Sky Lakes Medical Center

Fall Prevention/Hourly Rounding Program
Utilizing Lean Methodology

The problem at Sky Lakes

- No organized hourly rounding program
- Confusion about our previous "falling Leaf" program, vague, decoration
- We were not preventing harm, or even identifying potential harm. Patients were not aware of the fall program or their own fall risk
- Lack of communication at all levels
- Caregiver time at the bedside was not optimal
- Falls team met monthly "just because"

Through Lean, we committed:

- To utilize lean methodology in fall prevention
- To research and tour hospitals that had established proven fall prevention using hourly rounding
- To involve front-line staff to find the solution
- To involve management and directors in collaboration with front line-staff to problem solve
- Seek quick gains and long-term sustainment
- To respect each other **always**
- Fail small, fail often

DMAIC A3 AND PDCA

PDCA	DMAIC A3
Plan	Define
	Measure
	Analyze
Do	Improve
Check	Control
Act	

Non-linear, continual processes

Going to the Gemba

… the action of going to see the actual process, understand the work, ask questions, and learn

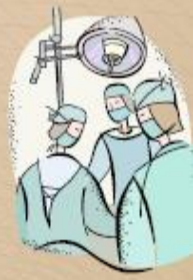
Go to Gemba

Voice of the Customer (staff) Interviews

Kaizen Walk Interview Method

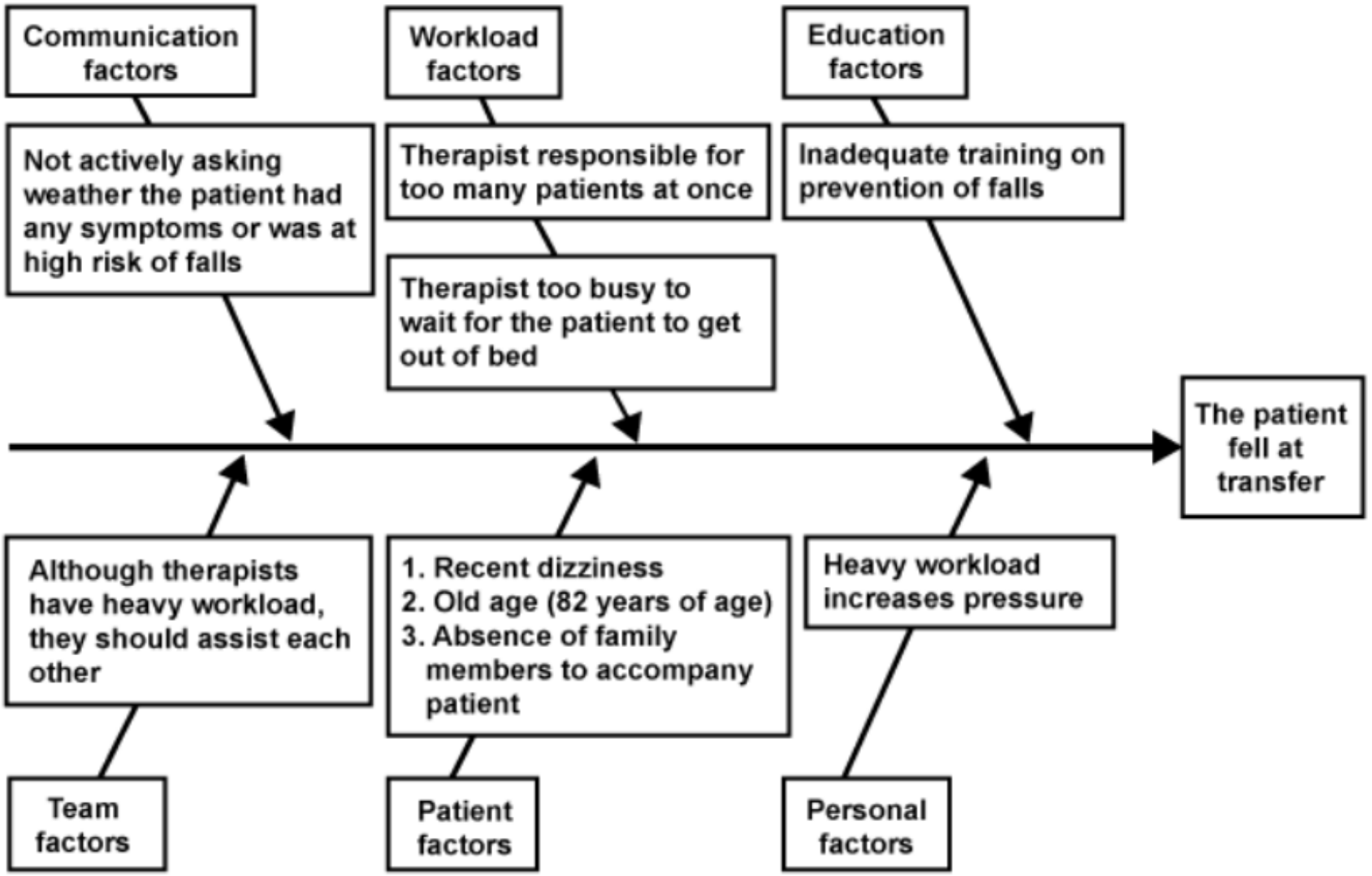
- Go To The Actual Place
- Talk To The Actual People
- View The Actual Process
- Take Notes

