THA Falls Collaborative Final Report

Table of Contents

I. Preface

II. Background

III. Project Design

IV. Strategies Undertaken

V. Project Data Results

VI. Lessons Learned

VII. Impact of COVID-19

VIII. Future work and Conclusion

IX. Resources

THA Falls Collaborative Final Report

Preface

Dear Healthcare Leaders,

Each year, somewhere between 700,000 and 1,000,000 people in the United States fall in the hospital setting however research has shown us that close to one-third of those falls could have been prevented[1]. Staff balance the need to provide safe care while managing a patient 's underlying risk factors. A fall, whether or not it results in injury, can lead to increased hospital costs, increased length of hospital stay, and other hospital acquired conditions such as pressure injuries. Ideally, fall prevention requires a multi-disciplinary approach.[1]

With an aim of zero preventative harm and direction from our Board of Directors, the Tennessee Hospital Association looked for ways to partner with hospitals and other organizations to reduce falls and falls with injury in the hospital setting. One key strategy identified entailed a falls collaborative utilizing national faculty for learning and sharing of successful strategies to implement.

Many thanks to the leadership of Jackie Conrad, MBS, BS, RN, RCC™, Improvement Advisor, Cynosure Health for sharing her knowledge, coaching hospital teams, and facilitating the sharing of successful strategies. Many thanks also to the 27 hospitals who completed the THA Falls Collaborative and their dedication to reducing inpatient falls in the face of a world-wide pandemic.

The Tennessee Center for Patient Safety

[1] Agency for Healthcare Research and Quality at https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/overview.html#Problem

THA Falls Collaborative Final Report

Background:

In December of 2019, the THA Board of Directors identified falls as a topic for focused improvement across all of Tennessee. As a part of this, the THA Board supported all hospitals reporting their falls data through THA to establish a statewide baseline and to track improvement; showcase successful hospitals and learn from their improvement efforts; and identify facilities for whom improvement opportunities might exist.

In addition, the Tennessee Center for Patient Safety (TCPS) determined that a collaborative would be a mechanism to engage multiple facilities during a set timeframe to engage in efforts to reduce injuries related to falls. Historically, TCPS has had great success hosting events whereby hospitals are able to share their work and learn from each other. A collaborative would provide this opportunity.

Project Design:

Initially, TCPS determined that the falls collaborative would be comprised of a mixture of face-to-face meetings coupled with virtual opportunities for learning, sharing, and individual team coaching. With the COVID-19 pandemic initially affecting large portions of the state, the original collaborative plan required adjustment to allow for a totally virtual platform. A six-month time frame was selected as it allowed time for hospitals to identify their areas for focus and initiate that work without obligating a prolonged time commitment. Jackie Conrad, MBS, BS, RN, RCC™, Improvement Advisor, Cynosure Health was selected as national faculty for the falls collaborative due to her extensive background in falls prevention. TCPS staff had previously worked with Cynosure Health and various members of their staff throughout the Hospital Improvement Innovation Collaborative (HIIN) including Jackie Conrad.

Recruitment began with an informational webinar held on June 30, 2020 to outline the THA Falls Collaborative and answer any questions. Hospitals were also recruited through electronic communications using directed memorandums and newsletters along with one-on-one outreach. Individual outreach was determined based on those who had previously self-reported their falls data to THA and had opportunity for improvement based on their data results. One-on-one outreach was also made based on prior outreach and communications through Quality Committee contacts who expressed interest in the collaborative. The six-month collaborative ran from August 2020 through January 2021.

To determine improvement, it was agreed to continue use of THA's Report Distributor and the falls with injury measure that THA had utilized throughout the Hospital Engagement Network (HEN) and the Hospital Improvement Innovation Collaborative (HQIC). This measure captures the number of inpatient falls with injury minor or greater using the NDNQI (National Database of Nursing Quality Indicators) Injury Level Definitions.

