



Reduction Of Falls On A Neuroscience Unit Through Implementation Of Signage Indicating A Patient's Fall Risk



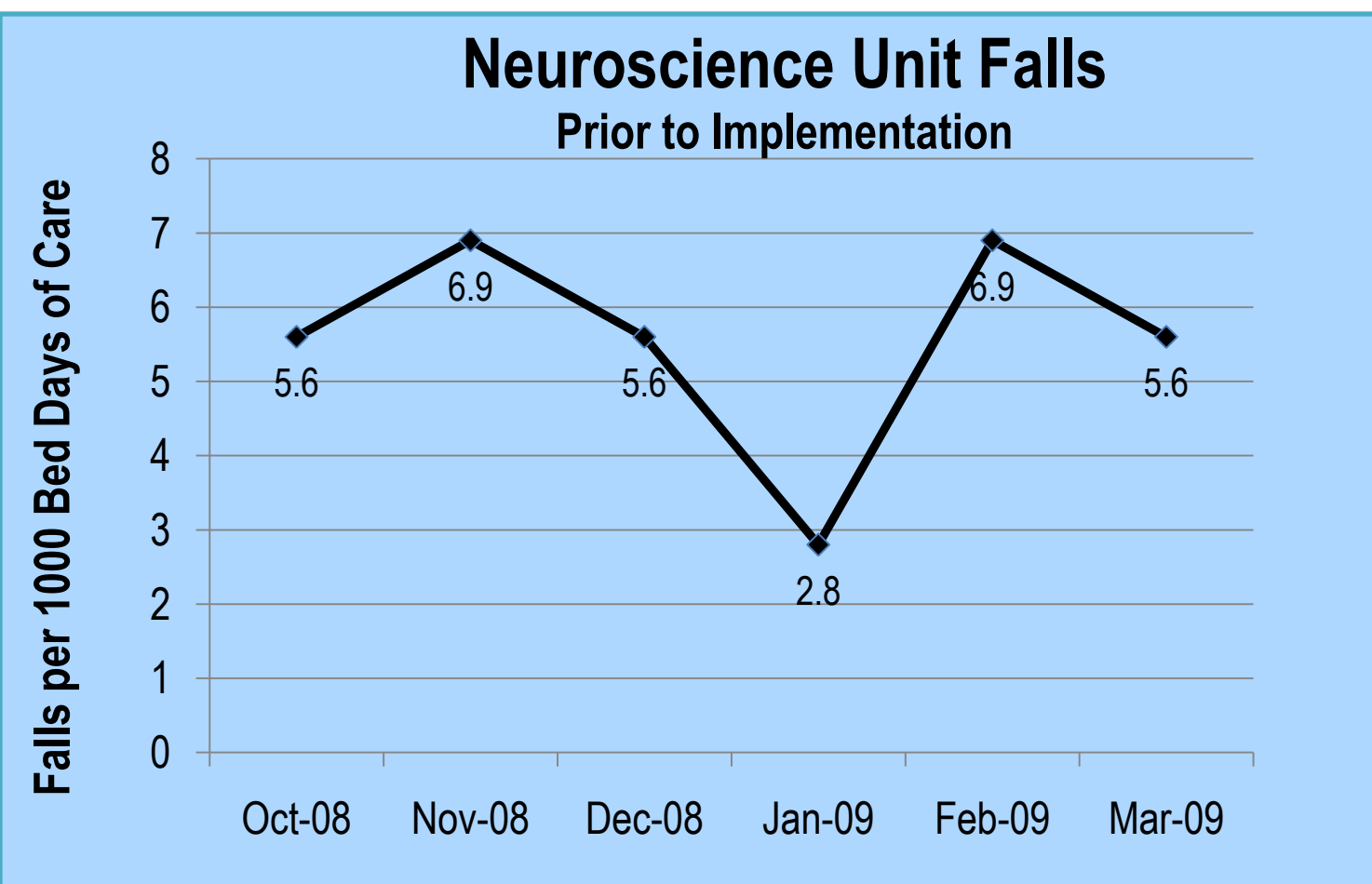
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Introduction

Neurological patients admitted to an acute care facility are at an increased risk for falls due to decreased mobility and impaired cognitive function. According to reports published by the Centers for Disease Control and Prevention in 2007, falls are the third most common cause of unintentional death across all age groups and are the leading cause among people sixty-five years and older. Research has shown that one out of every three people over the age of sixty-five will fall each year, with falls being the leading cause of injury, hospitalization, and death for seniors. Patients within an acute care setting are at a greater risk for falls due to an unfamiliar environment, medications, and his or her illness or symptoms. Patient falls are the sixth leading cause of sentinel events in the hospital setting; with that comes the enormous cost to the healthcare system. By 2020, the cost of fall injuries is expected to be \$54.9 billion. Due to the prevalence and negative outcomes associated with falls, the Joint Commission has made fall reduction and resultant injury from falls a national patient safety goal.