- Document Reality
- Observe the Waste, Value, and Variation
- Begin mapping the process



- Take Pictures (be sure to follow policy)
- Time and distance

Root Cause Fishbone Diagram: Patient Fall



5-Why Form

Project:	
Organization: SLMC Date: May 18, 2013	Team: Team Leader: Jeremy Westover

Issue: Why don't fall prevention tools work to reduce falls?	
WHY?	Why are the tools so far from the room? (includes tool kit AND patient supplies)
WHY?	Why are the tool kits not being restocked?
WHY?	Why is accountability re: tool kit stocking unclear?
WHY?	Why is it that the process is not clear?
WHY?	Why is the kit stocking responsibility fall on the nurse?

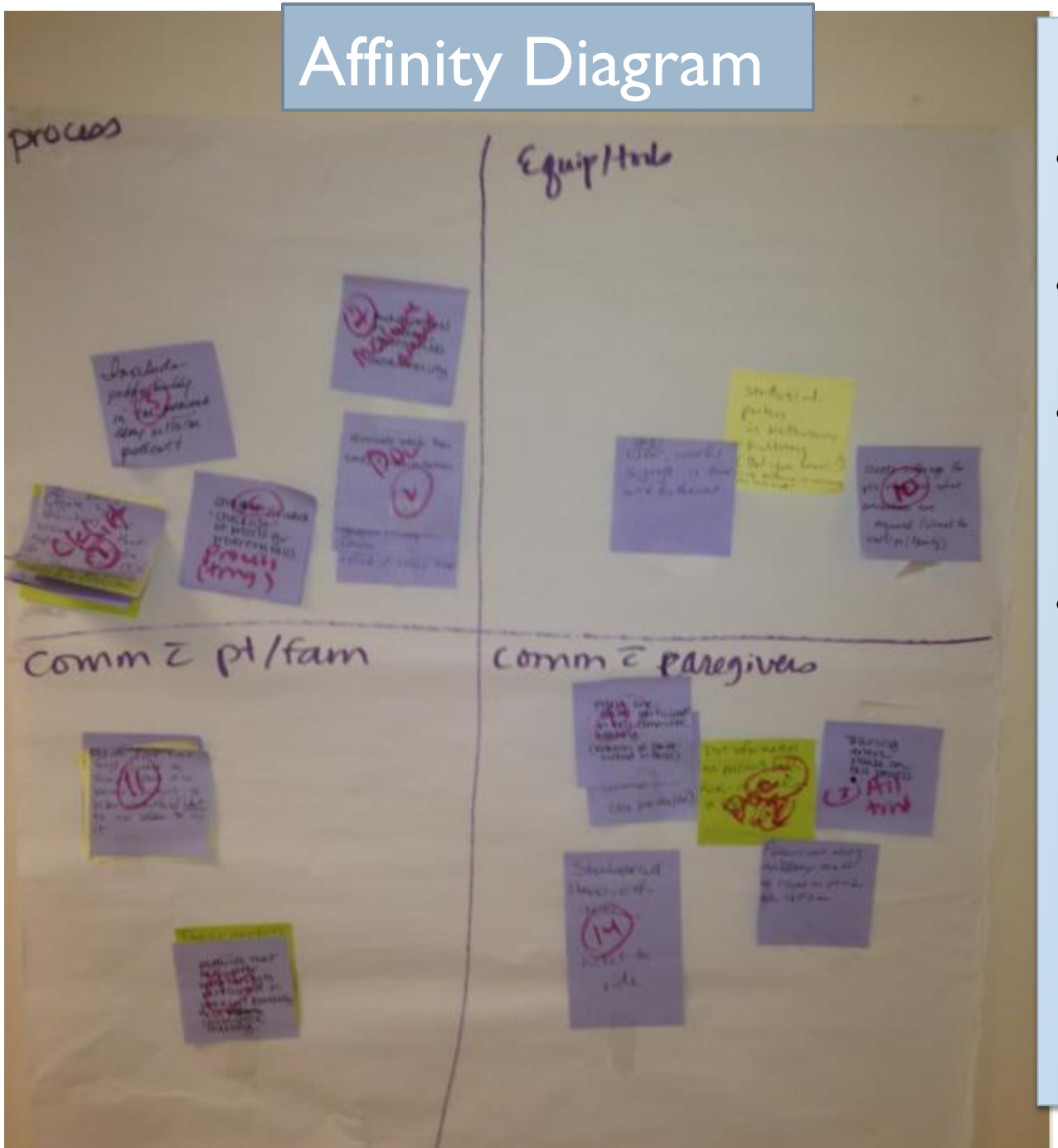
Are you at root cause?

