Washington State Hospital Association
Safety Action Bundle:
Protecting Patients from Falls and Fall-related Injuries

Contents

Background

Falls disproportionally impact the older population with 43% of all falls occurring in patients older than 65 years.[i] Each year at least 250,000 older people—those 65 and older—are hospitalized for hip fractures. [ii]

In 2010, 45% of the inpatient hospital population was 65 years and older, with 19% being 75-84 and 9% being 85 and older, confirming an aging trend of the inpatient hospital population and the increased risk for injurious falls, associated morbidity and mortality. [iii]

Falls and trauma (fracture, dislocation, intracranial injury – crushing injury, burn, other injuries) have been and remain the fall-related hospital adverse conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and ***(c) could reasonably have been prevented through the application of evidence-based guidelines***. [iv]

Falls with injuries remains one of the most reportable, serious, and costly type of adverse events that occur in United States (U.S.) hospitals, resulting in detrimental morbidity and mortality outcomes. [v, vi] In hospitals, one percent of falls results in a fracture and as many as 5 percent may result in a serious injury.[vii]

Persons experiencing a hip fracture during hospitalization have a greater risk of institutionalization and death compared with community-dwellers experiencing a hip fracture. [vii]

While interim estimates for 2014 reported a 17% decline in hospital acquired conditions overall, the in-hospital patient falls remained the same from the 2010 baseline compared to 2014 (260,000 rounded). [viii]

In December 2015, CMS began public reporting requirements for the HAC Reduction Program for each eligible hospital, which includes the PSI 90 Composite measure score that addresses only postoperative hip fractures as the fall with injury adverse event. [iv]

All hospitals should assess patients on admission for fall and injury risk factors and develop individualized fall and injury prevention plans of care.[ix]

AIMS: The CMS Hospital Improvement Innovation Networks (HIINs) are tasked with a 20% decrease in overall patient harm and a 12% reduction in 30-day hospital readmissions through 2016-2019.

MEASURES: The Washington State Hospital Association launches a stretch goal to achieve, as the State's Leader for patient safety.

OUTCOME MEASURES: For 2017-2019, they are:

- Zero Deaths from Falls;
- 50% reduction in falls with Moderate and Serious Injury; and,
- 40% reduction in Falls with Mild Severity of Injury

PROCESS MEASURE: Improve Infrastructure and Capacity to Protect Patients from Fall Related Injury Annually, as measured by improvements in Fall Injury Prevention Program Attributes on the Washington State Action Bundle below.

Organizations will measure program enhancement using this tool by answering via a Likert-type scale of 0-3 (0 – not in place; 1 – being discussed; 2 – in progress; 3 – fully implemented).

Organizations are encouraged and invited to conduct a baseline assessment of your program infrastructure and capacity by completing the entire organizational assessment. Organizations will be encouraged and invited to complete the survey by September 2017.

SUBMIT DATA: By using the Washington State Hospital Association Quality Benchmarking System at baseline 2017, and then annually thereafter for 2018 and 2019. Fall Injury Data by severity levels will be reported to WSHA quarterly.

Core Strategies at the Organizational Level:

A. Leadership Fall Injury Prevention Program Attributes
1. Executive leadership (i.e. hospital director, associate directors, nurse executive) "walk-arounds" with targeted questions about fall injury prevention.
2. Management (i.e. Executive Champions, Clinical Directors, Unit Managers) and clinical representatives facilitate periodic, announced, focus groups (unit briefings) of front line practitioners to learn about perceived problems with falls and fall-related injuries.
3. Employees are provided with timely (monthly/quarterly) feedback on falls and injury data, improvement results, significant events and close calls.
4. Fall-Injury Prevention strategies target the organizational and unit system, along with specific patient populations.
5. Fall-related injuries are discussed openly without fear of reprisal or blame.
6. All fall-related injuries are discussed with patients and families regardless of injury severity.
7. One or more specifically trained practitioners are identified to oversee the analysis of fall- related injuries, their causes and coordinate fall injury prevention activities. (Designation of Fall Experts and Unit Based Champions).
8. Employees voluntarily report fall injury hazards.
9. A non-blaming immediate post fall assessment (Safety Huddle) of every patient fall is conducted to identify root causes of fall and resulting injury.
10. After immediate assessment and reporting, how the fall and injury might have been prevented is communicated to all staff.
11. Staff participates in equipment and technology selection (i.e. surveillance and detection systems, floor mats, hip protectors).
12. Patient Communication / Hand-off Procedures include patient's risk for an injurious fall.
13. Fall injury prevention and intervention protocols are included in hospital and nursing new employee orientation (e.g. hip protectors, mats, low beds).
14. Staff participates in professional and/or clinical training programs that include skills training to prevent injuries for falls (i.e. Washington State Hospital Association Educational Programs and Safe Table Webinars).
15. Assess the current state, set aims, goals and timelines for practice changes including staffing considerations, necessary equipment, staff skill mix, etc. to reduce injuries from falls.
16. Identify, create and support the implementation of consistent, organizational wide processes incorporating the multi-disciplinary team in a fall injury prevention program.
B. Program Evaluation
17. Fall Rates are analyzed and reported by Type of Fall (Accidental, Anticipated Physiological, Unanticipated Physiological).
18. Fall-related Injury Rates are analyzed and reported by Severity of Injury.
19. Fall injury rate is reported per unit and hospital- wide by severity level and type of fall.

