BMHCC Falls Journey

April 2017

OBJECTIVES

The attendee s will:

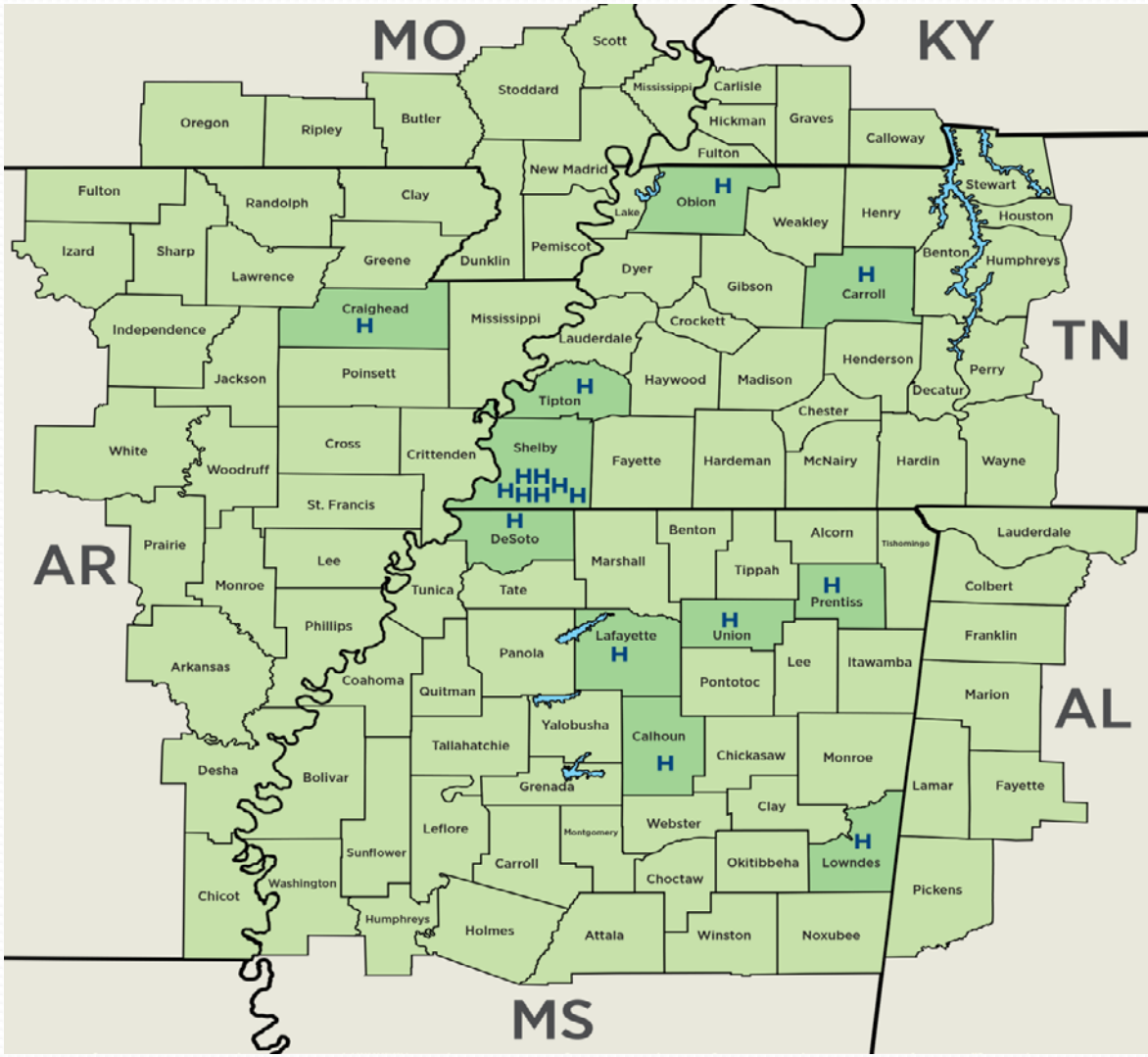
1. Name three major components of a comprehensive fall program.
2. Identify four new fall prevention practice strategies
3. Describe one strategy for identifying patients at most risk from fall injuries

Who We Are

BAPTIST MEMORIAL HEALTH CARE CORPORATION (TN, MS, AR)

Hospitals – 17
Home Care 4
Hospice – 5 programs & one residential Hospice House
Nursing Home – 1
Baptist College of Health Sciences - 1

Licensed Beds – 2,300+
Employees - ~ 14,000



In The Beginning……

Inpatient only……No “Near Fall” reporting concept

Viewed as Nursing Dept. responsibility…nursing issue…no designated Falls Team

Fall Assessment Tool & scoring inadequacies

Precautions primarily limited to “patient room” mentality

Visitor falls primarily owned by RM Dept.

In The Beginning……

General lack of staff awareness that falls:

- don't only involve cuts, bruises, fractures, etc.
- can result in death
- can significantly effect persons remaining quality of life
- can cost major $$$
- are responsible for many lawsuits
- are preventable

In The Beginning Summary

Lack of comprehensive, interdisciplinary approach to Falls Precaution Program

Lack of hospital-wide visual communication regarding assessed risk for falls

Disjointed efforts. Isolated investigations

SYSTEMS APPROACH

Corporate Risk Management established a SYSTEM FALL / RESTRAINT TEAM

Meet quarterly in central location

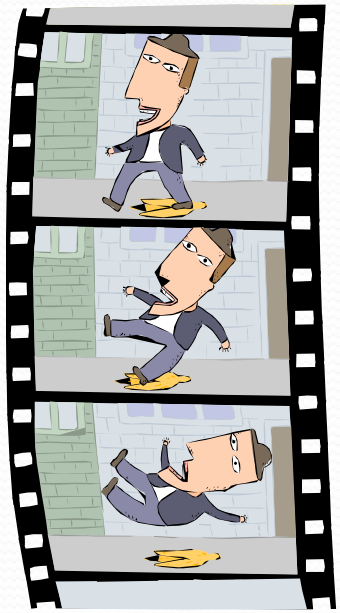
Each facility sends 1-2 Fall / Restraint Leader representatives to the system meetings

Each representative then facilitates their entity Falls / Restraint Team utilizing information provided at the system meeting.

