Salinas Valley Memorial Healthcare System

Fall Prevention Awareness Day: GAME ON!

Lourdes Escolta, MSN, RN, CNS, CMSRN, CNN, ONC; Doreen Faiello, MHA, RN; Agnes Lalata, MSN, RN, CMSRN

Make SVMHS A FALL FREE ZONE

BACKGROUND/SIGNIFICANCE:

Fall prevention awareness is a top patient safety priority for high performing healthcare organizations. Hence, when a member of the Fall Team brought back information from a conference about celebrating the first day of Fall with a fun event on Fall Prevention Awareness, the Fall Team immediately started to plan the event utilizing an interactive teaching methodology that is far different from the usual Informational Fairs. The Team wanted to attract staff from every department to participate in SVMHS' First Annual Fall Awareness Day. The Team enlisted the help of the Marketing Department who came up with the Wheel of Fortune Game. The next challenge was to find a location visible to all departments and staff. The cafeteria was chosen as the perfect location. The next challenge was to structure the times the game was available or staff to play. The Team chose times that would enable staff from all three shifts to participate.

Since its introduction, The Wheel of Fortune is now being used for Orientation; Safety Fairs and even this year's NICU reunion. The Wheel of Fortune game can be used as a teaching strategy that can enhance learner's participation and knowledge retention in a fun and interactive manner.

PURPOSE:

The purpose of the game is to make learning fun and even win some prizes in order to reinforce fall prevention strategies among all hospital departments.

DESCRIPTION OF EVENT:

The first Fall Awareness Day was in September 2014. The first year, the Team provided candy and hand sanitizers as prizes. Everyone who participated stated had a good time.

SVMHS just completed the 2nd Annual Fall Awareness Day. Participation doubled the second year. The Team enlisted more staff nurses to host the game which was still held in the cafeteria. Also the 2nd year, Employee Health joined our Awareness Day to demonstrate Safe Patient Handling and Mobility Aides. The Team donated two gift cards as the "Grand Prizes". The Team also enlisted support from Environmental Services who donated 10 free cafeteria meal vouchers; 10 Starbucks gift cards for $5 each; three miscellaneous gift bags from the Foundation and a Department Director. Attendance this year included the CMO, Sr. Administrative Director Risk Management; Sr. Administrative Director Regulatory Compliance/Organizational Improvement and Sr. Administrative Director Nursing Operations.

LESSONS LEARNED FROM THE FIRST YEAR:

- Advertise earlier
- Include more non-clinical questions regarding Fall Prevention

PLAYING THE GAME:

Much like the popular game show, the participant spins the wheel but instead of shouting out a letter when the wheel stops, a category is revealed. The Team chose the following categories:

- Documentation
- Assessment
- Pictures
- Environment
- After the Fall
- Rounding
- Signage
- Fall Education
- Why Do Patients Fall
- Handoff
- Free Space (Players Choice)
- Miscellaneous (Host Choice)

OUTCOMES & STAFF FEEDBACK:

"Very interactive and engaging."

"I did not think being from a non-clinical area that I could play—I learned something today."

"Good information and very short so it did not take time away from my lunch break."

Salinas Valley Memorial Healthcare System

Fall Prevention Innovation Program:
Our Journey Toward Best Outcomes

Lourdes Escolta, MSN, RN, CNS, CMSRN, CNN, ONC; Doreen Faiello, MHA, RN; Agnes Lalata, MSN, RN, CMSRN

PURPOSE AND/OR OBJECTIVES:

The purpose of this project is to identify current innovations and best practices related to fall prevention in the acute care setting.

BACKGROUND AND SIGNIFICANCE:

Fall prevention is one of the major hospital initiatives for patient safety. Our 2014 CalNOC data indicates variation in fall incidences, where 50% of the data points scored above the mean. The fall team completed chart audits, staff interviews and patient rounding. The outcome identified that the majority of our patients were being categorized as high risk to fall (HRTF) using the current Morse Fall Risk Scale (MFRS) causing patient and staff dissatisfaction. Our current fall risk program lacks risk stratification and interventions were generalized. Implementation of an effective acute care fall prevention program brings utmost clinical value from an outcomes measurement and patient safety perspective. Furthermore, Costello and Edelstein (2008) explain that fall-prevention costs continue to increase significantly. A single incident of fall can impact morbidity and mortality rates as well as increase utilization of a variety of health care services and resources.

