A Multi-Pronged Approach for Reducing Falls in an Acute Care Setting

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Purpose

To establish a culture of safety by engaging clinical associates in the prevention of falls

Background/Significance

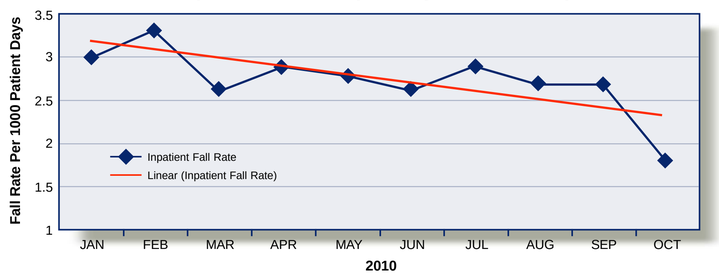
- Falls are the most common preventable iatrogenic event in the acute care setting with 20% resulting in injury
- In 2009, the Fall Prevention Performance Improvement Committee identified a significant increase in falls and falls with serious injuries
- Root Cause Analysis indicated a need to improve nurse associate engagement by incorporating consistent fall prevention strategies into daily practice
- Research indicates that falls may be reduced by:
  - Evaluating and identifying risk factors,
  - Developing an appropriate plan of care for prevention,
  - Performing comprehensive investigations of falls, and
  - Instituting a post fall evaluation of care

Methods/Implementation

- Evidence Based Policy developed
- PI team: increased unit participation
- PI dissemination of information
- New risk screening tool: Heindrich II
- Incorporated Heindrich II into Electronic Medical Record (EMR)
- Mobility Matters Clinical Skills Acquisition Program
- Unit-specific Action Plans
- Nurse Leader Validation Rounds
- Post Fall debriefing tool
- Laminated tool attached to EMR carts
  - Interventions based on specific category of risk (e.g., confusion)
  - Definitions of Heindrich risk categories
- Access to supplies/materials, e.g. large socks; specialty beds lowers closer to floor
- Standardized nurse leader response to performance management process
- Small tests of change
  - Change slipper color
  - Voice activated alarms
- Corporate Fall Prevention Symposium speaker: Dr. Heindrich Speaker
- Corporate committee identified need for Standardized Process

Results/Evaluation

Inpatient Fall Rate (January-October 2010)



Conclusions/Implications for Nursing Practice

Process standardization

- Focused and continual evaluation at unit level
- Supplies and materials easily accessible
- Real-time unit-specific outcomes data displayed on unit
- Celebrate success

Standard Fall Prevention Intervention

Standard Interventions for All Patients	Interventions for All High Risk Patients
Place frequently used objects within reach, including: • Call light. Position the call light so that the patient can reach it. • Personal Items. Place personal items within easy reach (phone, bedside table, call bell, water, urinal, eyeglasses, cane or walker, etc.) and provide non-skid slippers • Remove Clutter Ensure clear path to bathroom, remove long electrical cords and clean spills immediately. Educate Patient and Family: To the room, call light use, and fall prevention strategies.	• Halt for Hand Off – The patient's high fall risk status should be included as part of nursing report and in the transfer report of a fall-risk patient to a procedural area. • Identify patient's door and front cover of medical record with "Fall Risk" sign • A staff member must remain with patient when assisted to the bathroom • Check patient every hour and toilet and provide comfort measures. • Initiate the use of a bed and chair alarm Provide and document education provided to the patient and family regarding the potential risk of a fall occurring and associated fall prevention safety interventions initiated.
Get Up and Go Score > 3	**Alteration in Elimination**
• Use of Walkers, Canes – Determine if your patient uses an ambulation device at home. If yes, encourage family member to bring in the device from home. An ambulation device must be available and within reach of patient. • Obtain PT/OT consult • Gait Belts. Use a gait belt to assist in patient movement • Implement High Risk Fall Precautions Interventions (i.e., bed and chair alarms) Teach patient to NEVER ambulate without assistance.	• Perform meaningful rounds • Communicate high fall risk to all caregivers during staff huddles. • Provide hourly toileting • Explain to the patient the importance of calling for assistance. • Implement High Risk Fall Precautions Interventions (i.e., bed and chair alarms) NEVER Leave the Patient Alone on the toilet or commode.
Depression	**Confusion, Disorientation, Impulsivity**
• Implement Basic Environmental Safety Interventions • If patient is a suicide risk implement appropriate suicide precaution interventions immediately. • Provide assistance with self care. • Monitor for antidepressant side effects: impaired gait and mobility, dizziness and vertigo and confusion/disorientation. • Monitor for changes in lab values including: - Fluid and electrolyte changes - Blood Glucose Levels - Acid-Base - Magnesium and phosphate levels. Contact LIP with laboratory and vital signs and assessment results to implement interventions strategies to address any fluctuations or abnormalities noted.	• Implement High Risk Fall Precautions Interventions (i.e., bed and chair alarms) • Keep a consistent daily routine • Provide frequent orientation to person, place and time. • Perform all interactions with the patient in a calm and unhurried manner. • Monitor for changes in lab values including: - Fluid and electrolyte changes - Blood Glucose Levels - Acid-Base - Magnesium and phosphate levels • Monitor for Fever, changes in O2 level and or increase in pain levels Contact LIP with laboratory and vital signs and assessment results to implement interventions strategies to address any fluctuations or abnormalities noted.
Dizziness and Vertigo	**Antiepileptics and Benzodiazepines**
• Perform Gait Assessment • Perform orthostatic vital signs • Teach patient to dangle at bedside with assistance prior to standing. • PT/OT consult • Explain to the patient the importance of calling for assistance. • Implement High Risk Fall Precautions Interventions (i.e. bed and chair alarms) Teach patient to NEVER ambulate without assistance	• Perform Gait Assessment • Assess for irritability, unsteady gait, ataxia and in-coordination. • Monitor drug serum levels • Explain to the patient the importance of calling for assistance. Collaborate with pharmacy and LIP regarding medication management

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References Available on Request

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