METHODIST

Methodist Hospital

Omaha, NE

Decreasing Falls Through Shared Governance

Process of Identifying Need

- The hospital saw an increase in its injury falls rate (falls per 1000 patient days).
- The majority of inpatient nursing units were not outperforming the National Database for Nursing Quality Indicators (NDNQI) benchmark for injury falls.
- Methodist Hospital uses Shared Governance or decision-making between staff and leadership to actively engage direct care staff in quality improvement efforts.
- Using the Plan Do Study Act (PDSA) methodology, the Falls Committee (a Shared Governance Committee) identified the following gaps:
  - Handoff communication inconsistencies
  - Majority of falls were bathroom related

Process Improvement Methods

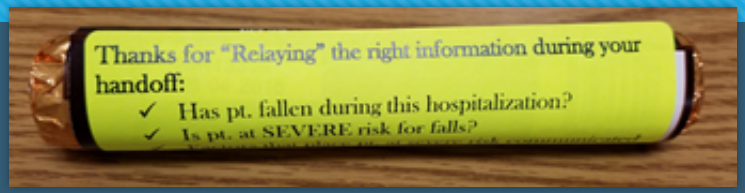
WHO:

- The improvement team consisted of members of the Falls Committee:
  - Direct Care Nurses
  - Nursing Assistants
  - Nurse Manager
  - Nursing Director
  - Physical Therapist
  - Quality Director
  - Continuous Improvement Analyst
  - Clinical Nurse Specialist.

WHAT:

- Using the Plan Do Study Act (PDSA) methodology, the team identified the following gaps:
  1) Handoff communication inconsistencies
  2) The majority of falls were bathroom related

Process Improvement Methods

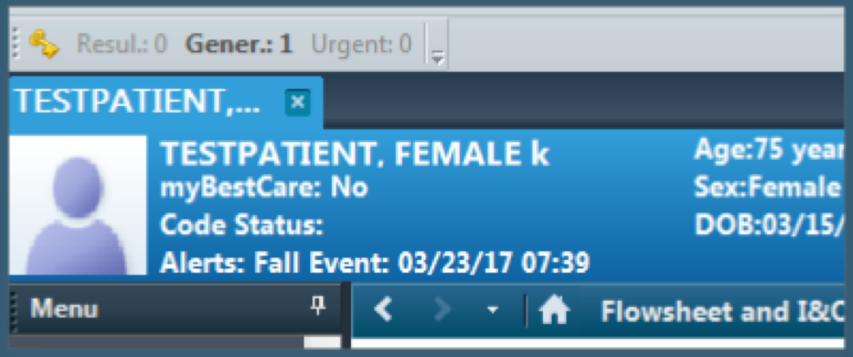


Contributing Factors

Inconsistent or incomplete communication of patient risk for falls between caregivers

Actions Taken

- Fall reps described how shift to shift report occurs on each unit & standardized.
- Fall reps began handoff audits with just in time education to peers.
- Fall alert added to banner bar in Cerner.



