Advances in Protecting Patients from Fall Injury: VHA Innovation Community

Pat Quigley,PhD,MPH,ARNP,CRRN,FAAN,FAANP Associate Director, VISN 8 Patient Safety Center Associate Chief for Nursing Service/Research

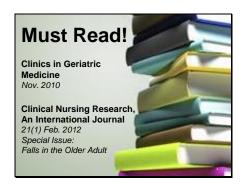
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VHA - NCPS - VISN 8

Preventing Injurious Falls
Preventing Adverse Events Associated
with Wandering

To support clinicians in providing safe patient care by designing and testing safety defenses related to the patient, provider, technology, and organization.





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Limits to Science

- Failure to Differentiate Type of Fall
- Anticipated Physiological
 Unanticipated Physiological (Monoe 1997)
 Failure to Link Assessment with Intervention

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Hospital Falls: we know.... (D. Oliver, et al. Falls and fall-related injuries in hospitals. (2010, Nov). *Clinics in Geriatric Medicine*.

- 30% to 51% of falls result with some injury
 80% 90% are unwitnessed
 50%-70% occur from bed, bedside chair (suboptimal chair height) or transferring between the two; whereas in mental health units, falls occur while walking
 Risk Factors: Recent fall, muscle weakness, behavioral disturbance, agitation, confusion, urinary incontinence and frequency; prescription of "culprit drugs"; postural hypotension or syncope

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Best Practice Approach in Hospitals

- Implementation of safer environment of care for the whole patient cohort (flooring, lighting, observation, 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
 Interventions to reduce risk of injury to those people who do fall

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Types of Falls

- Until Organizations Know Types of Falls occurring, they cannot know the effectiveness of your program.
- Types of falls are:

 - AccidentalAnticipated Physiological
 - Unanticipated Physiological (Morse, J. 1997. Preventing patient falls. Sage publication.) Intentional Falls
- Failure to Link Assessment with Intervention

Fall Scale (1	Morse, 1997, Preven	ting pati
	Morse Fall Scale	
Risk Factor	Morse Fall Scale Scale	Score
story of Falls	Yes	25
Secondary Diagnosis	No	0
	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane / None / Bed Rest / Wheel	15
	Chair / Nurse	
IV / Heparin Lock	Yes	20
	No	
Gait / Transferring	Impaired	20
	Weak	10
	/ Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15

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Screening to Assessment

- History of Falls
 Screen: yes or no
 Assessment: based on positive or negative screen response
- Required for rest of nursing process



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What About?

- The 85 yo who says No to a history of recent falls?
- The patient who gets admitted because of a fall?
- The patient who falls in our care?

Best Practice Approach in Hospitals

Implementation of safer environment of care

Identification of specific modifiable fall risk factors

Implement interventions targeting those risk factors so as to prevent falls

Implement interventions to reduce risk of injury to those people who do fall





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IHI RWJF 2006

Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls (2008)

Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at: http://www.lHl.org.

• Updated 2012

How to Guide: Revision 6 Steps (2012)

- Screen risk for anticipated physiological falls on admission and Screen risk for injury (history of FRI) on admission
 Complete multifactorial fall risk assessment
 Assess Multifactorial Risk Factors for Anticipated Physiological Falling with members of the interdisciplinary team, and Risk for a Serious or Major Injury from a Eall
 Communicate and Educate About Patients' Fall and Injury Risk
 Implement Universal Fall and Injury Prevention Interventions for Patients at Risk for Injury

5 Essentials to Protect from FRI					
Program Shi		structures: add risk for FRI and		Change in erventions: rironmental Redesign	
	prote	ess to ective entions	Organi: Sup	zationa port	al
You ca	n prote	ct patie	nts from	injur	ious falls



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Creating Safe Environment

Reduce Blunt Force Trauma Try to eliminate sharp edges Decrease impact from falls Ensure Safe Bathrooms! Why?

Slide 21	From	
	www.visn8.va.gov/patientsafetycenter/fallsTeam/defau lt.asp • C. Environmental Safety to Reduce Severity of Injury • Hip Protectors • Floor Mats	
	Non-slip flooring Height-adjustable bed (in low position, except during transfers) Bed-rail alternatives (body pillows, assist rails) Raised toilet seats Elimination of sharp edges Use of safe exit side from bed (pt transfer to unaffected side)	
	Use of alarms (bed, w/c) Pt access to mobility aides (walkers, canes) as appropriate The access to mobility aides (walkers, canes) as appropriate	
Slide 22	Bathroom Safety	
	Enough Grab Bars? How about folding grab bars?	
	 Elevated Toilet Seats- Yes or No Toilet Alarms – clips on emergency cords Non-skid floors with grit or traction kleen 	
	 Rubber floor mats- antimicrobial Padded walls and sharp surfaces? Motion Sensing Lights 	

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Eliminate Sharp Edges • KidCo • KidSafe Search: • Furniture Corner Cushions

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Shower Rooms

- Grab Bars
- Liquid soan vs har soan
- Plenty of towels available
- Grit on floors vs. floor mats
- Shower chairs in working order/wheels lock? Right size?
- Does water drain off quickly?

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Universal Injury Prevention

- Educates patients / families / staff

 Remember 60% of falls happen at home, 30% in the community, and 10% as inpts.

 Take opportunity to teach

 Remove sources of potential laceration

 Sharp edges (furniture)

 Reduce potential trauma impact

 Use protective barriers (hip protectors, floor mats)

 Use multifactorial approach: COMBINE Interventions

 Hourly Patient Rounds (comfort, safety, pain)

 Examine Environment (safe exit side)

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Hip Protectors





Best Practice: Patient Education Video Osteoporosis in Men

This 15 minute video is targeted for men with osteoporosis, addressing myths, diagnosis, treatment, and healthy living for prevention of osteoporosis in men.



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Resources and toolkits on fall

prevention include:
ECRI Falls Prevention Resources

• http://www.ecri.org/falls
VA National Patient Safety Center Falls Prevention
Toolkithtp://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html
Joint Commission Resources C

Oint Commission Resources, Good Practices in Preventing Patient Falls http://www.jcrinc.com/patientfalls
Minnesota Hospital Association SAFE from FALLS

http://www.mnhospitals.org/index/tools-app/tool.362

VISN 8 (Veterans Integrated Service Network 8 [Florida and Puerto Rico]) Patient Safety Center of Inquiry Falls Team

http://www.visn8.va.gov/patientsafetycenter/fallsTeam/def ault.asp

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Up Coming This Year! 2013!

- Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012.
- Preventing Falls in Hospital Falls: A Toolkit for Improving Quality of Care. AHRQ. D. Ganz

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