Fall Definition

General – the failure to maintain an appropriate lying, sitting, or standing position, resulting in an individual's abrupt, undesired relocation to the ground or surface below

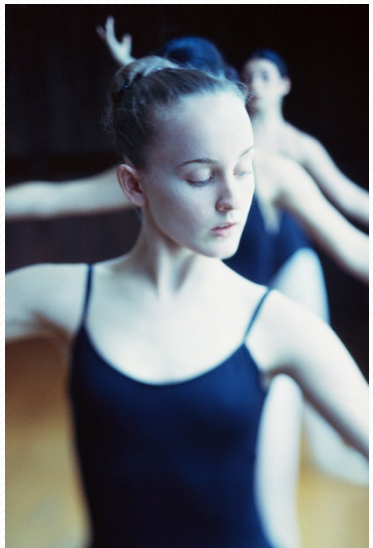
BMHCC historical definition – Unplanned movement to the ground or from one plane to another



Fall Definition cont'd…

"An assault on the normal physiology that keeps us upright. Staying upright & walking are beautifully complex processes, integrating functions of eyes, ears, sense of touch, NM system, nervous system & cognitive abilities. These functions work together to create a dance in which walking is actually controlled falling, & every step we take is the beginning of a fall because gravity always wants us to fall."

Russell Massaro, MD, Executive V.P.
Commission Accreditation Operations



Intrinsic and Extrinsic Factors

- History of previous falls
- Increased age
- Impaired mental status
- Decreased mobility; Increased functional dependence
- Abnormal gait or posture due to pain, fatigue, etc.
- Foot problems – bunions, calluses, etc.
- Sensory changes; impaired vision, hearing, touch, vibration sense
- Motor deficits (coordination/balance, LE weakness & postural sway)
- Acute illness of any kind ("premonitory fall")
- Medication effects/interactions
- Neurological disorders – stroke, TIAs, epilepsy, seizures, vertigo, etc.
- 24 hrs. post-op

- Bed Related – raised, unlocked, side rails w/no exit, space b/t mattress & rails, unlatched cribs, etc.
- Lack of nonskid footwear and/or ill-fitting shoes
- Floor surfaces – wet, damaged, raised, reflective, under-waxed, rug frays, obstacles, etc.
- Furniture w/ inappropriate height for transfers (toilets & tubs)
- Poor lighting; No lighting
- Restraints
- Distance between bed and bathroom
- Tubing, cords, wires, IV pumps/poles

SOME FALL FACTS

Opportunities for fall prevention are overlooked…risks become evident after injury and disability have occurred

Environmental factors are responsible for 50% of falls

Falls are the leading cause of injury deaths and serious injury in older adults, especially involving fractures, traumatic brain and spinal injuries (National Center for Injury Prevention and Control)

SOME FALL FACTS

Most falls occur in bedroom and bathroom & activity involved is transferring from one location to another

Increased incidence of fall if history of fall within past 6 months. Knowing if pt had a recent fall is the single #1 most predictive factor for a future fall

Loss of self-confidence to ambulate safely, results in self-imposed functional limitations

Fall Implications

"Once someone has fallen a powerful post-fall anxiety syndrome often sets in, which can have a dramatic impact on one's mobility, autonomy, and overall quality of life."

Kevin Kavannaugh, Director of Public Affairs for the Illinois Council on Long Term Care

COMPREHENSIVE FALL PROGRAM

1. **DETECTION**

2. **PREVENTION**

3. **PROTECTION**

Fall Program assessment/analysis/action in largest facility (1999-2000)

- Fall Team redesigned (comprehensive membership)
- Data Reviewed
- Internal Charts Reviewed (moderate to severe harm)
- Extensive Literature Search
- Networked with Other Facilities across country
- Falls/Restraints comparison
- Policy Reviewed
- Sitter Guidelines established
- House-wide Bed Inventory / Assessment

Some Early Actions

- **Spills Response Time / Inclimate Weather awareness;**
- **Annual Falls Safety Training- Synquest Training Program developed**
- **Marketing Campaign – (Seasonal Posters, Logo, Brochures, Table toppers)**
- **Lift Team Considerations**
- **Scheduled times for Diuretics changed (no later than 3 PM) with Medical Staff approval**
- **Falls Bundle adopted**
- **Online Falls Toolkit developed**
- **Unit Safety Champion Role (Bulletin Boards, Staff meetings, etc.)**

Some Early Actions

Hospital-wide Orientation / Education

Hospital-wide Communication of Fall Precautions pts (Ticket to Ride)

Environmental Considerations (Rugs, thresholds, etc.)

FP initiation by Therapies / Gait Belt Training

Fall Investigations and Performance Improvement

Developed System Falls Task Force Manual of Resources for each facility

Fall Precaution website developed under Pt Safety


FALL PRECAUTION
AWARENESS
Stay On Your Feet
1 Report any potential fall risks to your supervisor.
2 Clean up any spills immediately.
3 Always leave patients in a safe environment.
4 Be aware of all patients' FALLS PRECAUTION status.
5 Report any behavior that could contribute to a fall.
6 Always use siderails during and after transport.
7 Always return patients' items to places where they can be easily reached.
Examples include:
* Telephones * Call lights
* Eyeglasses * Hearing aids
Things to remember when patients are on FALLS PRECAUTION:
1 Keep the bed in the low position.
2 Put siderails up appropriately.
3 Turn the bed alarm on.
4 Place the call light within reach.
5 Leave the door open.
6 Provide patient/family education.
7 Get the patient's family involved.
8 Check for the FALLS PRECAUTION sign above the bed.
BAPTIST. Memorial Health Care
SmartMedicine. InspiredCare.

Stay on the Ball This Summer

Falls Precaution Awareness

Stay on your Feet

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- Check for the FALLS PRECAUTION sign above the bed.

Autumn Poster

Harvest Safety This Fall

Falls Precaution Awareness

Help Keep Patients on Their Feet:

- Report any walking unsteadiness to the nurse.
- Reassess patients for status changes.
- Orient patients to rooms and bathrooms.
- Use night-lights when available.
- Increase awareness in your area by being proactive.
- Communicate safety daily.
- Remember - this is a multidisciplinary responsibility.

