

Fall Reduction on a Medical Surgical Unit in a Rural Hospital

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Background

Aurora Memorial Hospital of Burlington is an integrated not-for-profit health care provider serving a rural community in Southeastern Wisconsin. The small size does not reduce the array of services, resources, and specialties that we have available for our community. We partner with our patients to provide comprehensive, individualized, quality healthcare. This makes health care more accessible and efficient.

Licensed Beds	109
Staffed Beds Hospital	67
Total Med/Surg Beds	30
Total Caregivers RN	33
Total Caregivers ACNA	30
Total Caregivers LPN	3

The Problem

In 2013 Aurora Memorial Hospital ended the year of 2013 with 33 falls.

- Two of the falls resulted in significant injury for our patients.
- Our falls per patient day ratio was 5.6 falls per patient day. *Action needed to be taken.*
- Falls contribute to:
 - functional decline,
 - increased mortality,
 - result in injuries that increase length of stay and
 - could result in need for placement for our elderly population.
- Decreasing falls would be better for our patients and would result in better outcomes and decreased health care costs.

Resources

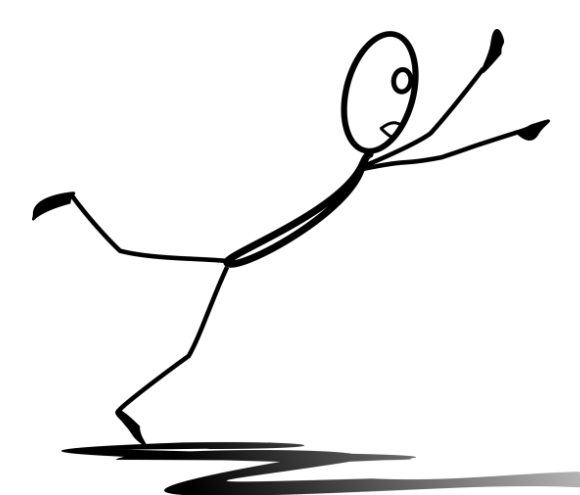
- From Oct 2013 our hospital was able to acquire new inpatient beds.
- These beds have a feature that allows the RN to program the bed to alarm when certain parameters are breached.
- Training was provided to:
 - All the RN's and ACNA's on Medical Surgical,
 - ED,
 - ICU,
 - Postoperative Overflow Unit,
 - Physical Therapy staff,
 - Kitchen staff,
 - Radiology, and
 - OR/PACU.



Barriers

- Several barriers were identified.
 - The Morse fall Scale was not being assessed accurately.
 - This was giving inaccurate scores on patients.
 - ALL RN's were given educational packets on the correct way to complete the Morse Fall Scale, and how to initiate fall precautions based on result of the Morse Fall Scale.

Morse Fall Scale
History of Falling: Immediate or within 3 months
Secondary Diagnosis
Ambulatory Aid
Intravenous Therapy/Saline Lock
Gait
Mental Status
Morse Fall Scale Score
Participates in Fall Prevention Activities



More Barriers Identified

- Another barrier we identified was that the staff had a "that's not my patient mentality." So if we had a complex or confused patient not everyone knew that patient was at risk.
- Falling star magnets were placed outside the room on the door frame so anyone that passes that room can see this patient is a fall risk.



Training

- Training was done in collaboration with our Industry Representative, who came to the facility and facilitated hands on education with our staff.
- This training was deemed mandatory by educator and all managers.
- On admission the Morse Fall Scale is completed anyone 45 or greater would be considered a fall risk and the fall prevention protocol would be implemented.

- Fall protocol is as follows
- Bed set up
- Brake on
- Two side rails up
- Bed in lowest position
- Bed Alarm set to Zone 2
- Bed activated.



Data Collection

The first three months of the new protocol the educator and the industry representative completed random audits to ensure the staff was following the initiative.

Our Goals were:

- Reduce all falls by 50%
- No falls with significant injury

Nursing Unit: 2nd floor		n-total patients assessed		Fall Compliance Audit								
Product: S3		n-total patients at Fall Risk (Morse Score 45)		Survey Date:								
		by:										
patient related		environment		bed related								
Fall Risk	45+	Yellow	PT Close	Room	Nurse Call	Bed Plug	Brake	Side Rail	Bed	Bed Exit	Bed	misc interventions
Room #	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Notes

Results

30 Day Results: **No Falls**
60 Day Results: **No Falls**

- What happened over the next several months was amazing.
- We had staff literally running to alarms,
- Staff was working together to prevent our patients from falling we were counting the days down to our 100 day no falls.
- On day 68 we had a fall on the Medical Surgical Unit
 - The patient was lowered to the floor by Therapy when he became weak and could not walk another step.
 - The patient was uninjured but the nursing staff took it hard especially since it was not a nursing fall but it still counted against the unit.

Success

- Staff continued to follow protocol and our total numbers at the end of the year were more than half from 2013.
- The program met our goal of 50% reduction in falls.
- We did have a significant injury so we were unable to meet that goal.
- Our unit's longest time between falls was 68 days.*
- Key to success was teamwork and everyone making the effort to keep our patients safe!

Falls	2013	2014	Falls per patient day	Fall per patient day
			2013	2014
	33	13	5.6	2.11