

Collaborative Breakthrough Series on Reducing Falls and Injuries Due to Falls

Topic: Implementing a Falls Assessment Program

The Opportunity

Falls are the number one cause of reported adverse events in VA. Among the 620 serious falls reported to the VA Adverse Events Registry in 1999, 60% resulted in hip fractures and 7% resulted in death. Reducing veteran falls and injuries due to falls remains a top priority of VA. In the United States, one of every three adults 65 years old or older falls each year. Falls are the leading cause of injury deaths among people 65 years and older and are the most common cause of injuries and hospital admissions for trauma among the elderly (Centers for Disease Control and Prevention, CDC).

Demographic reports have profiled veterans' aging projections to plan for their health care needs. Due to the increased aging population, prevention of falls and fall related injuries have received national attention with the Veterans Health Administration. According to Doweiko (2000), 7,000 – 12,000 people 65 years and older have lost their lives due to falls in the past few years (p. 38). "Nearly one-third of older Americans fall, costing more than \$20 billion in direct health care costs, according to the U.S. Department of Health and Human Services" (Doweiko, p. 38). Falls are a major component of adverse patient events, consistently the largest single category of reported incidents in hospitals (Gaebler, 1993), with estimates of 25% to 84% of all adverse events in health care agencies (DiBella & Harvey, 1998). In 1996, falls accounted for more than 14,000 deaths and 22 million visits to hospitals and physicians' offices (Hoskin, 1998).

A Northeast Veteran Integrated Service Network (VISN) focused-review-team analyzed fiscal year 1996 data and determined that 20.4% of all falls occurred in the Nursing Home Care Unit, 14.8% on the Acute Medical Unit, and 60% were 65 years of age or older (DiBella & Harvey, 1998). Estimates are that 45% to 70% of residents in long-term care settings fall each year, twice the rate of those dwelling in the community (Thapa, et al., 1995). This epidemiological profile is particularly relevant as the VA veteran patient population ages.

Falls are the leading cause of death in the home, taking the lives of 10,700 people in 1998, a 9 percent increase from 9,200 in 1996; and more than 86 percent of these fatal falls are in people 65 years old or older (National Safety Council, 1999). **The U.S. Public Health Service estimates that two thirds of the deaths associated with a fall are preventable.** Adverse outcomes go well beyond the injuries sustained as a result of a fall. An injurious fall increases estimated costs (relative to non-fallers, in 1996 dollars) by \$11,042 in hospitals, by \$5325 in nursing homes, by \$253 in the emergency room, and by \$2,820 in a home health setting (Rizzo, et al., 1998). Staffs in hospitals and long term care settings work hard to reduce the number of patient falls and the resultant injury to the patient. These efforts are challenging at a time when facilities are striving to have restraint-free environments in the climate of a nursing shortage.

On July 12-13, 2001, 40 Multidisciplinary Falls Improvement Teams came together with experts on reducing falls and injuries due to falls, for an initial two-day learning session to learn both specific strategies for reducing falls and injuries, and a model for implementing changes. For eight months after the first learning session, the teams were supported through conference calls, e-mail/listserv, and coaching to reduce falls and injuries at their facilities. The teams turn in monthly "Senior Leader" reports on

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progress and changes made. On March 7-8, 2002 the teams came together again to share their results and create these documents. This document is a synthesis of the teams' work in a specific area. It represents what the teams learned about how to make changes and improve care, and is supported by the actual outcome the teams achieved.

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Key Changes to Reduce Falls and Injuries (What Teams Did):

- Morse scale (MFS)
- Initial assessment
- Within 2h of admit
- Added into extended care notes
- Completed by RN
- RN or LPN completes
- Does not have MD supply to do the scale as reported from Washington, DC, site
- Interesting how residents and/or interns can be used if present
- Other scale
 - appropriate homemade instruments
 - Hendricks scale
 - Try to avoid high risk rating
- Establish that falls are a problem...posters, presentations, videotape to show data to entire institution
- Scale does not matter as much as the intervention
- At admit, q90days, change in status, post fall
- Write a free text order for assessment to be completed

The Improvement Process-(How Teams Did It):

- Presented data to facility leadership
- Shared data with front line staff
- Article in newsletter was not effective in generating interest
- Monthly monitoring process
- Post notes in the bathroom
- Present to quality management meeting, nursing meeting, resident (patient) council
- Same message to QM and nurses
- Modified message to patient
- Include acquisitions manager to consider financial aspects of intervention
- Record time of falls
- Have falls risk assessment form as part of initial intake form instead of a separate form
- Also have separate template available at other times

