EXPERIENCE OF NH HOSPITALS: FALLS DATA

NH FALLS RISK REDUCTION TASK FORCE

ANNUAL DATA MEETING

MARCH 1, 2016

PRESENTED BY:

ANNE DIEFENDORF

FOUNDATION FOR HEALTHY COMMUNITIES

Objectives

- Review 2014 NH Adverse Event Report
  - Key Findings, RCA and CAP activities
- Provide data from Partnership for Patients
  - Falls with injury

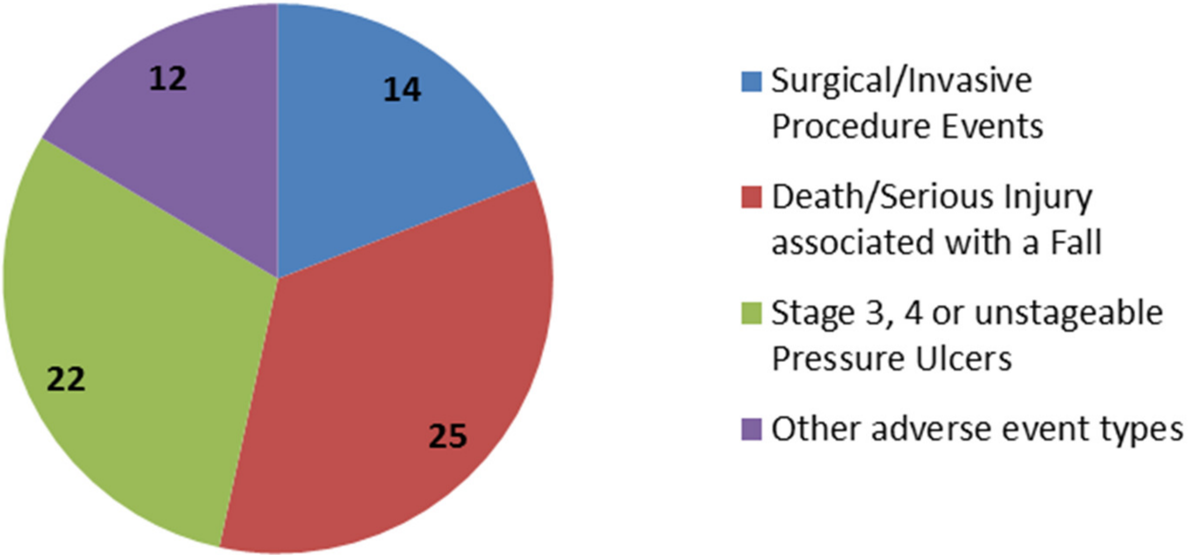
State of New Hampshire ADVERSE EVENT REPORTING 2014 REPORT

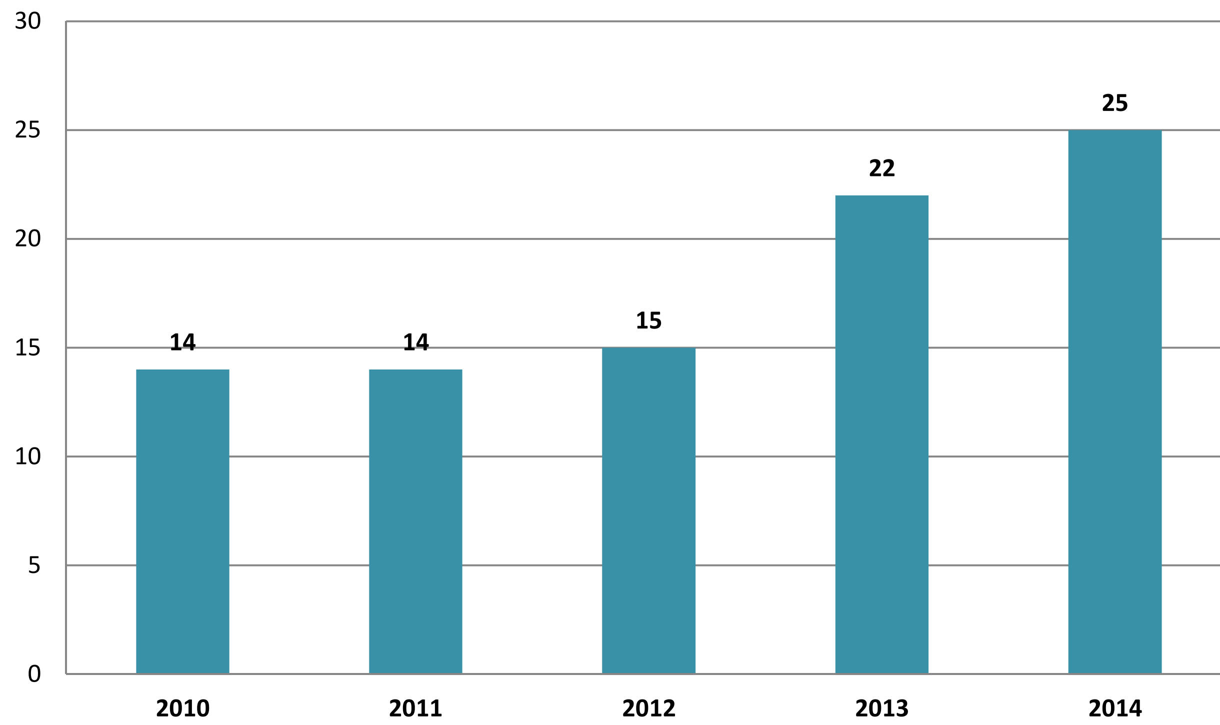
Provided by
New Hampshire Department of Health and Human Services
Office of Operations Support
Bureau of Licensing & Certification