20. Analysis of Repeat Fallers (falls at the person-level) is analyzed based on post fall assessment. (Evaluate the effectiveness of post fall huddles on repeat falls by elimination of immediate cause.)
21. Analysis of falls and injury are reported and analyzed by Age Groups (<55, 55-65, >65-75, >75).
22. Falls with injury trend data are compared with staffing matrices.
23. Annual Staff Education on Fall and Injury Prevention is evaluated.
24. Measure the percent of fall and injury risk factors treated (mitigated or eliminated) as a result of individualized care planning.
25. The entire fall prevention program is analyzed at least annually and evaluated for potential risk factors and opportunities for improvement.
26. Trended injurious falls data are reported to the Board of Directors/Senior Leaders routinely.
27. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to team or unit.
28. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to Extranet measures.
29. Data analysis at Organizational and Unit Levels.

Core Strategies at the Unit Level

A. Fall Injury Risk Assessment Methodology
30. A Fall Injury Risk Assessment is conducted on every patient on admission, transfer, change in patient status and after a fall.
31. The history of fall injury risks (osteoporosis, anticoagulants, or other condition that might predispose to injury) is included in the patient assessment upon admission.
32. A history of a fall-related injury, especially a fracture, is included in the patient assessment upon admission.
33. Signage is utilized at the bedside if patient is at risk for injury.
34. A patient-specific injury prevention plan of care is reliably implemented.
B. Fall Assessment Methodology – Use of Valid and Reliable Instrument
35. Assess:
• Patient's history of falls.
• History of Repeat Falls.
• Altered Mental Status (confused, disoriented, depressed, restless).
• Altered elimination (incontinence, diarrhea, nocturia, frequency, urgency or requirement to help to toilet).
• Review of medications that increase risk for falls (could include meds that are triggers for injury risk, e.g. steroids, resorptive agents).
• Altered mobility (unsteady gait, uses assistive devices, impaired balance).
• Orthostatic hypotension.
36. Patient-specific fall risk fall prevention plan of care is reliably implemented.
C. Environmental Safety to Reduce Severity of Injury
37. Hip Protectors are used for patients with history of fracture.

38. Floor Mats are used at the bedside to reduce trauma if a fall occurs.
39. Non-slip flooring is in place, especially in the bathroom and shower.
40. A height-adjustable bed (in low position, except during transfers or standing) is provided for select patients.
41. Bed-rail alternatives (body pillows, assist rails) are available and in use.
42. Raised toilet seats and bilateral grab bars are available and in use.
43. Any environmental sharp edges are eliminated.
44. Patient uses the safe exit side from bed (e.g. patient transfer toward unaffected side).
45. Alarms (bed, wheelchair) are used based on patient-specific criteria (not level of fall risk).
46. Camera surveillance / detection systems are used appropriately.
47. Patients have access to mobility aides (walkers, canes, bedside commode) as appropriate
D. Additional Fall Risk Assessment if Positive Screen: At Risk for Falls and Injury
48. Formal tests of mobility, gait (see listed tools in comments section: 8 ft Up and Go, Berg Balance Test).
49. Medications are reviewed for contributing causes.
E. Post-Fall Injury Assessment Includes
50. Conduct a neurological assessment if impact to patient's head is suspected.
51. Assess any change in patient's Range of Motion post fall.
52. Evaluate orthostatic vital signs if condition permits.
53. Document any injury(ies) by severity level.
54. Modify the patient's plan of care after the Safety Huddle to prevent a repeat fall/injury.
F. Patient / Family Education / Discharge Education
55. Engage patients and family in identifying the patient's fall and injury risk on admission as partners in their fall prevention program.
56. If on anticoagulants, review the patient's anticoagulation therapy prior to discharge.
57. If on anticoagulants, provide patient education on "*What to do if you fall and are on Anticoagulation*" (patient education brochure).
58. If osteoporotic, review the potential need for osteoporosis therapy prior to discharge.
59. If osteoporotic, educate the patient (and family) about osteoporosis (video, patient education brochure).
60. If a known faller, provide patient education on "*What to do if you fall and cannot get up*" (patient education brochure).
61. Conduct an Environmental / Home Assessment.
TOTAL SCORE **If Score using Likert-Type Scale 0-3, Range = 0-221**

References

References for Fall Injury Reduction Organizational Assessment Tool:
Boushon, B., Nielsen, G., Quigley P, Rita S, Rutherford P, Taylor J, Shannon D, Rita S. Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012. Released February 2013.

