5) Bed Alarm Removal Initiative

Hebrew Senior Life

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PROJECT DESCRIPTION

Approximately 2 years ago frontline staff presented a proposal to remove bed and chair alarms facility wide. Their rationale was that alarms were noisy, often agitated our residents/patients and did not prevent falls but only alerted staff that a fall occurred. There was no evidence based research supporting the notion that bed alarms prevented falls. With the support of the multidisciplinary fall committee, a six month pilot was conducted utilizing the Plan Do Study Act (PDSA) methodology. After a successful pilot process a carefully implemented plan resulted in removal of all but 2 chair alarms for impacting a removal of approximately 300 alarms from patients and residents. The alarms were removed from our 3 service levels: Long Term Care, Skilled Rehabilitation and Medical Acute floors all the while maintaining a stable fall rate for all areas. Staff reported a much quieter environment that fosters a supportive healing experience.

The success of this project was possible due to the following key components:

- Front line staff were a critical part of the education design and the process improvement implementation. They identified key teaching concepts and determined a step by step approach to alarm removal that they felt would keep residents/patients safe.
- The leadership team's role was to support staff directed teams with implementation and not actively lead the project.
- Alarms were replaced by individualized purposeful rounding- a proactive instead of reactive approach. The 4 P's (position, pain, potty, and possessions) concept was instituted.
- Weekly huddles occurred during the alarm removal phase to ensure family, resident, and patient's understanding of the reason for removal and that care plans considered the unique needs of each resident/patient.
- A post fall huddle form was initiated that required a real time follow up for each fall with the intent of identifying the cause and altering the care plan to prevent further falls at the time of the incident.
- Ongoing data review regarding fall rates and reason for falls were discussed on the floors on a frequent basis to identify any changes and encourage proactive and timely follow through. The constant and in time review of information was essential to rule out "removal of bed or chair alarms" as the reason for a fall.

OUTCOMES ACHIEVED

- Fall rates in the hospital were generally stable compared to 2014 and were deemed to be in statistical control without significant deviations or patterns of change.
- Staff surveys around the effects of the changes was conducted and showed a majority of staff rated the changes conducive to less anxiety and noise while contributing to an environment where interventions such as purposeful rounding could better meet the patient's needs.

LESSONS LEARNED

- Buy in from frontline staff is critical when implementing untested clinical practice standards. The staff are instrumental in the design, implementation and sustainability of the new process.
- Use of PDSA methodology creates a logical blueprint for staff to follow and for others to replicate.
- Ongoing and real time review is essential so that there is confidence from the clinical team that that fall could not have been prevented by the placement of an alarm. Without this awareness any monthly increase of fall rate increase may easily be attributed to the removal of alarms.