NQF SRE
4. CARE MANAGEMENT EVENTS

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities


2014 Adverse Events
12
14
22
25
Surgical/Invasive Procedure Events
Death/Serious Injury associated with a Fall
Stage 3, 4 or unstageable Pressure Ulcers
Other adverse event types



Falls
30
25
20
15
10
5
0
14
14
15
22
25
2010
2011
2012
2013
2014

Contributing Factors:

- Advanced age of patients
- Physical challenges with mobility and oxygenation impairments
- History of falls prior to admission
- Adults who fall while walking to bathroom may not call the nurse because:
    - They don’t remember to call the nurse
    - They are adults who have independently toileted themselves up until recently
    - Men can experience a sudden decrease in blood pressure while standing
- Patients are much higher acuity and present with complicated care issues
- Medical conditions may impact mobility
- Medications may interfere with mobility and judgment
- History of Substance abuse - alcohol or non-prescribed medications

Strategies in place in NH hospitals include but are not limited to:

- Focus on patient rounding
- Fall Risk Assessment upon admission, updated and re-evaluated after every fall
- Staff debriefing (discussion) after every fall to determine contributing factors
- Dedicated resources to a “sitter” program to provide human companionship and help alert nurses
- Use of motion sensors - pads and alarms activated by patient movement
- Consultations with Pharmacist –medication management on potential fall risk
- Fall Prevention Teams – interdisciplinary team to review and discuss ways to prevent falls and reduce injury.
- Gait Belts – Used to help maintain balance and give staff more control

Plan Moving Forward:

- Link specific interventions to prevent a fall to the fall risk assessment score
- Staff education refresher on fall prevention
- Expand the act of purposeful rounding to include toileting at least hourly.
- Revitalize fall prevention teams
- Evaluate the logistics of the physical environment to optimize staff ability to respond to alarms of patients at high risk of injury from falls
- Re-evaluate and improve use of sitter programs and incorporate patient family engagement in the process
- Pharmacist consults to eliminate or replace medications that may contribute to fall risk
- Expand risk assessments upon hospital admission to include a history of falls at home as well as assessing for signs of falls such as bruising
- Expand risk assessment to Primary Care Physician practices so that strategies to prevent falls can be initiated before a serious fall occurs

Foundation *for*
Healthy Communities

Foundation for Healthy Communities
NH Partnership for Patients
Hospital Engagement Network (HEN) 2.0

Our charge is clear: reduce preventable harm by 40% and reduce preventable readmissions by 20% by 9/23/2016.

Falls With Injury (minor or greater)

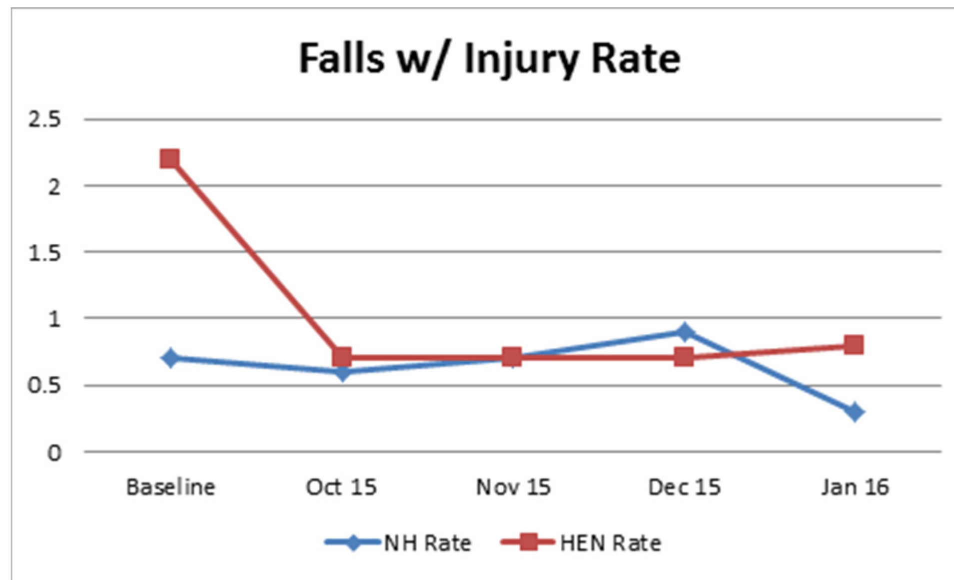
- All documented patient falls with an injury level of minor or greater
  - **Numerator:** Patient falls with minor or greater injury
  - **Denominator:** Patient days

- **# NH Hospitals Reporting: 26**

National Database of Nursing Quality Indicators (NDNQI®) Definitions

- **None**—patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury
- **Minor**—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion
- **Moderate**—resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain
- **Majo**r—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall
- **Death**—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Falls with Injury



Timeframe	NH Rate	# NH Reporting	HEN Rate	# HEN Reporting
Baseline	0.7	26	2.2	1,284
Oct 15	0.6	15	0.7	802
Nov 15	0.7	14	0.7	762
Dec 15	0.9	14	0.7	663
Jan 16	0.3	5	0.8	266

Proposed Statewide Education Conference

- SME: Pat Quigley
- Peer to Peer Sharing – NH Activity:
  - Falls Clinics – DHMC & CMC
  - EMS Program
- Role of Pharmacist:

  Acute Care – participation in post fall huddles

  Community – retail pharmacy review of meds. & fall risk

  Falls Clinic – Pharmacy review of medication lists
- Intentional / purposeful rounding – (focus on toileting)
- Community based programs – MOB & Tia Chi Quan – grant update
- ED setting – high risk patients & referral to PT
- The Fall Experience – from a patient / family perspective