

The Military Health System's

PARTNERSHIP FOR PATIENTS CAMPAIGN

SAFE CARE SAVES LIVES



Guide Sustaining the Gain

Overall Aim: *Reduce the injury (harm) associated with patient falls*

April 02, 2014





1 Table of Contents

1. Introduction	2
2. Background	3
3. Evidence-Based Practice Guidelines	4
4. Documentation.....	7
5. MHS Falls Performance Measures	7
6. Sustaining the Gain.....	8
7. Performance Improvement.....	9
8. References	10
9. Resources	11
Appendix A: Johns Hopkins Fall Risk Assessment Tools	12
Appendix B: Teach Back Model	13
Appendix C: Staff Communication and Training.....	14
Appendix D: Falls Categories/Classification	14

1. Introduction

This Sustainment Guide supports the 2012 - 2013 Military Health System (MHS) Partnership for Patients initiative to improve the quality and safety of health care in all Department of Defense (DoD) Medical Treatment Facilities (MTF). The purpose of this guide is to provide the tools and resources to ensure a reduction in falls and harm from falls at your Military Treatment facility (MTF).

In June 2011, the Assistant Secretary of Defense for Health Affairs, Dr. Jonathan Woodson, signed the Partnership for Patients (PfP) pledge on behalf of the Military Health System to which all Surgeons General committed to the aims of the National PfP.

Each Service and the National Capital Region Medical Directorate collaboratively agreed to a standardized definition of a fall, implemented a standardized risk screening tool (The Johns Hopkins Assessment Tool) for adult inpatients across all DoD Medical Treatment Facilities (MTFs), and began to collect and review falls information across all to assess progress. The fall risk assessment tool and associated documentation in the electronic medical record (ESSENTRIS) are standardized across all MTFs providing inpatient healthcare.



2. Background

2.1 Standardized Definition of Patient Fall

The National Quality Forum defines a fall as a sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This includes situations where a patient falls while being assisted by another person, but excludes falls resulting from a purposeful action or violent blow.¹

2.2 Key Fall Risk Factors

Risk factors may be defined as intrinsic (inherent to the patient) or extrinsic (inherent to the environment). Extrinsic (environmental) risk factors may contribute to an accidental fall, such as falls from slips or trips, caused by water or electrical cord on the floor, or by errors of judgment, such as not locking the wheelchair before rising.

A fall can be anticipated due to the patient's existing physiological status, history of falls, and decreased mobility at assessment or unanticipated due to physiological events that cannot be predicted such as seizures or fainting.²

2.3 Key Components to Reduce Inpatient Falls

Evidence-based practices provide direction, yet ensuring that all the components are working together will allow for a successful reduction of inpatient falls. The following components are briefly reviewed in this guide to allow a focal point of reference as the MTFs continue to sustain the gain in preventing injury (harm) associated with inpatient falls.

- ❖ Patient Safety Culture - Championing a fall prevention program
- ❖ Fall Categories/Classifications
- ❖ Early screening of the newly admitted patient
- ❖ Patient and Family Education
- ❖ Tailored Interventions
- ❖ Re-assessments
- ❖ Post-fall interactions
- ❖ Documentation

2.4 Patient Safety Culture

Maintaining a culture of safety is instrumental in sustaining a falls prevention program. Embedding standardized processes and tools for reduction of falls into MTF staff procedures allows for focused interventions to mitigate falls, leading to safer patient care and greater patient/staff satisfaction. The culture must continue to reflect the "No falls" objective for the MTF.



2.4.1 Championing a fall prevention program

The Institute for Healthcare Improvement (IHI) recommends a multidisciplinary team approach to the prevention of injuries from falls to sustain the culture of patient safety. Multidisciplinary teams bring diverse staff together that work to gain buy-in and cooperation from all departments. Team members may include: MTF Senior leadership, nursing leadership, staff nurses, staff educators, pharmacists, procurement staff, and providers such as physicians physical and occupational therapists.⁶

Many successful improvement efforts require frontline unit champions as critical members of the falls prevention team. Frontline staff engaged in fall prevention can reinforce and maintain awareness of good prevention practices on the unit, provide ongoing motivation and enhance the culture of safety.