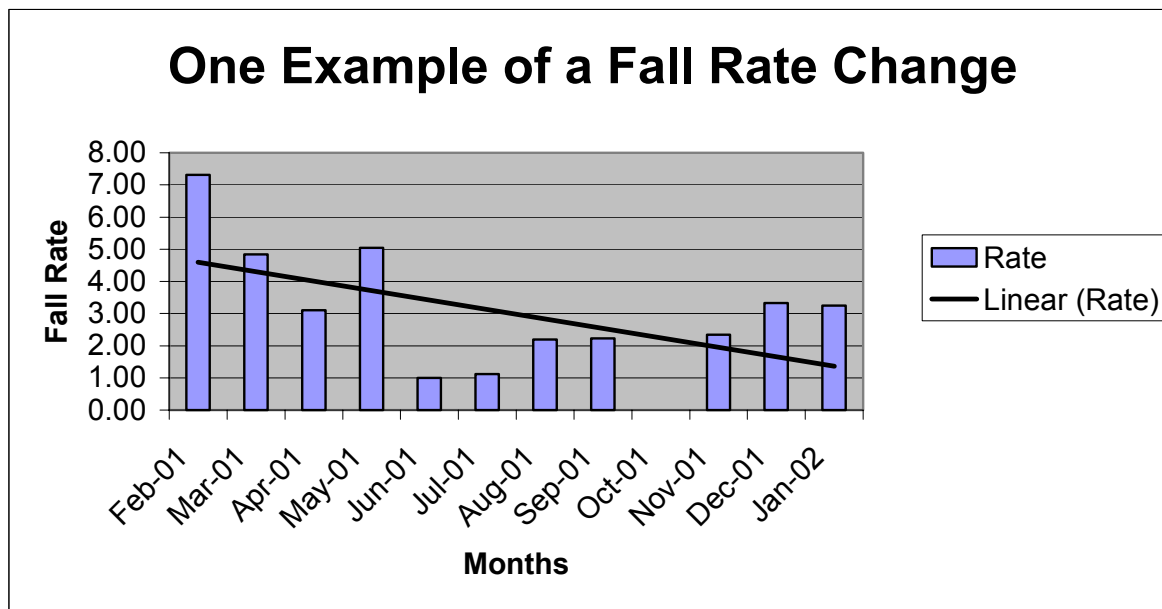
Measures: (How Teams Monitored the Process of Improvement):

- Monthly versus quarterly data
- Baseline data (1-2 years) was very helpful

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- Inter-rater reliability
- Have gold standard person to evaluate
- Come to consensus agreement on disparities
- Chart audit to demonstrate compliance with completion of the scale
- Retrospective look at chart after a patient falls to see whether initial assessment was done and whether patient was identified
- Measurement of front line workers attitudes towards program
- Establish goals and see whether goals are met (increase proper completion of assessment)

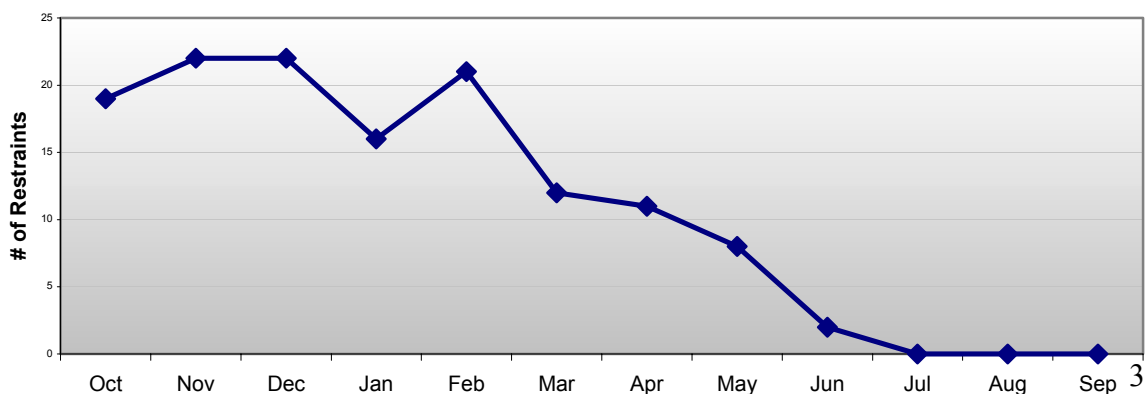
Outcomes:



Average Fall Rate: Before: 3.73 After: 2.22 Decrease: -1.51

The next chart shows restraint reduction for one site:

Use of Restraints in NHCU



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More Detailed Process:

Examples from the one team.

1. Fall Risk Assessment-MFRT (Morse Fall Scale)
2. Education-MFRT
3. Fall Hazard/Near Miss
4. Environmental Rounds
5. Name the Workgroup
6. Poster Contest
7. Post Fall Assessment
8. Develop Post Fall Monitor
9. Falls Prevention Program
10. Patient Safety Note
11. Trial Safety Devices
12. Medication Review
13. Inter-rater Reliability-MFRT
14. Medications Associated with Falls Education
15. Patient Safety Note Trial
16. STARS Program Roll Out
17. Safety Note/PIR Education
18. Safety Pamphlet
19. HBPC Roll out
20. MVAC Roll Out
21. 24 hr Post Patient Safety Note

Sample Time Line:

1. Find and evaluate baseline data (1 month)
2. Present data to stakeholders to build buy-in (1 month)
3. Select an assessment tool and train staff (1-2 months, depending on size)
4. Check reliability and accuracy (1 month)
5. Establish documentation standards (1-2 months)

Key Success factors in the VA system:

- Match policy to actual practice
- Keep leadership informed
- Electronic medical record
- Use of PDSA more advanced in VA...non-VA seem unaware of these process

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- Collective VA brainpower
- VA experts from VISN 8 and VISN 1
- Discipline of reporting change at regular intervals
- Developing a culture of change rather than a culture of blame
- Associated with local research centers for collaboration
- Creating a teamwork atmosphere
- Listserv, but volume was concerning
- Conference calls

Pitfalls to avoid:

- Do not let the assessment scale get in the way of protecting patients who are at risk and preventing falls in other
- Assessment must lead to a targeted intervention, not just a labeling of the patient
- Use existing, valid tools
- Bias towards incomplete reporting
- Turnover of staff
- Time constraints
- Real-time and up to date assessment of risk...do it often enough to keep up with changes in patient status
- Informal chain of command
- Resist the urge to go too big too soon...keep changes small and manageable
- Screening must precede intervention
- Ignoring the successes

Key Contacts; Facility and person to call:

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Book About the Morse Scale:

Preventing Patient Falls by Janice M. Morse

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