The *Got-A-Minute Campaign* to Reduce Patient Falls with Injury in an Acute Care Setting

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Literature Summary

- Fall prevention toolkits are available from multiple sources (Agency for Healthcare Research and Quality, 2013a, 2013b).
- A qualitative study of three hospitals implementing falls prevention programs described the *real world journey* (Ireland, Kirkpatrick, Boblin, & Robertson, 2013).
- A review of core experiential and pragmatic *do-and-don't* messages on how to customize care to each patient's unique fall risk is provided (Quigley, 2015).
- Reflective practice can promote evidence-based practice (Asselin, Schwartz-Barcott, & Osterman, 2013).
- Peer group discussion prompts deeper reflection (Asselin & Schwartz-Barcott, 2015).

CQI Model

The organization used Lean principles (Scoville & Little, 2014) of continuous quality improvement, which have been branded as LEAP (Learn, Engage, Aspire, Perfect) methodology.

Quality Indicator with Operational Definitions & Data Collection Methods

Falls with injury per 1,000 patient days (calculated monthly) was used as the quality indicator. Fall incidents were identified when staff generate an incident report (SAFE reports [Safety Alert From Employees]). The SAFE report included patient name and medical record number, date and time of the fall, fall location and fall position, level of injury, and event summary.

Clinical Setting

The setting was a medical-surgical unit with average daily census of 35 patients in a safety-net hospital. A *safety-net hospital* provides a significant level of care to low-income, uninsured, and vulnerable populations (National Association of Public Hospitals and Health Systems, n.d.).

Program Objectives

- Build and implement a bundle of evidence-based best practices to prevent patient falls with injury, taking into consideration the high-risk patient population and skills/knowledge of nursing staff.
- Reduce the rate of patient falls with injury by 40%.

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Patient falls and fall prevention remain complex phenomena for every acute care setting. The Got-A-Minute Campaign was effective in facilitating accountability for practice and underscored the importance of using multiple strategies to engage nurses in effecting change and sustaining their engagement after change was realized.

Preventing patient falls with injuries in acute care settings remains a challenge for healthcare professionals. According to the Agency for Healthcare Research and Quality (2013b), fall rates range from 1.3 to 8.9 falls/1,000 patient days, and higher rates occur in units that focus on eldercare, neurological diseases, and rehabilitation. The Joint Commission (2015) reported 30%-50% of patient falls result in injury.

Project Site and Reasons for Change

This report describes the first 3 years of an ongoing campaign to reduce patient falls with injury on a medical-surgical acute care unit in a safety-net hospital serving low-income patients. Patients at the project site often have complex, chronic, medical and mental health diagnoses. Some of the patients at high risk for falling are on legal holds, diagnosed with dementia, or homeless, or withdrawing from alcohol and/or drugs. The baseline

year had a patient fall with injury rate of 1.21/1,000 patient days. In addition, many patients preferred to receive healthcare information in a language other than English.

Program

An interprofessional team of nurses, pharmacy personnel, and a physical therapist reviewed evidence-based practice (EBP) recommendations in the literature. A 5-year review (2008-2012) of EBSCOhost to search English-language peer-reviewed journals for studies with the search terms *nursing*, *adult*, *patient fall*, and *hospital* identified over 150 articles. Team members realized they did not have the skills to evaluate the studies. Following Stevens' (2012) recommendations, they focused on evidence summaries, including systematic reviews and other forms that integrated all research on a given topic into a single, meaningful whole. Fall prevention toolkits were essential to the program launch. Adopting the name *Stumble Stoppers*, this team was charged with finding answers to the following questions: Which fall prevention practices should be used? How should a standardized assessment of fall risk factors be conducted? How should staff assess and manage patients after a fall? The focus was falls with minor or greater injury.

Personalizing the Statistical Reports of Patient Falls

The Stumble Stoppers focused on individual patients rather than overall fall rates by personalizing statistics on patient falls. Although the number and rates of falls had been reported at unit meetings, the statistics appeared to have little meaning to clinical nurses and seemed disassociated from their day-to-day work of patient care. Transforming the numbers and rates into patient stories personalized the issue. Each patient fall had a story, complete with the patient's age, unit, and outcome. During the *Got-A-Minute Campaign*, nurses were given a list of patient stories and asked, "Do you know them?" All nurses knew of at least one patient. They may have been assigned to the patient when he or she fell, working the shift when the patient fell, or heard stories about the fall.

Structuring Time for Reflection

Reflective practice can promote EBP; the deliberative process of thinking critically about situations can lead to insight and subsequent changes in practice (Asselin, Schwartz-Barcott, & Osterman, 2013). Although reflection may be an essential characteristic of professional practice, nurses seldom seem to have time for reflection during their shifts. The *Got-A-Minute Campaign*, however, provided structured times for reflection.

The immediate prompt for reflection was the question, "Do you know them?" A nurse assigned to a patient who fell would share perceptions of the event and offer suggestions for what could have been done differently. The first opportunity for structured reflection occurred after staff education had been completed in a one-on-one meeting at the start of the campaign. These meetings involved clinical nurses and the nurse educator or a Stumble Stopper. After each nurse reviewed the patient stories, the facilitator used a list of fall prevention interventions to open discussion about nursing practices. After discussion with the facilitators, nurses checked the interventions they used consistently and added interventions they committed to use more in their practice. Discussion ended with signed commitments by the nurses to their patients and themselves to increase the use of fall prevention practices. Scheduled time for reflection now also occurs during the annual skills day review. Reflection times are structured for groups of three or four nurses.

