Rounding with purpose to tackle pesky falls problem

UMMC earns Stand Up for Patient Safety Management Award for dramatically cutting patient spills | BY MARTY STEMPNIAK

Despite years of analysis and dozens of interventions designed to prevent them, upward of 1 million patient falls occur in U.S. hospitals every year, the Agency for Healthcare Research and Quality estimates.

To draw attention to the issue, the National Patient Safety Foundation this year presented the University of Mississippi Medical Center in Jackson with the Stand Up for Patient Safety Management Award.

Saddled with a fall rate above the national average in one inpatient unit — at 6.2 per 1,000 patient days — UMMC was able to dramatically reduce that number within a few months by the end of last year.

Data were key to targeting the root cause, says Nurse Manager Cissy Lee, who designed the intervention as part of her work toward a doctorate of nursing degree. Digging into the numbers, she found that falls occurred most frequently between 11 p.m. and 7 a.m., with a peak time around 4 a.m. That period is when the phlebotomist typically enters the room to draw blood or a nursing assistant comes by to check vital signs. Medicated patients often awoke in a daze and, when the clinicians left, would climb out of bed to use the bathroom. Tumbles were all too common.

"You disturb them, wake them up and they're groggy; then they try to get up and go to the restroom by themselves," Lee explains. "They overestimate their ability to function and walk, resulting in a fall."

Clinical leaders retooled the rounding efforts within the unit to add an extra layer of protection, particularly between 3:30 and 5 a.m. Now, both nurses and nursing assistants check patients every hour, instead of on alternating hours. An extra nursing assistant is kept as a "variable rounder" to respond immediately when a patient is in distress.

Because they know someone will be by more frequently, patients are more likely to wait for help before trying to get out of bed.

Rounding clinicians keep a keen eye out for certain risks in the room — what Lee calls the four Ps: potty, personal items, pain and positioning. Mats are placed on the floor to cushion falls, beds are positioned at a low height with their safety rails up, and belongings are left within arm's length. Patients who are considered at high risk for falls receive an extra buzzer to alert
The top 10 factors contributing to falls

Working with seven hospitals since 2011, the Joint Commission Center for Transforming Healthcare has strived to eliminate preventable falls. Using a set of measurements and solutions, those taking part in the "Preventing Falls with Injuries Project" have reduced all falls by 35 percent, and those with injury by 62 percent. The center compiled a list of the 10 most common factors causing falls from that work. Erin DuPree, M.D., chief medical officer and vice president of the center, says it's important to determine which factors are in play for each unique hospital, rather than just tackling all 10.

"The old way would have been taking this list and trying to fix all of them, as opposed to taking more time up front to actually measure those contributing factors, and discover which ones actually matter in each local project area," she says.

"The benefit is that a few targeted solutions lead to dramatic improvements, instead of just throwing everything at the wall and hoping it solves the problem."

1. | Patient fell while toileting.
2. | Some medications increase the risk of falling when combined with toileting.
3. | Patient did not know, forgot or chose not to use a call light.
4. | Fall prevention education given to patient and family was not used or inconsistent.
5. | Patient is not aware or has not acknowledged a risk for fall.
6. | Assessment tool is not a valid predictor of actual fall risk.
7. | There is a variance in risk assessment ratings by different caregivers.
8. | Prescriptions are not assessed for risk of contributing to falls.
9. | Inconsistent or incomplete communication of patient risk for falls exists between caregivers.
10. | Poor culture of standardization of practice and application of interventions exists.

The Joint Commission Center for Transforming Healthcare, 2014

staff, in addition to those built into the beds.

The intervention was implemented in September and by December falls had dropped to 1.19 per 1,000 patient days. There were no falls with injury during that time.

UMMC is further educating and engaging at-risk patients with posters placed throughout the hospital and educational chats with family members.

"There has to be a partnership with the patient," says Tejal Gandhi, president and CEO of the NPSF. "Unlike some other types of errors, the patient's involvement, engagement and partnership are really critical in this because the patient is the one who has to know what they can and can't do, and what's safe from an activity standpoint."

The Joint Commission estimates that each patient fall results in an extra 6.5 hospital days, and an added cost of about $14,000. The Centers for Medicare & Medicaid Services identifies falls as preventable events that should never occur. It deems them hospital-acquired conditions and limits reimbursement for treating the consequences.

UMMC hopes to spread its best practices to all inpatient units across the organization starting this summer. It's also implementing a hospital-wide tool to assess every inpatient's risk for falling, says Terri Gillespie, R.N., chief nursing executive and chief nursing officer of the adult hospitals and clinics. Called the Hester Davis Scale for falls risk assessment and developed by nurses at the University of Arkansas for Medical Sciences, the tool helps nurses to collect details about patients, including age, mental or physical disabilities, and medications that may lead to confusion or dizziness. Based on that information, the scale produces an individualized plan, with suggested interventions such as alarms or signs warning staff of an increased fall risk.

Lee says one of the biggest challenges in addressing UMMC's falls issue was finding nurses with the skills and commitment to spearhead the effort.

"The hardest part is finding the right person to put in those roles because they've got to own it, believe it and stay on top of it," she says. "I went through a lot of people before I got the right ones in there."

Gillespie says it's important for the C-suite to buy into the effort, but it's the bedside clinicians who have to own such improvement efforts. "I think this sort of goes back to Nursing 101, as I would call it," Gillespie says. "If you just get back to basics and commit to seeing your patients on a frequent schedule, answering call lights within a defined amount of time, you can reduce the number of falls. It doesn't take lots of bells and whistles to make a significant improvement, if you just get back to the basics, and do them with a purpose."

NPSF's Gandhi hopes the UMMC award encourages other organizations to share what they've learned about reducing patient falls. "There's a ton of different interventions out there and yet, despite all of this, we still have falls," she says. "One of the things that we struggle with in health care is people don't necessarily promote their successes as well as they ought to, so this is one way we're trying to address that."