Mercy Hospital Springfield
Falls Prevention Success Story

Mercy Hospital Springfield, Springfield, MO

Submitted by the J.C.R. H.E.N. with hospital permission

According to the CDC, more than 18,000 older adults die from unintentional fall injuries and one in three adults age 65 and older fall each year. Up to 50% of hospitalized patients are at risk for falls, and almost half of those who fall suffer an injury. The average hospital stay for patients who fall is 12.3 days longer than for those who do not fall (Fitzpatrick). In 2007, the average cost per fall with injury was $33,894 (CDC). Mercy Hospital Springfield reports Fall / Slip Events as one of the top 5 events with 4.06 Falls per 1,000 Patient Days reported for CY2011. Our Hospital Fall team was going through a redesign and participation in the J.C.R. H.E.N. project was great timing. The Partnership for Patients goal and the Mercy Hospital Springfield goals are:

- National Goal**:** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years
- Mercy Hospital Springfield Goal**:** Decrease falls with injury to zero by year end 2013

Some of the challenges and barriers we faced included:

- Falls awareness prevention was perceived to be a nursing responsibility
- Misconception that falls cannot be prevented regardless of efforts put into place to prevent them
- Alarm Fatigue
- Supply, Processing and Distribution did not stock yellow non-skid socks
- Standardized “huddle/debrief”
- Underutilization of Mercy Event Reporting System (MERS) to report falls/near misses due to time or lack of knowledge regarding data entry process into MERS. This also affected data analysis for process failures
- Consistent interpretation of Fall Definition
- Merging NDNQI and MERS data elements
- Lack of knowledge regarding analysis of data and graphs.
- Equipment (walker, bedside commode, shower chair, gait belt) readily available and in good working condition
- Stryker beds not available, and/or return of them to appropriate unit; staff learning how to operate various types of beds
- Subjectivity of current fall risk assessment
- Implementation of intentional hourly rounding
- Patients that must be unrestrained and or free of a sitter for 24 hours in order to be accepted for transfer to a nursing home
- Consistent medication review by nurse, physician or pharmacist
- Standardized education of patient, family and staff regarding fall prevention

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We participated in an all day "workout" with our J.C.R. H.E.N. consultants and our interdisciplinary team (nursing, pharmacy, environmental services, physical therapy) and conducted an analysis of our Strengths, Weaknesses, Opportunities, and Threats (S.W.O.T.); an analysis of our Suppliers, Inputs, Processes, Outputs, and Customers (S.I.P.O.C), reviewed our tracer findings and data, developed a High Level Flow Diagram, identifying our risk points, developed a Cause and Effect Diagram and left the workout with an implementation plan of Who, What, and When (3W Deployment Plan). In launching our plan, we:

- Secured Leadership commitment and involvement
- Project team meets weekly
- Education for awareness of fall prevention required for all hospital based co-workers
- Small test of change for each initiative conducted on the various pilot units
- Nursing Shared Governance implemented recommendations throughout hospital
- Participating in the J.C.R. H.E.N. Falls Affinity Group

We began our efforts on three pilot units and are now reporting on all hospital patient falls. Some of the changes we have hardwired include:

- Fall Prevention is Everyone's Responsibility
- Various tools implemented such as Post Fall Assessment Form, Concurrent Fall Tracker.
- Fall prevention kit includes ,yellow non-skid socks, yellow arm band, yellow falling star door signage, stop-light room signage
- Stop light signage in room consistently placed on communication board
- Utilization of gait belt on high fall risk patients
- Equipment (walker, bedside commode, shower chair, gait belt) readily available in the patient room.
- Reporting and reviewing data with graphic display on pilot units. Utilize organizational publications to heighten awareness of fall prevention and best practices.

While it may not appear that we have sustained our improvements, we continue to monitor our patient falls closely, report our data to leadership, provide immediate feedback to staff, engage our patients and families, and communicate our fall reduction efforts.

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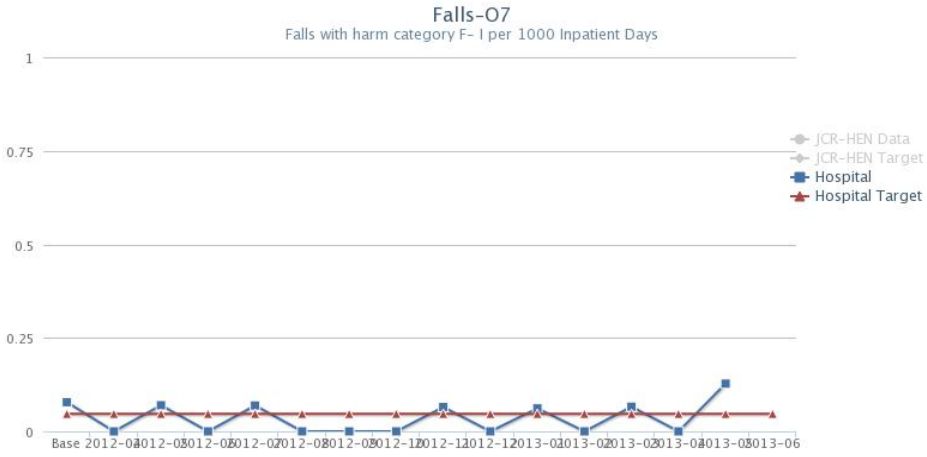

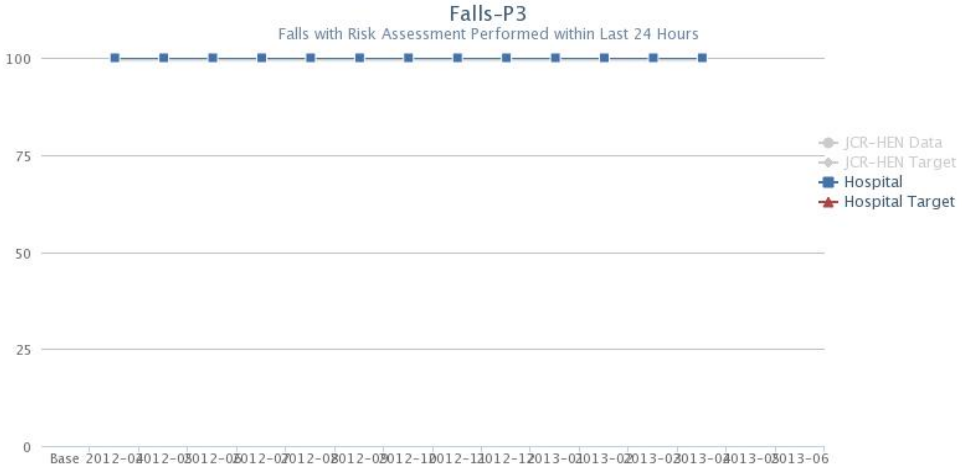

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