- Is the root cause controllable?
- If we correct/improve the root cause we have identified, will that ensure that the identified problem will not reoccur?
- Can we turn the problem on and off when we turn the cause on and off?
- Have we checked to see if our identified root cause is applicable to more than one process or problem?

Potential Actions to Eliminate Root Cause:

Supplies are centralized and away from the room to assist with efficiencies of MM restocking the floor.
It is not clear who is accountable to restock tool kits
The process regarding stocking is not outlined nor overseen on a continual (no one owns it)
There is not checklist of process to know if and what supplies within tool kits have been restocked or not between patients.
The tool kit stocking process currently is led by nursing staff whom have to spend time assessing missing pieces and parts in kit and then pick part/pieces to complete kit.
Fall alarms are not consistently utilized

Affinity Diagram



- Great brainstorming activity
- Group like ideas/themes
- Name the groups once themes start to emerge
- Rank the themes to determine which ideas to focus on first

Opportunity Prioritization Ranking

Rank each opportunity from 1 - 10 based on the criteria in the left-hand column: 1 = very low 10 = very high

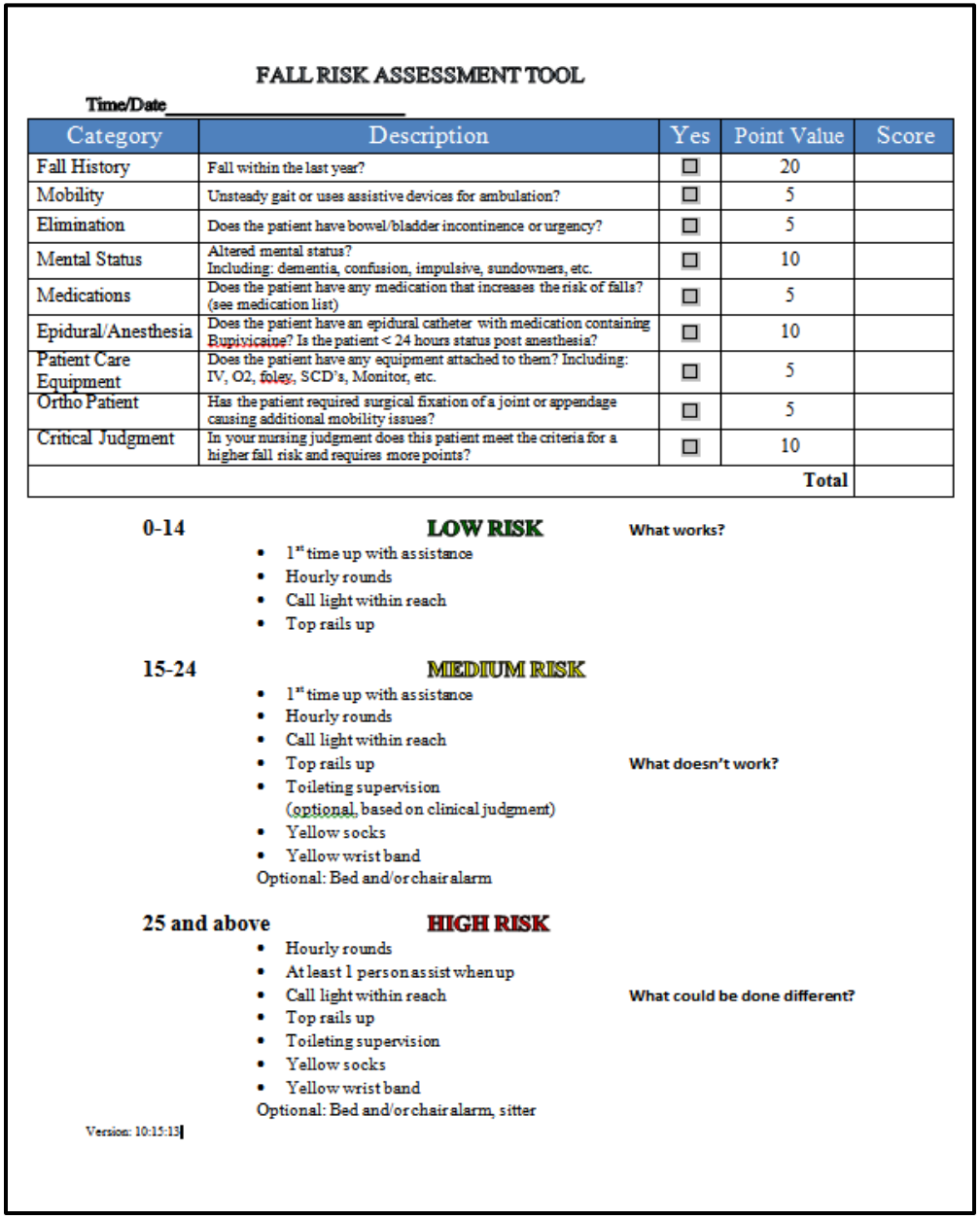
Criteria for Opportunity Selection	Opportunity Number						
	#1	#2	#3	#4	#5	#6	#7
Impact on customer / patient	8.6	9	8.5	9			
Extent of impact (How many are affected?)	9	9	6.75	10			
Impact on employee satisfaction	6	8.5	8	8			
Financial impact of the problem	7.5	8.5	6.5	7.75			
Likelihood of achieving successful resolution	8.2	7.8	6	6.8			
SUM	39.3	**42.8**	35.75	**41.55**	0	0	0

