A Unified Approach to Decreasing Patient Falls

Aurora St. Luke's Medical Center

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Problem

Identify strategies to decrease the number of patient falls on an inpatient medical surgical unit

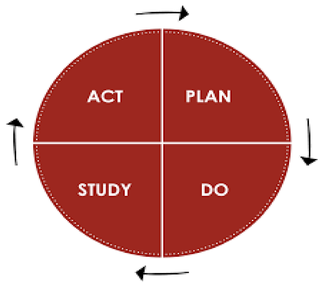
Background/Significance

- Falls in the acute care setting are a significant patient safety issue
- Falls have been identified as a leading cause of injury for adults aged 65 years+ and can result in disability and negative impact on quality of life (Christopher et al., 2014)
- Falls are a persistent and significant health care problem and are considered a nurse sensitive indicator (Spano-Szekely et al., 2019)
- Nurses' perception varies regarding who is responsible for the actual mobilization of patients (Doherty-King & Bowers, 2013)
- Hospital inpatient units continually strive to provide safe effective care for patients with the goal of zero-harm.

Population/Setting

- 24 bed Medical Surgical Unit in a 4-time Magnet designated, 600+ bed urban quaternary care hospital
- 44 nursing team members and dedicated leaders
- Falls were analyzed starting mid-2016
- Team members mplemented short-cycle quality improvement interventions from 2016-2018

PDSA Model



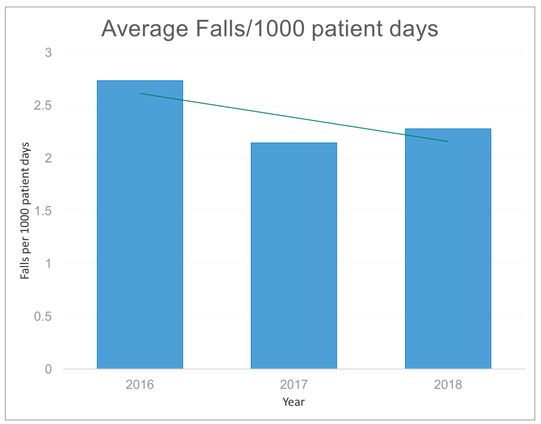
Methods

- Nurses on different workgroups collaborated for a unified approach to decrease falls
- The team identified an opportunity to make fall prevention equipment readily available for staff
- The Falls Workgroup designed a "fall bag" to be given to each patient upon admission containing:
  - patient education materials,
  - gait belt,
  - non-skid slippers,
  - toilet paper,
  - a chair alarm pad
- Unit leadership and the Patient Experience team validated caregivers on hourly rounding to proactively meet patient needs and reduce unassisted falls
- Two sequential PDSAs were implemented by the Geriatric Resource Nurse to strengthen patients and reduce falls related to deconditioning. The PDSAs focused on structured out of room ambulation titled
  - "On Your Seat to Eat"
  - "On Your Feet to See who You Meet"

Fall Bag Contents

Findings

- The unit achieved a 40% reduction in falls between 2016 and 2017
- This was sustained through 2018 in an environment of increasing mobilization of patients
- Zero falls with major injury have been sustained since January 2018
- Delirium was an identified risk factor for patients who fell after interventions became embedded in practice



Conclusions

- Collaboration of inpatient medical surgical nurses to devise unit specific interventions is an effective strategy to help decrease the overall number of inpatient falls.
- Employing education on safety and fall prevention to patients is a means of partnering for safety.
- Continued collaboration between nursing staff and therapy to support patient goals of progressive mobility is critical to success.
- Future staff education of delirium detection and prevention strategies is planned.

References

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4EF Geriatric Resource Nurses and unit staff