A commitment letter outlined the benefits of participation in the collaborative along with the requirements to include involvement in webinars and coaching sessions as well as data collection and reporting. Each team was asked to submit a team roster to further establish

accountability. Executive leader and collaborative leader signatures were required to establish involvement and dedication to the collaborative work.

Strategies Undertaken:

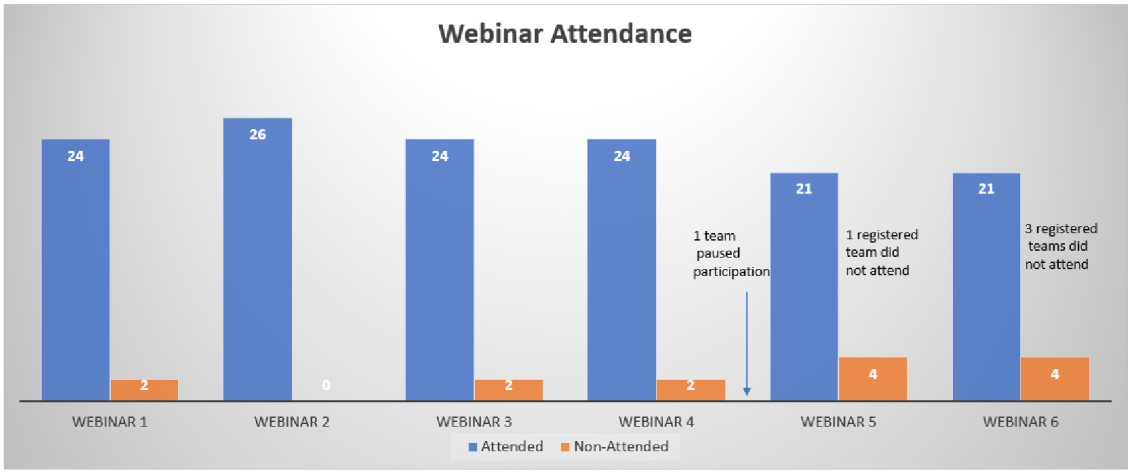
Following the initial informational webinar, six additional webinars were facilitated by Jackie Conrad, MBS, BS, RN, RCC™, Improvement Advisor, Cynosure Health. The initial two webinars were primarily educational with some team sharing interjected. As the collaborative continued, the webinars included less educational content and increasing amounts of team sharing based on their identified gaps, strategies implemented, and updates on their improvement work.

In addition to the webinars, each team was afforded the opportunity to schedule three one-on-one coaching calls with Jackie Conrad for focused strategic planning and follow-up. Prior to initiation of the coaching sessions, each team was asked to complete a Falls Discovery PI Tool, created by staff at Cynosure Health. This tool would allow review of 5-10 patient falls spending a limited amount of time on each record to identify trends or gaps for their individual improvement efforts. Each team's completed Falls Discovery Tool was reviewed by Jackie Conrad prior to their initial coaching call allowing her some insight into their falls improvement needs. Each team was also asked to complete a team roster which identified their team lead(s) as well as the individual members of their team and their role. Each coaching session was built off the previous session and each team expressed continued appreciation, enthusiasm, and commitment. These sessions allowed the teams to utilize the falls discovery tool to identify areas for focused improvement and to identify strategies that were felt to be beneficial but also realistic based on the culture of their hospital and readiness of staff, especially considering the COVID-19 pandemic. During the coaching calls, the conversations hinged on team's individual improvement needs while also serving as an opportunity to share improvements in real time as well as to discuss obstacles encountered. Tools and resources that were identified as needed or relevant to their improvement work were shared with the individual team leaders, along with a synopsis of each coaching call, to share widely with their team members and others. It was determined to post the identified resources from the collaborative on the TCPS webpage to allow broad dissemination to all the Falls Collaborative teams and post collaborative, any interested facility who needed tools and resources found to be effective regarding reduction of falls.

