A PICTURE IS WORTH A THOUSAND WORDS: Using Data to Drive Outcomes
Decreasing Falls and Standardizing Best Practices

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BACKGROUND

• Our Falls outcome data showed increasing numbers of falls and falls with harm across our adult inpatient units.

METHODS

• Data was displayed in the form of Pareto charts for rankings, run charts for outcomes, and tables of contributing factors for analysis and improvement strategy sessions.
• Using these tools, the units with the highest opportunity for improvement were identified, and we began a targeted fall prevention improvement project on 3 units in July 2014.
• Utilizing the PDSA cycle, multi-disciplinary engagement, coaching, and literature review, these units paved the way for other adult inpatient units by standardizing best practices for fall prevention, while adjusting for the unit’s patient population.

• Sponsored and endorsed by executive leadership, these steps were executed for each pilot unit:
  • Kick-off meeting with unit administrator, manager, medical director, clinical staff leaders, fall prevention champion, and quality for:
    • Data review
    • Facilitated Discussion – current state, previous efforts, brainstorming
    • Gap Analysis
    • Action Planning
  • 6-8 PDSA Cycles generated current state materials and plan

ACTION PLAN / MATERIALS

• Through specific action steps, structured timelines and collaboration between all three units we addressed the following:
  • Literature reviews for best practices
  • Environmental/ Systems assessments
  • Educational needs for staff, patients and families
  • New signage for visual cues
  • Post Fall Huddles
  • Observations
  • Small tests of change
  • Implementation of:
    • Shift Safety Huddles
    • Targeted Toileting focus during Purposeful Rounding
    • Safety Rounding with Quality Partners
    • Shift Leader Rounding
    • Unit based Fall Champions/ Committees
    • Increased Use of Bed Alarms
    • Performance Boards to monitor performance
    • Unit Celebrations to recognize and reward successes

RESULTS

• Data was displayed in the form of Pareto charts for rankings, run charts for outcomes, and tables of contributing factors for analysis and improvement strategy sessions.
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• Utilizing the PDSA cycle, multi-disciplinary engagement, coaching, and literature review, these units paved the way for other adult inpatient units by standardizing best practices for fall prevention, while adjusting for the unit’s patient population.

• Overall, our 3 pilot units experienced the following from June 2014 – July 2015
  • 31% decrease in falls with harm:
    • 26% decrease in total falls
    • 53% decrease in falls with harm for Unit A
    • 40% decrease in falls with harm for Unit C
    • 51 fewer opportunities for harm from falls for these 3 units when compared to the previous year

• After the pilot, this work was replicated on all of the remaining adult units:
  • Data was provided to each unit as Pareto & run charts and tables.
  • Leader workshop was held in May 2015 to focus on Fall Prevention,
  • Pilot unit leaders became subject matter experts for their peers
  • 100% of units created action plans with routine status updates being provided to leadership and CNO
  • At least weekly or more frequent touchpoints with Quality Consultants about Falls prevention.

• 46% Decrease in falls with harm during first two months of this new fiscal year (July and August 2015) compared to July and August 2014.

CONTACT INFORMATION

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