Organization: Sinai Hospital of Baltimore
Solution Title: Call, Don't Fall Initiative

Program/Project Description: What was the problem to be solved? How was it identified? What baseline data existed? What were the goals—how would you know if you were successful?

Patient falls are the highest cause of complications in hospitals across the United States. Fall reduction has been a quality initiative at Sinai Hospital for years. However, in 2010, LifeBridge Health, Inc. decided to make fall reduction one of two clinical initiatives in its organizational objectives. This was done for many reasons, but mostly because it is the right thing to do, it is something that can be minimized, and reimbursement will be reduced if a patient experiences a fall with injury.

Baseline data in January of 2010 for Fall with Injury rate was 1.53/per 1000 inpatient days. The institutional goal was to reduce this rate to 1.0/per 1000 inpatient days. The Sinai fall team focused its efforts to reduce this rate.

Process: What methodology or process was used to develop the Solution?

Multiple methodologies were utilized to develop a solution. Sinai participated in the Maryland Patient Safety Center (MPSC) initiative related to fall prevention. During the on-line meetings and conferences, several institutions presented different initiatives that they had undertaken. Following these meetings, these ideas were brought back to Sinai for consideration. Internally, we began looking at each of our patient falls for trends and even did a week long 'fall swat team' to more closely identify the cause of the falls. During this week, when the fall swat team existed, the team was activated by the nurse or nurse manager in the area where the fall occurred within an hour or two of the fall. The team would then come up and analyze what occurred, see what was implemented, talk to the patient, and assist in initiating alternative fall/injury prevention interventions. It was called a 'debriefing,' but it was very similar to a failure mode evaluation and analysis (FMEA). It was a team of interdisciplinary individuals that brought an unique perspective to what could be done differently. Based on this group's feedback, the data trends, and the ideas that were generated from the MPSC sessions, our team began to initiate multiple, different interventions.

Solution: What Solution was developed? How was it implemented?

There were several solutions utilized to move our goal of decreasing patient falls with injury. This is probably one of the most important concepts to understand in fall prevention. There is no silver bullet. It requires a complete redesign of culture, available tools, data collection, accountability, training, communication, and physical environment to make and sustain change.

Culture redesign was done in two ways. An important component was having the Board of Directors at the hospital agree that this was a clinical initiative that had to be included in the organization's annual goals. The second concept was making every employee of the hospital understand their role and responsibility in preventing patient falls. This particular component was accomplished through education/training, various tools of communication, and management accountability.
Education and training included creating Fall Prevention training modules that were placed in the hospital's electronic training system (Healthstream) and requiring direct care staff to take this module. If a staff person directly interacts with a patient, then they were required to take the on-line module. This immediately meant that staff from other departments outside of nursing receive the training. Providers were sent a one-page sheet that summarized the fall program at Sinai hospital, so that they could understand and participate in the program as well. Any time a fall team member reported an incident or the occurrence reports indicated a misunderstanding of the fall prevention program, this information was placed on one of the monthly Fall Pearls that are created as a one-page sheet that highlights components of the fall program. If a new initiative was introduced this was communicated through department leaders and through the next Fall Pearl.

Accountability has also been approached in several different ways. Initial feedback on the fall program progress was tied to the total fall rate and rate of injury. Occurrence reports were filled out stating there had been a fall, but the details were frequently omitted, and required extensive research. Our fall team revised the occurrence report format to include only the pertinent questions and feedback that would help prevent a future fall for this patient. Units that had more than double the target fall goal are expected to audit 10 charts a month for not only documentation of interventions, but also correct assessment and implementation of interventions at the bedside. And finally, Nurse Managers had to perform audits and staff are 'counseled' and re-educated about their lack of following the prevention program. All this data is collated and returned to the Nurse Managers and the fall team on a monthly basis.

Based on additional feedback other tools were created or brought in to help the staff prevent injury to the patient. Since it was agreed that everyone is responsible for keeping the patient safe, it was important to devise a mechanism to communicate to other care providers the fall risk status of the patient. We have always had a fall packet that is initiated when a patient is identified to be moderate or high risk for fall. This packet includes yellow non-skid socks, a fall magnet for the door, a fall sticker for the medical record, a safety booklet for the patient and family about fall prevention, and a yellow patient ID band. All of these components help others to more easily identify patients at risk for falls. The Ticket to Ride concept was introduced to help communicate fall risk when the patient is off the unit. Every time a patient must leave the nursing unit, they have a ticket printed that communicates critical information about the patient that can be referred to if the patient gets into any kind of trouble and give the transporting and receiving staff key information about the patient. Fall team members expressed concerns about patients that insist on leaving the nursing unit to smoke that are at moderate or high risk for fall. A release form was created to help the patient better understand our seriousness and concern about them leaving the unit and help the staff feel like they have clearly done all that they could do to try and prevent a fall when the patient is making a decision on their own against our advice.

