Partnering with the Patient to Prevent Falls in the Medical-Surgical Areas

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Background

• Falls are the leading cause of injury-related death in adults over the age of 65 with costs totaling 34 billion (78% paid by Medicare) in 2013.²
• Inpatient falls lead to prolonged length of stay which results in increased costs and the potential discharge to a rehabilitation setting instead of home.⁹
• An estimated 11,000 inpatient falls result in deaths each year leading to the Centers for Medicare and Medicaid Services identifying falls and falls with injury as a hospital-acquired condition not available for additional reimbursement if injuries occurred during hospitalization.²⁸
Our Problem

- Increase falls on unit 4A
- Higher rate of falls when compared to other Med-Surg units in Hospital
- Lack of communication with the patient/family on fall prevention
- Inconsistent use of bed alarms and chair alarms
- Patients and families not involved in fall prevention activities

Unit 4A Falls Data Pre Implementation

- April: 4 falls, Rate per 1,000 BDOC: 9.37
- May: 4 falls, Rate per 1,000 BDOC: 6.94
- June: 4 falls, Rate per 1,000 BDOC: 7.89

Falls Comparison Data Between 4A and 5A Pre Implementation

- 4A Number of Falls
- 5A Number of Falls
- 4A Falls Rate per BDOC
- National Falls Rate

- April: 4 falls
- May: 4 falls
- June: 4 falls
History (The Journey)

Falls Rounding Tool with Navy Corpsmen

Falls Signs

Monthly Falls Debriefing

Partnering with a Patient

Falls Rounding Tool

- Created a tool containing interventions staff had to follow when a patient was on falls precautions.
- Rounds were completed with CNS, Falls Coordinator, and the Navy Corpsmen.
- Checking patients room for compliance
- Program was hard to maintain

Falls Signage

- Requests from staff to create a sign
- Created a sign involving staff members to enhance buy in
- Staff noncompliant with process for managing fall signs
- Signs noticed at first but then became less noticeable
Monthly Falls Debrief

- Once a month the falls champion would put together a presentation of the falls that occurred during that month.
- The falls champion would review details of the falls to include precipitating factors for the falls.
- The group would then debrief the falls situation.
- More open sharing about the causative factors contributing to the fall was shared during the monthly falls debriefing versus the immediate literature review.

Literature Review (Evidence)

Most interventions (48/59), 81% targeted primarily healthcare provider behavior to include introducing a new risk assessment or care protocol or post fall evaluations. Interventions combined different components and care processes including risk assessments, visual alerts, patient and family education, rounding, or bed-exit alarms. Screening patients for falls were employed in almost all studies. Falls can be reduced by providing structured education to cognitively intact patients.

Technology including video monitoring and patient interactive TV systems which allows patients to watch educational videos was newer interventions in the literature.

Healthcare Provider

- Visual Alerts/Alarms
- Patient/Family Education
- Technology

Literature Review (Evidence) Engaging Patient and Families

- Engage Patients and Families seeking their perspective in the design and implementation of fall injury prevention activities at the organization level and patient level is advantageous. Studies have shown that falls can be reduced by providing structured education to cognitively intact patients.
- The Fall Risk and Prevention Agreement Partnership for Patient Safety was signed by patients and/or families acknowledging their understanding and reception of fall prevention education.
- Change of risk level was communicated to patients and families on the agreement. The signed agreement demonstrated the full partnership in safety for the patient and their family. The agreement was not part of the chart and was placed on the whiteboard in each patient room.
- Berwick (2015) recommended 8 ways to improve safety in healthcare systems which included partnering with patients and families for safe care.
Possible Solutions

• A patient contract

Possible Solutions

• More Rounds
• There is no getting around rounds

Possible Solutions

• Get Another Alarm
• How about a better chair alarm?
Implementation Methodology

- **TeamSTEPPS 2.0® Team Structure**
  - Partnering with the Patient
    - Strategies for involving patients in their care
      - Include patients in bedside rounds
      - Conduct handoffs at the patient’s bedside
      - Provide patients with tools for communicating with their care team
      - Involve patients in key committees
      - Actively enlist patient participation