2.4.2 Training as a proponent of Safety Culture

Training for new and current staff is an essential component in sustaining fall prevention practices and supports the fall prevention culture.

- New-hire orientations: a session on fall prevention standards and processes, the types of falls, environmental, physiological and psychological components of fall prevention, the Johns Hopkins Assessment Tool, and respective fall interventions.
- Unit-based training and refresher training: response times for bed alarms, call lights, hourly rounding, communication techniques.

To ensure uniformity in the training, conduct education and training for all clinical staff, support staff and ancillary staff, such as housekeeping and nutritional services.

3. Evidence-Based Practice Guidelines

Best practices in hospitals deliver implementation of safer environment of care for the patient (flooring, lighting, observations, threats to mobilizing, signposting, personal aids and possessions, furniture, footwear), identification of specific modifiable fall risk factors, implementation of interventions targeting those risk factors so as to prevent falls, and interventions to reduce risk of injury to those people who do fall.⁷

3.1 Screening

The MTF inpatient should be initially screened for fall risk based on age, fall history, medications in use or ordered PRN, elimination (bowel and urine), patient care equipment, mobility, and cognition. The evidence-based practice selected for standardized implementation across all MHS direct care hospitals is the Johns Hopkins Risk Assessment Tool (available via ESSENTRIS) for adult inpatients. (Key points on completing the JHFRAT are found in Appendix A).



Each Service maintains licensing for additional supportive tools that are available through your designated Service Lead:

- *Fall Prevention Guidelines by Risk Category (Low Fall Risk, Moderate Fall Risk, High Fall Risk)*
- *Suggested Format for Comfort and Safety Rounds – Strategy for conducting patient safety rounds*
- *Management of Falls Events – Actions to take immediately following a fall event*
- *Patient Safety: A Guide to Preventing Falls in the Hospital – an educational tool for the inpatient*
- *Patient Safety: A Guide to Preventing Falls at Home – an educational tool for the patient being discharged to home*
- *Patient Information Guide to Preventing Falls in the Hospital.*

3.2 Patient and Family education – Teach back strategies

Upon admission and throughout the shift as needed, educating the patient/family on actions to mitigate the chance of a fall is crucial to a successful fall reduction program. The teach-back method is used to assess the patient/family understanding and retention of fall precautions. It involves asking patients to explain or demonstrate what they have been told. However, it is not to test the patient's knowledge but an assessment of how well explained the concept was explained.⁵ The Teach-Back model steps are found in Appendix B.

3.3 Communication

Communication of fall prevention strategies to patients, family and staff is vital to a successful fall prevention program. Ensure standardized handoffs occur between nurses (e.g., at shift change) and unit staff and relevant members of other MTF departments. Communicate the patient's risk factors and review medications, mental status, and associated physiological changes documented in the medical record or patient care worksheet.

Include any change in fall risk factors during the shift, including relevant medication changes, and incorporate findings from hourly rounding. Incorporating the shift change at the bedside with the patient/family supplements their education. (See Appendix C for additional interventions)

3.4 Re-Assessment

Assessment for fall risk factors and calculation of the inpatient's level of risk should occur not only on admission, but once a day and as needed when the patient's condition and treatment changes. Assessment is repeated each day based on the short length of stay and the changing acuity of the patient in the inpatient setting. Evaluate when a risk assessment needs to be repeated; mental, physiological and/or medication changes. Particular attention should be paid to interventions/treatments that alter the patient's physical, emotional or behavioral state. These include PCA/opiates, anti-convulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropics.



Revalidate with each transfer throughout the MTF whether or not there has been a fall that occurred during that hospitalization. If so, consider the patient to be deemed at high risk for the remainder of their stay. Any assessment that changes the fall risk status requires coinciding changes with the interventions; higher risk level demands more intensive interventions to be applied immediately.

