AHA/HRET HEN 2.0 CASE STUDY
Falls with Injury

Mary Washington Healthcare

Mary Washington Hospital

LOCATION: FREDERICKSBURG, VIRGINIA

BED SIZE: 437 BEDS

WEBSITE: MWHC.COM

NEED FOR IMPROVEMENT

Patient falls, and falls with injury, while hospitalized is a global problem that is devastating to the patient, family and caregivers. When a patient falls, it not only affects that hospital stay, but may also have an effect on the future quality of life for that patient and family, as well as the morale and confidence of the caregivers. Mary Washington Hospital (MWH) identified fall prevention as a top priority to enhance the overall safety of the organization.

Mary Washington Hospital, Federicksburg, VA

STRATEGY

The fall prevention interdisciplinary team was created which consisted of nurse leaders, frontline nursing staff, nursing assistants, patient transporters and physical therapy. This team utilized a collaborative team approach to decrease falls utilizing evidence-based practice and internal falls trending. All clinicians were educated on MWH's comprehensive fall prevention program. Hospital leadership made a substantial investment in obtaining additional resources and equipment needed to implement and sustain a successful fall prevention program such as bed and chair alarms, gait belts, walkers and bedside commodes. This best practice pilot was implemented on a 32-bed neuroscience medical unit on January 1, 2014 and the success was replicated throughout the hospital. Monthly falls team meetings were held and continued post-pilot. All MWH leaders and associates are considered fall prevention champions.

Specific tactics implemented:

- Fall prevention education for current associates and all new hires.
- All patients are considered "high risk" within the first 24 hours of hospitalization.
- Bed/chair alarms in use for all high risk patients.
- Utilization of a "yellow" falls kit as a visual cue (door magnet, bracelet, non-skid socks, and blanket).
- Use of a gait belt for transfers and ambulation for all high risk patients.
- Use of a bedside commode at night for all high risk patients.
- The use of a "safety chaperone" was implemented so that a clinical caregiver remained with the patient during toileting and showering.
- A safety huddle was performed for all patient falls with notification to senior leaders and managers.
- All associates held accountable for all ***preventable*** falls.

American Hospital Association

U.S. Department of Health & Human Services Partnership for Patients

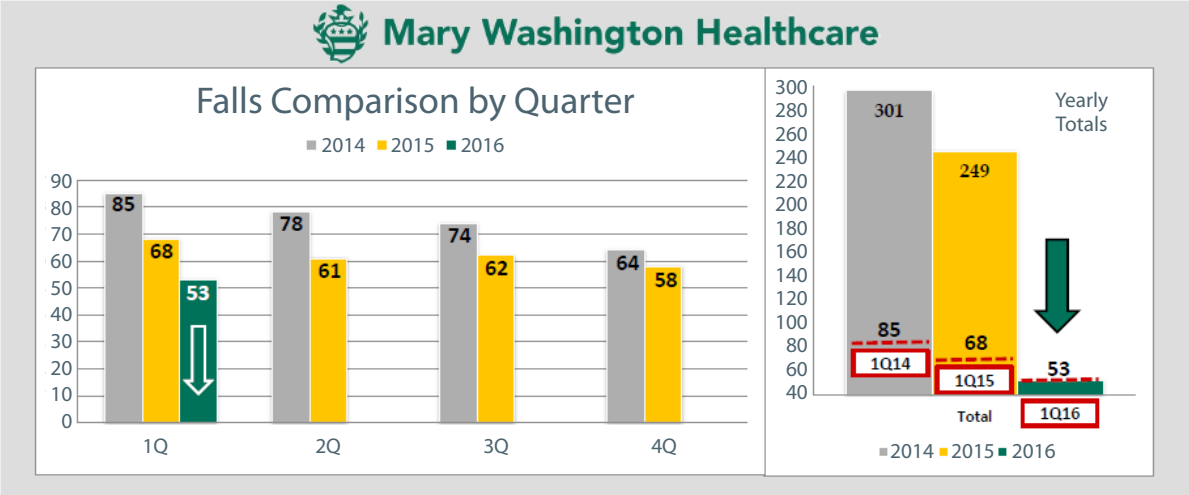
HRET Health Research & Educational Trust in Partnership with AHA

RESULTS

The pilot unit had a reduction of 14 falls from 2014 to 2015. The overall hospital had 301 falls in 2014; 249 falls in 2015; and 53 falls Q1 2016 (Figure 1). Data is collected daily and trends are being reviewed in all patient care areas. MWH's organizational goal for fall prevention is to reduce total falls and falls with injury. MWH's goals are defined as good, better and best. The "good" goal for 2016 is 249 total falls with only 84 with injury (3.310/1.14 per 1,000 patient days). The "better" goal is 224/75 (2.979/1.03 per 1,000 patient days) and the "best" goal is 211/71 (2.814/0.97 per 1,000 patient days). To prevent falls with injury, additional floor mats have been ordered and are in use.

The comprehensive fall prevention work has been communicated to associates through the falls team meetings, updates at quality and safety meetings and team huddles. Patients and families were educated via information published in the hospital patient guidebook, posters and tent cards displayed in the patient's room, shift-to-shift handoffs and throughout the day via the nurse and other clinicians knowledgeable about fall prevention practices.

Figure 1



PEARLS OF WISDOM

The first important strategy was that ALL hospital leaders and associates made a commitment to fall prevention. The second successful strategy was having a multi-disciplinary team composed of leaders and frontline staff at the table making practice decisions. The third strategy, and most effective, was holding others accountable to the tactics agreed upon by the falls team. The engagement from all hospital leaders and associates was truly remarkable and has resulted in a total transformation of the hospitals commitment to patient safety. By adopting structure, consistency and accountability, we have truly become one team, one message and one voice for comprehensive fall prevention.

CONTACT INFORMATION

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For more information on Falls please visit http://www.hret-hen.org/topics/falls.shtml

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