Title:

Meeting the Challenge: Fall Minimization on a Neuroscience Floor

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Introduction:

The fall rate on one 50 bed combined neurology/neurosurgery nursing floor has been consistently above the NDNQI benchmark for "Number of Falls per 1000 Patient Days". The goals of intervention were to raise fall awareness and decrease the fall rate by at least 30 percent or to NDNQI target.

Problem:

Neuroscience nursing floors face challenges in keeping this high fall risk patient population safe and free from falls while in the hospital. A proactive, collaborative approach to fall minimization was used to reduce the number of falls on a neuroscience nursing floor.

Methods:

In January 2010, the unit based shared governance council was challenged to develop an action plan detailing fall minimization interventions to be implemented above and beyond existing hospital protocols.

Hospital protocols included:

- Fall risk assessment
- Fall Minimization and Post Fall Care
- Hourly Rounding

Shared Governance interventions included:

Fall Calendar:

The shared governance council asked the question: “What does a fall rate of 8.30 mean?” To determine the answer to this question, a fall calendar was posted in the break room and updated daily, indicating whether or not a patient had fallen. This allows immediate feedback to the staff and helps correlate number of falls with the fall rate.

Fall Huddle:

The shared governance council wanted to raise fall minimization awareness with all members of the healthcare team. This was accomplished by forming a proactive, collaborative fall huddle group to meet weekly, every Tuesday at 0930. A fall huddle tool was developed to guide this group in identifying potential fall risk factors in the neuroscience population. Members of the huddle group include nurses from the unit, nursing assistants, clinical nurse specialist, clinical instructor, assistant nurse manager, and a representative from the physical therapy department. The fall huddle group discusses 2-5 patients fall risk and interventions each week, making recommendations for additional interventions as needed. Current research is disseminated to the group as new evidence is produced. Communication to the following shifts is accomplished via the fall huddle folder, evening and night shift assistant nurse manager, and SBAR nursing communications.

Event Review:

The shared governance council is interested in understanding any spikes in fall rate. The CNS provides a detailed report to the group for review following a high incident month. As problem areas are identified, changes are made to the action plan. Some falls were noted to occur during physical therapy visits. The PT department provided educational sessions for new PT staff on-boarding to the neuroscience area.

Quality Review:

The shared governance council reviews quality data reports at each meeting.

Other Interventions:

- Utilization of the HEV system to identify fall risk patients
- 24 hour Bed alarm for all patients admitted from the ICU or step down for a minimum of 24 hours
- Landing strip trial and utilization
- Utilization of personal alarms

Outcomes:

- Initial downward fall rate trend, still above the NDNQI benchmark, with occasional spikes
- Increased awareness of fall risk factors
- Increased bed and personal alarm utilization
- Consistent use of landing strips
- Improved communication among care givers

Nursing Implications for Practice:

Implications for nursing practice include improved patient outcomes, decreased length of stay, decreased financial burden to the organization, improved communication, and increased staff satisfaction. Opportunities exist to benchmark against like neuroscience units.