

FALLS REDUCTION IN A RESTRAINT FREE INPATIENT REHABILITATION UNIT

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Falls Defined

- **2010 National Patient Safety Goal #9 – to reduce the risk of patient harm resulting from falls.**
- **According to several sources, falls are: “a sudden, unintentional change in position causing an individual to land on a lower level, an object, the floor, or other surface including slips, trips, or loss of balance”.**

Goals for Fall Reduction

- **Reduce the number of falls without the use of restraints.**

Fall Reduction Evidence Based Practice

- **Hourly rounding**
- **Bed Alarms**
- **Room placement considerations**
- **One to One monitoring**
- **Low Beds**
- **Post Fall Assessments**

Fall Reduction Plan

- Staff Education
- Use of Henrichs II Fall Assessment
- Proper signage
- Use of Bed Alarms
- Use of Low Beds
- Hourly Rounding
- PM Walking Group
- Use of Patient Care Companions for one to one oversight
- Placement in proximity to nurses station
- Medication Review
- Use of non-skid shoes or socks
- Post Fall Huddle



Hourly Rounding

- Performed on off shifts, nights and pms
- Provides greater oversight and closer monitoring of patient status
- Rounding performed with the purpose of toileting, pain control, repositioning or moving closer to nurses station for one to one monitoring
- Results in decreased falls and decreased unit acquired pressure ulcers

Evening Walking Group

The requirements for patients in the walking group:

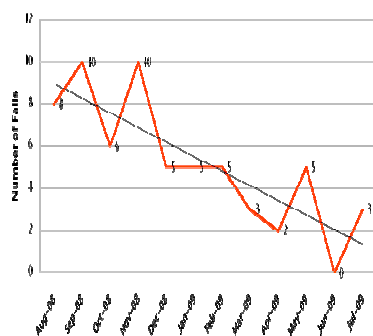
- Physical Therapy Approval
- Able to ambulate 100 feet with assistive device
- Must be CGA or SBA

Benefits of Walking Group

- Stress Relief
- Additional Exercise leading to increased strength and stamina
- Positive Mental Attitude
- Better sleep, decreased restlessness
- Decreased Falls

Inpatient Rehabilitation Falls

August 2008 through July 2009



- 2008 NDNQI - 6.94
- ALGH - 4.17
- 2009 NDNQI - 6.94
- ALGH - 2.0

Result: 68% Decrease 2008 vs. 2009

Decreased Unit Acquired Pressure Ulcers

An added benefit to our falls reduction program was the decrease in our unit acquired pressure ulcers.

- **Jan – Aug. 2009 – 0 pressure ulcers**
- **July – Dec. 2008 – 4 per 1000 pt. days**

Lessons Learned

- **Acute Rehabilitation Patients are at high risk for falls.**
- **Fall incidents can be reduced in high risk patients without using restraints through the use of fall reduction strategies.**
- **Unit Acquired pressure ulcers are also reduced with fall reduction strategies.**
- **Higher quality care results in increased patient satisfaction**

References

1. Bonner, Alice K, RN, GNP, FAANP (2006) "Falling Into Place: A Practical Approach to Interdisciplinary Education on Falls Prevention in Long Term Care". *Annals of Long Term Care*, Volume 14, Number 6: June, 2006
2. Ward, Annette, MSN, RN; Candela, Lori, EdD, MS, RN, CRRN, Judy Mahoney, MA, RN, CPHQ. "Developing a Unit Specific Falls Reduction Program". *National Association for Healthcare Quality*. March/April, 2004
3. www.health.vic.gov.au/agedcare/maintaining/falls/definition.htm
4. [www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/chapter 1](http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_falls/chapter_1)
5. www.premierinc.com/safety/topic/falls