

Fall Prevention and Management in the Adult Patient

Presented by:

Peggy Cmiel RN MBA CNAA

Director of Nursing Medical-Surgical and
Post Acute Services

California Pacific Medical Center

(with Thanks to Donna Tobey in Quality for brain
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Falls, falls and more falls –

- Falls Prevention Committee was very frustrated
- We couldn't get a handle on all our patient falls
- Small group of team members for Fall Committee
- So we enlisted our Quality Dept to help by doing an FMEA

FMEA Defined:

Failure Modes and Effects Analysis is proactive.

A team of “experts” is convened to :

- identify every possible failure of a process, to determine the potential effect of the failure on the customer of the process (e.g., the patient)
- determine the frequency and impact of the potential failure.
- rank & prioritize the possible causes of failures as well as develop and implement preventative actions, with responsible persons assigned to carry out these actions.

What prompted this FMEA?

- Recent patient falls resulting in significant morbidity identified the SNF patient population as being at particular risk
- This team met to consider the potential impact of a failure to communicate falls risk of patients being transferred from acute to SNF
- The team was made up of frontline experts: staff nurses from both acute and SNF, the patient safety advocates, and nursing leadership.
- The team was facilitated by Quality Improvement

What we discovered:

- As the process around determination of a patient's falls risk was flowcharted and broken down, we found out that there were multiple opportunities for failure of communication of falls risk as the patient moved across the continuum
- Handoffs of all types were considered...

We found out ALL handoffs were at risk --



Key finding:

- A close look at falls handoff communication at CPMC indicated that there is no systematic way that a patient's falls risk is being communicated:
 - Shift to shift
 - At breaks
 - When the patient is transported to another department (e.g., Surgery, Radiology)
 - or transferred to another unit or level of care

The new Falls Prevention protocol was a radical departure from the current scoring system for Falls Risk:

- The team concluded that the existing protocol was confusing and too complicated. They decided to “blow up” the assessment piece of the existing protocol and simplify!
- ALL patients are now considered at risk for falls, and a new designation of “universal falls precautions” was created.
- The protocol contains a provision for hourly safety rounds on all patients
- The Falls Risk score was modified to make it more meaningful and focused on active intervention.

Revised falls score:
(the post falls algorithm remains unchanged)

Table 1: NOTE: ALL patients are at risk for falling; Please use standard fall precautions for EVERY patient	
High Fall Risk Assessment Scoring Scale	Record Points
Fall History ■ Fall within 3 months before admission (4 points) ■ Fall during this hospitalization (8 points)	
Age ■ 70-79 Years (2 points) ■ ≥ 80 Years (3 points)	
Mobility ■ Unsteady gait or weakness, or uses assistive device (4 points)	
Elimination ■ Incontinence, urgency, nocturia, frequent urination (3 points)	
Cognition ■ Confusion, impaired judgment, agitation (4 points) ■ Dizziness (4 points)	
Medication ■ Medications that increase risk of falls (review current patient medication list and compare to <i>Appendix A: Medications Associated with Fall Risk</i>) (3 points)	
	<i>Total Points:</i>
For a Fall Risk Score of <u>5 or higher</u>, initiate MANDATORY INTERVENTIONS described in section B	

Fall Risk Assessment

- On Admission
- When patient transfers to different level of care
- Whenever there is a change in condition that could increase the risk of a fall
 - Post surgery or post procedure
 - Change in cognitive status that could increase falls
 - Onset of physical impairment
 - Initiating medications that could increase fall risk
- After a patient falls
- **EVERY SHIFT!**

KNOW THE SCORE!!!

- Patient Safety Team educated staff
- “Know the Score” Magnets for room doors and patient identifier board
- Fun posters to remind staff and raise awareness

Roll out of the new Falls Campaign is scheduled for May 1, 2006

Know
the
Score!



*Watch for buttons, pens, door magnets and posters
coming your way...*

Don't Let Yourself Fall Behind!

Know the Score!



Document the Score:

- For a Fall Risk Score less than 5, initiate **Standardized Falls Precautions INTERVENTIONS**
- For a Fall Risk Score of 5 or higher, initiate **MANDATORY INTERVENTIONS**

Standardized Fall Precautions

- Hourly rounding
- Orient patient to room, call light, ambulation devices
- Clear room of clutter, spills, physical hazards
- Educate patient and family on fall precautions

HIGH Risk Fall Precautions MANDATORY!!!!