3.5 Interventions

Interventions applied are based on the risk score (low, moderate, high) calculated via the JH Tool. However, preventative actions such as maintaining a safe inpatient environment are done on an ongoing basis. Monitoring the patient's pain, toileting, position, and personal needs is a key preventive strategy for fall reduction. Any assessment that changes the patients fall risk status requires coinciding changes with the interventions, higher risk level demands more intensive interventions to be applied immediately. Please see the falls Implementation guide for detailed interventions.

3.5.1 Hourly rounding

Patient safety rounds are instrumental in mitigating the fall risk and targeted at every one - two hours in frequency. Combine frequent and regular toileting rounds with existing patient care tasks, such as patient turning, environmental safety assessments, and pain assessment. Address all patient needs (e.g., pain, position, toileting, and environment) in one effective encounter.⁶ Suggestions for making hourly rounding effective may include:

- Assigning a specific staff member(s) to routine rounding to ensure that responsibility for the task is clear.
- Creating hourly rounding posters create a visual reminder to not only staff but inform the patient/family of the new rounding process.
- Placing the documentation forms inside the patients' rooms and near the unit's communication whiteboard offers convenience to the staff.

3.6 Post-fall Assessment

Immediately following a fall, an assessment is to be conducted on the physical and mental status of the patient. Notify the physician of the fall event and findings.

- Determine why patient fell.
- Were the nursing processes in place to mitigate risk? Did they work?
- Was the John Hopkins assessment tool used at each shift and with a change of patient condition? What risk level was predicted?
- Re-assess the patient's fall risk score to modify fall prevention strategies and risk category interventions.
- Assess mental/physical status to identify changes from pre-fall status, degree of injury and assist back to bed/chair using appropriate transfer techniques.
- Assess for contributing factors leading to the fall such as medication changes and consider corrective or more restrictive prevention strategies to prevent a repeat fall.



- Review the patient's admission history for co-morbidities, history of falls, Was John Hopkins (JH) assessment done at time of admission?
- Obtain the patient and family's perspectives on the fall. Was the risk level communicated to the family? By what means?

3.6.1 Post-Fall Huddle

A Post-fall huddle is best conducted on the local unit level to have an individual who is assigned to follow up on fall events. It is imperative that all staff involved in the care of the patient discuss the fall event in order to discuss key points that will modify the fall prevention strategies and prevent further falls.

Identify the type of fall that occurred by fall classification and adjust interventions to the identified fall category (Appendix D). What happened and why? What intervention worked or didn't work? What can be done differently?

3.7 Falls Categories/Classification

Fall categories and classifications are used to strengthen awareness of preventable fall events that can be predicted through screening and ongoing reassessment of the inpatient. Understanding the types of falls that already occurred on an inpatient unit allows greater insight into fall events that may be preventable, anticipated physiological or unanticipated physiological, leading to greater insight of associated interventions to mitigate future fall events.

Recognizing and implementing interventions associated with each fall category strengthens prevention of and mitigates the risk of harm from fall events. (See Appendix D for the components and interventions associated with fall classifications)

4. Documentation

Documentation of an inpatient fall through the Patient Safety Reporting (PSR) system is mandatory. Information gained from the post-fall huddle should be placed in the PSR, but NOT in the patient record. The PSR report can be used for further analysis to review the type of fall, mitigating circumstances, interventions implemented and patient/family/staff education.

5. MHS Falls Performance Measures

Comprehensive reporting and accuracy of data is essential to assessing improvement of falls prevention at your MTF. Data is used to identify trends and plan performance improvement and needs to be reviewed at the MTF. It is also imperative to review and discuss inpatient unit level data with the respective unit staff. To measure performance with the intent is to improve performance over time at your facility:





- ✓ Raise awareness of reporting falls in PSR
 - What is your confidence level staff consistently report falls?
 - What is your confidence level that staff report near misses or unsafe conditions that do not result in falls?
- ✓ Verify the accuracy of falls data reported in PSR
 - Inpatient Fall (not outpatient)
 - Degree of Harm?
 - Sentinel Events for Falls entered in PSR?
- ✓ Review your facility's outcomes data for falls
 - What patterns do you expect over time?
 - How does that match up to the outcomes data?