Stay on Your Feet:

- Wear appropriate footwear.
- Minimize use of extra-long tubing, electrical cords and similar items when possible.
- Watch out for wet floors and slippery surfaces due to weather.
- Report hazards or potential hazards to Facility Services at 226-5030. (Examples: broken tiles, spills, etc.)
- Clean your shoes when entering the building (wet leaves can be hazardous).
- Reduce clutter when possible.

falls precautions

AWARENESS

stop falls cold this winter

- Call for assistance with transporting, if needed.
- Alert Environmental Services of wet spots, spills, etc.
- Keep footwear dry when entering the building.
- Be aware of slippery, icy surfaces.
- Use cleaned or salted walkways at all times.
- Pace your movement when walking (don't rush.)
- Use handrails when available.
- Wear appropriate footwear.
- Offer non-skid socks to patients during their hospital stay. (Remind patients to be careful when wearing non-skid socks.)

SAFETY matters

Falls Precaution is a
National Patient Safety Goal

falls precautions

AWARENESS

get a fresh start with these spring safety tips

- Remember: **Falls precautions are everyone's responsibility.**
- Pay attention when walking.
- Report any risks for falls to Facility Services immediately.
- Dry your feet when entering the building.
- Minimize water dripping from umbrellas.
- If you find a spill or wet area, use the "wet floor" signs and get assistance to clean it up.
- Check to make sure bed plugs are intact.
- Report broken and bent bed plugs immediately.
- Monitor the bed alarms of patients on Falls Precautions.
- Slow down.....an extra minute is not worth a fall.
- COMMUNICATE, COMMUNICATE, COMMUNICATE to prevent patient, visitor and employee falls.

SAFETY matters

Falls Precaution is a
National Patient Safety Goal

Fall Team Enhancements

System Falls Team divided into 4 work groups:

A. Falls Team composition & expectations; Data Analysis & Measurement

B. Policy, Procedure, Assessment and Falls Definition

C. Post Fall Management; Reporting Tool

D. Prevention Strategies; Resources; Communication

Guidelines for Entity-Based Falls Team

*

Multidisciplinary core membership who meets on regular basis & reports findings to Hospital PIC (Pharmacy, Nursing, Therapies, Radiology, Environmental Services, Plant Ops, Security, Dietary, Transportation, Outpt Dept., Safety Officer, Quality, RMgmt, Admissions, Staff Development, Home Health, Administration)

* Agenda Items - Confidential minutes, Feedback from System Falls, Lit reviews/alerts, Data Review w/ drill down, PI Data Review w/trends analyzed, Selected severity of injury chart reviews, CAP monitoring/revisions, Education needs, Fall Products Review

*Reporting – Falls Team findings and activities reported to appropriate Patient Safety Committee and/or Performance Improvement Committee and as appropriate to Entity Board.

P&P, Assessment, & Definition Team

* P&P revised to include Out patient Screening by non-clinical staff

- "Get up and Go Test"; staff trained to administer test – adapted distance from bed to bathroom

* Falls Definition enhanced

BMHCC Fall Definitions

An unexpected event which results in patient coming to rest unintentionally on the ground or other lower surface.

Observed falls – when staff sees pt experience loss of balance during walking/transferring and lands on floor or another object such as bed, chair or WC, or when pt comes to rest on ground (lower plane without intending to do so

Assisted falls – when staff or non-staff member lowers pt to floor (lower plane) or when pt lowers him or herself to floor because of dizziness/weakness (symptoms)

BMHCC Fall Definitions

Unobserved falls – when pt found on floor & neither pt nor anyone else knows how he/she came to be on floor or pt reports they have fallen. Until proven otherwise, this is considered a fall. Often referred to as "found down" or "found on floor."

Near falls – when pt experiences a sudden loss of balance that doesn't result in fall or other injury. Ex: pt may slip, stumble, trip but is able to regain balance control, thereby avoiding fall to lower plane. Episodes where pt loses his/her balance & would have fallen were it not for staff intervention, is a near fall. Intercepted falls are near falls.

The presence of absence of a resultant injury isn't a factor in definition of a fall. The distance to next lower surface is not a factor in determining whether a fall has occurred.

Out Patient Screening

- At all points of entry by non-clinical staff:

1. Have you fallen in last 6 months?
2. Do you have any difficulty walking? Use assistive devices to ambulate?
3. Are you experiencing any dizziness?
4. Do you have vision problems (not corrected by glasses or contacts)?

One YES answer places pt in “High Risk” Fall Precautions with yellow armband applied. Patient & paperwork are labeled accordingly & appropriate escort is provided.

Post Fall Management Team

* Post Fall Assessment Guidelines
* Post Fall Physician Orders
* Post Fall Observation & Monitoring Practice
* Post Fall Guidelines for Head/Facial Injury and/or Anticoagulant/Antiplatelet Therapy
* Fall Unusual Occurrence Report

Physician Orders

1. Assessment & MD Notification
2. Anticoagulant/anticoagulant Therapy? Facial or Head impact? Diagnostic orders
3. Fall Precaution instructions
4. Family/Administrative notifications
5. Observation and Monitoring
6. Other Orders received

Equipment Resources

* Alarms (bed, chair, tethers, etc.)

* Monitors/Cameras (Video, audio, Baby monitors)

* Bed related (enclosure, low, SR inserts, cribs)

* DME (BSC, seat extenders, padded/colored toilet seats, button/pad or hand held call lights, shower chairs, walkers, etc.)

* Other (footwear, mats, gait belts, hip protectors)

Environmental Resources

* Signage (Wet floor, Umbrella bags, Spills # to call)

* Railings (Halls, Bed & Bathrooms)

* Flooring (Flat Thresholds, Mats, Non skid flooring, wax preparations)

* “Safe Room” concept and Safety Bundle

* Furniture (Round edged trash cans, Rubber legged movables, braked)

Community Resources

* Senior Citizen Education
* Tai Chi / Strengthening classes
* Home Safety Assessments for Fall Risk patients
* Fall Safety Booths at BMH Health Fairs

Education Resources & Communications

* Room Orientation (Bed, call lights, alarms, location of phone/ TV controls/ lights/ call cords, etc.)

