AMERICA'S ESSENTIAL HOSPITALS

A featured project from the Essential Hospitals Engagement Network (EHEN)

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco General Hospital and Trauma Center (SFGH)

Sounding the Alarm for Injury Risk

Problem Identified

Falls and falls with injury began to decrease at SFGH after the introduction of beds with integrated exit alarms during the last quarter of 2010. There is scant evidence of bed exit alarm effectiveness in reducing frequency of falls or injury. There were 496 patient falls from 2011 through June 2013. Falls during night shift were 1.6 times more likely to result in injury.

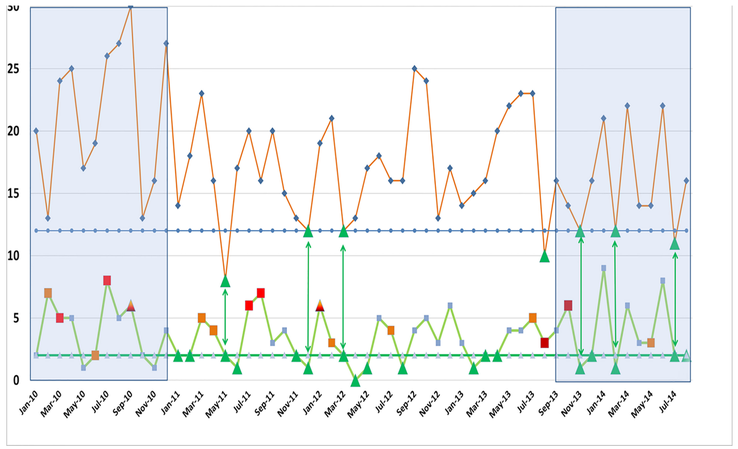
Interventions

The SFGH falls prevention task force analyzed the association and put in place a series of measures to address the higher frequency and severity of falls during the night shifts. The measures included: targeted education during shift change, staff meetings, and staff education with a bed alarm demonstration during the night shift; new employee orientation; annual updates, and input from the SFGH Nursing Research Council. Bedside inter-shift hand-off was encouraged. Individualized icons and a patient education video were created.

Outcomes

During the previous 12 months, from September 2013 through August, the median monthly falls and falls with injury frequency declined 32 percent and 33 percent, respectively. Night shift falls and falls with injury were reduced to their lowest level since 2011. The serious injury rate decreased 50 percent (0.10 to 0.05/1000 days). SFGH achieved a 40 percent reduction on claims-based falls with injury processed through UHC's clinical database.

SFGH Falls and Injury January 2010 through August 2014



Leadership and Patient Engagement

CEO Sue Currin (executive sponsor) encouraged identifying errors and using coaching to correct them. A joint union-management night shift committee shared interest in improved safety. The University of California-San Francisco Leadership Academy and Evidence-Based Practice Fellowship provided the team with skills. The team shared interest in safe mobility with the hospital-acquired pressure ulcer prevention team and quality department. Patient advisors assisted in video and graphical icon evaluation. The effort also received grant support from Hill-ROM.

Lessons Learned

Targeting a high-risk period (nights) and sub-population (confusion) for bed alarms may help. Bedside hand-off and individualized patient education was a challenge.

Strategies for Successful Replication

Aligning patient and staff education goals across teams may help staff and patients see the importance of minimizing harm while being hospitalized. Involving and rewarding staff for creativity, such as the falls "ICONtest" (see illustration), and encouraging critical thinking by discussion of falls and injury may be helpful in replicating results. Use of multimedia allows for improved and efficient patient safety education.