Collaborative Breakthrough Series on Reducing Falls and Injuries Due to Falls

Topic: Creating a Safe Environment to Prevent Falls and Injuries Due to Falls

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

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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 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):

- Create a Safety Room
  - Group patients
  - Low toilets
  - Room that is well equipped/designed
- Make rounds looking for environmental issues for safety (stop overwaxing floors, remover clutter, re-configure lighting, fix broken wheelchairs).
- Use increased observation
- Toileting issues: Be alert to urgency and have a clear pathway to toilet
- Use a sitter in safety room
- What is best furniture and best flooring for patient population?
- Configuration of furniture
- Safety Room
  - low bed
    *need to budget
    *pilot use of low bed
  - hip protectors
  - voice activated bed exit
  - shows some falls d/t higher bed
  - mats with low beds
  - need staff/patient/family input to implement
  - pressure sensitive bed alarm
  - can engineering shorten existing beds (if money is an issue)
  - swimming noodles as artificial side rails - but fire hazard
  - clinically oriented assignment of patient room
  - wheeled objects need to be evaluated for contribution to falls
    *patients may not realize objects can roll
  - work with vendors; sound source for information
  - side rails need to be evaluated for contributions to falls
  - hip pads offer promise
  - wall different color than toilet; color contrast for visual cue
  - examine if hand held urinal a risk for fall for someone who is unsteady
  - baby monitor allows distance monitoring

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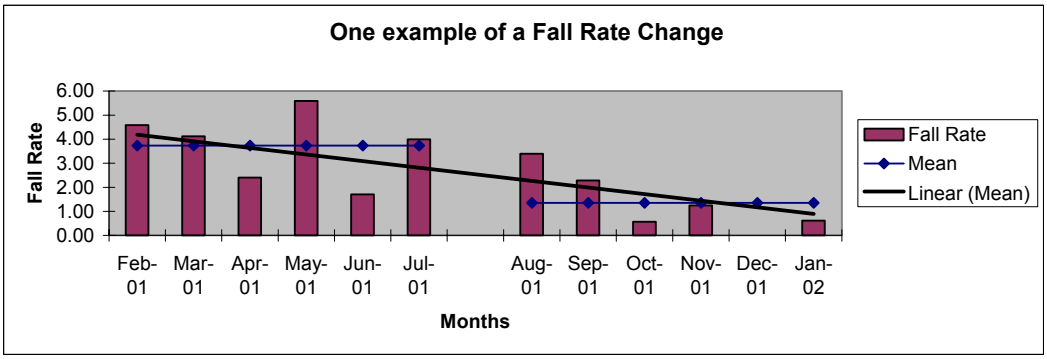
The Improvement Process-(How teams did it):

- Policy and procedure for use of low bed
- Falls risk note in chart

Measures: (How teams monitored the process of improvement):

- Evaluate why falling
- Falls team investigates falls
- Need to evaluate mat choices for safety
- Measure falls/injuries in those environmental areas (falls from low beds, for example)
- Nurse injuries – measurements, back injuries

Outcomes:



More Detailed Process:

- Use PDSA; Small test of change
- Education
  - Who?
  - When?

Sample Time Line:

- Timeline:
  - lead in time
  - time for ordering and delivering
  - Supply dept

Key Success factors in the VA system:

- Ask effectiveness of change from staff and patients
- Obtain funding:
  - Grants are one source
  - From local safety construction
  - Voluntary services as a resource
- Politics

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  - Who needs to be involved /influenced?
  - How do you influence them?
  - Where are levers for change?
- Buy-in (include as many involved departments as possible)

Pitfalls to avoid:

- Leadership in transition
- Fit change process into existing work

Key Contacts; Facility and person to call:

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