

# Rhode Island Hospital Uses Integrated Approach to Prevent Falls

Falls have been a patient safety concern for years. Yet there has been an increased focus on this issue in recent times, as its scope and resulting costs have come into clearer focus. Pressure has come from many directions. In July 2000, the Joint Commission issued *Sentinel Event Alert 14*, "Fatal Falls: Lessons for the Future," and in 2005 made reducing the risk of patient harm from falls one of its National Patient Safety Goals (NPSG).

The Joint Commission surveys all accredited healthcare organizations for implementation of the NPSGs, requiring specific measures to be taken. In the case of falls, that means developing a fall reduction program and implementing measures for the individual assessment of a patient's risk for falls. Organizations are also required to monitor the effects of the program. (Reducing falls is also a NPSG for long-term care and assisted living facilities accredited by the Joint Commission.)

At the same time, the National Center for Injury Prevention and Control, part of the Centers for Disease Control and Prevention (CDC), has been working to raise awareness of the impact of falls in the general population. The issue is prominent on its website, which gives a range of startling statistics, including an estimate of the total direct cost of all fall injuries for people aged 65 and older. From \$19 billion in 2000, the cost is expected to more than double by 2020, to \$54.9 billion (in 2007 dollars).

## Financial Impact

Most significant for hospitals, perhaps, has been the change in reimbursement policies implemented by the Centers for Medicare & Medicaid Services (CMS) in October 2008. Under the so-called "Never Events Initiative," the CMS no longer compensates healthcare organizations for reasonably preventable hospital-acquired conditions. Falls with

injury are prominent on the list of conditions that are no longer covered.

Hospitals have not been slow to realize the potential financial implications of this change. David Carroll, RN, BSN, manager of patient safety and quality at Rhode Island Hospital, in Providence, Rhode Island, estimates that the cost of a single serious injury can run into the hundreds of thousands of dollars. "If a patient falls and fractures a hip, that could result in a longer length of stay, plus the costs of surgery, rehabilitation in a long term care facility or other sub-acute care, and any other complications that develop later on. It can have a huge impact financially to the hospital."

The emotional impact on the staff is of equal concern. "The nurses feel very bad when patients fall. They could have been in the room just five minutes before. To come back in and find them on the floor, it's almost like they let the patient down. It can be fairly overwhelming," says Mr. Carroll.

These factors have made the effort to develop a sound methodology to prevent falls all the more urgent for healthcare organizations like Rhode Island Hospital. This 719-bed acute care hospital and academic medical center and Level 1 trauma center began putting increased emphasis on reducing falls four or five years ago, in response to a number of factors. Although its rate of injuries from falls is well below the national mean according to data from the National Database of Nursing Quality Indicators® (NDNQI®), the hospital has an usually high total number of patients that it deems to be at risk of falling.

"I'd say about 75% are at risk of falls," says Mr. Carroll. "It's always been a concern, but because of the recent changes in reimbursement and a focus on patient safety, falls have really come to the forefront here, because it seems to be the most difficult task for us to tackle.

There are so many different variables that will cause a patient to fall. There are multiple interventions we need to implement."

## Integrated Approach

Rhode Island Hospital has taken several steps to increase the effectiveness of its fall prevention efforts and to raise awareness of falls across the organization. A standing Falls Committee was formed in 2007, with representatives from nursing—including certified nursing assistants—physical therapy, and occupational therapy, as well as a consulting physician. In addition, the committee is in close communication with the risk management and quality management teams for Lifespan, the health system to which the hospital belongs.

The committee is co-chaired by Carroll and Linda Pappola, RN, BSN, an assistant nurse manager at Rhode Island Hospital. It began its efforts to systematize the hospital's fall prevention program with a review of practices at peer institutions. "We contacted other facilities, to benchmark what they were doing for a program, both in the surrounding area and across the country," says Pappola. "We took what we needed to create a program to fit the specific needs of the hospital." Components of the program include individual assessment of each patient, a range of interventions that staff can use to prevent falls, the use of fall monitoring technology, and a system to record the individual care plan for each patient.

When patients are admitted to any floor, they are assessed on a safety scale designed to identify patients at risk for falls. Points are assigned based on various factors, including age over 65 and having had a fall within the last six months, potential for withdrawal from alcohol and drugs, and prescription for medications that have been identified as

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contributing to a fall risk. The risks are weighted depending on their severity, and once the total score exceeds a certain level, the patient is deemed at high risk of falling.

The next step is for the nursing staff to determine what interventions are required to reduce the risk of a fall and create an individual care plan. Interventions include such measures as frequent ambulation, placing the patient close to the nursing station, the use of soft utility belts or an activity apron, and using fall monitors to warn of patients attempting to get out of bed without assistance.

The task of creating an individual plan is key, says Carroll, “What makes fall management so difficult is that it could require as many as 30 or 40 interventions individualized for each patient. You need to spend the time to create an individual plan of care.”

Pre-printed care plans with the most common interventions make it easier for the nursing staff to create a plan for each patient. They check the desired interventions, and attach the plan to the patient record. This system is supported by the online system for nursing or physician orders, where nurses can also choose interventions for patients at risk. These orders are pushed out three times a day to nursing staff and attached to the patient report.

The hospital has also invested heavily in fall monitoring technology. The monitors connect to a pressure pad on either the patient bed or a chair. When the patient attempts to stand, the monitor detects the change in pressure and generates an alarm.

The hospital made its technology decision after a six-month trial in 2008 on the neurological floor, during which

the rate of falls was dramatically reduced. Even as the economy was entering into the recession and money became scarce, the hospital decided to implement the monitors on all units outside of intensive care, mainly because of the support shown by the staff of the neurological floor. “They were our cheerleaders,” says Carroll.

The monitors are interfaced to the nurse call system in each room, so that alarms can be monitored at the nursing station by the unit secretary. Achieving this was not as simple as it sounds. In one of the main adult patient care areas, the Jane Brown building, there were four different nurse call systems of varying ages. The installing company



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## TECHNOLOGY OVERVIEW

In its falls prevention program, Rhode Island Hospital uses the Tabs line of fall monitors supplied by Stanley Healthcare Solutions, and the services of systems integrator New England Medical Specialties.

had to source a range of different adapters to make this happen.

However, this was key functionality for the hospital. Carroll notes, "Every piece of medical equipment has an alarm: IV pumps, beds, any kind of electronic equipment. We didn't want to risk the alarm getting missed. The call light was just one more way to signal to the staff that something wasn't right."

Another innovative feature that the hospital relies on heavily is a customizable voice message that encourages the patient to lie down. Pappola explains, "We serve a diverse community—Spanish, Portuguese, Cambodian; we can ask a family member to record their voice on it. It's a comfort for patients to hear a message in their own language: 'Please get back to bed, Mom,' or whoever."

A final important part of Rhode Island Hospital's fall prevention program is continual staff education and frequent communication. The hospital has named its program "Falling Star" to help raise the prominence of fall prevention. Monthly staff meetings are also used to reinforce the consistent application of assessment rules and appropriate interventions, including technology.

Pappola points out that some nurses have a tendency to resort to sitters for patients who seem particularly restless, and shy away from the fall monitors, which are a fraction of the cost. The hospital is therefore taking steps to increase education on fall prevention. The hospital is planning to add fall prevention as part of the annual competency reviews in October of each year. This will include both computer-based quizzes on the fall prevention program and hands-on refresher sessions on the use of the fall monitors. It's all a part of

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keeping fall prevention a priority for the entire hospital organization. **IPSQH**

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