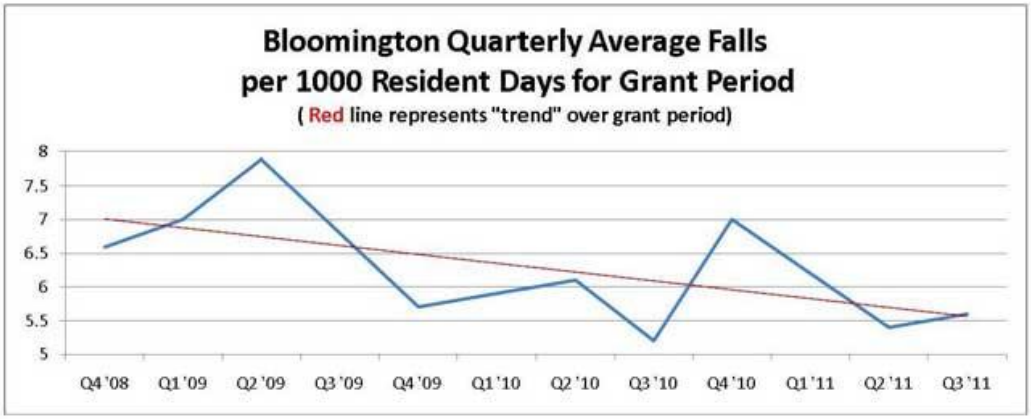
MINNESOTA MASONIC HOME:

Taking Fall Reduction to a New Level

When the Minnesota Masonic Home staff submitted an application for a grant to reduce falls in their facility, they never imagined the program they would get and the work they would do would pay off with such huge benefits. Here is their story, written by Jean Jorlett, the Fall Coordinator and Quality Assurance (QA) Coordinator at the facility.

The Minnesota Masonic Home in suburban Minneapolis has 350 seniors on its campus. The skilled care facility has 214 beds, including an 80-bed transitional care unit, and 134 beds of long term care, of which 40 beds are a memory care unit. The facility is a member of a local quality improvement and education organization called Empira. In 2008, Empira submitted an application to the Minnesota Department of Human Services for a pay-for-performance (PIPP) three-year grant to reduce falls by 20 percent over baseline measures in 16 participating nursing homes in Minnesota. Over the course of the three years, the facility not only achieved the goal of fall reduction, but improved quality of care and life for its residents.



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*Written for GuideOne Insurance by Jean Jorlett, QA Coordinator at the Minnesota Masonic Home, and published with permission.

While many insights were gained over the course of the three years, several key elements were essential to the success of the program at Masonic. The program required an RN to be a Fall Coordinator at each facility, reporting to the Administrator. Data collected on each fall was entered into an Excel spreadsheet, which allowed analytics for specific units to be run, including time of day, day of week, location of fall, and severity of injury. Primary focus is on discovery of the root cause of falls. All existing and new staff were trained to improve observation skills for clues leading to identification of the root cause of falls in an exercise called Fall Scene Investigation, or FSI. Direct feedback was given to individual nurses on fall report completion and charting regarding falls to help emphasize the importance of good documentation and follow-through on interventions. All staff and volunteers at the facility were taught to identify by symbolic indicators those residents who were "recurrent fallers", defined as residents who fell at least twice in 30 days. Once staff identified a resident as a person highly likely to fall, they focused on anticipating the resident's needs as a means to prevent a fall.

Interdepartmental collaboration in preventing falls in specific residents occurred daily in interdepartmental team (IDT) meetings and in weekly fall committee meetings for each unit. The resident status and the fall report were reviewed at the first meeting following the fall, again at the fall committee, and then weekly for a month to be sure the interventions were effective or appropriately modified.

Nurses and fall coordinators weren't the only staff members who were helping make the program successful by reporting incidents. Housekeepers often reported critical information to nursing staff, the maintenance staff was able to quickly respond to identified concerns or suggest modifications to room arrangement, and therapeutic recreation (TR) staff suggested specific interventions to engage falling residents. In addition, social workers suggested residents who may benefit by being included in group therapy for adjustment to moving to the facility, or in Keepsake programs to involve staff in reminiscing. OT and PT received referrals regularly following falls for review of transfer status, seating adjustments or strengthening after acute illness. TR programs now routinely encourage residents to stand as a means to maintain strength and balance.

Early on data analysis demonstrated early-on the effect of unwanted noise as a cause of falls and led staff to an understanding of sleep interruption as an additional cause of falls. Those insights and the benefits of overall reduction of doses and numbers of medications administered are now the focus of new initiatives to further reduce falls and improve resident quality of life. Some initiatives that were identified late in the process of the grant have proved to be elements that would be recommended to any facility wanting to reduce falls. These include:

1. Hourly rounds on all residents to better anticipate needs and assure customer satisfaction;

2. Fall "huddles" of all staff and others, that occur immediately after a fall, to determine factors that may have led to the fall; and

3. Elimination of personal alarms from the facility.

These last initiatives, when taken together, shifted care delivery from reacting to alarms to anticipating resident/family needs and being pro-active in providing care through learning about the resident.

The Administrator embraced the program from its start, reinforcing initiatives with staff during meetings at all levels and one-on-one with staff on rounds. While culture change was not the goal of the program, it has been a result of the collaborative efforts of the facility staff. Efforts are now underway to build "fall prevention" language into staff evaluations. No one could have guessed the new information we learned about causes and prevention of falls, or anticipated the dramatic changes that occurred in the facility as a result of program. We know that we will continue to learn and grow as we maintain our commitment to fall reduction.

Jean Jorlett, the Fall Coordinator and QA Coordinator at the facility can be reached for questions at 1-952-948-6903 or by email at jean.jorlett@mnmasonic.org.

GuideOne Risk Resources for Health Care
1111 Ashworth Road
West Des Moines, Iowa 50265
1-800-688-3628