Innovation Profile: Hospital wide efforts successfully reduced falls and increased patient safety.

**Snapshot**

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<th>Summary</th>
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<td>The Providence St. Vincent Medical Center (PSVMC) approach to reducing falls was a hospital wide intervention which emphasized teamwork, innovation, and monitoring. National Benchmarks from the National Database of Nursing Quality Indicators (NDNQI) initially began the conversation about fall prevention at PSVMC. Leaders were surprised to learn about PSVMC’s fall rates in 2008, which were brought to the attention of the Chief Nursing Officer (CNO) who decided that fall rates needed to be addressed. Setting goals, implementing multi-tiered efforts and encouraging rigorous data monitoring contributed to lowering fall rates.</td>
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<th>Hospital Background</th>
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<td>Not-For-Profit Mixed Payer Magnet Hospital</td>
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<th>Date First Implemented</th>
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**What They Did**

**Project Origins**

- The Chief Nursing Officer (CNO) made fall prevention a focal point at PSVMC. Because rates were high, the team analyzed the voluntary incident reporting system of Unusual Occurrence Reports (UOR) to determine the main cause of falls. A root cause analysis was conducted of three sentinel events in 2009. The most common causes of falls were identified a plan was developed to address the each issue. The Director of Nursing Practice and Research looked into other hospital’s fall prevention programs, which was helpful during the planning stages. The Providence Oregon Region made fall prevention a priority, which encouraged collaboration and standardized fall prevention programs among the 7 acute care facilities.

**Description of the Intervention**

- **Setting Goals and Establishing Plans**: The benchmark data from the National Database of Nurse Quality Indicators (NDNQI) were used to develop goals. By the end of 2011 goals were set to reduce falls to 2.0/1000 patient days for medical surgical and critical care units and to reduce moderate to severe injuries associated with falls to 0.0/1000 patients days for medical surgical and critical care units. The main focus of the intervention was to reduce falls with injury. Debriefing protocols were established for falls with or without injury. Falls without injury required an end of shift debrief with a nurse and the charge nurse. Falls with moderate to severe injury required both a debrief and a root cause analysis.
• **Developing and Revising Fall Prevention Tools:** A number of prevention tools were utilized to reduce fall risk at PSVMC:
  o A revised fall risk assessment tool helped determine what types of patients were at a higher risk for falls, as assessments are completed upon admission, with any handovers in nursing care, during each shift, and with any change of condition.
  o The ATTEND acronym was used for the fall prevention bundle (Assess, Turn, Toilet, Engage, Never Leave at risk patients alone on commode/toilet, Debrief).
  o LAMP (Look at Me Please) signs featuring a picture of Florence Nightingale’s lamp, which are placed on the doors of high-risk patients to help staff recognize patients with a high fall potential.
  o High risk patients are placed in a teal gown, a component of the universal identification at PSVMC. The patient's mobility status is written on the whiteboard in a patient’s room and updated as their condition changes.

• **Patient and family education:** Fall prevention information was disseminated to both the patient and family at hospital admissions. Signs that read “Call Don’t Fall” are posted in hospital rooms to remind patients to call for help when needed. Pamphlets and other written materials were available, but it was discovered that verbal communication works best for patients and their families. Fall risk signs posted in room in both English and Spanish were utilized previously, but are no longer used.

• **Recognizing Fall Team Leaders:** Departments in the hospital were contacted about fall prevention and staff members were asked to volunteer as leaders for the fall prevention program. Once the leaders were identified, a Fall Summit was held to organize and inform the leaders of the program. The leaders were enthusiastic about reducing falls and dedicated to the program -- essential characteristics for recognizing fall risk and preventing future occurrences. Team leaders were instrumental in disseminating fall prevention tools and education to their various departments.

• **Tailoring fall prevention to each department:** It was determined that falls were not just a nursing issue. Early on it was recognized that falls are a hospital-wide responsibility to address. Staff meetings were begun with a patient story about what happens to people who fall. Telling stories personalized and humanized the issue, creating an emotional impact on hospital staff. The program was named “Many Hands Make a Team – It Takes a Team to Prevent Falls” since employees from Food Services to Boardroom were included in the intervention. Tailoring fall prevention to each department allowed different groups to be involved in the improvement process.

• **Educating staff:** Continuing the education of fall prevention was crucial to keeping rates down. Falls prevention was added to the new staff orientation as well as periodic reminders to the staff. All departments were educated in the universal identification tools such as placing a high fall risk patient in a teal gown.

• **Disseminating results to staff:** Providing routine reports to staff reemphasizes organizational commitment to reducing falls.

• **Staying focused on falls:** After positive improvements were made from 2008 to 2010 it was noted that fall prevention needed more attention since falls rates started climbed slightly. The recent transition to a new EMR system (EPIC) and other hospital priorities challenged falls prevention. Due to focusing on other hospital initiatives, it was reiterated that reducing falls is an ongoing process which requires consistent effort and focus. Changes were implemented in 2010 (fourth quarter) and continue to be worked on. Refocusing on falls was reemphasized by integrating new employees in the fall risk group and updating department goals.
Did it Work?

Results: Falls with injury have declined over the past four years.

Factors Important to Success

- **Teamwork:** Collaboration among the Chief Nursing Office, the Director of Nursing Practice and Research, and the Providence Oregon Fall Team leaders assisted in the planning and implementation of the program.
- **Variety of tools:** Signage, universal identifiers, and assessment tools engaged hospital staff in the fall reduction program.
- **Monitoring and reporting data:** Consistent monitoring and reporting data to hospital staff was crucial to staying focused and keeping fall rates at a minimum.
- **Staying focused on falls:** One of the greatest challenges of the intervention at PSVMC was maintaining low rates. When other hospital initiatives were addressed, fall rates tended to increase, so keeping a focus on reducing falls was essential to sustaining success. The team stressed the commonalities between fall prevention and other new hospital initiatives in order to retain the focus on fall prevention.
- **Spread:** Summits were held for the Providence Oregon Region and the Washington Region to address falls issues. A Regional group meets quarterly, where fall team leaders talk about falls in their facility, what they learned in debriefs, what worked well, what could be improved.

If you would like additional information about this success story please contact: admin@HENlearner.org