* Falls Brochures, Posters, handouts, Falls Bundle concept

* Staff – Orientation, Unit specific, Pt Education documents, Falls Fair, Staff meeting topic, Annual Synquest testing

* Armbands, doors, above beds, stretchers, charts, unit safety briefings, admission screening, multi-disciplinary consultations, MDs and families

Post Fall Observation & Monitoring

Vital Signs, Neuromuscular, Pain, and Range of Motion:

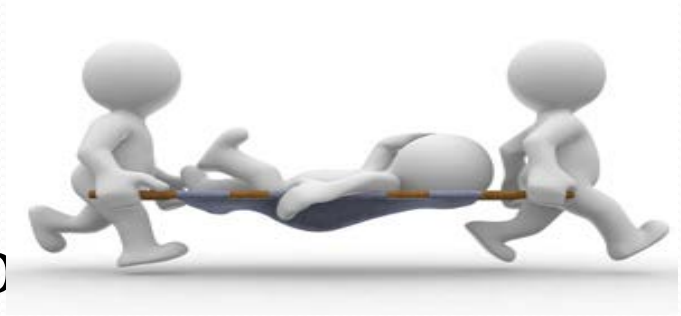
Every 15 minutes x 4, then
Every 30 minutes x 2, then
Every hour x 2, then
Every 4 hours x 5

Unless specifically ordered otherwise by MD

"Our children bounce when they fall.

As we age, we bounce less.

Eventually we break."



Russell Massaro, MD, VP Jo
Commission Accreditation
Operations

BMHCC SYSTEM FALL ACTIONS 2011 TO PRESENT

- **Bed and Bed Exit Alarm Assessment**
  - 14 facilities participated
  - 2,297 beds assessed (95.6%)
  - 11 different bed types identified
  - 376 (17%) beds found in need of repair
  - 100% beds repaired or no longer in use
  - Educated all incumbent staff on each bed type BEA; NetLearning module revised
  - Built BEA training into orientation program

BMHCC SYSTEM FALL ACTIONS

- **Tether Alarm Assessment & Standardization**
  - 15 facilities participated (Hospice House)
  - Several facilities with no back up alarm system
  - Tethers standardized to 3 within system
  - Tether criteria developed
  - Tether alarm competencies developed
  - Tether and BEA PI measurements designed and implemented

Tether Alarm Guidelines

For patients on high risk fall precautions, the following represent criteria to consider for tether alarm application in addition to bed exit alarm activation (criteria may not be all inclusive).

- **Confusion**
- **At high risk for injury or bleeding**
- **Mobile but confused**
- **Recent falls (within last 6 months)**
- **Attempts to get out of bed alone**
- **Short term memory loss or short memory span**
- **Impulsivity**
- **Patients unable to get up alone without assistance and/or require use of assistive device(s)**
- **Non-compliance**
- **Incontinence / Urgency**
- **Medications (Diuretics, Laxatives, Enemas, Narcotics, Sedatives, Anticoagulants**
- **Weakness**
- **Patient unable to verbalize “Teach Back” instructions**

BMHCC SYSTEM FALL ACTIONS

Safe Patient Handling Discussions/Demonstrations

- Sara Steady demonstration to System Fall Team
- Patient Lift Equipment installations
- Culture alignment with safe patient handling equipment availability

BMHCC SYSTEM FALL ACTIONS

Hospital-wide Out Patient Fall Screening Assessment

- 14 facilities participated & submitted A3 presentations; 13% falls in past 5 years were outpts

- Gaps in Fall Precaution practices included:
- Lack of consideration for limited English proficiency with screening tools
- Triage RN variability in performing fall assessments
- Performing screening at triage vs ED registration (time delay)

BMHCC SYSTEM FALL ACTIONS

Hospital-wide Out Patient Fall Screening Assessment

- Department variances in administering screening
- After hours staffing affects hospitals ability to escort pts identified with FP needs
- Series patients aren't being screened with each visit
- ED – if pt bypasses registration, triage RN isn't performing screening
- Lack of correlation b/t screening and appropriate actions
- Additional out pt areas identified that hadn't considered: Pre-admission testing, ED, Ambulatory Cath Lab, Ambulatory CA Centers

BMHCC SYSTEM FALL ACTIONS

Out Patient Fall Screening Actions ID for Sharing

- Table tents for pts to read fall screening questions
- Tethers supplied in ED and procedural rooms
- Radiology stools with support arms supplied vs stools without arm supports
- Designated parking spaces for FP pts and phone number supplied to call for assistance in getting out of car
- BEA and Tether champions assigned to Radiology, RT, ED & Observation units
- Making fall data available monthly on internal web site
- Tethers available in out pt surgery, out pt testing and cath labs

BMHCC SYSTEM FALL ACTIONS

Nutrition and Weight Loss Impact on Falls

- Added System Nutritional Director to System Falls Team
- Began education on role of malnutrition and weight loss & the increased risk of "never events" inclusive of falls
  - " Nutritional Status is associated with Mobility and Functionality in Older Adults: Implication for Fall Risks"
  - An elderly inpatient loses 2.2# of muscle after 3 days of hospitalization.
  - 45% of patients who fall in the hospital are malnourished.
  - 50% of women greater than 65 who fall and sustain a hip fracture may never walk again..

- Two key questions to identify people on admission who may be at risk of malnutrition are:
  - 1. Have you lost weight recently without trying?
  - 2.Have you been eating poorly because of a decreased appetite?

- Proposed revision to FP Policy to include nutritional screen for fall risk; Malnutrition Screening Tool (MST)
- Recommended entity Dieticians be included on entity Falls Teams
- Conducted "supplement sample tasting" for fall team members

BMHCC SYSTEM FALL ACTIONS

- **Ongoing Fall Prevention Education**

- Pat Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, provided a personalized live presentation to BMHCC System Fall Team Nov 2012:
  - All falls can't be prevented
  - Fall protection is as important as Fall Precautions; Shield from exposure, injury or destruction (death); Mitigate the exposure, injury or destruction
  - We fail to link patient assessments with interventions
  - Post Fall Safety Huddles are crucial to conduct within 15 minutes of fall to determine type of fall
  - Introduced concept of fall classifications: Accidental, Anticipated Physiological, Unanticipated Physiological, and Intentional

BMHCC SYSTEM FALL ACTIONS

- **Ongoing Fall Prevention Education**
- Provide current literature to system team for distribution
- Participated in 100% IHI's Fall Conference Calls
- Provided Highlights of IHI Conference calls to system team
- Educated system team to difference between NDNQI, HEN and BMHCC fall programs and metrics

BMHCC SYSTEM FALL ACTIONS

- **Fall Prevention Practices/ Injury Reduction Survey**
- 14 facilities completed survey which included 40+ fall precaution practices which could reduce falls
- Results showed wide variation in FP preventive measures
- Results showed consistent lack of harm mitigation strategies in place (low beds, hip protectors, floor mats, chair alarms, etc.)