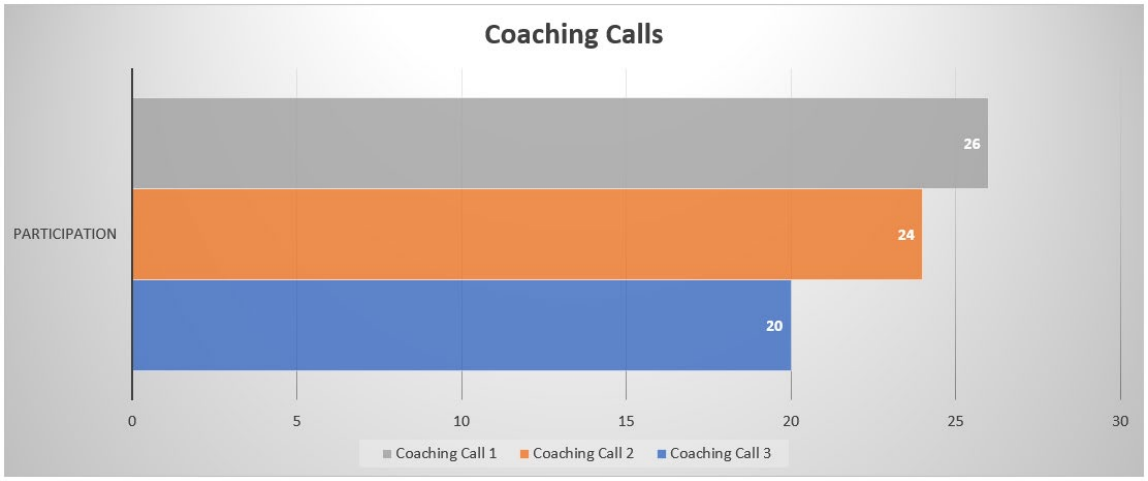
While not a requirement of the collaborative, teams were encouraged to complete and share a final report template which highlights their individual work, team members, and data. 18 of the teams successfully completed and shared this template and utilized it to share their falls reduction journey during the last two webinars of the collaborative.

THA Falls Collaborative Final Report

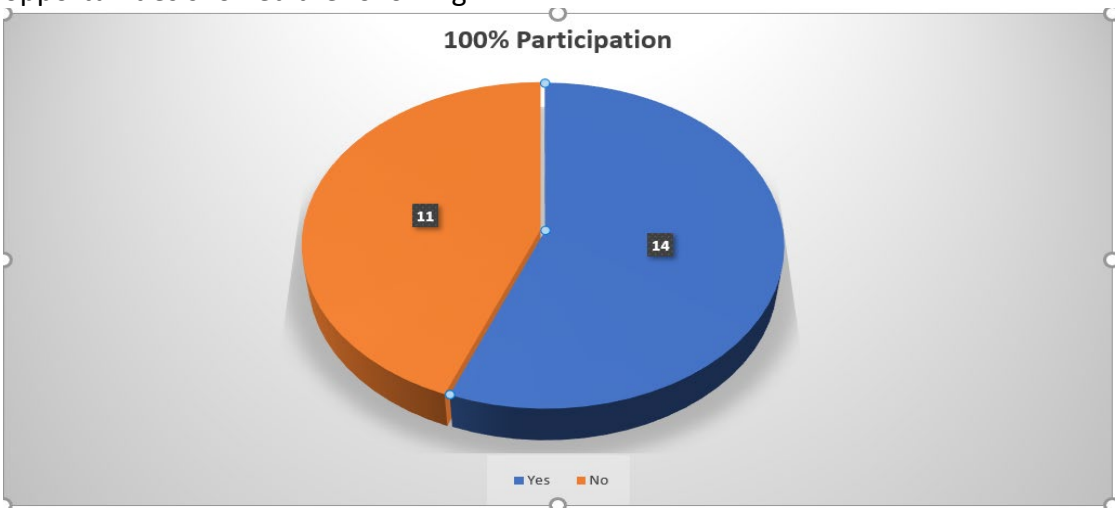
To assist in gauging success of the Falls Collaborative, participation tracking was undertaken. Webinar attendance garnered the following results:



Likewise, tracking of the one-on-one coaching call opportunities was also completed with the following results:



Lastly, tracking of 100% participation in all six webinars and three one-on-one coaching call opportunities showed the following:

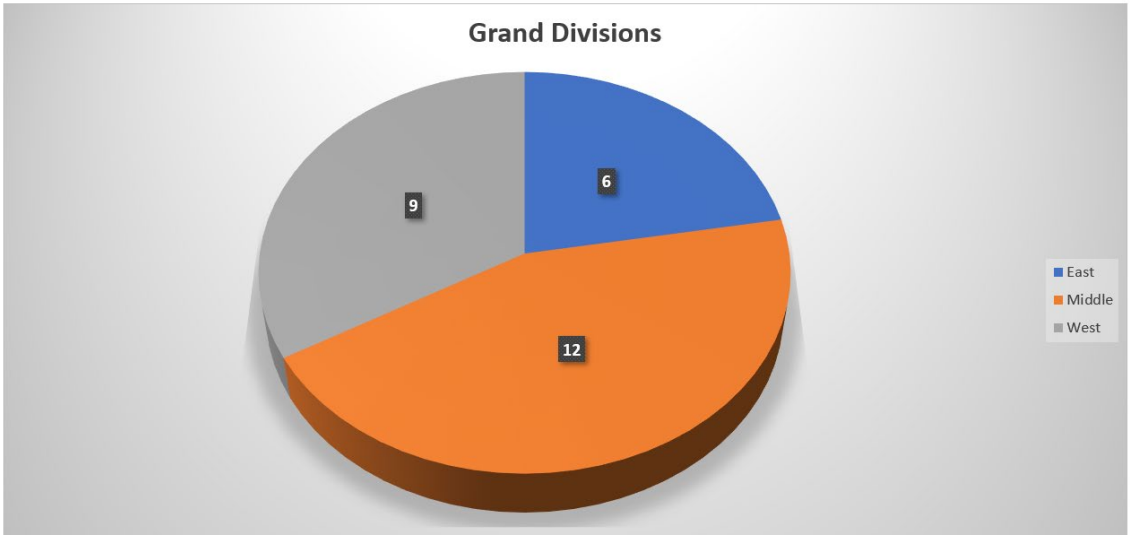


THA Falls Collaborative Final Report

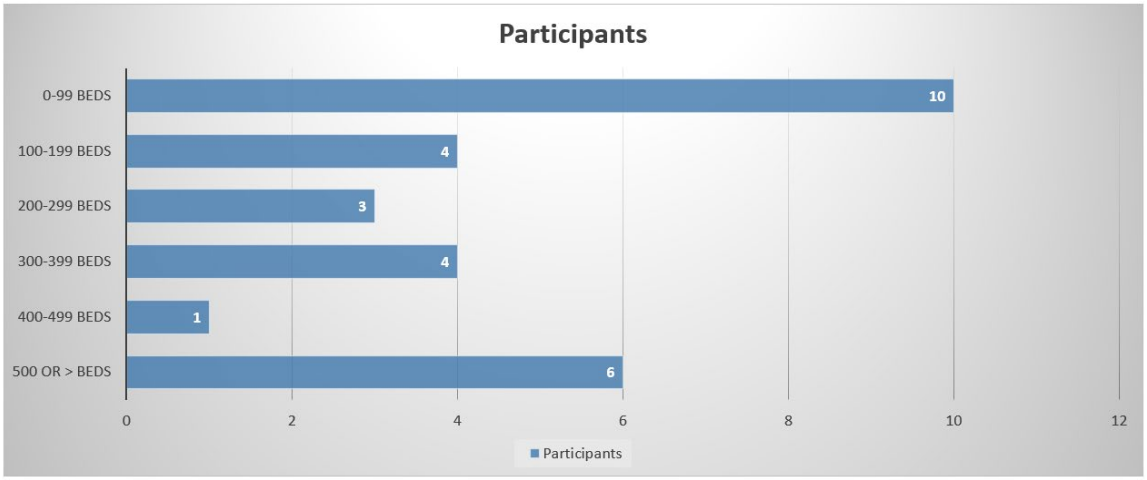
Project Data Results:

This virtual collaborative consisted of six webinars for learning and team sharing along with three separate opportunities for one-on-one team coaching. A total of 28 hospitals committed to the THA Falls Collaborative with three hospitals comprising one team representing their system for a total of 26 teams. With the surge of COVID-19 adversely impacting their free-standing facility, one hospital paused in mid-December of the collaborative and was unable to fulfill their obligations prior to the collaborative timeline. This resulted in 27 hospitals or 25 teams completing the entire collaborative.

The collaborative participation was greatest in the middle division of the state followed by the west and east divisions, respectively.



Participation by hospital bed size showed a significant number of smaller facilities (99 beds or less) participating with good participation from other sized facilities as well.



THA Falls Collaborative Final Report

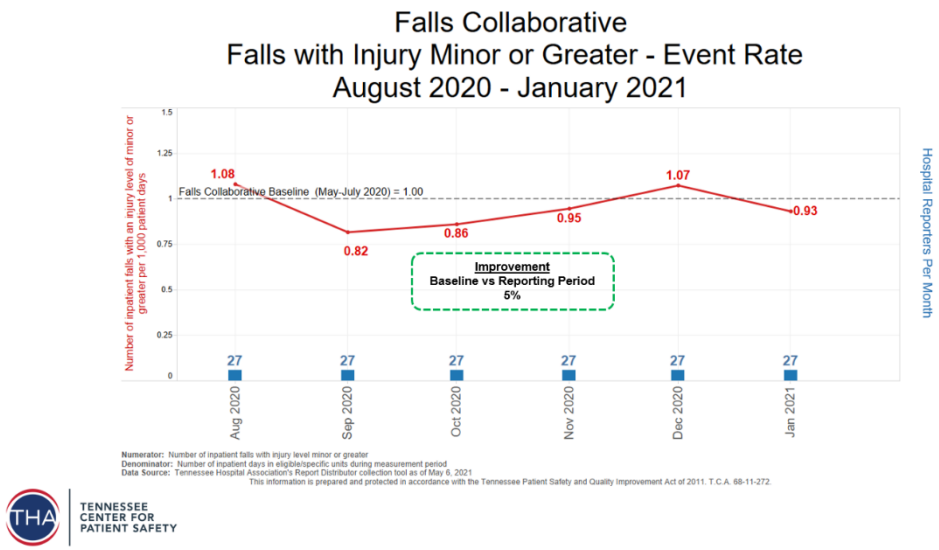
The 27 teams completing the THA Falls Collaborative are to be commended for their dedication and resilience, not just to the efforts to reduce falls in their facilities, but in doing so during an international pandemic with surging occurring throughout the entirety of the state. The THA Falls Collaborative hospitals are:

Facility Name	
Ascension Saint Thomas Midtown Hospital	Regional One Health
Ascension Saint Thomas Rutherford Hospital	Riverview Regional Medical Center
Ascension Saint Thomas West Hospital	Saint Francis Hospital - Bartlett
Baptist Memorial Hospital Collierville	Saint Francis Hospital – Memphis
Baptist Memorial Hospital Memphis	Siskin Rehabilitation Hospital
Baptist Restorative Care Hospital	Southern Tennessee Regional Health System – Lawrenceburg
Bristol Regional Medical Center	Tennova Healthcare Cleveland
CHI Memorial	TriStar Skyline Medical Center
Franklin Woods Community Hospital	Trousdale Medical Center
Hardin Medical Center	Unity Psychiatric Care Columbia
Henry County Medical Center	University of Tennessee Medical Center
Livingston Medical Center	Vanderbilt University Medical Center
Maury Regional Medical Center	West Tennessee Healthcare Dyersburg
Nashville General Hospital	

Self-reported data collection and reporting by the collaborative hospitals yielded the following results:

- Project baseline calculated using May-July 2021 data.
- 27 of the 28 facilities provided complete baseline and project (August 2020-January 2021) data.
- The collaborative achieved a 5% overall aggregate improvement rate. Aggregate improvement was calculated using facility wide data. Most teams identified 1-2 units for their improvement work and therefore accurate targeted reductions in those units was not feasible as unit level data only was not utilized for reporting during the collaborative.
- 13 hospitals individually made improvement during the entire project period based on their baseline data with improvement rates varying between 4-59% (August 2020-January 2021).
- 14 facilities individually demonstrated improvement during the last three months of the collaborative (November 2020-January 2021).
- Improvements were achieved during a worldwide pandemic with rising numbers of COVID-19 inpatients coupled with staffing and resource challenges.

THA Falls Collaborative Final Report



TENNESSEE CENTER FOR PATIENT SAFETY

Lessons Learned:

COVID was a hindrance but did not prevent work from moving forward by the falls teams. The collaborative afforded teams the opportunity to review their current processes and make small changes that in turn could yield big results. Several teams were comprised mainly of nurses. Often, expanding their falls team to include a physician champion, physical therapy, and pharmacy was indicated as a multidisciplinary approach is best to prevent falls. They learned that a physician champion does not need to commit to attending meetings but in providing overall guidance and to serve as a vessel to communicate to other physicians. Likewise, pharmacy involvement related to medication reconciliation or advising alternatives when possible, to limit confusion or unsteadiness and physical therapy to provide guidance and instruction on proper use of gait belts, exercises, and other equipment is helpful for frontline staff.

Communication and rounding were found to be essential elements for teams to utilize. Bedside rounding, to include involving the patient and family, was important as it afforded the opportunity to explain why the patient was at risk for a fall and emphasize the need to call for assistance. Indicating falls risk on white boards in patient rooms served as a reminder to patients and families. Multidisciplinary rounding afforded the opportunity for the various disciplines to intermittently assess patient for overall status, medications that could impair mental status, and allowed time for discussion of strategies to prevent falls. Leadership rounding allowed for staff to identify patients at high risk for a fall and what strategies were being implemented which encouraged critical thinking skills while providing information to leadership. In turn, as leaders rounded on high-risk patients, they could relay the same information to patients regarding their fall risk which added importance and emphasis to the patient as this was coming from a hospital leader. Unit white boards were also an opportunity for all disciplines to communicate to each other which patients had fallen or were felt to be at high risk for a fall.

THA Falls Collaborative Final Report

Educating staff related to resources available to prevent a fall is important but also important is educating on their location in the unit/facility along with understanding proper selection and use. Bed and chair alarms, hip protectors, floor mats, lifts, transfer equipment, walkers, and gait belts were identified widely among the collaborative hospitals although often not well utilized. The location of equipment was identified as an issue in low utilization along with lack of staff education on proper use. Employing physical therapists to educate nurses and technicians on proper use of gait belts proved a successful strategy in increasing safe mobilization of patients. Several hospitals placed gait belts either inside or just outside patient rooms for increased use. Educating patients and family using available resources i.e. white boards to remind to call for assistance or implementing the Falls TIPS Tool, a pictorial tool that aligns with the Morse scale, which allows education and collaboration with the patient to complete and will act as a visual reminder.

Staff engagement in any work is key to improvement and sustainment. Examples of injecting fun into learning was a way that several facilities implemented to educate and heighten awareness of their staff. Two examples are creating a "Falls Escape Room" and hosting a poster contest between units. After two facilities shared their experience, many other teams tried this approach with positive feedback from their staff. This also proved a way to focus on something other than COVID-19 for a short period of time. Using a tree with falling leaves was also shared to indicate either a patient fall or to indicate those at high risk for falls as both examples were provided.

