



Three Hospitals in Madison, Wis., Extend the Work of a Falls Team Started by a Patient Safety Collaborative

In 2000, the local hospitals and medical groups in Madison, Wis., organized the Madison Patient Safety Collaborative—a formal effort to develop, share and implement patient safety solutions across the community.

The collaborative's work included formation of a Falls Team to direct efforts to reduce hospital falls by 20 percent. The Robert Wood Johnson (RWJF)-funded *Prevention of Hospital Falls* initiative supported an extension of the Falls Team's efforts. The initiative was managed by the Institute for Healthcare Improvement (IHI) in Boston, Mass.

Meriter Hospital, the recipient of the RWJF grant, is a 448-bed community hospital where the executive director of the collaborative was based. Two other Madison hospitals—University of Wisconsin Hospital and St. Mary's Hospital—also sponsored the collaborative. The William S. Middleton Memorial Veterans Hospital was not a sponsor but participated in the collaborative.

Interventions

An analysis of the five most recent injury falls at each of three Madison hospitals resulted in two findings that "surprised" the Falls Team and helped shape the interventions tested:

- Many of the patients who fell were relatively young—under 70.
- Some falls occurred even though the patient had a bed alarm.

Two of the three hospitals designated pilot units for the project while one hospital tested the changes systemwide. (The collaborative report did not identify the hospitals by name). While details of the interventions differed from one hospital to another, in general the three tested the following:

- Post-fall *huddles*
- Patient *teach back*
- A fall-prevention kit
- Assessment for high risk of fall

- "Prompted" toileting
- Patient-safety *rounds*

Results

The participating hospitals met the target of one or fewer fall-related injuries of moderate or greater severity per 10,000 patient days during the 12-month project period. However, because injury falls that severe are rare and the hospitals had low rates to begin with, "this design target was not likely to be sensitive to any change after 12 months," the collaborative noted in its report to RWJF.

The collaborative also reported that the hospitals' retrospective data did not support the IHI hypothesis that age greater than 85 or bone and blood disorders (osteoporosis and anticoagulants) increased the risk of harm from a fall:

"While these risk factors were present in some cases, there were a substantial number of falls with harm where these risk factors were not present."

The collaborative's work indicated that the risk factors for falls in general—particularly, altered mental status and mobility impairment—had a better correlation with harm from fall than did the harm-from-fall risk factors identified by the IHI team.

Therefore, the collaborative team "concluded that the best way to reduce harm from falls is to prevent the fall from happening.... The most successful implementations during the course of this grant were of fall-prevention strategies, not harm-prevention strategies."

Afterward

In 2009, the Madison Patient Safety Collaborative dissolved, mainly as the result of limited resources, according to Mary Zimmerman, M.S.N., R. N., patient safety officer at Meriter. However, fall prevention continued to be an important focus, she said. As a result of their work during the project, the Madison hospitals initiated a variety of steps and tools, including comfort and safety *rounding*, *teach back*, repositioning of bed alarms and use of floor pads.

At Meriter, one of the concrete changes that came out of the RWJF project—specifically from the face-to-face team meeting at the end—was increased use of low beds and floor pads, Zimmerman said.