Fall Precaution "Practice Guidelines":

1. **Individualized Fall Precaution care plan**
2. Prompt call-light responses
3. Locked bed is raised to pt's knee height when arising from bed
4. Bed in lowest position and locked when patient unattended
5. **Purposeful** Hourly rounding w/4 Ps (Position, Personal, Potty, Pain)
6. Practice of no diuretics after 3-6 PM
7. Practice of toileting prior to pain meds
8. Practice post-procedure, post-op, post/partum assisted transfers x 2-3 until cleared
9. Practice infant bassinette transfers only (no arm carries)

Fall Precaution "Practice Guidelines":

10. Practice personal assistive ambulation devices at BS & in good working condition

11. Practice safe-exit-side based on pt assessment; arrange room to favor strongest or unaffected side or shortest path to bathroom

12. Refrain using restraints as fall prevention tool

13. Four SR not utilized as a fall precaution strategy in any clinical unit

14. Previous (frequent or repeat) fallers relayed at safety briefings/huddles

15. Utilize wheelchair transfer for discharge patients

16. Patient refusal of fall precautions escalated up COC

17. Utilize 1:1 sitter as indicated based on pt need

18. Relocate higher monitoring need pt closer to Nursing Station (repeat fallers)

Fall Precaution "Practice Guidelines":

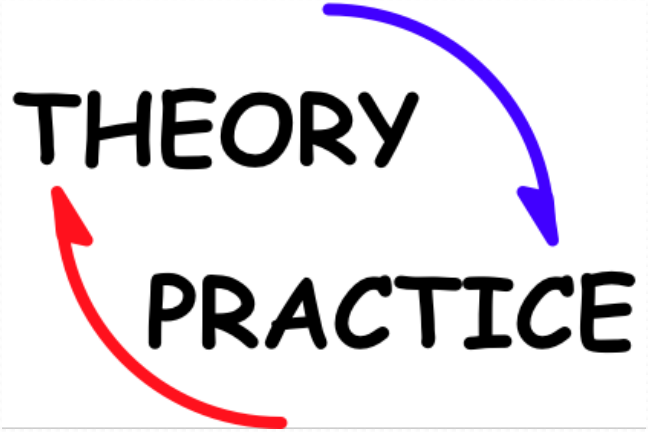
19. Utilize **TEACH BACK** with fall instructions & document

20. Medication review by Pharmacy (polymeds over age 65)

21. Utilize occupational diversion activities for cognitively impaired

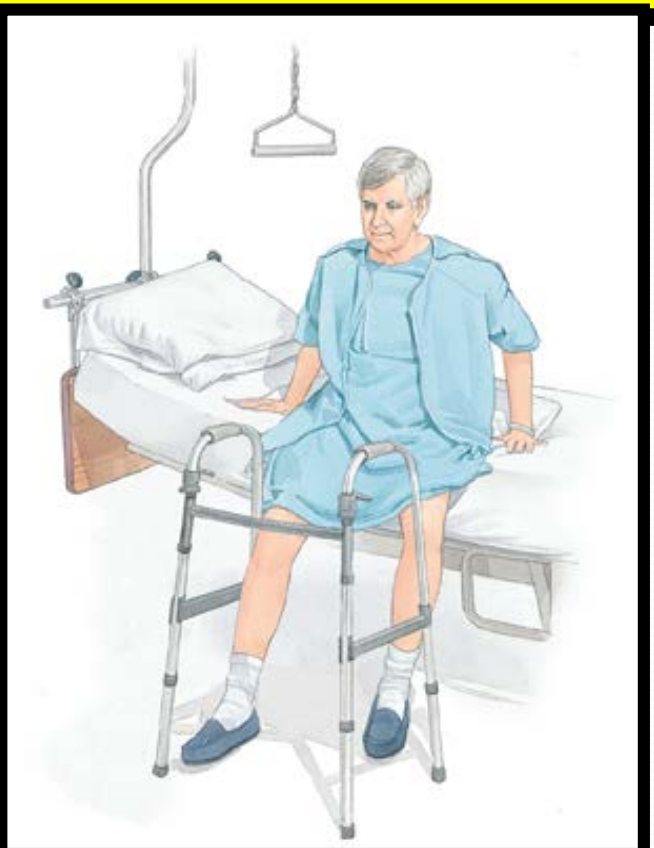
22. Toileting early AM lab draws prior to phlebotomy

23. **Do not leave patient sitting alone** on the side of the bed; no one dangles alone



Baptist Fall Prevention Message
PATIENTS DO NOT SIT ON THE SIDE OF THE BED

- This is not a stable or safe position to leave our patients in unassisted.
- Over bed tables can roll away when used while sitting on side of bed or for support when standing.



Sitting on side of bed is ONLY for:

- Transferring to stand
- Increasing trunk muscle endurance
- Activity tolerance assessment

- When patients are sitting on the side of the bed they should be able to place feet flat on the floor.
- Adjust bed heights appropriately to aide safe foot placement
- Teach patient/families to not leave patient sitting alone on side of bed

NO ONE DANGLES

BAPTIST®

10/2016

Fall Precaution "Equipment Guidelines":

1. Tether Alarms (available in every room)
2. Bed Exit Alarm (BEA) process established
3. Shoes or non-skid socks (adults, pediatric, bariatric sizes as indicated)
4. Safe patient handling equipment used when appropriate(lifts, sliders, Sara Steady, etc.)
5. Gait belt for assisted hallway ambulation
6. Utilize Velcro lap belts for chair patients
7. Geri-chairs with established footing
8. 100% Cribs with toppers
9. Bed check process (brakes, alarms, cables) at discharge

Fall Precaution "Equipment Guidelines":

10. Video monitoring for "extreme" risk fall patients (as available)
11. BSC availability when indicated
12. Commode seat extenders as indicated
13. Battery operated chair alarms activated
14. Visual High Fall Precaution signage (armband used on in and out patients)


Call
Don't
Fall
BAPTIST
MEMORIAL HOSPITAL
GOLDEN TRIANGLE

Fall Precaution "Environmental Guidelines":

1. Call light accessibility for all patients (includes ED & ancillary depts.)
2. Cord Control / securement
3. Accessible wet floor signs as needed
4. Flat doorway thresholds from room to bathroom
5. Tub and shower rubber mats & exit surface
6. Working night lights in every room including ED
7. ADA compliant railings in bathrooms, bedrooms, hallways
8. Colored/marked toilet seats and emergency cords
9. White board, Fall Stop Signs or posters "Call, Don't Fall"


What do you see?