Opportunity Name (themes)	Opportunity Description
#1 Process (or lack thereof)	Policy and procedure is poorly written and does not clearly define expectation, causing variation and poor compliance. Based on VOC, process is too complex.
#2 Communication with patient/family	Based on VOC, nurses are not comfortable and feel it is unnecessary to communicate the fall risk to the patient. Patient is neither involved or engaged in the process.
#3 Equipment/tools	Based on the VOC, many options but unclear guidelines and expectations for their use (signage, bed/chair/commode, alarm, bracelet, socks, gait belt, walker, etc.).
#4 Communication between caregivers	Lack of hand-off communication (verbal & visual) re: fall risk and precautions necessary (shift to shift, department to department).

Hourly Rounding/Fall Prevention
So what tools did we come up with ?

Fall Assessment Tool

- Developed from current tools used at other facilities (Reno, Medford, OHSU) and staff input.
- Modified (PDCA) 11 times per front-line staff input before final version.
- Developed computer version and implemented into daily charting system on 10/28/13.
- Computer version connects to BMV for meds and shows fall level on status board.



FALL RISK ASSESSMENT TOOL

Time/Date_____

Category	Description	Yes	Point Value	Score
Fall History	Fall within the last year?	☐	20	
Mobility	Unsteady gait or uses assistive devices for ambulation?	☐	5	
Elimination	Does the patient have bowel/bladder incontinence or urgency?	☐	5	
Mental Status	Altered mental status? Including: dementia, confusion, impulsive, sundowners, etc.	☐	10	
Medications	Does the patient have any medication that increases the risk of falls? (see medication list)	☐	5	
Epidural/Anesthesia	Does the patient have an epidural catheter with medication containing Bupivicaine? Is the patient < 24 hours status post anesthesia?	☐	10	
Patient Care Equipment	Does the patient have any equipment attached to them? Including: IV, O2, foley, SCD's, Monitor, etc.	☐	5	
Ortho Patient	Has the patient required surgical fixation of a joint or appendage causing additional mobility issues?	☐	5	
Critical Judgment	In your nursing judgment does this patient meet the criteria for a higher fall risk and requires more points?	☐	10	
			Total	

0-14 **LOW RISK** — **What works?**

- 1st time up with assistance
- Hourly rounds
- Call light within reach
- Top rails up

15-24 **MEDIUM RISK**

- 1st time up with assistance
- Hourly rounds
- Call light within reach
- Top rails up — **What doesn't work?**
- Toileting supervision (optional, based on clinical judgment)
- Yellow socks
- Yellow wrist band

