Mercy Health Urbana
Culture of Safety: Preventing Falls

Thank you to Ohio Hospital Association Hospital Improvement Innovation Network!

Thank you to Mercy Health Urbana!

A Culture of Safety:

One Team- What does that mean?

Safety culture is the sum of what an organization ***is*** and ***does*** in the pursuit of safety. The PS chapter defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety.

Definition of Patient Safety

Definition of Patient Safety by NQF;

- Freedom from injury or illness resulting from the processes of care
- Patient safety event is an occurrence or potential occurrence, that is directly linked to the delivery of healthcare that results, or could result, in injury, death, or illness

Scope of Problem

Falls

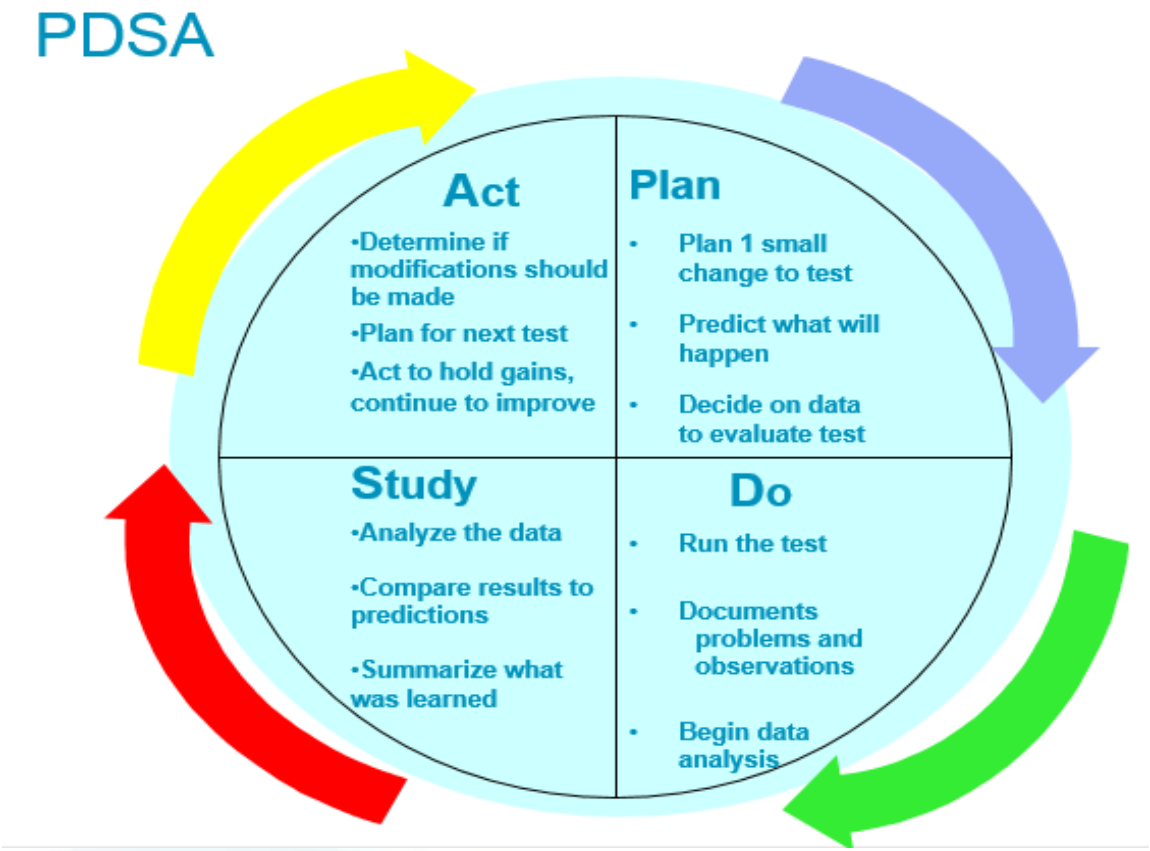
2016

13 Reported Falls

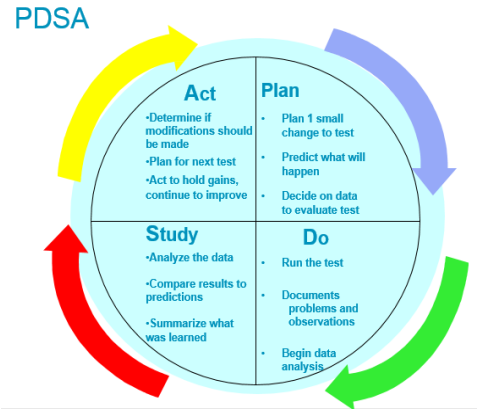
3 Reported Falls in January 2017

= Falls Stand Down

Plan – Do – Study - Act

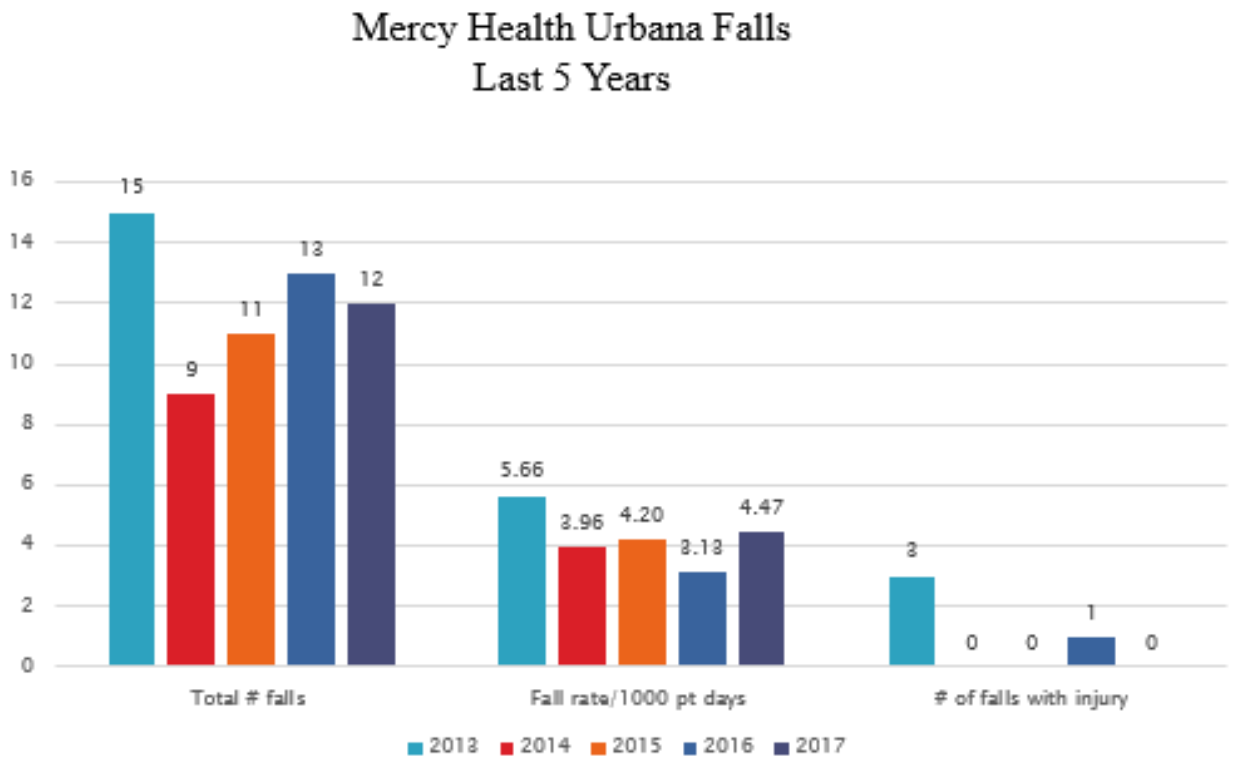


Plan Do Study Act

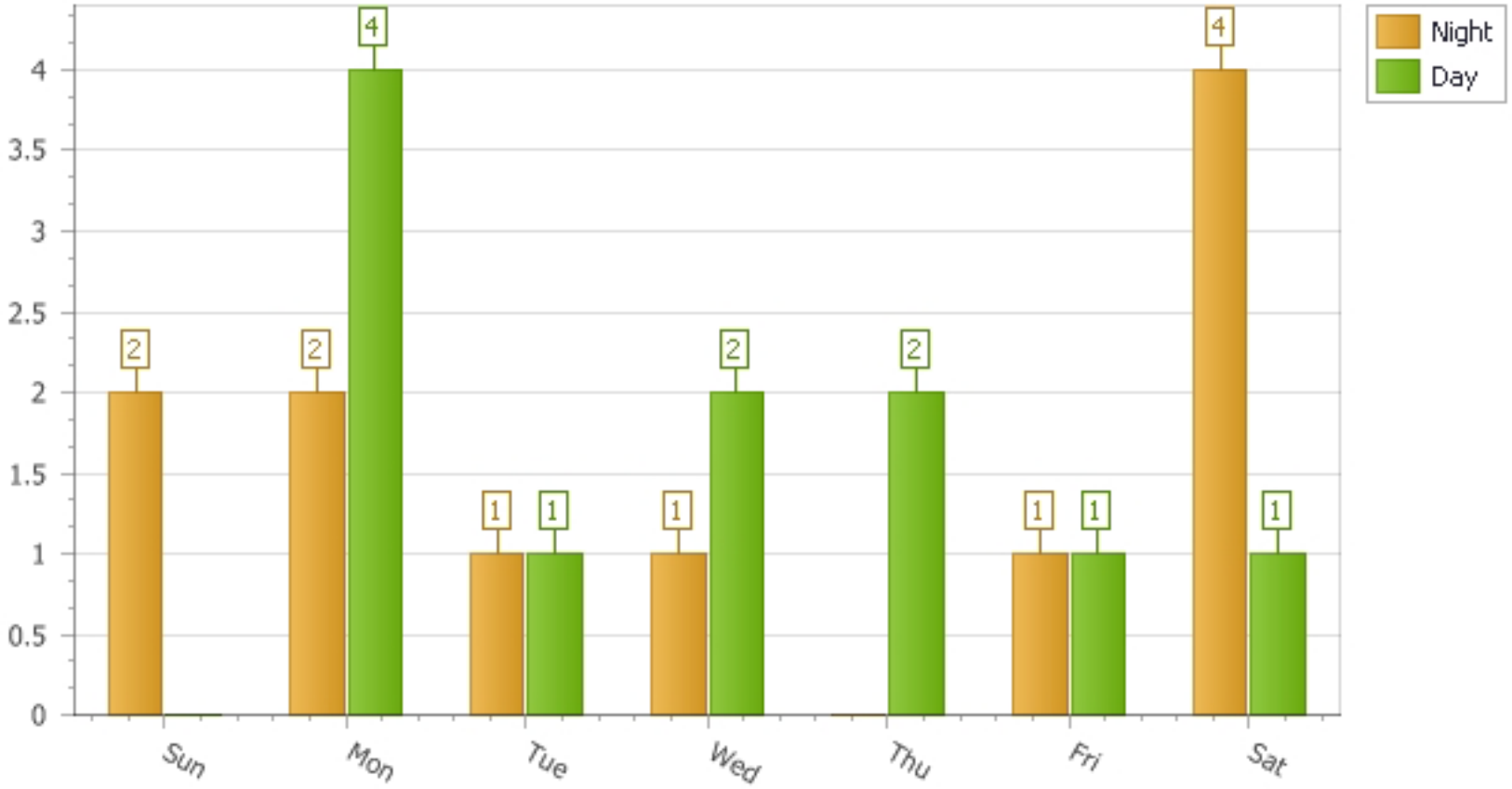


- Make careful observations- review previous falls look for trends (utilizing our incident reporting system SafeCare)
  - What did we find? A) Falls were occurring with family helping their loved one go to the bathroom B) Staff were not re-establishing/ or turning on falls alarm after tests
- Manage expectations of stakeholders- it is everyone's responsibility… **Is it?** Ancillary departments didn't feel as though they could/should help?
- Make sure everyone knows what is expected of them- Unit council wanted to lead a Stand Down.
- **Communicate, communicate, communicate**
- Modify solutions based on data analysis and feedback- Unit council wanted to lead a Stand Down
- Celebrate successes! Urbana hasn't had a fall ***with injury since 2016***