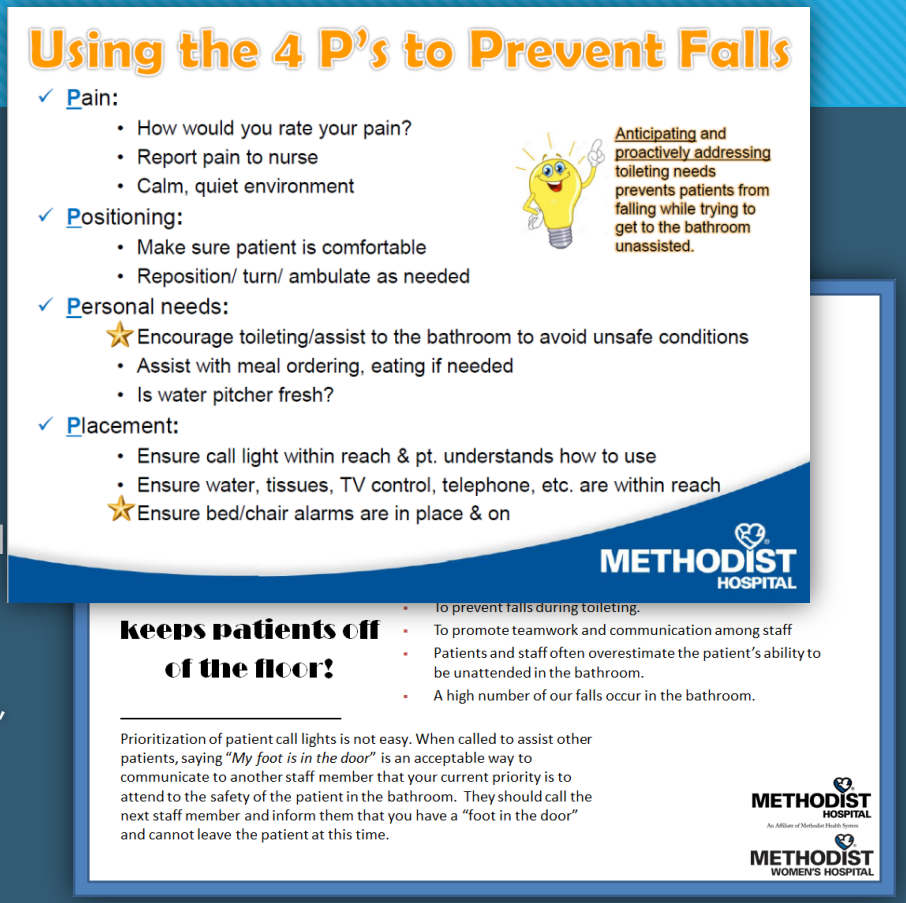
Process Improvement Methods

Contributing Factors

High fall risk patients being left in the bathroom

Actions Taken

- Implemented "Foot in the Door" campaign as a communication tool for staff and to better provide for patient safety while maintaining privacy.
- Educated staff on the Four P's (pain, positioning, personal needs, placement) to prevent falls by anticipating the patient's personal/bathroom needs.



Using the 4 P's to Prevent Falls

- ✓ Pain:
  - How would you rate your pain?
  - Report pain to nurse
  - Calm, quiet environment
- ✓ Positioning:
  - Make sure patient is comfortable
  - Reposition/ turn/ ambulate as needed
- ✓ Personal needs:
  - ★ Encourage toileting/assist to the bathroom to avoid unsafe conditions
  - Assist with meal ordering, eating if needed
  - Is water pitcher fresh?
- ✓ Placement:
  - Ensure call light within reach & pt. understands how to use
  - Ensure water, tissues, TV control, telephone, etc. are within reach
  - ★ Ensure bed/chair alarms are in place & on

Anticipating and proactively addressing toileting needs prevents patients from falling while trying to get to the bathroom unassisted.

METHODIST HOSPITAL

Keeps patients off of the floor!

- To prevent falls during toileting.
- To promote teamwork and communication among staff
- Patients and staff often overestimate the patient's ability to be unattended in the bathroom.
- A high number of our falls occur in the bathroom.

Prioritization of patient call lights is not easy. When called to assist other patients, saying *"My foot is in the door"* is an acceptable way to communicate to another staff member that your current priority is to attend to the safety of the patient in the bathroom. They should call the next staff member and inform them that you have a "foot in the door" and cannot leave the patient at this time.

METHODIST HOSPITAL
An Affiliate of Methodist Health System
METHODIST WOMEN'S HOSPITAL

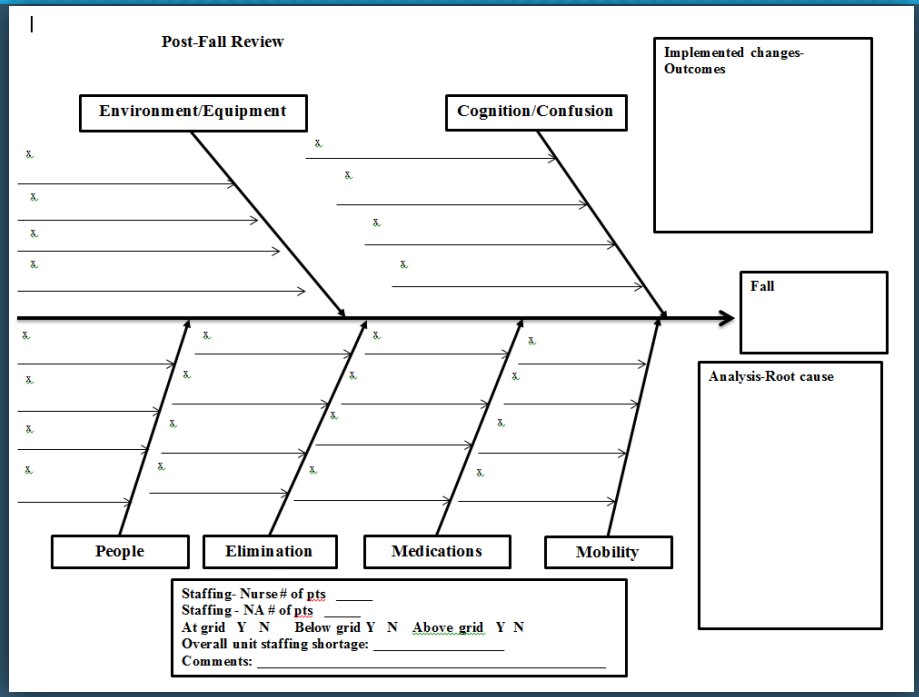
Process Improvement Methods

Contributing Factors

Lack of identification & trending of root causes of injury falls at the organizational level

Actions Taken

- Unit managers together with staff conducted fall fishbone diagrams on all injury falls to determine root cause(s).



