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*"We were able to significantly impact not only patient outcomes, but also the safety of 100 percent of our patients, by focusing on our goal to lower our emergent care falls rate. It was a tremendous opportunity to impact the health of our community."*

*Connie McCammond*

## Summary of Project

When Interim Healthcare of Greenville, South Carolina, sat down to embark on their 2004 performance improvement activities they took a close look at their data, in addition to looking at overall agency needs. They wanted to undertake a project that would have a positive impact on all of their patients.

They started by looking at the emergent care rates for injury due to fall or accident at home. The leaders of Interim Greenville identified this as an important metric, not only because it's an adverse event, but because almost every single patient had some risk of falling. Even though their emergent care rate was slightly below the national norm, 1.1 percent of their 7,000 unduplicated census still meant that almost 80 patients were seeking emergent care for a fall every year. Add to that the number of patients hospitalized for the same reason, and the agency saw an opportunity to impact the health of their entire patient community.

## Project Description

Once they made the decision to focus on falls, the agency faced many of the same questions other agencies were grappling with— How do they approach the problem of patient falls? Is there a certain percent of falls that they cannot predict and cannot prevent? What tools are available to help them achieve their goals?

The agency' created an interdisciplinary Falls Prevention Team to find answers to these questions. The members of the team wanted to fully understand the depth of the problem before they took any action. To gain that understanding, they looked to industry publications and standards and then to the data.

The industry research helped them identify potential risk factors for falls, specifically the number of medications, age, diagnosis, urinary incontinence, and ability to ambulate. They used this new knowledge as they looked into the falls that occurred in their patient population in 2003.

In the data investigation, they noticed a couple of interesting items. The first that caught their attention was the hypothesis they developed based on the literature review was not reinforced in the data. The team had theorized that a high number of medications and urinary incontinence would be consistent risk factors for the patients who fell. The data did not support this speculation.

With that realization, they began to notice other commonalities among patients who fell. They found that 41 percent of patients who fell, of which 93 percent were women, had all three of the following characteristics in common:

1. Over the age of 75
2. Scored a 1 or a 2 on M0700, ambulation/locomotion
3. Diagnosis of Abnormality of gait

Armed with this information, the team created a two-part action plan to reduce the rate of falls among their patients. The first part of this plan was to identify, or flag, patients who had an increased risk of falling. For example, every female patient over the age of 75, with an ambulation score of 1 or 2, and a diagnosis of abnormality of gait, was identified as a high-risk patient. The team refined the agency's policies to include a Personalized Safety Plan (PSP) for all patients that meet the high risk profile.

The team also created new care protocols designed to reduce risk and better educate patients on preventing and avoiding falls. All patients admitted with a diagnosis of abnormality of gait, as well as all female patients over the age of 65, are immediately assigned to a physical therapist. One of the primary responsibilities of the therapists is falls prevention education.

The Interim Falls Prevention Team knew that integrating new practices and policies into daily operations was only the first half of the battle. The second half of their action plan was devoted to monitoring progress towards their goal. Key data included the characteristics of patients with falls, in addition to emergent care and hospitalization rate trends. The latter would let them know if their efforts were paying off or not, the former would help them find ways to improve their high-risk identification process.

Towards those two ends, the team decided to look at OCS Adverse Event Patient lists weekly, do 100 percent chart review of patients with falls, and trend statistics about the characteristics of the patients who did fall.

Further, the Team and the leaders of Interim Greenville made a point to educate the rest of their colleagues about the project, why it was important, and how data played a critical role. Outcomes were added as an important component of quarterly staff meetings, monthly PI meetings, and case conferences with clinicians. In addition, the team posted quarterly performance results in the offices and the leaders provided outcomes to the agency's governing body.

## Process Defined and Implemented

- Identify a performance area important to the organization
- Select an interdisciplinary team to work on the PI project
- Understand current performance
- Review industry literature to better understand the problem and commonly accepted best practices
- Review historical data to gain insight into underlying causes to the problem at your organization
- Create an improvement plan
- Identify high-risk patients up front
- Design educational and support activities to prevent risk

- Monitor progress
- Keep all stakeholders informed
- Stay on top of what's important—continually communicate to staff and patients

## **OCS Tools Used to Support the Project**

- The OCS-OASIS Adverse Events Patient List was a key tool to quickly identify instances of adverse events
- The OCS-BBI Reporter Quality Tracking Report reviewed on a quarterly basis to track ER and hospitalization rates for injury due to fall or accident at home

## **Project Results**

End result improvement rates were remarkable for 2004:

- Reduced the rate of hospitalization for injury due to fall or accident at home from 1.1 percent in 2003 to 0.7 percent in 2004. This translates to preventing at least 19 patients from being hospitalized.
- The implementation of the PSP drove a decline in the rate of patient falls by 1.19 percent in 2003 to 0.87 percent in 2004.
- An unanticipated positive outcome of the project was an increase in the improvement rate in the outcome of ambulation/locomotion by 5 percent during the life of the project.