Optional: Bed and/or chair alarm

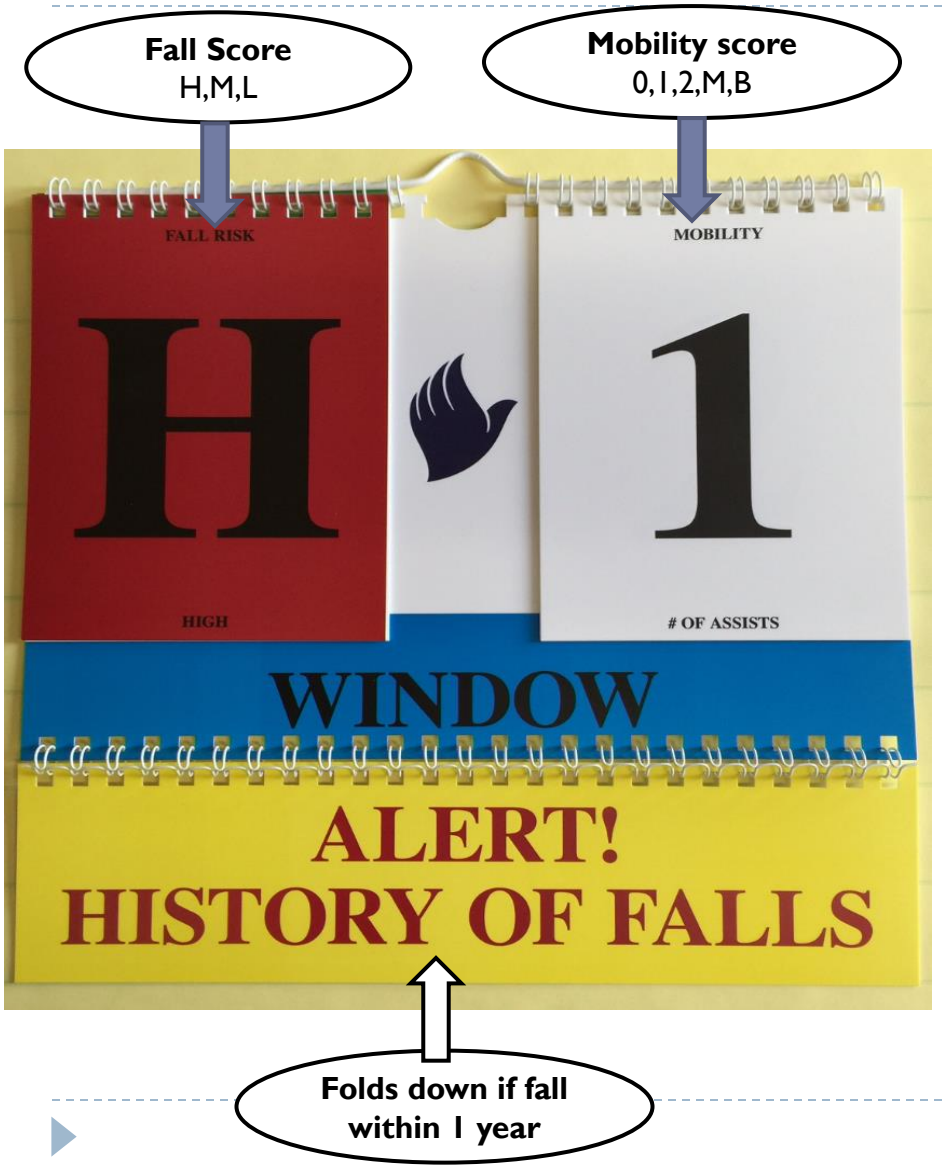
25 and above **HIGH RISK**

- Hourly rounds
- At least 1 person assist when up
- Call light within reach — **What could be done different?**
- Top rails up
- Toileting supervision
- Yellow socks
- Yellow wrist band

Optional: Bed and/or chair alarm, sitter

Version: 10:15:13

4-in-1 Flip Chart (hangs outside room)



- All patients (even low risk) are assigned a risk level
- "History of falls" information is no longer lost from shift to shift
- Mobility is fluid and can be changed as the patient changes (no charting required).
- Identifies where the patient is located (door, window, or private room)
- Anyone who enters room immediately knows fall status

How it works

Nursing fall Assessment points determine H,M,L

Mobility Score

Score Indicates mobility requirements

0 – no assist (up ad lib)

1 – one assist **(at all times, even in the bathroom)**

2- two assist **(at all times, even in the bathroom)**

M – mechanical lift

B – bedridden/bedbound

*The mobility score is changed at ANY time by the nurse in collaboration with the care team with no additional documentation.

How it works

BIG 11X17 flip SIGNS on wall in patient's room

80% don't even know their fall risk level!