Conducting Patient-Centered Fall Rounds

Rounds on patient falls were conducted every 8 hours or once per shift for 3 months. They were attended by the manager or nursing supervisor after business hours, the charge nurse, the patient's nurse, and the certified nursing assistant (CNA). Patients in these rounds were identified as high risk for falls based on the Morse Fall Scale, anecdotal reports, or an assigned safety attendant. The safety attendant, a CNA, may have had one to three patients who were clustered together.

The team went to each patient's bedside and engaged the patient using a structured assessment and interview guide. If the safety attendant had been assigned, initial discussion explored reasons for the assignment. Did the ratio of attendant-to-patient need to be increased or decreased? Should the use of a safety attendant be discontinued? Key environmental factors and behaviors were reviewed next, including use of bed alarms as well as patient placement on the unit. Patient assessment included short-term memory deficits, unstable gait, and the inability to be redirected. A patient's pain intensity score and medication administration patterns were reviewed along with documentation that the patient was offered toileting or toileted every 2 hours. The team concluded rounds by providing the patient with a summary of the assessment and inviting the patient and family to provide additional information. A plan for the patient was developed for the next 8 hours and posted on his or her whiteboard.

Debriefing Patients and Family After a Fall

A scripted debriefing of patients and family was conducted after a fall.

> "Good morning/afternoon/evening, I am _____ (state your name and your role). I am aware that you have fallen. I am here to understand what you experienced and what happened, what went wrong, and what needs to be done to assist you in staying safe. We take the fact that you had a fall very seriously. Be assured that we want to understand what happened and how we may best address your needs. Our goal is for you to be safe with no further falls, so bear with us as we try to understand the situation."

These debriefings were conducted on the day of a fall. The Stumble Stoppers were eager and enthusias-

tic to learn from patients who had fallen. One theme recurred most frequently: patients had little recollection of what contributed to the fall. Accordingly, the Stumble Stoppers perceived the only course was to reorient patients to their safety plans.

Creating Transparency of Fall Data

A falls board, visible to patients, families, and staff, displayed the number of patient falls every week. The goal was to achieve transparency with patients and families, increase awareness, and demonstrate the staff took patient safety seriously. Staff move a yellow figure from a tree to the ground for every patient fall. The following message is posted with the fall data:

> Please, EVERYONE, help us keep our patients safe. The above tree poster represents patient falls. As the week progresses, if there is a patient fall a yellow person, also known as a *boo-boo guy*, is taken out of the tree and placed on the ground. Families, we care about our patients' safety and need your help to keep them safe.

Every Sunday morning, the charge nurse returned the yellow figures to the tree.

Evaluation and Action Plan

At the start of year 1, the patient injury fall rate was 1.21/1,000 patient days. At year 2, the patient injury fall rate was 0.66/1,000 patient days; the patient injury fall rate at year 3 was 0.15/1,000 patient days.

Results and Limitations

The *Got-A-Minute Campaign* has proven successful. Keeping the core team of Stumble Stoppers together was difficult as time passed. Implementing and sustaining changes in practice takes time, and compensating for turnover and replacement of core team members was a challenge. Although the Stumble Stoppers understood the fall prevention program was not time-limited, the continuous effort required to support and sustain the initiative was not appreciated fully until 36 months into the initiative.

Personalizing the patient fall phenomenon engaged nurses and honored the nurse-patient relationship. This strategy is being adapted in other improvement initiatives. Reflection was structured at the start of the campaign and during the annual skills review. Although Asselin and Schwartz-Barcott (2015) found peer group discussion prompted deeper reflection, initial reflection was structured individually because of time constraints and difficulty in assembling groups. Ongoing reflection is conducted in small groups using the EBP and best practices document as a guide. Asselin and colleagues (2013) concluded "structured facilitated reflection could assist nurses in achieving the depth of reflection necessary to move from changes in perspective to changes in practice" (p. 912). The nurse educator and the Stumble Stoppers thought group reflection was more effective than one-on-one reflection because it allowed peer-to-peer support and coaching. Small group reflection processes also appeared more supportive of experienced nurses. Asselin and Schwartz-Barcott (2015) suggested experienced nurses may need assistance to enhance the scope of their reflection.

Rounds were conducted for several reasons: to reinforce the falls campaign, involve patients, provide a role model for staff, and empower patients and families in the care planning process. This process was difficult to sustain around the clock because many people had to be committed to the rigor of the intervention. Rounds were continued for 3 months with a great deal of vigilance from the chief nursing officer as the executive sponsor of the initiative. After 3 months, rounds were reduced to once every 24 hours because the experience demonstrated the patients on the project unit did not have frequent changes in their fall risk assessment.

Lessons Learned/ Nursing Implications

Patient stories were more meaningful than statistics when the campaign was introduced, and the fall prevention toolkit was essential to launching the program. In addition, complementary strategies included incorporating group reflective practice accompanied by signed commitments to use fall prevention practices, engaging the patient and family in the assessment and plan, implementing a scripted debriefing after a fall, and ensuring transparency with patients and families.

Driven by continuous quality improvement, planning and introducing a change in practice should be a multi-year plan, including monitoring outcomes of the practice change and its sustainability. Implementation of the fall prevention bundle underscored the importance of using multiple strategies to engage nurses in effecting change and sustaining their engagement after the change was realized.

Conclusion

The *Got-A-Minute Campaign* was effective in facilitating accountability for practice. The change has been sustained for 36 months, and many of the practices are now routine care for patients on the project unit. Patient falls and fall prevention remain complex phenomena for every acute care setting. MSN

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