5.1 Making Data Meaningful

Reinforce the MHS standard patient fall definition for accuracy in reporting fall events. Questions to consider as you review your facility level information: What is my confidence level that falls are being accurately captured? What do these outcome measures over time indicate? What patterns emerge?

Reiterate the process of reporting all fall events in the PSR. Assure that the PSR reflects accurate information: Event description, Inpatient vs. outpatient status, appropriate Harm level, type of fall.

Verify the validity and reliability of reported falls: "If a fall were to occur in this unit, how often is that reported?" "If the potential for a fall exists on this unit, how often is that reported?"

Assess the data frequently (e.g. monthly) to note expected patterns that emerge to indicate progress and share that progress. Revisit actions if data does not indicate progress.

Determine intervals to share data (e.g. weekly) with units and share the Falls Dashboard information with MTF units. When aggregating fall data look for trends such as falls related to toileting or repeat fallers. This can lead to focusing on reducing particular types of falls. To do this you keep track of:

- Where a fall occurred (e.g., a specific unit or a place like a bathroom or hallway).
- What the patient was doing, or attempting to do, at the time of the fall

6. Sustaining the Gain

Sustaining improvement from the MTF fall prevention program requires ongoing diligence in keeping the program integral to unit processes and embedded in the culture of safety. What are the strategies for keeping the MTF fall prevention program fresh to the staff?

Realistic fall-related case scenarios provide insight to staff about fall prevention and give managers feedback as to what staff has learned. Interactive learning keeps staff engaged and strengthens problem solving skills. It also allows for exploration of solutions for complex issues.





MTF leadership and fall champions can conduct chart audits for proper documentation, room checks for compliance, monthly fall audits, and reinforce accountability. Auditing charts for proper documentation on the unit level – peer to peer audits, and subsequent coaching is also effective in sustaining the gain.

Additional strategies to sustain the gain:

- ✓ Include falls as a point of regular discussion each month and review the data. Provide staff information regarding the data and decentralize accountability to the unit level.
- ✓ Continue to encourage and foster fall champions that have a passion about safety and keeping fall prevention on the radar.
- ✓ Hold a fall prevention workshop or table at “Skills” fair.
- ✓ Regularly schedule lunch and learns to maintain sustainability of the prevention program.
- ✓ Integrate a new-hire into the fall prevention culture on Day One.

7. Performance Improvement

Performance improvement is an ongoing process as studying outcomes is critical to sustainment of the falls reduction program at the MTF. Improvement over time stems from a continuous cycle of analyzing outcomes, refining interventions, evaluating barriers/challenges and identifying opportunities for change.

The Plan-Do-Study-Act model is designed to convert opportunities to enhance systems, processes and structures into improvements. This model aids in efforts to conduct small tests of change throughout the sustainment process.⁴

- ✓ Plan – What are you trying to accomplish? What is the ideal state? What is the current state? What plan or strategy will provide improvement to the gaps identified between the ideal and the current? Understand the plan and the purpose.
- ✓ Do – Test the improvement in your case the implementation, document problems, observations, lessons learned.
- ✓ Study – what went well, what didn't go well? Utilize qualitative analysis. Why did it go well or not go well?
- ✓ Act – Do you adopt the plan (standardize it), adapt the plan (modify and try again), or abandon the plan (begin the cycle again).



8. References

¹ National Quality Forum. (2011). *NQF Patient Safety Terms and Definitions*.

http://www.qualityforum.org/Topics/Safety_Definitions.aspx

- ² Ganz DA, Huang C, Saliba D, et al. *Preventing falls in hospitals: a toolkit for improving quality of care*. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHS290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ Publication No. 13-0015-EF.
<http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallpxtoolkit/index.html>

³ Morse, J. (1997). *Preventing patient falls*. Thousand Oaks, CA: Sage.