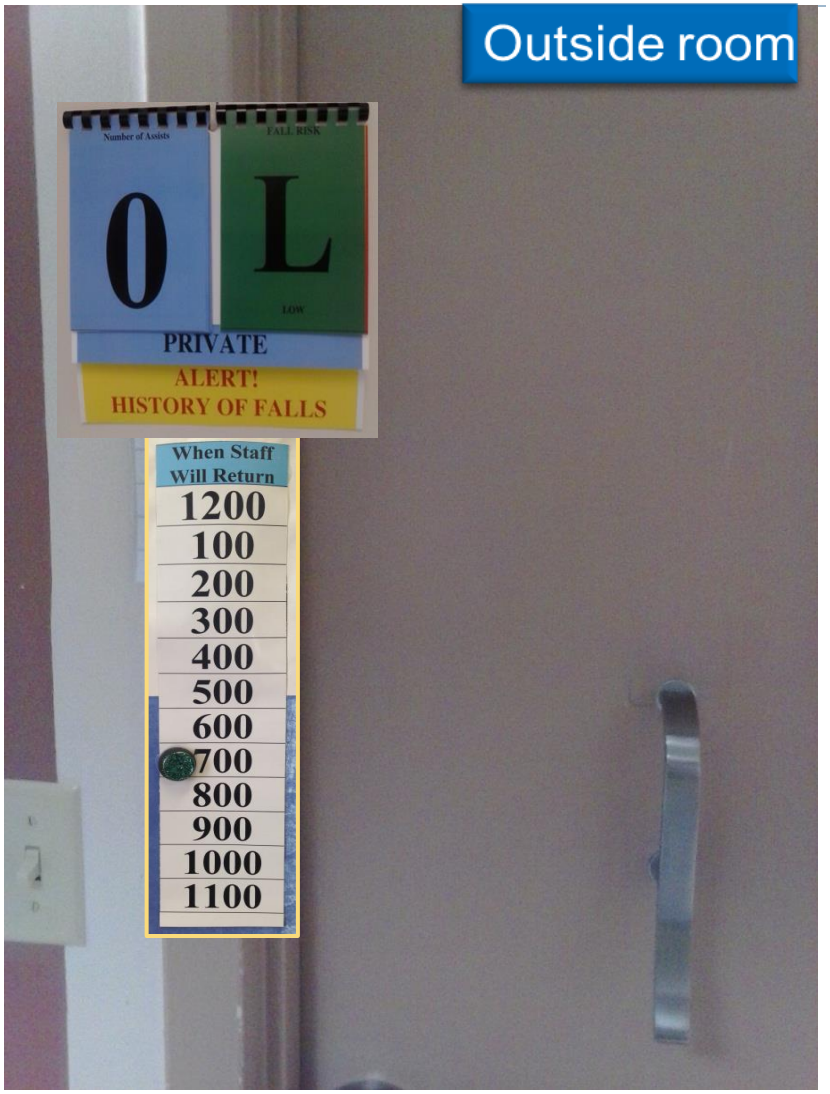
Signage Reviewed During Hourly Rounding

Accountability to our patients with sign above white board

Bathroom

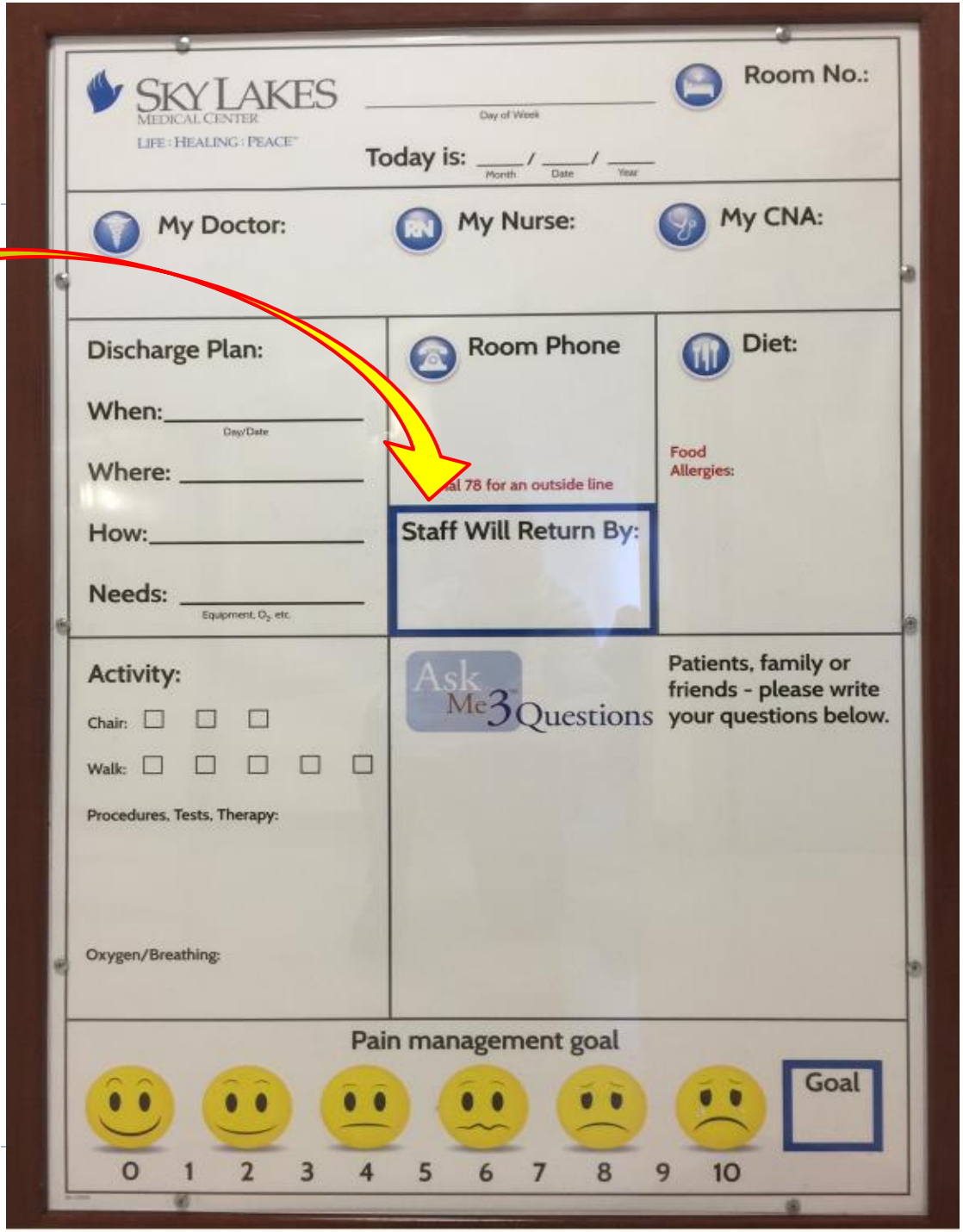
In Patient Room

Hourly Rounding



- **Needed to be seen as everyone's task (RNs & CNAs)**
- **Specific & focused**
- **3 "P's" (pain, position, potty) & 3 "R's" (reach, reassure, and return) need to be addressed every hour while awake**
- **Communication between caregivers on outside of door**
- **Must give a time for return and write it on the white board**