WE CARE ABOUT YOUR SAFETY

Arms length distance for patients with balance or cognitive issues

NO ONE TOILETS ALONE
PLEASE CALL FOR ASSISTANCE

BAPTIST®

1/2017

SCHEDULED TOILETING OR BLADDER RETRAINING

- Individualized Schedule
  - Monitor Fluid intake
  - Q2H – Odd or even?
  - Scheduled?
    - 4am
    - Before meals
    - After meals
    - Bedtime

NO ONE TOILETS ALONE PLEASE CALL FOR ASSISTANCE

- Arms length distance for patients with balance or cognitive issues

BAPTIST®

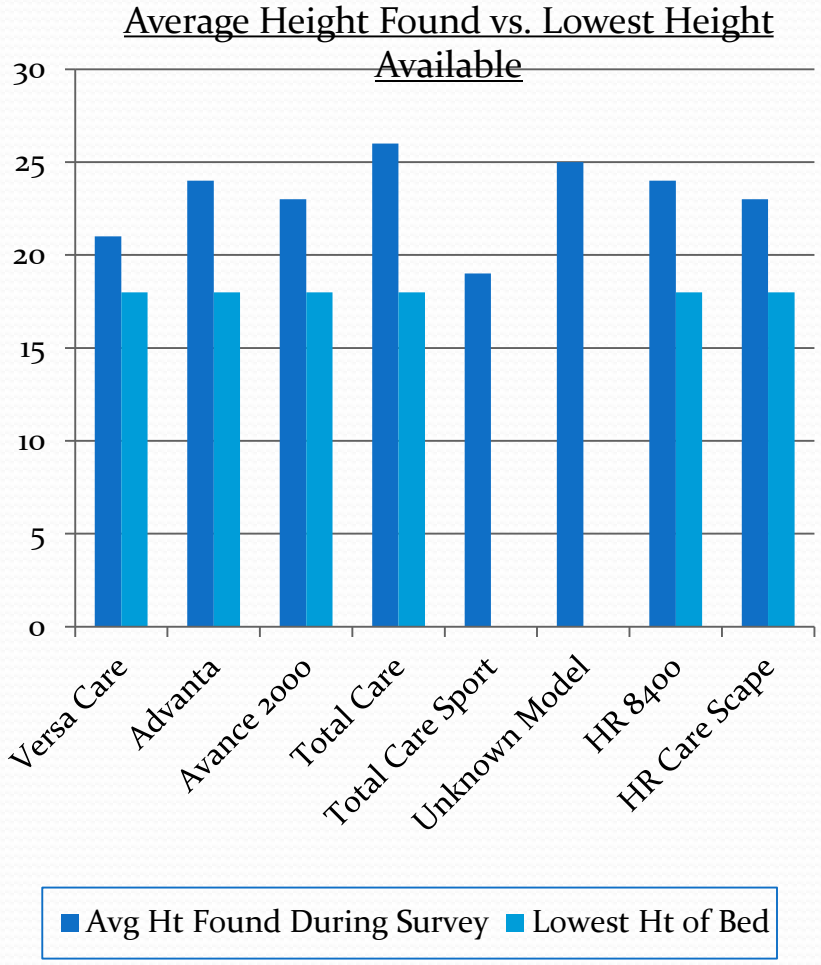
Injury Minimization Strategiess / Guidelines:

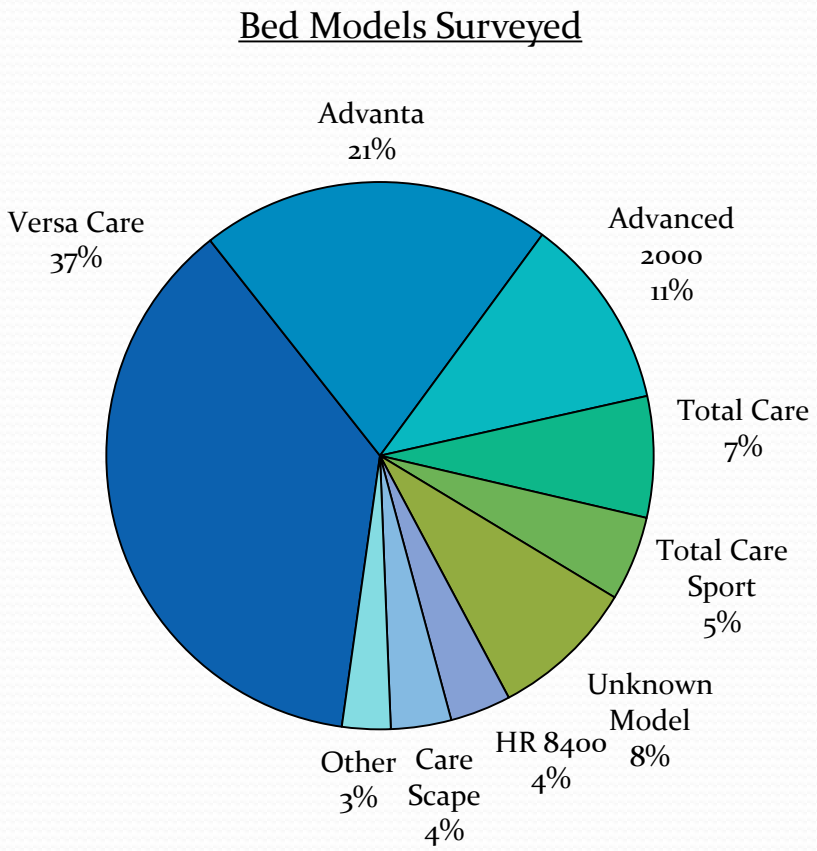
1. Post Fall Order Set house wide (includes L&D/Nursery)
2. Post Fall safety huddles stat
3. Low Beds (8-10 inches off floor)
4. Floor mats
5. Rounded edge furniture and garbage cans
6. Hip protectors
7. Helmets (Traumatic Brain injury, low platelets, etc.)
8. 1:1 for toileting/Sara Steady as appropriate (Pt safety before privacy)

