Successful Unit Level implementation of a Hospital Policy

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Abstract

Purpose: The unit had experienced an increase in the number of falls and injuries related to falls. Under the guidance of the Falls Best Practice Committee, the strategic plan was to implement measures that were found to be best practice in accordance with literature.

Significance: There has been a significant emphasis placed on hospital acquired complications that are perceived as preventable. As public reporting of quality data becomes the standard, hospitals must develop plans to improve and/or eliminate these complications. Hospital leadership teams must utilize evidence based practices and shared leadership structures to create cultures that focus on patient safety. Regulatory agencies are aligning their reimbursement structures for hospitals to deny payment for "never events' (an event that should not have occurred). Falls resulting in injury are considered a "never event."

Strategy and Implementation: The Progressive Care Unit (PCU) is a 25 bed unit that cares for ventilator dependent patients that are de-conditioned. While reviewing our quality data, we noticed that our fall rate was slowly increasing. For calendar year 2006 our fall rate was 3.89. Since our rate was above the National Database of Nursing Quality Indicators (NDNQI), we joined the hospital Best Practice Council on falls. We successfully implemented the elements sited by the Best Practice Council, including daily huddles. The huddles are conducted at the beginning of each shift. All patient care staff, including unit secretaries and monitor techs, participate in the huddles. The team quickly realized that instead of expecting one person to be responsible for each patient who was at risk for falling, that it took a "community" to prevent falls. The staff focused on behavioral, physical and physiologic attributes that increase the likelihood of falls occurring.

Evaluation: By hardwiring the strategies for fall prevention, our fall rate had remained under the NDNQI benchmark for 2007 and 2008. For the first three quarters of 2009, our fall rate is 1.99. Due to a rise in injuries for quarters one thru three of 2009, our focus will be on re-educating staff as well as ensuring all newly employed individuals are aware of the standards of practice that have been implemented to prevent patient falls. The education will focus on the processes in place to assist with meeting these expectations as well as continual literature review to ensure we are abreast of the most current and successful practices.

2008-2009 Progressive Care Staff

Fall Prevention Initiatives

- Safety Huddle
- Bed Alarms – when they ring Unit Secretary pages overhead to all staff
- Patient's at risk are considered "community property" all staff to respond to all bed alarms regardless of assignment
- Patients are out of bed to chair for meals
- Patients are placed on two hour toileting rounds
- Patients are never to be left unattended in the bathroom
- Patients are transported to test/procedures by stretchers
- Review fall debriefing form with staff after each fall to review which interventions in place prior to fall, why they weren't effective and what interventions need to be implemented to maintain the patient's safety.

Visual cues to patient and families:

•Colored non-skid socks: YELLOW = high risk, RED = history of fall
•Yellow armband indicates patient is a fall risk
•Yellow signage posted on patient's door & front of chart
•Fall prevention signs posted in the patient's room "Cal Don't Fall".

Huddle Sheet

"HUDDLE"@ SHIFT START

DATE: _____ TIME _____

High Fall Risk Patients

Room	Name	Toileting Sched.	Bed Alarm	PCC

"HUDDLE"@ SHIFT START

"PREVENT A FALL" ACTIONS

- 2 Hour toileting schedule
  - *Even Rooms on Even Hours –*
  - *Odd Rooms on Odd Hours*
  - *"It's Time to Assist You to the BR or BSC"*
- OOB in chair for meals
- Bed Alarm "Rings" and US will page to "all staff"
  - *Staff Closest to Room Will Respond*
- Prompt Response to Call Light by All Staff
  - *Patient is Community Property: The Patient Belongs to Everyone*
- **RN determines off unit transportation mode**
- **Never** leave a patient alone in the bathroom or on BSC
- Socks:
  Yellow = High Fall Risk **Red = Patient has Fallen**

Fall Debriefing

1. Form completed within one hour of the fall by the management team and staff.
3. The debriefing focuses on ensuring the patient receives an X-ray/CT scan if needed, what factors contributed to the fall, what interventions were in place prior to fall and why those interventions were not effective.

Outcomes