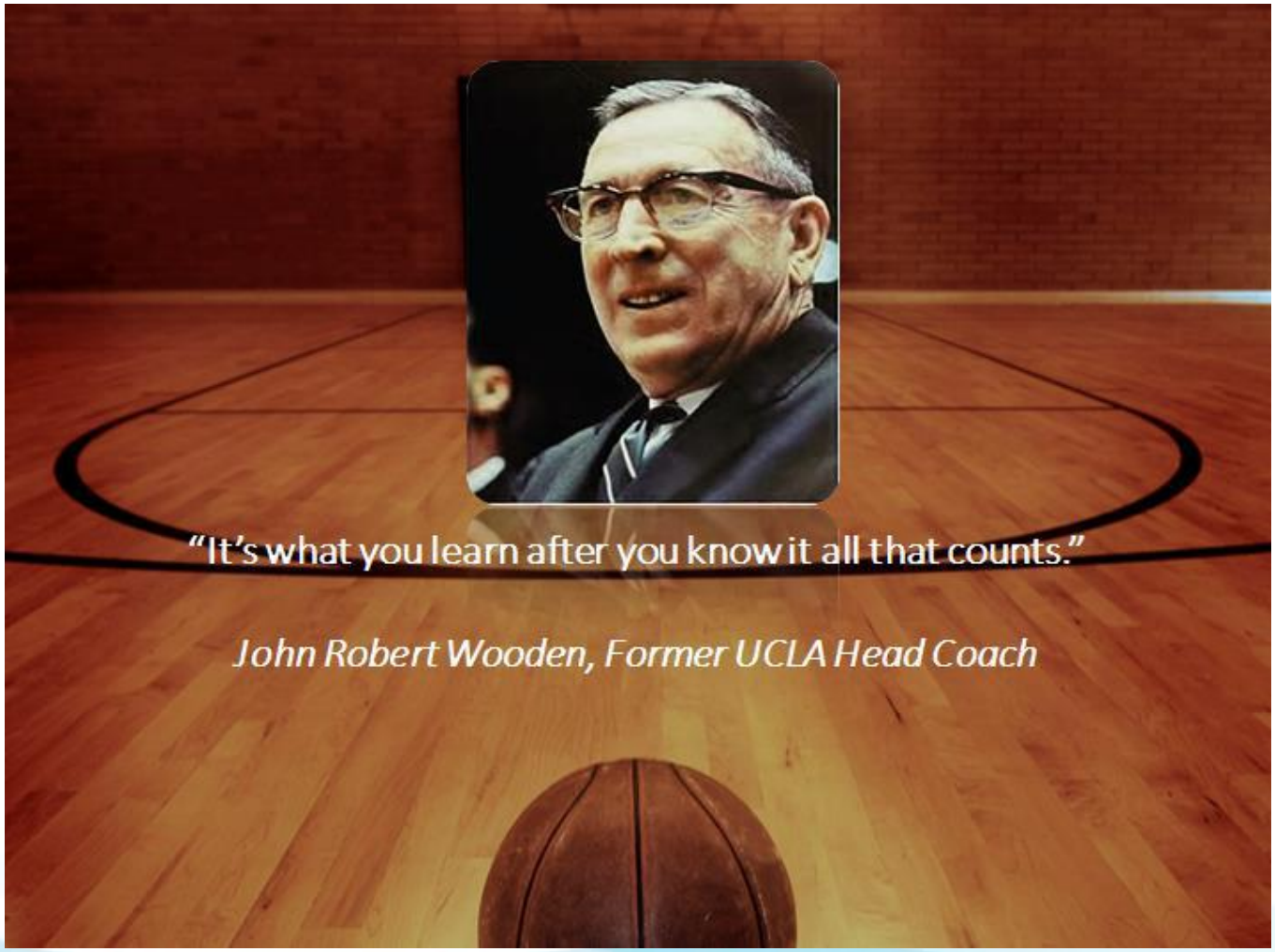
Fall History



Mercy Urbana Most Frequent Days and Shift YTD 2017: Monday and Saturday, Dayshift and Nightshift



Continuous Learning



How can you help?

- High Fall Risk Patient
- Three Foot Rule/ “No Passing Zone”
- Bed/Chair Alarms
- Pathway/Possessions
- “Stay with me”

Working together patients and staff

- Wear a Fall Risk Jewel
- Wearing non-skid socks
- Having a bed or chair alarm on to remind that patient needs assistance
- Placing a fall sign outside the door
- Writing staff nurse and aid name on white board
- Using the call button- we are here to help you!