HIGH FALL PRECAUTION SPOT CHECK OF BED HEIGHTS

- 11 BMH facilities participated in the survey
- 11 different bed types were surveyed
- 140 total beds were spot checked for bed height while patient was in the bed not receiving treatment and on high fall precautions
- Heights were measured from the top of the mattress to the floor (not floor mat surfaces)
- Two bed type models were not submitted for analysis

Bed Height Analysis for High Risk Fall Patients





BMHCC SYSTEM FALL ACTIONS 2011 TO PRESENT

- **Fall Harm Reduction Strategies**

- Hill-Rom Low Bed demonstration for system team; Requesting each facility to do in-house demonstration

- Conducted informal fall harm reduction equipment (floor mats, chair alarms, hip protectors)

ANALYSIS OF BED HEIGHT SURVEY FINDINGS

1. Fall Precaution safety plan of leaving patient in lowest bed height while unattended or prior to leaving room not consistently found
2. Purposeful hourly rounding with 4 Ps (Personal, Position, Potty, Pain) hasn't impacted leaving bed in the lowest position prior to leaving patient
3. Causations for bed height to be other than lowest could be: staff not following FP bundle, patient and/or visitor bed adjustments
4. Patient falls from bed are occurring more consistently from a higher heights than the lowest position available

Fall Injury Risk Score

A = Age (equal to or greater than 85) or frailty

B = Bones (fracture risk or history)

C = Anticoagulation (bleeding disorder)

S = Recent Surgery (during current episode of care

For all patients: Education is essential using TEACH-BACK strategies

Bundled interventions for each vulnerable population follow:

•**Age:** Individuals who are greater than or equal to 85 years old or frail

•due to a clinical condition

Assistive Devices within reach	
Hip protectors (if fracture risk)	
Floor mats (when pt is resting in bed)	
Height adjustable beds (low when resting only, raise up bed for transfer)	
Safe exit side	
Medication review to reduce fall risks	

- **<u>Bones:</u> Patients with bone conditions, including osteoporosis, a previous fracture, prolonged steroid use, or metastatic bone cancer**

Hip protectors (unless DEXA scan is negative)	
Height adjustable beds (low when resting only, raise up bed for transfer)	
Floor mats (when patient is resting in bed)	
Evaluation of osteoporosis	

- **<u>AntiCoagulation</u>: Patients with bleeding disorders, either through use of anticoagulants or underlying clinical conditions**

Evaluate use of anticoagulation: risk for DVT/embolic stroke or fall-related hemorrhage	
Patient education: what to do if you fall now that you are on blood thinners	
TBI and anticoagulation: Helmets	
Wheelchair users: anti-tippers	

- **<u>Surgery:</u> Post-surgical patients, especially patients who have had a recent lower limb amputation or recent, major abdominal or thoracic surgery**

Pre-op education: (teach-back strategies) Call, don't fall signage Call lights	
Post- op education	
Pain medication: offer elimination prior to pain medication	
Increase frequency of rounds	

Reference:

Boushon B, Nielson 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. Available at: www.ihi.org

Delirium (Brain Failure) and Falls

A neuropsychiatric syndrome also called acute confusional state or acute brain failure that is common among the medically ill and often is misdiagnosed as a psychiatric illness which can result in delay of appropriate medical intervention.

There is significant mortality, increased healthcare costs and long-term cognition deficits associated with delirium so identifying it is crucial.

Delirium (Brain Failure) and Falls

Delirium is a common condition in the elderly affecting up to 40% of all elderly medical patients.

Delirium is often not recognized by clinicians and is often poorly managed.

Delirium is a medical emergency!

