No Fall, Fall/Learnings from Post-Fall Huddle.
Calendars – updated monthly

Leading Indicator

Date of Last Fall

# of Falls for the Year

ICU Falls

November 2015

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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Preventing Falls is a Full Time Job, Not a Part Time Practice
Key Learnings

• Falls Workgroup members from each department want to receive the calendars and communicate with their Managers/Supervisors
• They will speak to the previous month’s calendar results at the next Falls meeting
• Run Charts are not always meaningful to frontline staff
• Senior leadership knows what to expect on each department’s Performance Board in their Quality/Safety column
McDonough District Hospital

Macomb, IL
Bedsize: 48
Pilot Units: Acute Care Med/Surg
McDonough District Hospital

Engaging staff/leaders

• Created an electronic audit tool to ease the burden of data collection.
• Staff can carry an IPad in rooms to conduct live audits.
• This will allow us to analyze the data quickly and efficiently, and help us prioritize opportunities
Meridian, MS
Bedsize: 260 Acute Care; 148 Post-Acute Care
Pilot Units: 2 East (Med/Surg and Pediatrics)
Telemetry and CCU Stepdown
Friendly Unit Competition

Poster boards divided into “working” teams

Each quarter reflects teams for day shift rotations and night shift rotations

Unit falls displayed in a more timely fashion

Creates transparency and friendly competition
VA Hudson Valley Health Care System

Wappingers Falls & Montrose, NY
Bedsize: CLC-94, Medical Unit-27, Mental Health-63
Pilot Units: E-2- Medical Unit,
Home of The Heroes Community Living Center—residents have cognitive loss
Peer Training to Engage Staff

• During the intentional rounding lean project implementation we utilized a teaching methodology that required staff members to teach each other at shift change.

• The CORE team trained the day shift.

• The day shift fall champion trained the evening shift.

• The evening shift was to train the night shift and then night shift to train days.

• Staff that were not trained on the night shift or not working those days were trained by the fall champions on additional days.

More staff involvement rather than passive acceptance of education!
UMassMemorial Medical Center

UMassMemorial Medical Center

Fall Prevention Program Implementation Team Members:
Ellen Felkel-Brennan, Brian Brisbois, Donna Guillaume, Lindsay Knight, Lynn D’Esmond, Mary Bonner
UMassMemorial - Engaging Leadership

• Chief Nursing Officer
  – ACNO of Acute Care at Memorial/University
  – ACNO Critical Care and Emergency Department
  – Director Nursing Professional Development

• Inpatient Units
  – Managers
  – Clinical Coordinators
  – Resource Nurse/Shift
  – Nurse Educators (Unit Based and Others)

• Interdisciplinary Managers
  – Housekeeping, Nutrition, Rehabilitation, Informatics, Materials Management
UMass Memorial Medical Center

Shared Leadership Model

- Patient Care Advisory Committee
- Nurse Executive Board

Professional Practice Council

- Quality & Patient Safety Council
- Informatics Improvement Council
- Nurse Practitioner Council
- Nurse Manager Council
- Unit Councils
- Clinical Practice Council
- Research & Evidence Based Practice Projects Council

Patient & Family Care
## The Falls Core Committee’s Purpose is to Oversee Outcomes, Education and Implementation of Action Plans to Reduce Patient Falls, Monitor Staff and Patient Adherence to Ensure a Safe Environment for UMMC Patients.

### Major Milestones/Project Schedule

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Status</th>
<th>By End Of Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk/Data Subcommittee-Responsible for tracking/trending of data by patient, unit, organization and benchmark marking</td>
<td>D.Guillaume/ I. Gupta/D.Vogel</td>
<td>complete</td>
<td>4/10/15</td>
</tr>
<tr>
<td>Clinical Practice/ Nursing Standards-Responsible for value analysis, interventions, documentation needs, framework or model to guide fall injury prevention program</td>
<td></td>
<td>complete</td>
<td>9/18/15</td>
</tr>
<tr>
<td>Education/Staff and patient Engagement-nursing and health care staff fall knowledge, patient and family education, education of new and current injury prevention interventions</td>
<td>K. Menard</td>
<td>complete</td>
<td>2/4/15</td>
</tr>
</tbody>
</table>

### Fall Intervention >=90%

- **Process Improvement Activities Related to Falls**
  - A. 2/2011 Established weekly fall reviews. 100% of patient falls reviewed by a core committee evaluating interventions and opportunities for improvement. Used monthly newsletters and calendars with key topics to inform managers of trends. At time of fall, a huddle with Manager/Supervisor and staff to go through a Safety Check list and summary of fall that the manager brings to the weekly fall meeting.
  - **Key Findings:**
    - Interventions available not used
    - Patient independence, not understanding their own vulnerability and or limits
    - Changes in medication
    - Need to teach patients in a manner that they buy into and accept their vulnerability
    - Need to have fall prevention be one of many top priorities in patient safety
  - **Process Improvement Identified:** Will be an ongoing and changing process platforms such as Soarian, usage of ABC’s, Morse Scale, and Yellow Arm Bands.
  - B. 2/2012 Initial and ongoing falls assessment is in the Electronic Medical Record Core
  - C. Standardized use of validated falls assessment tool using Morse Scale for adults/Humpty Dumpty for pediatrics.
  - D. April 2012 did a patient survey and found that 62/73 85% of patients who were identified at risk for falls did not think they were. 60/73 82% were told to use a call bell when needed to get out of bed. Survey reeducated staff were put into place and nursing evaluated to make sure that signs “call before you fall” were in place.
  - E. 12/13 began Purposefully Hourly Rounding (PHR) and Bed Side Shift (BSR) Report in select site through out the organization. PHR focusing on 4 P’s (position/pain/potty/personal items) for patient safety and comfort. BSR patient fall status included in handoff.
  - F. 1/14-3/14 Units initiated Safety Huddles that informed multidisciplinary staff of patients at risk for falls.
  - G. Committee re formed and subgroups developed. Subcommittee will report monthly to Core Fall Committee. Fall Core Committee will meet monthly and report to Quality Council.

### Goals & Metrics

<table>
<thead>
<tr>
<th>#</th>
<th>Goal/Metric</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Decrease falls and falls with injuries by 15%</td>
<td>FY 15 639/190 FY15 South 2 27/6 FY15 4 West 31/7</td>
<td>FY16 543/161 FY16 23/5 FF 16 26/6</td>
</tr>
<tr>
<td>2.</td>
<td>Increase HCAPS for cleanliness</td>
<td>South 2 March 78.3 4west March 66.7</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Safety Rounds – Fall Prevention</td>
<td>White Board/magnets South 2 4 West</td>
<td></td>
</tr>
</tbody>
</table>

- **Decrease in falls # of falls by 15% in 6 months**

### Current Action Items

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due Date</th>
<th>Status</th>
<th>Help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2014 Falls Education Subcommittee: Signs Fall Before You Fall being made and put up</td>
<td></td>
<td></td>
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<tr>
<td>12/2014 Pilot on 4th floor Posting sign at bedside assistive devices needed.</td>
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<td></td>
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</tbody>
</table>

### Project Status:

- Committee meets monthly. AHRQ Team meets monthly, Core Fall Committee meets monthly, Monthly AHRQ with 10 hospitals, Bi-weekly calls with AHRQ.
Steward Good Samaritan Medical Center

Brockton, MA
Bedsize: 267
Pilot Units: 3B (Cardiac/Telemetry), 4A (Med/Surg), & 4BH (Senior Behavioral Health)
Next Session:
December 16, 2015
Questions for Pat Quigley due November 30

Please complete the Webinar evaluation survey.
Thank you!