- Locate patient near nurses station
- Initiate bed alarm for patients with impaired judgment
- Staff must remain with patient during transferring and toileting
- Staff must remain with patient when ambulating if patient has unsteady gait
- Label patient door and white board with "Know the score" Fall risk warning sign
- Include fall risk score in all hand-off communication

Other Suggested Interventions:

- Adequate lighting
- **Physical Therapy consult**
- Family member to stay with patient
- Patient mattress on floor
- Quiet music to calm agitated patient
- Monitor for orthostatic vital signs
- **Pharmacy consult**

Fall Prevention Devices:

- Bed alarm
- Seat belt alarm
- Wedge cushion (but watch skin!)
- Lap top tray
- Bedside commode
- Side rail pads
- Floor cushions
- Lap cushions

Communicate, Communicate, Communicate!

- Educate the patient
- Educate the family
- Tell other care givers

STOP SIGN

Handoff Communication

DATE: _____ To DEPT: _____
To DEPT: _____

Pt. Name: _____ Unit: _____
Code Status: _____ Oxygen _____ LPM

<u>Precautions:</u>		<u>Conditions:</u>
<input type="checkbox"/> FALL	<input type="checkbox"/> Seizure	<input type="checkbox"/> NPO
<input type="checkbox"/> CONTACT	<input type="checkbox"/> Aspiration	<input type="checkbox"/> Restraints
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Sternal	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Bleeding (on anticoagulants)		<input type="checkbox"/> Diabetic

COMMUNICATION: Language Spoken _____

Hard of Hearing Non-verbal
 Blind /Visually Impaired Confused

Patient sent with: Glasses _____ / _____ ; Hearing Aid _____ / _____
Nurse Initial Dept Initial Nurse Initial Dept Initial

Dentures _____ / _____ ; Other _____ / _____
Nurse Initial Dept Initial Nurse Initial Dept Initial

MOBILITY:

Independent 2 Person Assist
 1 Person assist Totally dependent

Nurse: _____ Ext: _____
Dept: _____ Ext: _____
Dept: _____ Ext: _____

Falls Prevention Committee Refocused and invited new staff members to participate

- **INTERDISCIPLINARY** – Staff nurse, Managers, **Physical Therapy**, Risk Management, Quality Dept, **Pharmacist**, Outpatient
- Review Falls data
- **Request Action Plans from nursing units with increased falls**
- Revise and Update Protocol
- Educate staff

In spite of all your hard work to prevent the patient from falling,

The Patient falls.

What do you do?

Management of a Fall:

- 1. RN Assessment
 - Change in Neuro Status/Cognition
 - Orthostatic vital signs
 - Pain
 - Bruises, lacerations

- 2. Assist patient back to bed if appropriate
- 3. Notify physician
- 4. Notify family

HEAD CT and NEURO Checks are indicated if:

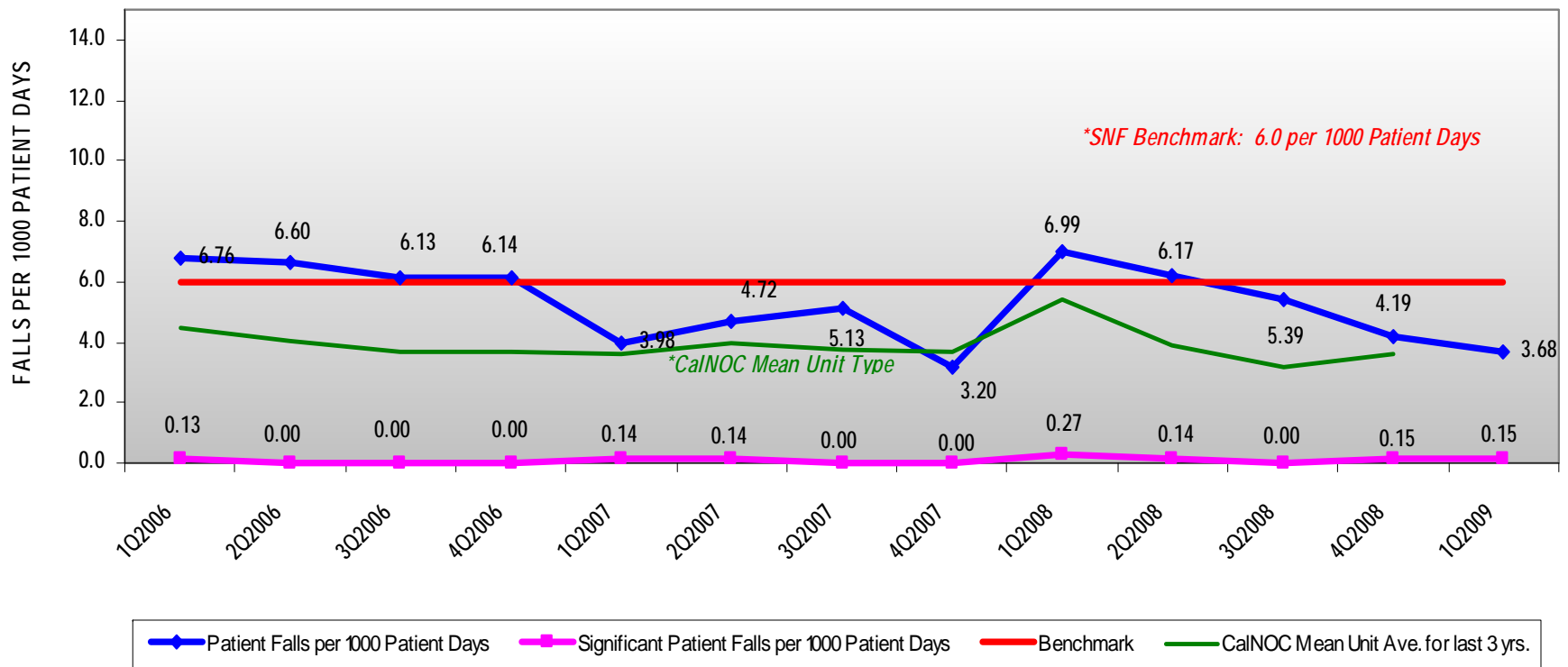
- Patient has a headache post fall
- Patient is vomiting
- Patient is on an anticoagulant or has a coagulopathy
- Patient is intoxicated (drugs or alcohol)
- Patient has short term memory deficits immediately before or after the fall.

HEAD CT and NEURO Checks are indicated if (con't):

- Patient has physical evidence of trauma above the clavicle
- Patient had a witnessed seizure
- Patient has any episode of loss of consciousness
- Patient has or had any alteration in mental status at the time of or after the fall (feeling dazed, disoriented or confused)