Overall, the other lessons learned through the collaborative can be segmented into four categories:

1. Injury prevention – assess to identify fall risk
    a. ABCS – while most teams utilized a standard falls assessment, this often led to most if not all patients being deemed a high risk for fall on a unit. When everyone is high risk then no one is at high risk. Using the ABCS assessment criteria was encouraged as it allowed staff to identify and focus their attention on patients at highest risk for a fall. ABCS is an acronym for:
        - ✓ A = age 85 years or greater
        - ✓ B = bone (history of fracture, osteoporosis, bone metastases)
        - ✓ C = coagulation – Are they taking an anticoagulant which increases likelihood of bleeding from injuries sustained from a fall
        - ✓ S = surgery (weak, post-anesthesia, pain meds, etc.)
    b. Segment the population – using the ABCS assessment criteria allowed staff to identify those top 3-5 patients for that shift that they were most concerned about related to fall risk and encouraged critical think during rounds as they identified prevention strategies to implement while alerting all staff to who is at highest risk for a fall.
    c. EGRESS test – quick and easy way to determine how much assistance a patient needs to ambulate. Use white boards and rounding to communicate results.

2. Whole house approach
    a. No Pass Zone – no staff member, regardless of their department or skill level, can pass a patient room with the call light going off. Non-clinical staff were educated to talk to the patient and let them know that they would be getting a nurse to assist them and not to attempt to get out of bed/chair until they return with help
    b. Environmental factors – can play a huge part in reducing falls. Encouraging environmental safety rounds but also having staff entering patient rooms to observe for tripping hazards such as IV tubing on the floor; obstacles between bed and bathroom such as IV pump placement, trashcan, bedside table, chair; ensuring that the bed is plugged into the wall properly so that the call light and bed alarm will function.
    c. Leadership rounding – impact of leadership rounding in supporting the messaging to patients that are at high risk for a fall to call and wait for assistance. This rounding also helped to improve communication lines between frontline staff and leadership and in turn, promotes critical thinking by staff as they share why the patient is high risk and which strategies that are putting into place to mitigate that risk
3. Safe mobility
    a. Links to delirium prevention, decreased LOS – educating staff to utilize mobility, when appropriate, to prevent delirium while retaining patient's muscle strength, decreases risk of pressure injuries, and decreases length of stay. Activity boxes and other activities such as opening blinds and using television/music can be utilized in non-mobile patients to prevent delirium. Medication review, to identify medications which may cause confusion, may allow for substitutions and decrease risk of delirium
    b. Transition falls teams to safe mobility teams – changing the mindset from "falls" to "mobility" teams encourages staff to proactively implement early mobility as an effective way to preserve strength and prevent falls. Using "mobility techs" which were nursing assistants who were educated by physical therapy on correct use of gait belts and equipment, both for transfers and mobility, is an effective way to promote mobility and decrease fall risk.
4. Peer sharing related to safety interventions in airborne isolation – COVID-19 presented unique situations for hospitals caring for high numbers of patients requiring isolation. These interventions, while appropriate to prevent a fall in any setting, became very important and highly discussed during the collaborative.
    a. Video monitoring – with hospitals needing to use non-ICU beds to care for many of their COVID-19 patients, sight access of the patient was limited. Also, many patients developed disorientation/confusion related to COVID-19 and therefore would often attempt to get out of bed/chair without assistance putting them at risk for a fall. One facility shared their experience with a formal tele-sitter/video monitoring system as it allowed monitoring of the patient but also the ability to converse back and forth with them. As the collaborative continued and patient numbers and severity increased, several hospitals had initiated use of baby monitors as a lower cost option to a formal tele-sitter/video monitoring system. Some who implemented baby monitors also pursued purchase of a formal tele-sitter/video monitoring system

b. Sitters monitoring multiple patients visually – while the literature does not support sitters as an effective approach for falls reduction, having one sitter positioned to monitor several patients by cohorting them or having them watch monitors if utilized, is an effective strategy and keeps the sitter from becoming distracted.
c. Rehab engagement to mobilize isolated patients and provide mobility plan for nursing to implement – engaging physical therapy in mobilizing isolated patients is an effective way to decrease delirium risk, maintain strength, and decrease falls and pressure injuries. Creating a formal mobility plan that nurses can implement increases mobility as most therapy departments have limited staffing and allows for communication and collaboration between nursing and therapy.
d. Bundling care to include toileting and mobilization – addressing multiple patient care needs while in the patient's room decreased the likelihood of the patient getting out of bed unattended which could result in a fall. It also became more important as the numbers of COVID-19 patients surged as time is needed to don and doff PPE between COVID-19 rooms which lengthens the time it would take a nurse to get from one patient to another to provide assistance.