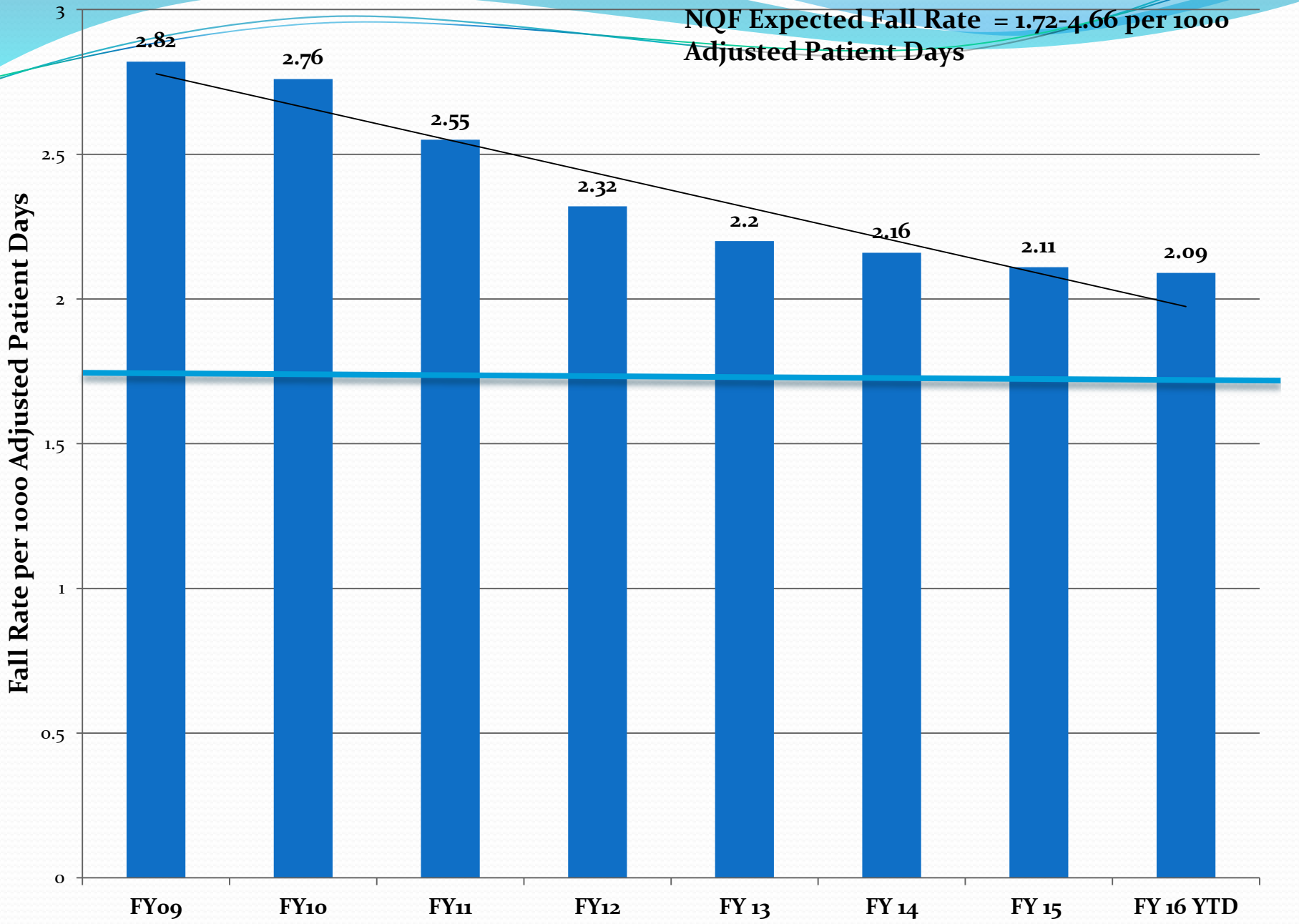
Delirium (Brain Failure) and Falls

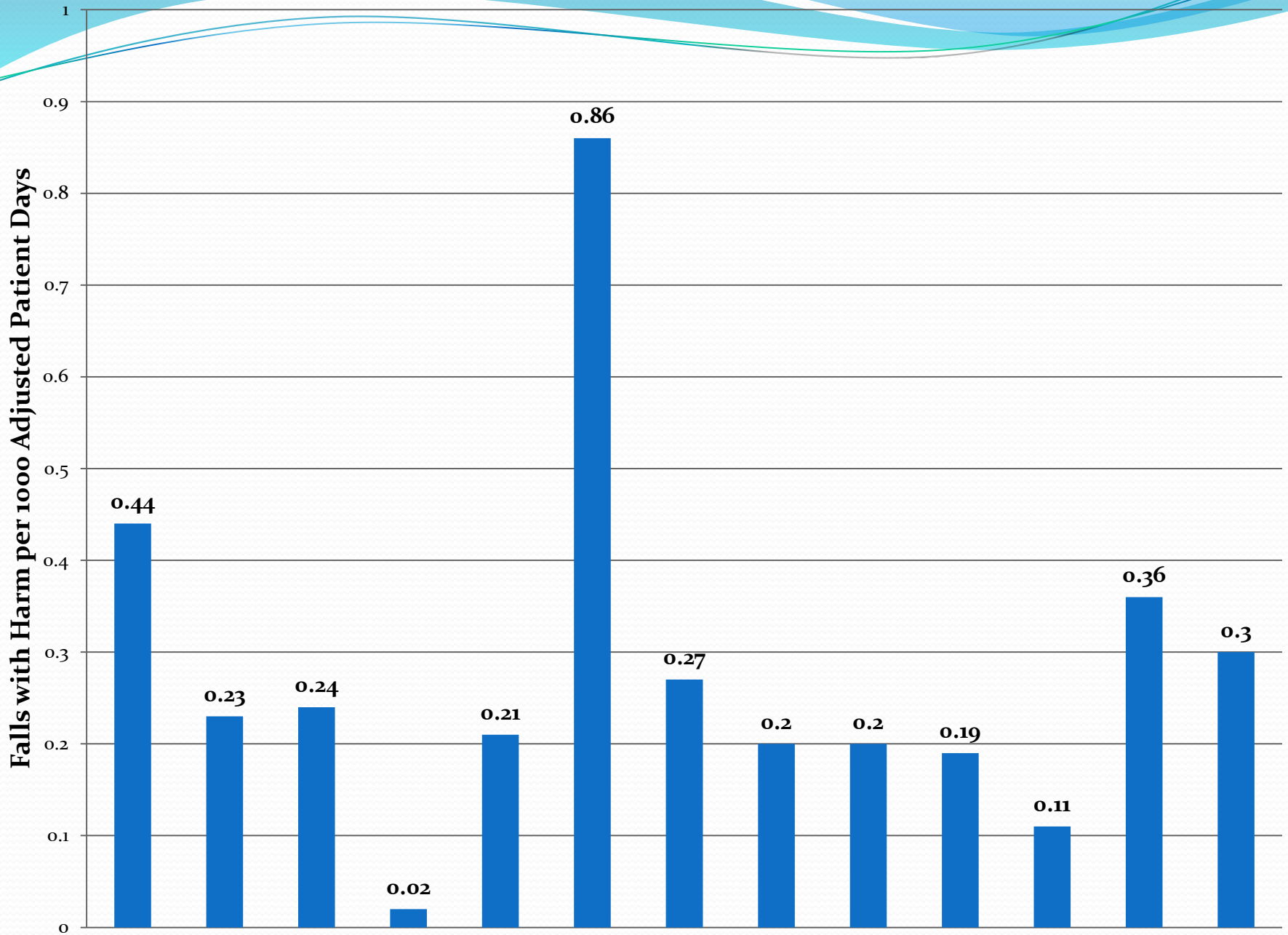
10-31% of fallers are delirious at the time of the fall.

With delirium, 4.55 times more likely to fall

Delirium is common, affecting as many as 56% of hospitalized patients.

Delirium affects 20-79% of hospitalized older patients.


NQF Expected Fall Rate = 1.72-4.66 per 1000 Adjusted Patient Days
Fall Rate per 1000 Adjusted Patient Days
3
2.5
2
1.5
1
0.5
0
2.82
2.76
2.55
2.32
2.2
2.16
2.11
2.09
FY09
FY10
FY11
FY12
FY 13
FY 14
FY 15
FY 16 YTD


Falls with Harm per 1000 Adjusted Patient Days
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.44
0.23
0.24
0.02
0.21
0.86
0.27
0.2
0.2
0.19
0.11
0.36
0.3

IN SUMMARY
Our Journey Continues…..