**TeamSTEPPS 2.0®**


Implementation Framework

- **Plan**
  - Met with Leadership
  - Searched the literature
  - Developed Project Interventions
  - Created flyers, certificates and handouts
  - Educated nurses

- **Do**
  - Implemented Program
  - Made certificates available
  - Reevaluated the program to check process
  - Concerned if certificates being handed out
  - Relooked at Falls Data
  - Based on feedback decided to put certificate in room

- **Act**
  - Placed certificates in room
  - Reevaluated Program
  - Discussed with unit stakeholders
  - Designed patient information card
  - Begun weekly rounding
  - Reeducated nurses
  - Checked certificate and card usage
  - Analyzed fall and LOS data
  - Continued rounding on unit

Interventions

- **Team Structure (TeamSTEPPS)**
- Checklist
- Staff Education
- Patient Education

**SAFETY FIRST**

**Partnership with the Patient**

- Patient Education
- Bed Rails Up
- Bed Alarms On & Set
- O’P’s Addressed
- ADL’s Fulfilled
- Assistive Devices in Room
- Call Light in reach
- Call Light in Room

**C.O.R.R.E.C.T.**

- Communication
- Orientation
- Respectful Care
- Environment
- CNAs
- Equipment
- Communication
- Training
- Equipment
The Reward
• Presented to the patient at discharge
• Updated process early in December
• Certificate was placed in patient room as a visual indicator

Additions: Rounding Card
• Added earlier in December
• Patient and Family Education
• Patient Intervention focused on patient behavior versus staff
• Watch the Fall Prevention Video on the patient education video Network

Purpose
• Reduce falls on 4A
• Include the patient/family with their plan of care with prevention

Measures
• Falls
• Falls Rate per BDOC
• Length of Stay
• Costs
Results

- Overall the program was successful for 4A and produced positive results. The falls rate decreased 71% from 8.06 to 3.18.
- Average number of falls decreased from 4 to 1.7.
- Average length of stay decreased 17% from 2.84 to 2.39.

There were no falls involving 4A patients during the months of December and January supporting the positive impact of the program in preventing falls when compared to another comparable unit without the Partnering with the Patient Program.

Hospital costs averaged $3,949 per day and each hospital stay cost an average of $15,734.

Results (Potential Cost Savings)

- $3,949 cost per one day of care
- $11,215.16 for 2.84 average LOS per patient
- $9438.11 for 2.39 average length of stay per patient
- Average Daily Census is 22 patients
- Admit about 30-40 patients a month

$1777.05
Per stay

$53,310
Per month

$639,720
Per year

- $336,450 cost for 30 patients for one month if the average length of stay is 2.84 days.
- $283,140 cost for 30 patients for one month if average length of stay is 2.39.
- $53,310 cost savings for one month
- $639,720 cost savings for one year

Discussion

- Researchers estimate fall related costs could reach 67.7 billion by 2020 and the average hospitalization cost for a fall related injury is $30,000. 1,2
- There was no solid way to tell if the certificates were being given to all the patients at discharge.
- Three rounds of education, visual cues of certificates in rooms, and staff being aware of the script all helped to influence staff and patient behaviors positively in terms of fall prevention.

More information regarding program impact on patients who frequently visit the hospital will be gathered 1 year post implementation.
Barriers and Limitations

Workload
- There were concerns throughout the project regarding the amount of bedside nurse/staff involvement due to workload issues and competing priorities.

Compliance
- Reeducation had to be done in November and on the spot education was done in December based on changes to program to help support compliance.

Sustainment
- Due to program requirement demands, enlist the help of the Navy Corpsmen to assist with rounding and keeping certificates in the room is a viable option to expand the rounding team throughout other areas.

Future Implications

- The hospital just recently implemented a Video Monitoring System which research has shown the potential to significantly reduce falls by 35%. The video monitoring system is not appropriate for all patients so it is still necessary to keep other fall prevention programs in place such as the “Partnering with the Patient” program.
- Due to the success of the rounding program, the Falls Coordinator and Medical-Surgical CNS is looking to expand the program to other areas within the hospital.
- Including patients as active participants in their care through this program is the first step in implementing other projects that include patients and families as active participants in their care.

Questions
References