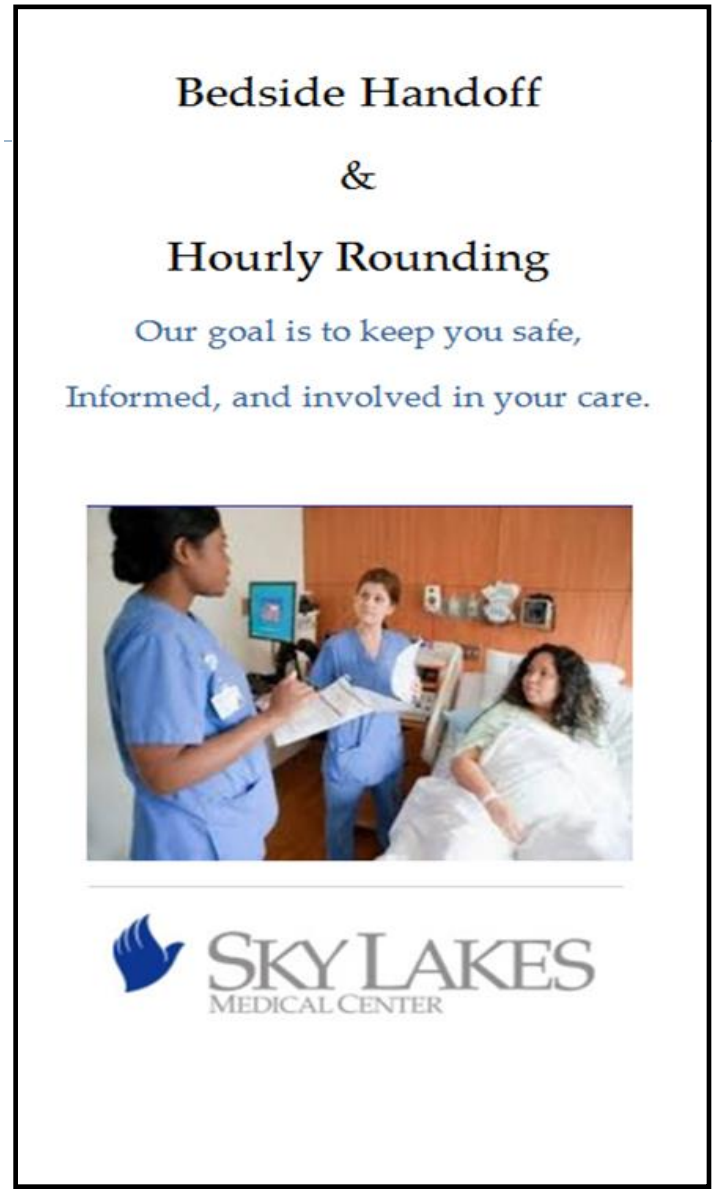
New patient communication board denotes when staff will return for hourly rounding



Recent Addition

- Sprayable/washable Yellow nylon gait belts in every single patient room
- Belts clearly Labeled with room number to prevent loss
- Required usage when transferring/ambulating all HIGH fall risk patients
- Belt washed down by environmental services after each room turnover

New brochure for all admitted patients explaining hourly rounding (and Bedside report) and what the patient and family can expect from us.



