Impact of Bed Alarm Utilization on Reducing Patient Fall Injuries

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Background

- Patient safety is one of Medical City's performance improvement priorities and is aligned with Medical City's five keys to success – patient loyalty; employee engagement; physician engagement; community awareness, and fiscal performance.
- The prevention and reduction of patient injury from falls is a keystone of Medical City's patient safe culture and correlates with the national patient safety focus on falls embedded in the Joint Commission's National Patient Safety Goals, Leapfrog Safe Practices, NQF's Nursing Sensitive Indicators, and Hospital Acquired Conditions.
- The Falls Prevention Team is the oversight body for the National Patient Safety Goal on reducing the risk of injury secondary to falls. The team is responsible for monitoring the effectiveness of the falls prevention reduction program – the Watchful Eye. Membership includes representatives from units with high or increasing patient fall trends as well as, "best practice" units.

P-Plan

Opportunity for Improvement	Literature Review & Analysis	Focus
3Q08 stable fall rate; however, inpatient fall injury rate high Aggregate root cause analysis revealed need for consistent fall prevention strategies	Lit. review inconclusive on the best nursing interventions regarding patient fall reduction strategies Evidence based practice for reducing falls included the assignment of a fall risk status for every patient at admission. Fall risk identification tool verified as accurate assessment already in place	Using the Performance Improvement method Plan-Do-Check-Act (PDCA), the Falls Prevention Team implemented a bed alarm focus to reduce patient fall injuries

D-Do

Product	Bed alarm inventory revealed the need for additional bed alarm resources. Additional bed alarm resources were obtained.
Policy	Policy wording was clarified to avoid misinterpretation of optional bed alarm use.
People	Mandatory staff education with a skills lab was completed.
Process	Unannounced observations were used to evaluate actual bed alarm use.

C-Check

- Measures of success were evaluated through unannounced bed alarm usage observations, reported fall events, and comparison with NDNQI benchmarks.

A-Act

- Bed alarms included on post fall assessment or "huddle" forms and on the Patient Tips sheet
- Exploration of additional alarm devices, such as chair alarms
- Continuation of partnering with patients and families via the Patient Tips sheet for improved bed alarm usage

References

- Joint Commission, National Patient Safety Goals, www.jointcommission.org
- Capezuti E, Brush B, Lane S, Rabinowitz H, Secic M. *Bed Alarm Effectiveness.* Archives of Gerontology and Geriatrics, 49 (2009): 27-31
- Currie L. *Chapter 10. Fall and Injury Prevention.* Patient Safety and Quality: An Evidence-Based Handbook for Nurses. AHRQ Publication No. 08-0043, 2008

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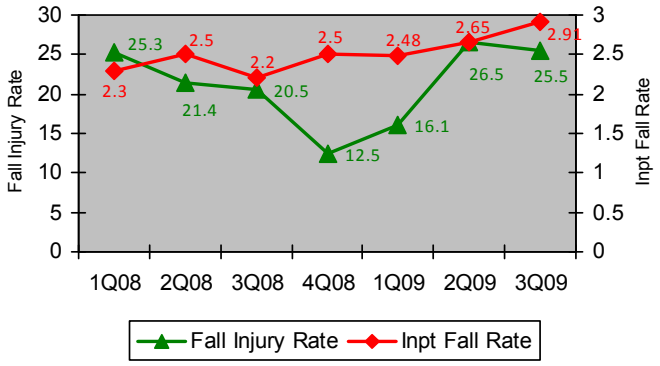
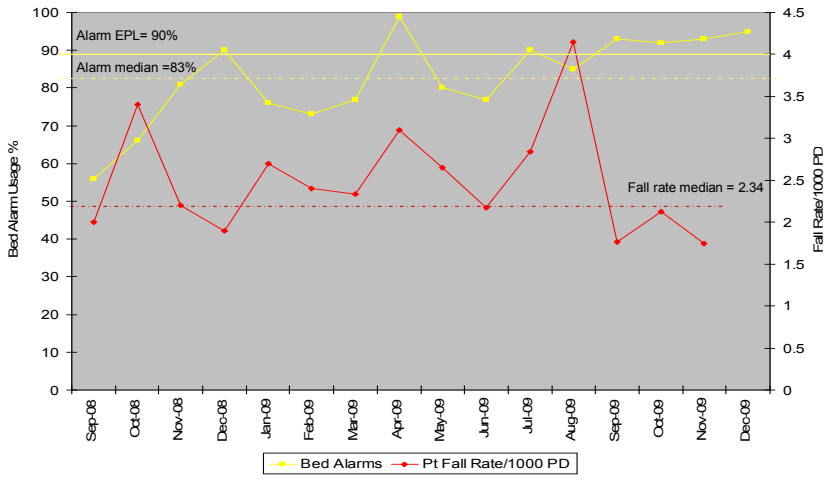
Fall Injury Rate vs Inpatient Fall Rate/1000 PD



Bed Alarms ON for High Risk Fall Patients* vs Inpatient Fall Rate/1000 PD



* Collected for specific units in the S and E towers per action plan

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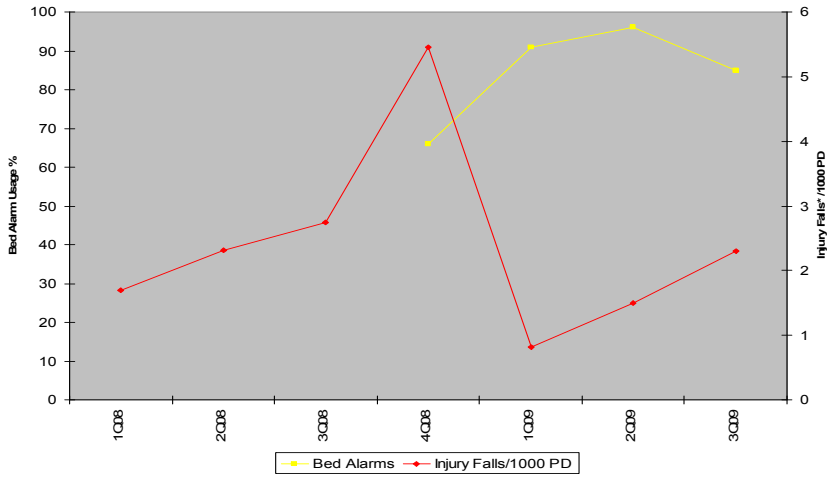
Bed Alarms ON for High Risk Fall Patients vs Injury Falls/1000 PD* Oncology Unit



Source: facility NDNQI data

Bed Alarms ON for High Risk Fall Patients vs Fall Rate/1000 PD Oncology Unit