Boushon, B., Nielsen, G., Quigley, P., Rutherford, P., Taylor, J., & Shannon, D. (2008). *Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls*. Cambridge, MA: Institute for Healthcare Improvement; 2008.

Quigley, P., Hahm, B., Collazo, S., Gibson, W., Janzen, S., Powell-Cope, G., Rice, F., Sarduy, I., Tyndall, K., & White, S., (2009). Reducing moderate and severe injury from falls in two VA acute medical surgical units. *Journal of Nursing Care Quality (*JNCQ*).* 24(1): 33-41.

Quigley, P., Barnett, S. Bulat, T., Friedman, Y. (2015, August). Reducing falls and fall-related injuries in medical surgical units: 1-year multi-hospital falls collaborative. *JNCQ.* doi: 10.1097/NCQ.0000000000000151

Quigley, P.A., Barnett, S., Bulat, T., & Friedman, Y. (2014). Reducing Falls and Fall-Related Injuries in Mental Health: A One -Year Multi-hospital Falls Collaborative. *Journal of Nursing Care Quality,* 29(1): 1-9.

Available National Fall and Injury Prevention Toolkits and resources that Support Core Strategies for Program Implementation Include:
Agency for Healthcare Quality and Improvement's Preventing Falls In Hospitals: A Toolkit for Improving Quality of Care. Ganz, et al. 2013

Leadership: Chapter 1
Patient Assessment, Care Planning, and Education: Chapter 3
Post Fall Management: Chapter 3
Environmental Safety: Chapter 4
Program Evaluation: Chapter 5

Department of Veterans Affairs. National Center for Patient Safety National Falls Toolkit. 2014.

Leadership: Falls Notebook –Falls Team; Falls Policy
Patient Assessment, Care Planning and Education: Falls Notebook – Falls Policy
Post Fall Management: NCPS Fall Toolkit – Resources Post Fall Huddle; Falls Policy
Environmental Assessment and Safety: Falls Policy
Program Evaluation: Falls Team

ICSI (Institute for Clincial Systems Improvement) Health Care Protocol. Prevention of Falls (Acute Care). Degelau J, et al. 2012.

Leadership: Chapter 1
Patient Assessment, Care Planning: Chapter 2
Post Fall Management: Chapter 7
Patient Education: Chapter 4
Environmental Assessment: Chapter 6
Program Evaluation: Chapter 7

Institute for Healthcare Improvement. How – to- Guide: Reducing Patient Injuries from Falls. Boushon B, et al. 2012.

Leadership: Section 1
Patient Assessment, Care Planning: Section 1
Post Fall Management: Chapter 1
Patient Education: Section 1
Environmental Assessment: Section 1
Program Evaluation: Section 2

References Cited

[i] Spaniolas, K., Cheng, J.D., Gestring, M.L., Sangosanya, A., Stassen, N.A., & Bankey, P.E. (2010). Ground level falls are associated with significant mortality in elderly patient. *The Journal of TRAUMA Injury, Infection and Critical Care, 69*(4), 821-825.

[ii] (CDC, HomeandRecreationSafety. HipFractureAmongOlderAdults. www.cdc.gov. Accessed August 15, 2016.)

[iii] Levant, S., Chari, K., & DeFrances, C.J. (2015). Hospitalizations for patients age 85 and over in the United States, 2000-2010. NCHS Data Brief. No. 182. Available at: http://www.cdc.gov/nchs/data/databriefs/db182.htm.

[iv] Centers for Medical and Medicaid Services (CMS) (2015). Fiscal Year (FY) 2016 Results for the CMS Hospital-Acquired Conditions (HAC) Reduction Program. Available: www.cmc.gov accessed August 14, 2016

[v] Agency for Healthcare Research and Quality (AHRQ) (2012). Never events. Patient safety primers (Retrieved from http://psnet.ahrq.gov/primerHome.aspx).

[vi] Centers for Medicare and Medicaid Services (CMS) (2012). Hospital-acquired conditions. (Retrieved from: http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/HospitalAcqCond/Hospital-AcquiredConditions.html). Accessed August 15, 2016.

[vii] Berry, S., & Kiel, D.P. (2013, June). Prevention of falls in nursing care facilities and hospital settings. UpToDate. www.uptodate.com/contents/prevention-of-falls-in-nursing-care-facilities- and-the-

hospital-setting Accessed August 15, 2016

[viii] Agency for Healthcare Research and Quality (2015). Saving Lives and Saving Money: Hospital-Acquired Conditions Update InterimDataFromNationalEffortsToMakeCareSafer,2010-2014; Internet Citation: Saving Lives and Saving Money: Hospital-Acquired Conditions Update . Content last reviewed December 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html; Accessed August 14, 2016

[ix] The Joint Commission, (2015, Sept. 28). Sentinel Event Alert 55: Preventing falls and fall- related injuries in health care facilities. Available: https://www.jointcommission.org/sea_issue_55. Accessed August 14, 2016