Impact of COVID-19:

The Covid-19 pandemic brought streams of patients to hospitals but also the fear and uncertainty of the unknown about the virus and how widespread it would become. In the days and weeks that then stretched into months, staff were stretched to their limit with the sheer volume of patients that began returning to hospitals after the initial lockdown occurred in March. As staff were quarantined due to exposure, illness, or both and as the numbers of patients in the hospitals increased, having enough staff to care for patients became an issue. Many staff left their positions and teammates to "travel" for the significant increases in revenue that would make for them. Items that were previously commonplace, such as gowns and gloves, became a commodity as did masks, both N95s and surgical masks. Unending stress, both physical and emotional, began to take their toil as sicker patients kept coming and the number of deaths from the virus grew.

The 28 hospitals that began work in the THA Falls Collaborative did so hoping that they would keep their focus and make improvements that would be sustainable and also be amenable for spread. The initial round of coaching calls were heavy with enthusiasm and most teams had several member in attendance. Some of the initial coaching calls reflected on the impact that particular hospital was having related to COVID. As COVID surged, it became more difficult to reach team leads to set up calls or calls were cancelled at the last minute due to staffing issues. Some were rescheduled and some were not based on what they could balance. In response to this, a COVID update was added to the coaching call agendas in an effort to allow teams to share their current status and how it was affecting them overall before diving into their work related to falls reduction. Participation on webinars and subsequent coaching calls fell off somewhat which resulted in about half of the hospitals having at least one of their team on each webinar and in participating in the three coaching calls. Data collection and reporting fell behind as quality staff were reassigned to direct patient care. Completed data reporting from

all of the collaborative hospitals was not received until the first week of April for January data. One facility determined to take a pause from the collaborative in mid-December due to the impact between patient volumes and inadequate staffing. They were unable to rejoin the collaborative before it ended in late January.

Recurring themes surfaced during coaching calls that were identified such as:

- Staff reassigned to direct patient care.
- Increased numbers of agency or travel nurses to accommodate lack of available regular hospital staff.
- Staff members were absent due to illness themselves, quarantining because of exposure to themselves or an immediate family member, and some for death of a family member from COVID-19.
- Juggling multiple responsibilities and roles
- Mental and physical fatigue of staff
- Comradery and increased collaboration between departments
- Improved communication channels between unit staff members, other departments, and administration
- Resilience and teamwork
- A renewed sense of pride in themselves and their coworkers for working together cohesively to care for patients

Future Work and Conclusions:

Collaboratives allow hospitals to work both separately and in unison to improve both individual and collective performance. By focusing on their individual patient populations and staff, interventions can be implemented to reduce harm. In sharing their work, all teams benefit from the knowledge of learning new strategies and in hearing of ways to improve or refine existing strategies to improve patient care and reduce harms. In sharing their own successes and opportunities for improvement, teams find comradery and form a network of their peers for whom they can continue to interact related to improvement. Sharing also allows refueling of their enthusiasm for the work while reinforcing their understanding that their behaviors, and the impact that their behaviors have in modeling to other staff, will have long-lasting effects on preventing and reducing harms. Efforts will continue to address reducing falls in the hospital setting as many falls result in some degree of injury. Sharing of lessons learned from the collaborative will allow better dissemination of successful strategies as well as meaningful tools and resources.

Resources:

An extensive compilation of resources, along with the final report templates that teams created to highlight their individual work, can be found on the TCPS website at https://www.tnpatientsafety.com/initiatives/falls-with-injury/