Small Test of Change: Hourly Rounding/Fall Prevention

- 3rd floor Medical: 12 beds, night shift
- 2 RN's and 2 C.N.A's
- Lean Team members on hand to offer support
- Lots of goodies
- Staff trained on process and materials beforehand
- Curve ball: sick call that night, float nurse clueless
- 2 weeks of day shift and night shift audits (1hour each)
- Several PDCA cycles with ongoing feedback
- Spread to 6 other departments over 2 months

Building reliability into the plan

- Patient and family involvement
- Front-line involvement (schedules can be a nightmare!)
- Daily Audits of all patients
- **Weekly** fall/hourly rounding Prevention Meetings
  - All falls are presented by nurse and C.N.A at fall Prevention meeting in a safe, non-judgmental setting
- Leadership rounding every day
- ALL employees understand plan!
  - Get on staff meeting agendas: Any staff that pass a patient room will need training

Daily Audits of all patients

Unit/tools audit		Auditor name:				Date:	Time of audit:		
	Names RN/ CNA	Fall Risk assessment form completed this shift?	Flip chart outside matches inside room?	"return by ___" is current on white board	**To patient:** Did you know what fall risk level you are?	**To patient:** Do you know when your nurse will be back?	**To Patient:** How often have you needed to use your call light?	Mobility score at time of audit	Comments
301		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
302D		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
302W		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
303D		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
303W		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
304		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
305		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
306		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
321		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
322		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
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325		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
326		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
327		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
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326		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
327		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			

Comments:

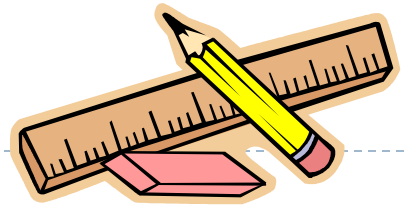
Falls Audit tool

Daily Rounding Audit: Shared at daily safety huddle

Hourly Rounding Data	**Feb 27th day shift**									
Unit	Flip Chart matches status board?		Flip Chart outside matches inside room?		Return by ___ is current on white board		To Patient: Did you know what fall risk level you are?		To Patient: Does staff come in to check in on you every hour?	
AM Shift	done/total	%	done/total	%	done/total	%	done/total	%	done/total	%
2A	10/12	83%	10/12	83%	12/12	100%	12/12	100%	12/12	100%
2B	12/18	66%	15/18	83%	14/18	77%	18/18	100%	18/18	100%
2C										
2nd floorTotal	22/30	73%	25/30	87%	26/30	87%	30/30	100%	30/30	100%
3A										
3B	12/17	71%	15/17	88%	17/17	100%	17/17	100%	17/17	100%
3C	10/12	83%	12/12	100%	12/12	100%	12/12	100%	12/12	100%
3rd floor total	22/29	72%	27/29	79%	29/29	100%	29/29	100%	29/29	100%
ACD										
Grand Total	44/59	75%	52/59	88%	55/59	93%	59/59	100%	59/59	100%

Lessons Learned (and Still Learning)

- Patients and families must participate (care partners)
- Several small tests of change: PDCA is not a one time event, fail small fail often
- No front-line participation?……No project!
- Fall occurs? Nurse reports to fall team meeting, "safe"
- Visit a hospital that already does it really well
- Pick your informal leaders (even the naysayers)
- Constant house-wide updates, announcements, e-mails on successes and challenges
- Willingness to be transparent



So how are we doing now?

- Recently began vigorous house wide mobility program to prevent patient deconditioning, inherently increasing the risk of assisted falls (gentle lowering)
- Since the beginning of the hourly rounding program in July of 2013, falls with injury have been reduced by 70%. That is measured in **actual lives preserved** as well as money saved.
- Though falls still occur (2 in January and 2 in February), we have changed the ***way*** patients fall:
  - **Hourly rounding is the #1 fall prevention tool (technology can't replace this one) staff do not get to opt out (it is a major part of their performance review)**
  - **If we have a fall, it is now most likely assisted gently to the floor**
  - **Bathroom falls are rare now (potty buddy program)**
- Some floors are better than others. Complacency/fatigue will always try to creep back in. There can be no letting up!

The Honeymoon is Over

- This stuff is hard! How do you keep the dream alive and create sustained success?
- It requires constant Planning, Doing, Checking, and Acting
- Weekly Fall Prevention/Hourly Rounding Council with front-line attendance and a solid agenda with follow-up
- Enthusiasm (even when things go south)
- Audit regularly, identify gaps, fix'em fast
- Celebrate regularly

Other Lean Efforts at Sky Lakes…..

- Recently put 40 employees through Virginia Mason Lean training
- Vice Presidents sent to Lean Training at Virginia Mason in Seattle
- Bedside Report hand-off process for all RN's and CNA's
- Currently participating in several kaizen events to reduce hospital acquired conditions

Sky Lakes Falls Prevention/Hourly Rounding Team

Thank You!

Questions?

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SKY LAKES
MEDICAL CENTER