The final piece of the fall prevention program was having a variety of tools available to the bedside nurse to prevent injury. Every patient room is maintained in an environment that limits falls. Cords are wrapped, low level lighting is maintained at night, and beds are to remain in the lowest position. We created signs for the room and the bathroom that are simple, but to the point. "Call, don't fall!" is our logo. The room sign has this logo and a picture of the call light. The bathroom signs are pictures of someone falling and again reminding the patient to call before getting up. If a patient is at high risk for falls, the bed alarm has to be turned on. There are various settings of the bed alarm to allow different levels of notification based on the level of concern for the patient. However, the alarm has to be on. If a high risk patient wants to get up to a chair, we now have chair alarms to notify us when they are getting up. We have fall mats to place on the floor next to the patient that keeps trying to get out of bed and are unsteady on their feet. We don't leave these on the floor during the day, because patients and staff can fall over the mat, but they do prevent injury if someone rolls out of bed at night. For a very select group of patients that meet a very special set of circumstances, we have implemented the posey bed to prevent falls. This is a restraint, so a very particular process and algorithm is followed to implement this tool, but it has been extremely successful in
preventing very confused patients from falling. And finally, our newest initiative is to have a toilet alarm that notifies us of a patient rising off the toilet, since some patients insist on privacy while toileting. Even though we tell them to not get up, they still do. In addition, our partnership with the Maryland Patient Safety Center (MPSC) has enhanced our program and decreased the risk of serious harm to all patients. Overall, Sinai's fall program has numerous approaches to fall prevention and each of them contributes to the success of the program.

**Measurable Outcomes:** What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data. (Please include graphs, charts, or tools as attachments.)
See attached graph

**Sustainability:** What measures are being taken to ensure that results can be sustained and spread?
The data presented above shows that the program appears to be sustainable, but our fall team is ever vigilant. We continue to meet monthly, review the data, tweak our educational programs, meet with areas that are having problems, and monitor the market for new equipment monitoring options. The real sustainability of the program is remaining vigilant, listening to the staff and the issues that hinder them from doing what they need to, sustaining the data loop, and keeping educational training fresh and applicable. Also, the CEO of Lifebridge Health has created a "Best Practice Council" to bring forth best practices in all the different LifeBridge Health facilities to help spread successful programs. Sinai’s fall program was highlighted at one of the first meetings. It is truly an honor to work for a company that believes in patient safety and supports what works from one institution to another.

**Role of Collaboration and Leadership:** What role did teamwork and collaboration play in the Solution? What partners and participants were involved? Was the organization’s leadership engaged and did they share the vision for success? How was leadership support demonstrated?
Please see the above paragraphs. The fall team is made up of nurses (bedside and managers), providers, therapists, pharmacists, and patient safety officer. The hospitalwide data is reported at the hospital administrative level monthly on the monthly report that reports all the way to the Board of Directors. Because of the success of the team, the fall with injury goal from the Board of Directors was dropped to 0.8 falls/per 1000 inpatient days and now our program is even beating that!

**Innovation:** What makes this Solution innovative? What are its unique attributes?
The innovative component of Sinai's fall program is that we have looked at every aspect of the fall program, and we are not stopping. We realized that saying you have a program is just as important as having the equipment at the bedside for the nurse to use. Documentation is important, but the way you require it be completed is just as important as completing it. Why one patient falls and another patient doesn't is important to understand. At present, our staff are asking for one location for all the fall materials, so our next move will be to create a fall website. We don't feel like our patients and families are engaged enough in our program, so we are creating an institution made video about our fall program that will run on our closed circuit TV system. At Sinai, we Think, Prevent, and Protect all patients inpatient and outpatient. Our fall program reaches across the continuum of care in the ambulatory setting with three critical questions: Have you fallen in the last 6 months? Have you ever had an injury from a fall? Have you started any new medications, or had any medication adjustments in the last month? The two attributes of our team that really make the difference are vigilance and willingness to embrace change.

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Data does not include the following areas: Rehab, ED, and Psych per standard reporting protocol.