DESCRIPTION OF PRACTICE CHANGES:

Careful fall risk-assessment and stratification is one of the key elements for fall prevention. The team reviewed a variety of fall risk assessment tools, and found the Johns Hopkins Fall Risk Assessment Tool (JHFRAT) as the most appropriate based on our patient demographics. The JHFRAT was implemented as a pilot program to ensure reliability and validity. During the pilot program staff rated the patient's fall risk using both the MFRS and the JHFRAT. The tool was evaluated for ease-of-use, risk stratification, and practical application. Following successful evaluation of the pilot program, the hospital's electronic fall risk assessment documentation screen was revised to formally adapt the JHFRAT model. Related policy and procedure in management and prevention of falls was updated accordingly. Risk stratification also involved the development of customized interventions to match each fall risk category, namely: low, moderate, and high. The interventions are interdisciplinary. The team revised the fall definitions to match CalNOC. A hospital-wide Fall Prevention Awareness Day was held including a Wheel of Fortune game. All these action plans led to improved patient outcomes.

EDUCATION AND IMPLEMENTATION:

Staff education was accomplished in two phases. The first phase was using an online e-learning module. Following the completion of the e-learning module the changes and modifications of the new Fall Risk Scale went live in the computer system. Education staff started rounding on all the nursing units to provide follow up one on one education and answer any questions. Additionally the new Fall Risk Scale was discussed at unit staff meetings. In conjunction with the additional education, audits on compliance were being performed with feedback going to the nursing units Directors.

RESULTS/OUTCOMES:

Results validated that majority of patients were now classified as moderate risk under the JHFRAT tool that was previously identified as HRTF under the MFRS. Preliminary results indicate that the risk stratification improved outcomes and patient satisfaction by accurately identifying patients at risk. Staff indicates JHFRAT is easy to use and has the ability to prioritize care for patients at highest risk to fall. After incorporating CalNOC fall definitions the team was able to gather meaningful data analysis for further program improvement.

CONCLUSION:

The team concluded that the JHFRAT is a more effective risk assessment for our patient demographics. Although early in our data collection and analysis, the new tool in combination with the stratification of fall interventions for low, medium and high risk are making a difference in patient care and safety. The raw data shows a steady decrease in falls each month.

CHALLENGES AND LESSONS LEARNED:

The implementation of the JFHRAT Fall program brought about some challenges and ultimately lessons learned.

Starting from the trial to evaluate the effectiveness and ease of use of the tool. The tool was a paper form. Reflecting back had we been able to develop the clinical screens to trial the tool in Meditech may have identified issues and provided the opportunity to resolve them prior to the housewide implementation.

Adding the intervention where Physical Therapy consult is added if the patient is HRTF was not highlighted in the staff education. This was a new intervention for both the nursing and Physical Therapy staff. This has resulted in a steep learning curve for both departments.

Staff education took on many forms. One of them was the e-learning module. The most successful mode of teaching was the rounding by the educators. They provided one on- one learning. In addition unit champions were enlisted to assist with additional education.