⁴ Degelau J, Belz M, Bungum L, Flavin PL, Harper C, Leys K, Lundquist L, Webb B. Institute for Clinical Systems Improvement. *Prevention of Falls (Acute Care)*. Updated April 2012.

http://www.icsi.org/guidelines_and_more/protocols/patient_safety_reliability_protocols/falls_acute_care_prevention_of_protocol/falls_acute_care_prevention_of_protocol_24254.html

⁵ Bertakis, K.D. (1977). *The communication of information from physician to patient: A method for increasing patient retention and satisfaction*. *Journal of Family Practice*, 5, 217-222.

⁶ Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D, Rita S. *How-to Guide: Reducing Patient Injuries from Falls*. Cambridge, MA: Institute for Healthcare Improvement; 2012. Available at: www.ihc.org.

⁷ Oliver et al. *Preventing Falls and Fall-Related Injuries in Hospitals*. *Clin Geriatric Med* 26 (2010) 645-692.

Department of Veterans Affairs National Center for Patient Safety Falls Toolkit, Measuring Success.

http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/07_measuringuccess.pdf.

Accessed 8/31/2012.



9. Resources

This guide is a resource to support efforts to educate the health care team by providing MHS-selected EBPs and quality improvement strategies. Additional resources include the DoD Patient Safety Learning Center (PSLC). This site enables connections among DoD, military and approved contractors who are engaged in patient safety activities. Members use the online space to access and share knowledge about patient safety, and collaborate on best practices across MHS.

In addition, members will be able to share files, access recordings and materials from Learning Circles and CoPs, access the results of the 2012 Culture Survey, and connect with groups such as Patient Safety Managers. To request access to the PSLC, complete the Access Request Form located at <http://www.health.mil/dodpatientsafety/ProductsandServices/PSLC/PSLCAccess>

PSLC: <https://intelshare.intelink.gov/sites/jko/pslc/default.aspx>

The PSLC Falls page contains presentation slides and audio recordings for each of the Falls COP (Community of Practice) monthly calls throughout the MHS PfP initiative. Additional learning resources include research articles and journal articles on falls evidence-based practices. <https://intelshare.intelink.gov/sites/jko/pslc/Pages/Falls.aspx>

DoD Patient Safety Program:

<http://www.health.mil/dodpatientsafety.aspx>

eBulletin:

<http://www.health.mil/dodpatientsafety/News/Publications.aspx>

Evidence-based practices for fall prevention and patient safety:

VISN 8 PSCI falls website:

<http://www.visn8.va.gov/patientsafetycenter/fallsTeam/default.asp>

VHA: National Patient Safety Center: <http://www.patientsafety.va.gov/>

AHRQ: <http://www.ahrq.gov/index.html>

Center for Medicare and Medicaid Services (CMS):

http://partnershipforpatients.cms.gov/p4p_resources/tsp-injuriesandfallsfromimmobility/toolinjuriesandfallsfromimmobility.html



Appendix A: Johns Hopkins Fall Risk Assessment Tools

Key Points for JHFRAT Completion: (Patricia Dawson, MSN, RN – 2012 December Falls CoP presentation)