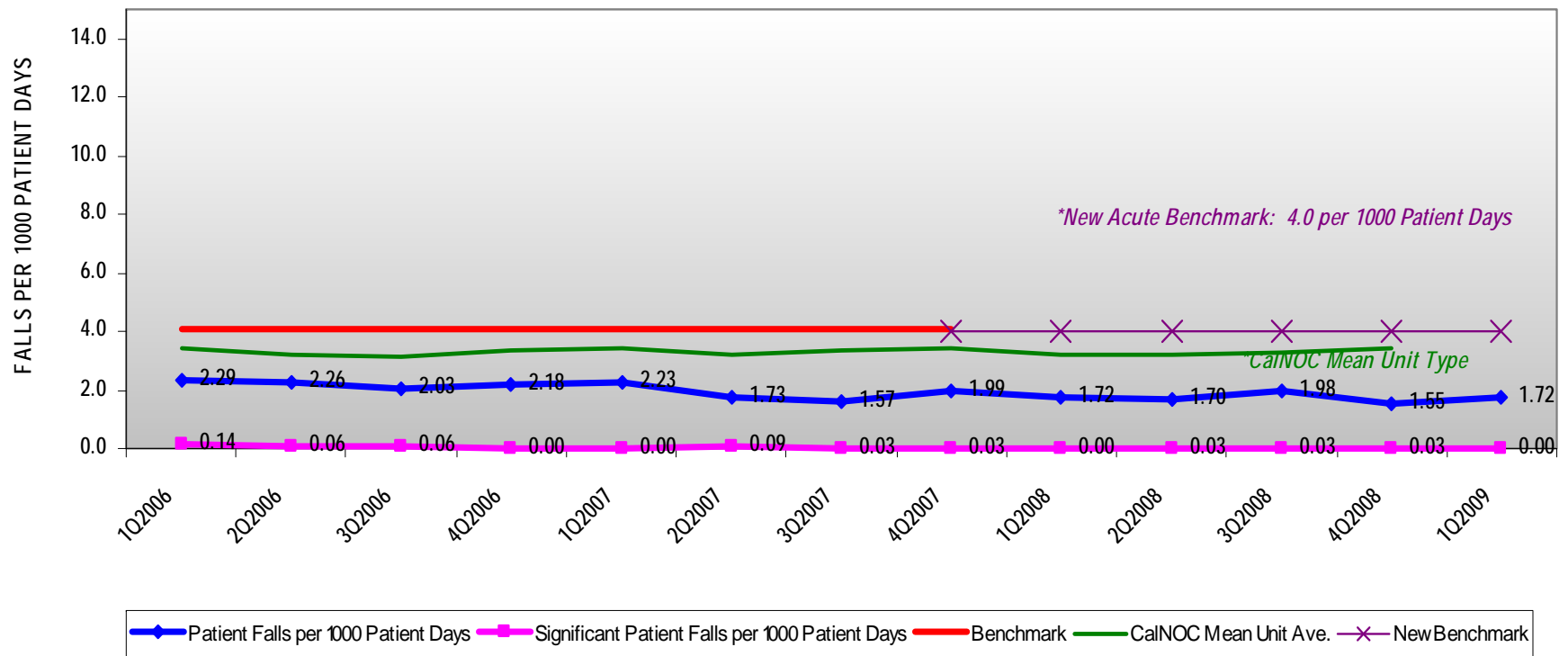
Data - SNF

SNF TOTAL
 REPORTED FALLS/SIGNIFICANT FALLS PER 1000 PATIENT DAYS
 2006 - 1Q2009



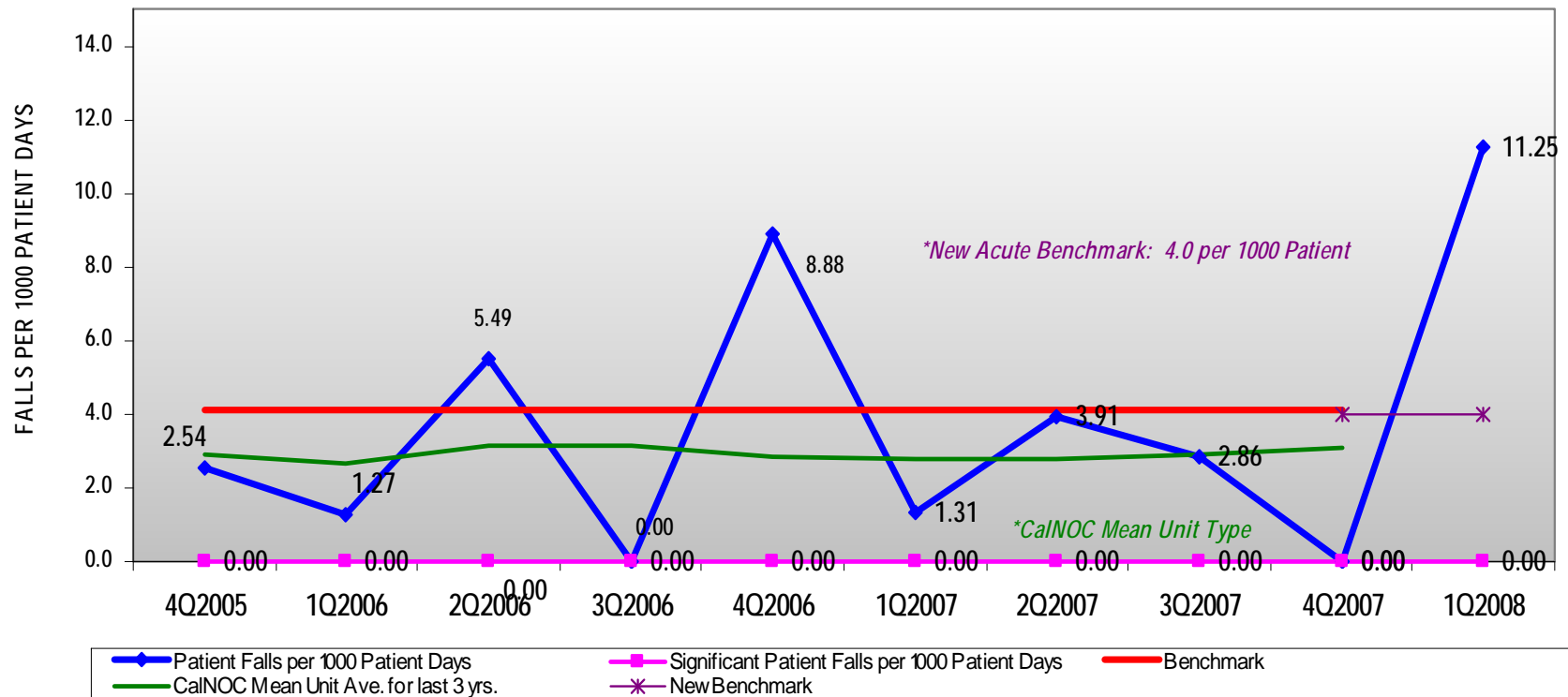
Data - ACUTE

ACUTE OVERALL
 REPORTED FALLS/SIGNIFICANT FALLS PER 1000 PATIENT DAYS
 2006 - 1Q2009



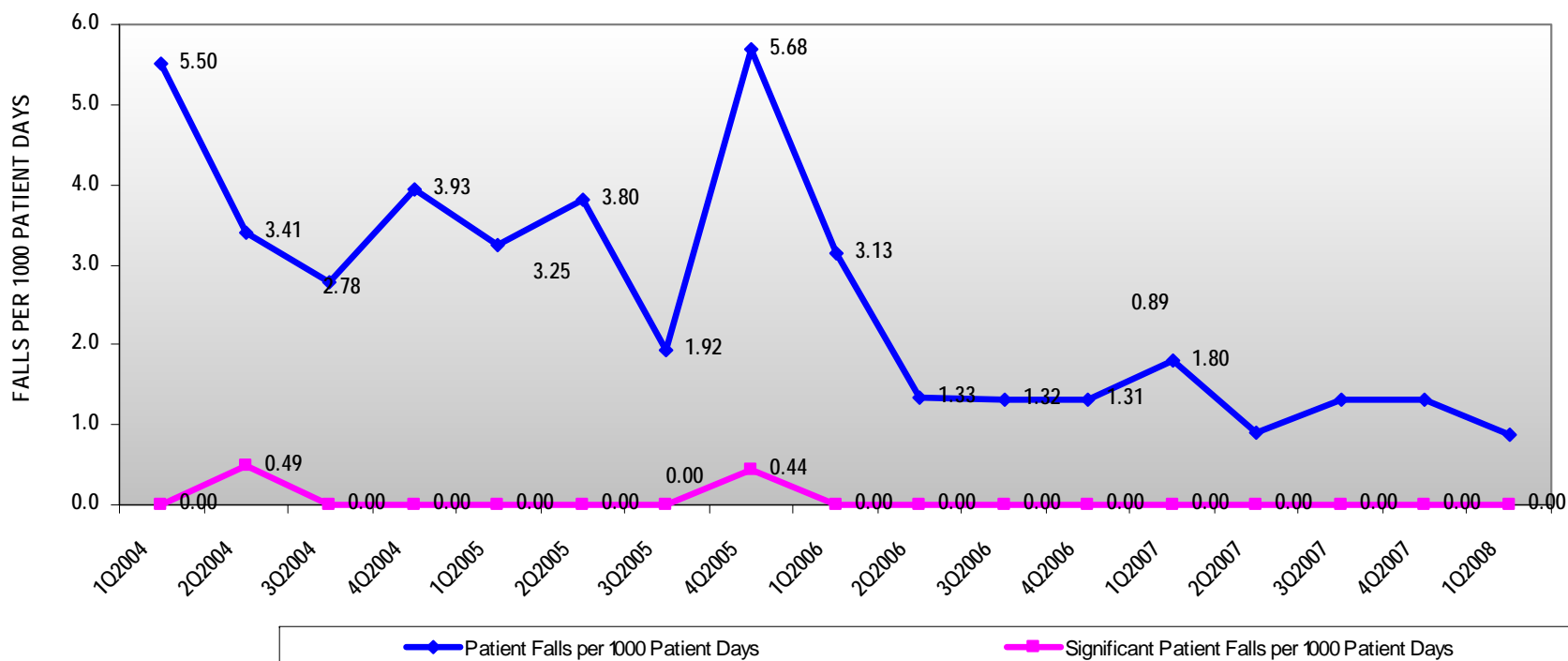
Acute Unit

T Unit PACIFIC
 REPORTED FALLS & SIGNIFICANT FALLS PER 1000 PATIENT DAYS
 4Q2005 - 1Q2008



Success Story

ALZHEIMER'S UNIT
REPORTED FALLS & SIGNIFICANT FALLS PER 1000 PATIENT DAYS
2004 - 1Q2008



KEY POINTS to prevent falls:

- Assess every patient for fall risk:
 - on admission
 - every shift
 - Whenever a change in patient status
- Highest predictor of a fall is a prior fall
- Involve multidisciplinary team in reviewing falls
- Engage staff
- Use bed alarms
- Stay with high risk patient when toileting
- Communicate Fall risk to other care givers

THANK YOU VERY MUCH!!!!