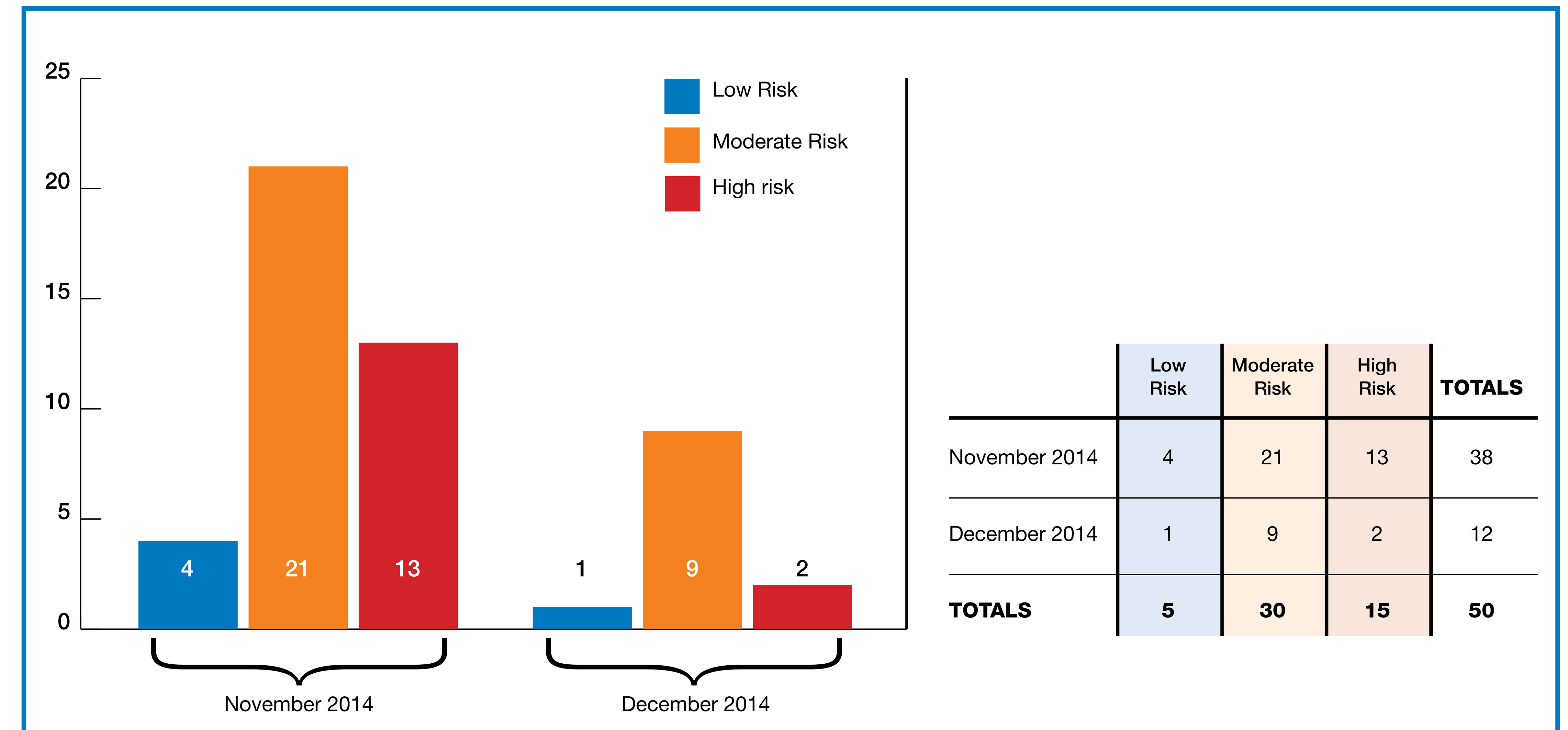
One of the criteria for meeting a HRTF is High Risk Factors. Staff was very creative at how they defined High Risk Factors. The Team in collaboration with Clinical IT redesigned the screen to define the High Risk Factors.

REFERENCES:

Costello, E. & Edelstein, J. E. (2008). Update on falls prevention for community-dwelling older adults: Review of single and multifactorial intervention programs. Journal of Rehabilitation Research Development, 45(8), 1135-1152.

Poe, S. S., Cvach, M. M., Gartnell, D. G., Radzik, B. R., & Joy, T. L. (2005). An evidence-based approach to fall risk assessment, prevention, and management: Lessons learned. Journal of Nursing Care Quarterly, 20(2), 107-106.

Using the Johns Hopkins Fall Assessment Tool, the patient was classified as:



	Low Risk	Moderate Risk	High Risk	TOTALS
November 2014	4	21	13	38
December 2014	1	9	2	12
TOTALS	**5**	**30**	**15**	**50**

JHFRAT Post Implementation Audit

	June 2015 % Selected to Presented	July 2015 % Selected to Presented	August 2015 % Selected to Presented	September 2015 % Selected to Presented	**TOTALS** **% Selected to Presented**
Patient's Fall Risk was assessed as:					
Low Risk	21	9	15	29	**17**
Moderate Risk	38	47	36	18	**38**
High Risk30	30	42	48	41	**39**
Noted flucuation between Moderate & Low Risk	11	9	6	24	**11**
For patient's assessed as HRTF was:					
Chair/Bed Alarm documented	18	28	19	29	**22**
No documentation found for Chair/Bed Alarm	35	6	0	0	**12**
No documentation found for Physical Therapy Consult	41	11	44	29	**31**
Chair /Bed Alarm inconsistently documented	47	39	13	71	**38**
Physicial Therapy ordered by physician	59	72	31	57	**55**
Bed check alarm documented as "no"	0	33	69	43	**34**
When "High Risk Factors" are chosen, identify the risk factors					
Active Seizures	0	13	0	0	**4**
Acute ETOH on CIWA	17	13	0	0	**9**
New Onset CVA with Residual Weakness &/or Cognitive Impairment	17	25	80	75	**43**
Post Op Joint Replacement	0	13	0	25	**9**
Unable to Identify Based on Documentation	67	38	20	0	**35**

ANALYSIS

- The flucuation between Moderate & Low are mostly due to the medications patient are scheduled to take during the shift.
- Physical Therapy consult is new to SVMHS for patients at HRTF; nursing and PT staff are still on a learning curve.
- Inconsistent documentation of bed/chair alarm. This will be reviewed with Fall Team.
- Staff choosing High Risk Factors for patients who are cognitively impaired.