THE CHALLENGE
Nurses are widely recognized as the foundation of the healthcare system. Oftentimes, they are the leaders in helping an organization achieve successful outcomes in clinical, patient safety, operational quality and regulatory compliance. And with the advent of pay-for-performance models, registered nursing is becoming an increasingly important job with enhanced responsibilities. Such is the case at Verde Valley Medical Center (VVMC) in north central Arizona. When the number of patient falls was rapidly rising within the organization, it was the nursing staff that took the lead at addressing the issue and helping to create a system-wide improvement initiative.

VVMC began as a small outpatient clinic in 1939, but has since grown into a full-service, 99-bed, nonprofit hospital with four locations and more than 800 professional and support staff. VVMC is a member of Northern Arizona Healthcare, which also serves patients through Flagstaff Medical Center, Sedona Medical Center, Northern Arizona Homecare, Northern Arizona Hospice and multiple outpatient clinics.

“Our organization had policies in place and a system for reporting patient falls, yet our fall rate increased significantly in one year,” said Cat Singletary, manager for Performance Improvement and Regulatory Compliance at VVMC. “Clearly something was broken and our nursing staff was instrumental in telling us what works, what doesn’t and what needs to change. They are in the trenches every day and they have the best understanding of how to help make the care we provide to our patients better.”

THE SOLUTION
The Quality Department at VVMC created a multi-disciplinary committee from Nursing, IT, Pharmacy, Therapy Services, Risk and Compliance Departments of both VVMC and Flagstaff Medical Center. This new Falls Prevention Committee met monthly to review huddle sheets, event reporting, policy, equipment, patient and staff education, documentation procedures, etc.

“The Falls Prevention Committee requested that both facilities conduct a baseline assessment and to interview staff. Internal audits were conducted and the data was shared with the committee. This information was critical in identifying the gaps in our processes and procedures,” noted Singletary.

One example, the nursing staff was not completing the huddle sheet because it was too cumbersome and it did not mirror the fields in the patient events reporting system (Remote Data Entry (RDE)).
Another example, the patient alarms were used sporadically since policy did not state it was a requirement. In addition, VVMC’s staff worked with their Evidence Based Practice and Research Department to identify best practices on patient falls.

“Our goal is to provide exceptional care, always. Through our research, we identified that educating the patient and their caregivers was key as well as posting visual prompts in the rooms to remind patients to ‘call, don’t fall,’” said Lori Stevens, VVMC’s Director of Nursing.

At the conclusion of the assessments, interviews and evidence-based research, the Falls Prevention Committee took several weeks to develop and then launch their initiative across the organization.

First and foremost, forms and policies were updated and standardized. The post-fall huddle sheet was condensed and the information being captured was aligned with the information in the RDE system. The committee worked closely with Intalere’s supplier Posey to test and roll out new chair, bed and bathroom alarms on all units of both hospitals – which are now required for all patients and even documented in the huddle sheet, RDE system and patient medical record.

Nurses have the greatest amount of patient contact during hospitalization and are the best suited to assess the risk for patient falls. This is where attention was focused.

“We updated our training documents, posted educational flyers, attended daily huddles, revised our mandatory falls learning module and conducted several other education sessions for our staff. All in all, we touched more than 1,000 nurses through this process. Nurses are most likely to witness falls and have the greatest power to prevent falls. Therefore, providing them the education and tools they need to be successful was the focus point for our initiative,” noted Stevens.

VVMC took a more proactive approach to new patient and family education than it had in the past. Call Don’t Fall signage was placed in all patient rooms and bathrooms.

Plus, the community was invited to a Health and Safety Fair at its facility which included education about falls prevention and other population health issues, but also offered additional activities including blood pressure checks, eye screenings and well woman health checks.

The Patient Falls Committee also implemented STATIT, a real-time analytic software program that is geared towards continual improvement. This program provides users a simple yet powerful means to access, track, trend, analyze, compare and contrast data in ways that provide insights from which to make objective, sustainable and defensible decisions.

By utilizing STATIT, both hospitals were able to collect data, identify trends and provide high quality fall reports to the nursing units and senior leadership.

Singletary commented, “Through this whole process we discovered the importance of keeping patient falls at the top of our minds. Our Quality Department now attends all patient care huddles. These huddles happen every morning, Monday through Friday, for about five to ten minutes. Patient falls are reported on at each huddle, every time. Simply having this brief overview and knowing how many high-risk patients are currently in the unit can really impact the care we deliver to our patients.”

THE OUTCOME

In nine months since implementing the new Patient Falls Initiative, VVMC achieved over 40 percent decrease in falls. This alone represents tremendous savings to the organization considering The Joint Commission reports that the average increase in a hospital's operational costs for a serious fall-related injury is more than $13,000, and the patient's length of stay increases by an average of 6.27 days.

“This was a huge quality improvement effort for our organization – the first large collaborative effort to create one unified nursing process between systems. Not only did we standardize processes between two hospitals, but we increased the safety of our patients, increased patient and family satisfaction and reduced the costs associated with patient falls,” said Singletary.
Costs for implementing the recommendations of the Patient Falls Committee were nominal to the organization. Most costs were associated with staff time at meetings and revising policies and forms. The Call Don’t Fall signage was printed in-house to reduce expenses and the Supply Chain Department utilized the Intalere agreement with Posey for purchasing the new alarms.

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Cat Singletary · Performance Improvement and Regulatory Compliance Manager · Verde Valley Medical Center

Using best practices and listening to its staff continues to be a focus for the system. The organization is continuing the positive momentum by testing new shower chairs in its post-surgical care unit since the nursing staff voiced the need for a wider and sturdier chair to help prevent falls.

“I’m extremely proud of our nursing team and the entire organization for their commitment in identifying patients at highest risk for falls and for developing falls-prevention strategies. While not every patient fall is preventable, I believe that the right combination of education, technology, care processes and focus can reduce the number of falls significantly and, more importantly, the injuries to patients they often cause,” said Stevens.