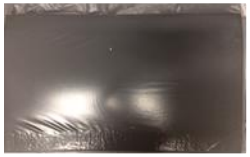
High Fall Risk Patient

How to Identify

- Fall identifier outside room on pull outs

- Yellow
  - Socks
  - Blanket
  - Jewel on armband

- Mat



- Telesitter /Avasys

Three Foot Rule/ “No passing Zone”

- Answer call light
- Turn off call light
- Help patient if possible
- Report to nurse if assistance is needed

➢ **Not a CHOICE, a RESPONSIBILITY of every employee**

Bed/Chair Alarms

- Bed Alarms
  - Zero Bed
  - Set Zone
- Chair Alarms
  - Before use ensure they are working

➢ **Check before leaving room after every patient encounter**

Pathway/Possessions

- Pathway
  - Ground Clear
- Possession
  - Call light/Phone position
  - Bedside table near bed/chair
  - Drink position
  - Trashcan near bed/chair)

“Stay with me”

•Any patient needing assistance with ambulation to the bathroom **MUST** have a staff member stay with the patient while they complete their toileting.

The majority of falls happen when toileting.

- **Check and re-establish alarm on bed or chair before leaving room after every patient encounter**

Falls from 11/2016-11/2017

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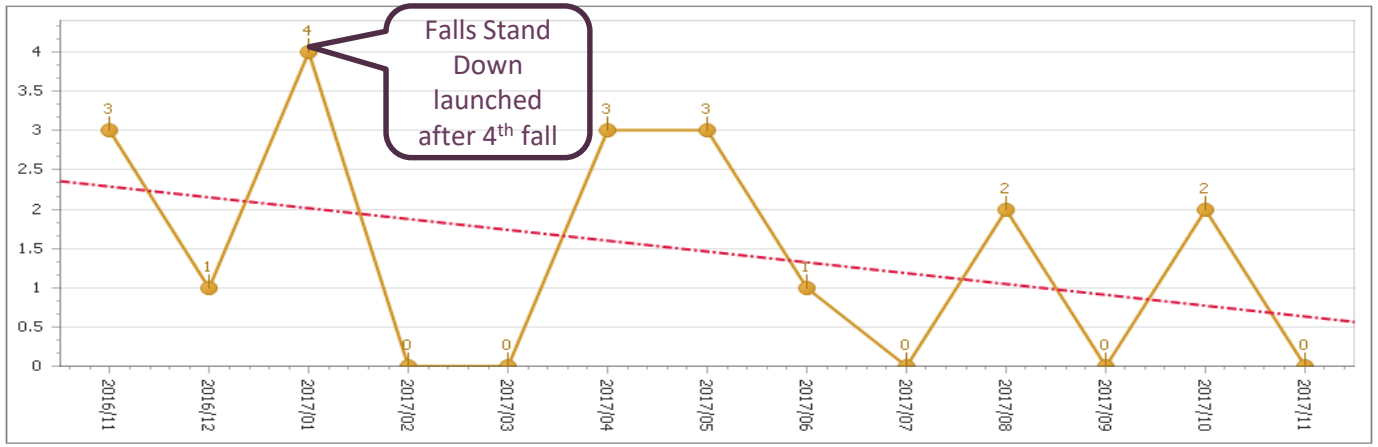
Patient Falls over time

Incident Date is within 11-01-2016 and 11-01-2017 - Make certain to add your facility and/or department in the conditions if need be, report will run based on your scope

((File State is equal to "New") or (File State is equal to "In-Progress") or (File State is equal to "Closed")) and (General Event Type is equal to "FALL") and ((Classification of Person Affected is equal to "IN-PATIENT") or (Classification of Person Affected is equal to "OUT-PATIENT") or (Classification of Person Affected is equal to "SUBACUTE PATIENT"))



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Summary

- No new policy changes
- No new programs
- No new resources
- It was simple Re-education about falls to all departments. Giving them the permission to help and reinforcing our team commitment to patient safety.


QUESTIONS

References:

National Patient Safety Foundation. ***Free From Harm: Accelerating patient safety improvement 15 years after To Err Is Human.*** 2015 (accessed Dec. 8, 2016).

The Joint Commission. Sentinel Event Alert, Issue 40; ***Behaviors that undermine a culture of safety.*** July 9, 2018 (accessed Oct. 28, 2016

Mercy Health **Fall Prevention Program, Approved by: Corporate Med Surg/CC Policy & Procedure**
Group and Behavioral Health Approval Date:12/01/2017 Next Review:12/01/2019

TeamSTEPPS