- Determine assessment frequency: At JHH, within the first 8 hours of admission to the unit.
- At minimum, once daily.
- As the patient's condition changes and/or risk conditions change.
- Pay attention to whether it is single-select or multi-select factor (choose all that apply).
- If patient is capable of any movement, they are not immobile.
- Ask the patient or family about fall history. Don't rely on H & P alone.
- If a fall occurs during the hospitalization, consider them at high risk for remainder of the stay.
- Calculate age at time of assessment using documented age information.
- Elimination addresses bladder and bowel. Assess risk without considering devices, e.g., Foley. Select choice based on observation and/or patient complaints.
- Assess all medications ordered for the patient. Assume any medication ordered could be given during the day the assessment is completed.
- Assess for all equipment that is ordered or could be used during the day the assessment is completed, even if it is not currently connected to the patient (e.g. IV minibag, compression device or cardiac monitoring).
- The time of day & patient's fatigue level can change during the day and affect the mobility and balance. Read and use information from rehab assessments and ongoing treatment to formulate the assessment.
- The need for people, furniture or devices to "steady" the patient indicates an unsteady gait.
- Surgery can cause new, worsening or transient visual or auditory impairments that require frequent re-assessment. Assign points even if impairment is corrected with visual or hearing aids.
- Awareness of immediate physical environment can be transient, especially following some medications (e.g., sedative, hypnotics & narcotics) or procedures. Frequent assessment of level of consciousness and appropriateness of response should be considered for ratings.
- Be aware of the link between inattention and impulsivity.
- Beware of patients with a strong sense of independence and lack of safety awareness. (e.g., "That's ok, I'm alright, I don't need any help. I don't want to bother you...").



Appendix B: Teach Back Model

Use the Teach Back Model with patients and family to improve their understanding of:

- The reasons that the patient is at risk for falling and/or injury
- The reasons fall prevention is important
- Actions the patient can take to stay safe
- The importance of patients asking for help when accessing the bathroom
- The location and use of the call light
- The importance of using non-slip footwear

Explain the fall prevention interventions to the patient or family caregiver and then ask in a non-shaming way for the individual to explain what he or she understood. For example: I want to be sure that I did a good job of teaching you about staying safe from falling in the hospital. Can you please tell me in your own words how you can prevent falling? ⁶

Step 1: Use simple lay language, explain the concept or demonstrate the process to the patient/caregiver.

Step 2: Ask the patient/caregiver to repeat in his or her own words how he or she understands the concept explained.

Step 3: Identify and correct misunderstandings of or incorrect procedures by the patient/caregiver.

Step 4: Ask the patient/caregiver to demonstrate his or her understanding or procedural ability again to ensure the above-noted misunderstandings are now corrected.



Appendix C: Staff Communication and Training

Safety huddles conducted at the beginning of each shift identify and discuss patients believed to be at greatest risk for a fall-related injury. These patients and their risk factors must also be conveyed to the multidisciplinary staff associated with patient care during the shift. Relaying safety reports to the unit at large at the beginning of each shift to provide attentiveness toward potential fall events and allows for unit involvement in mitigating fall-related injuries.

Additional methods of communicating the message may include:

- Post alerts in a staff area for patients at high-risk and require reinforcement of interventions;
- Maintain a central location for fall reports and documentation on fall prevention progress;
- Centrally place a whiteboard to create reinforcement of fall strategies (Tip of the Day),
- Use a “fall” calendar to reflect fall events and pertinent de-identified data;
- Showcase successful interventions and “No-fall days (weeks, months)” in banners, posters or other visual materials.

Appendix D: Falls Categories/Classification

Immediately following a fall, successful fall improvement efforts consider the type of fall based on the following designations. By understanding the type of falls that occur on the unit or at the facility, you will be better able to apply interventions more effectively and become more efficient with limited resources – staff time!

- **Accidental Fall:** Fall that occurs due to extrinsic environmental risk factors or hazards: spills on the floor, clutter, tubing/ cords on the floor, etc., or errors in judgment, such as not paying attention.
- **Anticipated Physiological Fall:** Factors associated with known fall risks that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur to the patient’s existing physiological status, history of falls, and decreased mobility upon assessment.
- **Unanticipated Physiological Fall:** Factors associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale: unexpected orthostasis; extreme hypoglycemia; stroke; heart attack; seizure.
- **Behavioral (Intentional) Fall:** Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.⁴

The last two categories of falls may not be preventable. Fortunately, falls research indicates that the majority of falls are associated with accidental or anticipated physiological.⁷