Results

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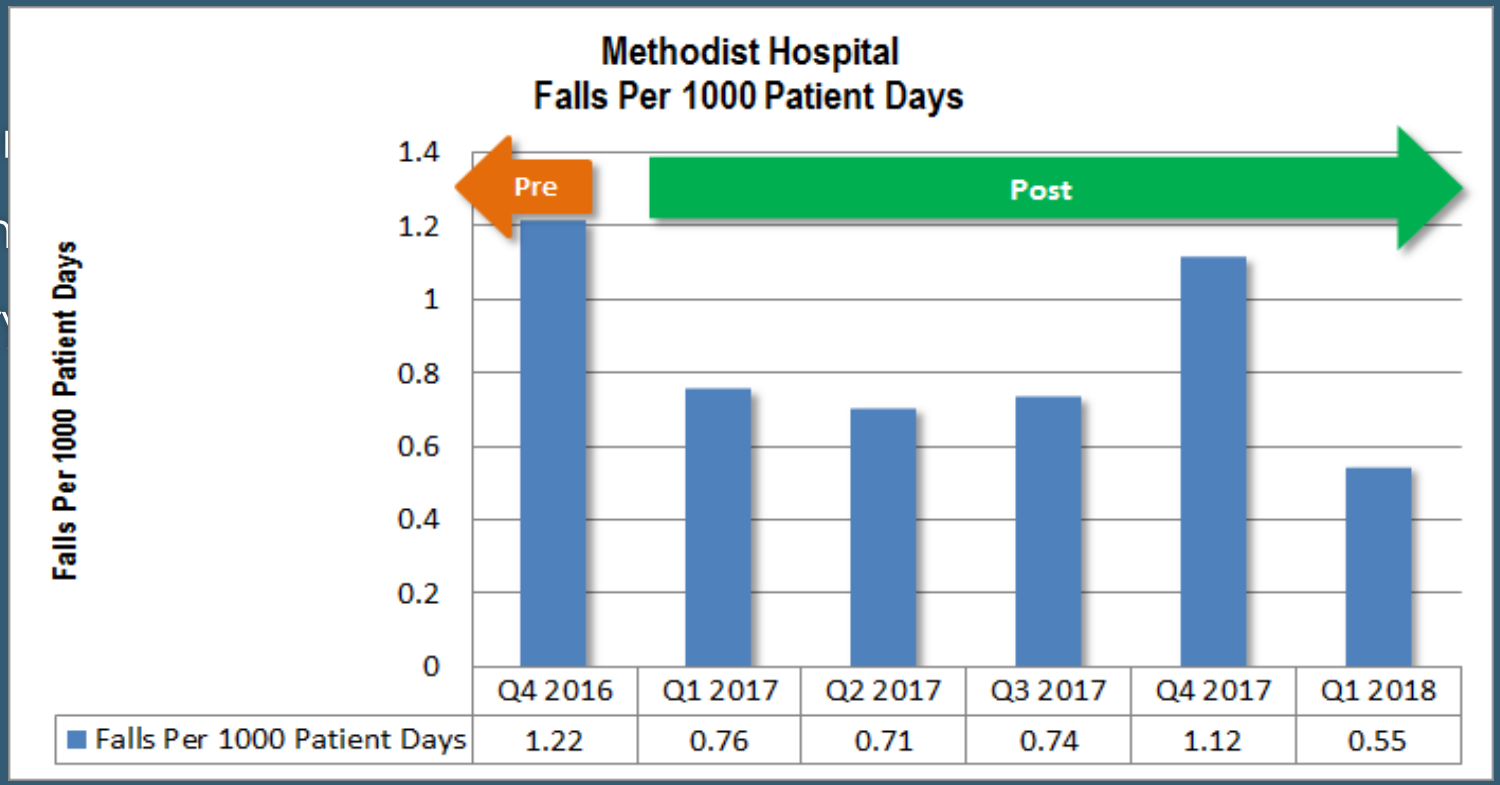
- Bath
- Injur



Lessons Learned

- Engagement of the direct care staff is key when undertaking a clinical practice change.
- Real-time shift to shift handoff audits are best conducted by a third person auditor.
- Fall prevention is multifaceted- successful programs identify the specific root causes leading to falls and implement targeted solutions to address the causes.
- The targeted solutions described in this quality initiative may be an effective solution for other organizations struggling with handoff communication and bathroom related falls.
- Sustainability of this work will be achieved primarily through quality audits and staff education.