Problem

During the 2009 fiscal year the neuroscience unit observed an increasing trend in the number of inpatient falls. Based on a standard of 29 falls during fiscal year 2008, the hospital set a standard to reduce patient falls on the neuroscience unit by 25% to a goal of 22 falls for fiscal year 2009. After the second quarter of FY 2009, the unit had already exceeded its benchmark with a total number of 24 falls. At this rate of falls, the unit would be at an approximate total number of falls of 50! This issue was taken to the members of the unit council to develop an intervention and plan to help reduce the total number of falls.



Patient Population

This study focused on acutely ill patients on a neuroscience telemetry unit with a nurse to patient ratio of 5:1. Patients with conditions such as seizure disorders, acute ischemic stroke, intracranial hemorrhage, spinal surgery, and other acute neurological disorders, have issues with gait instability, cognitive impairment, pain control, and fine and gross motor skills. This patient population receives several types of medications that may place them at increased risk for falls including benzodiazepines, narcotics, antiepileptic drugs, anticoagulants, and antihypertensives. Equipment utilized with these patients including IV pumps, telemetry monitoring, and sequential compression devices are also barriers to safe patient ambulation.

Brainstorming

In January 2009, the unit council met to formulate a plan for reducing patient falls. All members were requested to perform literature searches regarding patient falls, different fall prevention programs, and methods for fall prevention. The council examined the current fall prevention policy and procedure and bed fall monitoring equipment. Visual inspections were performed in each patient room to assess equipment and physical barriers. The council also reviewed statistics concerning unit-specific falls to recognize any commonalities or trends.

Research Findings

Upon review, it was noted that the current fall prevention policy and fall risk scale combined all patients into one of two categories, at risk or not at risk for falls. Since a neuroscience unit is comprised of a variety of patients with different cognitive and physical abilities that may be altered or changed at any time, it was decided that fall prevention should become more individualized. It was also found that with the current fall policy, a healthcare provider did not have a tool to guide them in determining a patient's fall risk. Evidence-based research also revealed that visual cues inside the patient's room helped enhance the patient's and family's knowledge of his or her own fall risk.

Intervention

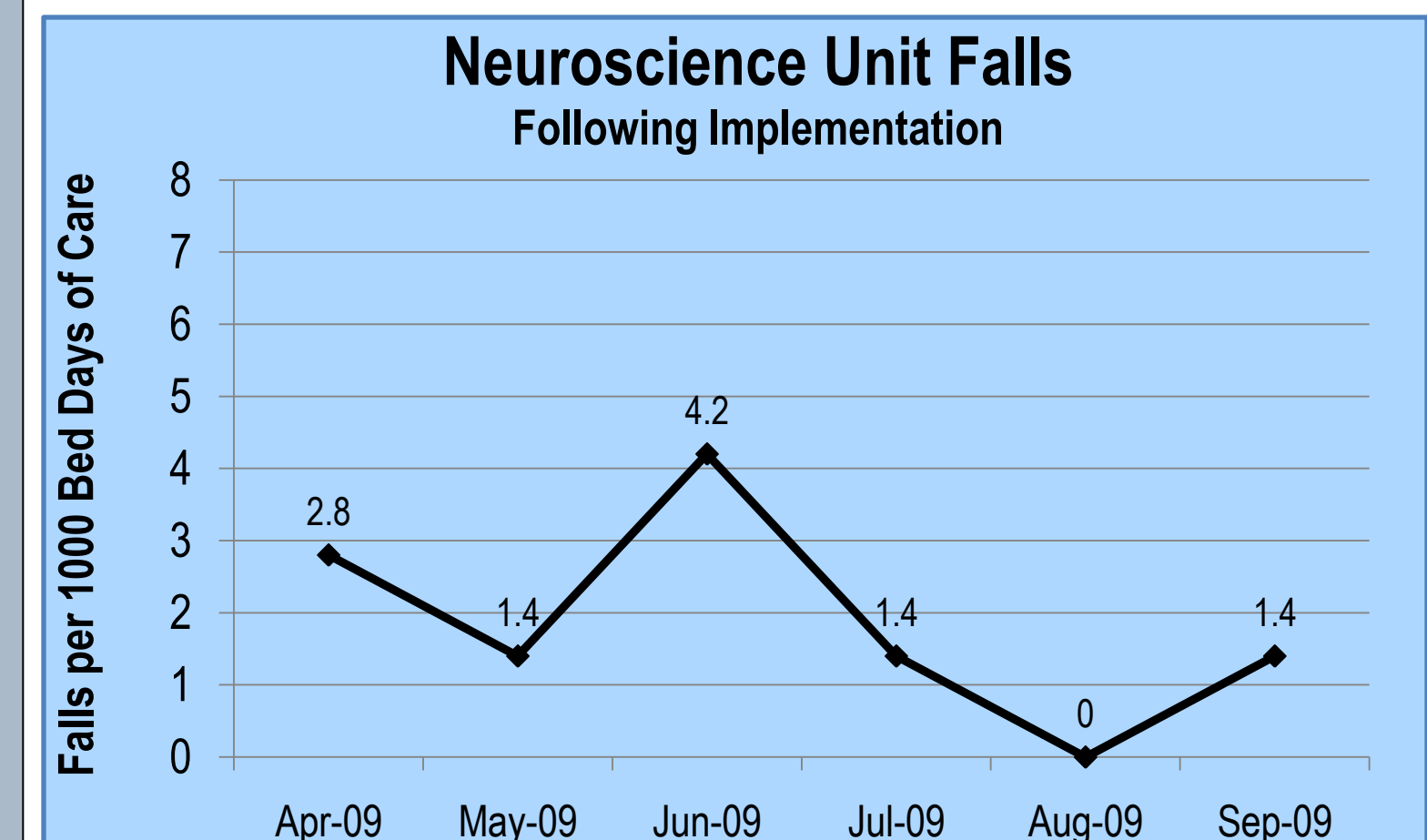
Evidence-based research indicated that visual signs placed in a patient's room were an effective tool to educate and involve patients and families in fall prevention. The unit council also identified that each patient had individualized risk factors and the current classification system did not accurately represent each patient's fall potential. Fall signs were developed classifying patients into one of the following categories:

<p>LOW FALLS RISK</p> <p>Patient Is/Has:</p> <ul style="list-style-type: none"> Alert & Oriented No Confusion Judgement Intact No Walking Aids No Falls Hx Normal Gait No Dizziness No Vertigo Normal Elimination No Weakness <p>BEDFALL MONITOR ON 2100 - 0700</p>	<p>LOW RISK</p> <p>Bed Fall Alarm "ON" 9P-7A</p>	<p>MODERATE FALLS RISK</p> <p>Patient Is/Has:</p> <ul style="list-style-type: none"> Alert Some Confusion Judgement Intact Walking Aids Falls Hx Forgetful Mild Dizziness Mild Vertigo Normal Elimination <p>BEDFALL MONITOR ON AT ALL TIMES</p>
<p>HIGH FALLS RISK</p> <p>Patient Is/Has:</p> <ul style="list-style-type: none"> Lethargic Disoriented Confused Impaired Judgement Fall Hx Abnormal Gait Dizziness Vertigo Abnormal Elimination Weakness Noted <p>BEDFALL MONITOR ON AT ALL TIMES</p>	<p>MODERATE RISK</p> <p>Bed Fall Alarm "ON"</p>	<p>HIGH RISK</p> <p>Bed Fall Alarm "ON"</p>
	<p>HIGH ORDERED BEDREST</p> <p>ALL ACTIVITIES ORDERED BY ATTENDING PHYSICIAN</p> <p>BEDFALL MONITOR ON AT ALL TIMES</p>	

- Patients categorized as low risk for falls were placed on bedfall monitor at night from 2100 to 0700. Patients at moderate and high risk for falls and patients on bedrest were to be placed on the bedfall monitor at all times.
- Signs were placed on the door to each patient's room allowing for all members of the interdisciplinary team who entered the room to understand that patient's fall risk. The same sign was placed directly in front of the patient on the wall at the foot of the bed to engage him or her in fall prevention.
- Staff were educated on the different ways to categorize patients based on their risk factors. Signs were placed in prominent areas throughout the nurse's station to assist nurses in determining a patient's fall risk category.
- Nursing staff was instructed to re-evaluate a patient's fall risk at least once per shift or with any change in the patient's condition. Staff were to report to the oncoming nurse the patient's fall risk during change of shift.
- Meetings were also held with patient transport services to educate regarding the unit's fall prevention program and to ask for nursing assistance as needed when moving or ambulating patients.

Results

The program was fully implemented April 1, 2009. After implementation of the fall risk classification program, there was an overall reduction in the total number of patient falls. Prior to implementation of the program, the goal was to decrease the total number of falls by 25%. The total number of falls for fiscal year 2009 prior to beginning the program was 24. After implementation of the program, the total number of falls for the second half of the fiscal year was eight resulting in a 33% decrease in the number of falls.



Implications for Practice

A comprehensive approach to fall prevention is an effective way to reduce the overall number of patient falls. Each patient admitted to an acute care hospital has individualized risks for falls. Neurological patients have unique characteristics increasing their susceptibility for falls. A key aspect to fall prevention is the involvement of the patient and family in avoidance of falls along with accurately categorizing each patient's risk. Involvement of the interdisciplinary team in fall prevention is crucial including nursing staff, ancillary staff, transport services, and physical/ occupational therapy. The key to prevention is communication with all involved in patient care, including the patient and family.

References

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