Strategies for engagement: One organization's path to decreasing fall rates

Adrienne Banavage,BSN,RN,OCN
Kathleen Sackett,MSN,RN,CCRN
Denise Stimpson,BA,RN,C

Objectives

- Participants will be able to significance of falls on patients and nurses
- Participants will be able to identify components of fall prevention plan
- Participants will be able to discuss the strategies created and implemented to decrease falls
- Participants will be able to identify tools used to identify efficacy of falls program

Where did we start?

- For the final quarter of 2009 oncology contributed 32 out of 125 falls
- 2009 institutional fall rate of 3.21/1000 patient days
- 2010 goal 2.81 falls /patient day

Review of the Literature

- Major academic medical center reported a rate of 4.88 falls per thousand patient days with a goal of 3.2 falls/thousand patient days
- Injury Rate reported as "good"

Miller and Limbaugh,2008

Impact of Falls on Patients

- Injury
- Loss of confidence in care givers
- Loss of confidence in physical abilities

Impact of Falls on Nurses

- Loss of time
- Distraction
- Job Dissatisfaction

Institutional Impact of Falls

- Cost
- Decreased patient satisfaction
- Decreased reimbursement

- Falls need to be viewed like a medication error! Avoidable and preventable with appropriate level of diligence

First Steps

- Identification and education of vested parties
- Identification of barriers to goals
- Identification of structures and processes already in place
- Identification of our opportunities for improvement

Pilot Units

- Inpatient adult oncology units
  - Four Units
    - Surgical Oncology
    - Medical Oncology
    - Hematology Oncology Unit
    - Bone Marrow Transplant Unit

Who are the Vested Parties?

- Nurses
- Ancillary personnel
- Patients
- Families
- Physicians/LIPs
- Anyone the patient may come into contact with!

Nursing Education

- How are rates report
- Importance of all aspects of the falls plan
- Validation of rounding
- Call director or designee with every fall

Clinical Care Technicians

- Role as Fall Champions
- Role in Safety Huddles
- "First line of defense"

Unit Secretaries

- Role in Safety Huddle
- Facilitation of communication

Patients and Families

- Falls education upon admission
- Family role in fall prevention
- Consistent re-enforcement

Physicians and LIP

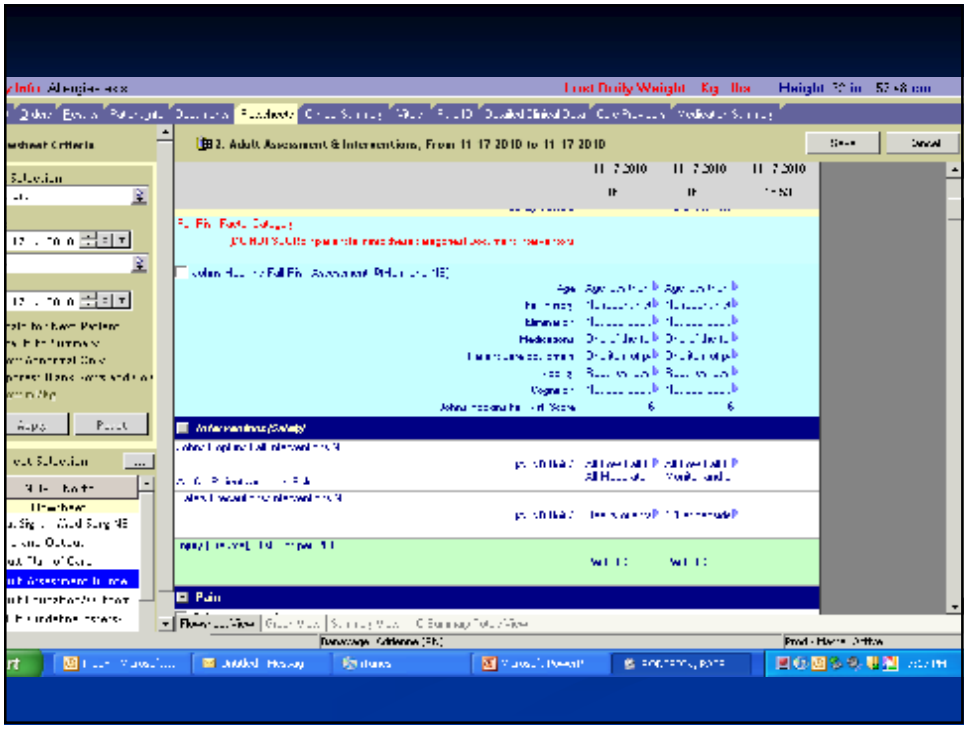
- “state of the union”
- Use of sitters/ one to ones

Additional Staff

- Therapists: Physical, occupational, speech
- Unlicensed personnel
- Visitors
- Volunteers
- Who else?

Falls Plan

- Fall Risk Assessment
  - Johns Hopkins Fall Assessment
  - Humpty Dumpty Falls scale
- Products
  - Bed exit alarms
  - Socks with treads
- Rounding
  - 4Ps: Position ,personal needs, pain and potty



- Recommendations for families related to age appropriate safety initiatives and cautions
- Specific information about the inpatient environment

New Additions

- Falls Champions
- Safety Huddles
- Post Falls Huddles
- Falls web site
- Adjuncts to bed exit alarms
- Toilet rails
- Falls drills
- Falls agreement

Falls Champions

- Empowering for both professional and ancillary staff
- Additional Education
- Accountability
- Shared leadership
- A form of peer review

Safety Huddle

- Short focused discussion of patients at risk for falling
- Beginning of every shift
- Entire staff participates

Post-Falls Huddle

- Immediate focused discussion after a fall
  - Participants include all personnel including leadership
  - Brief questionnaire
- Goal: What do the nurse and the patient feel contributed to the fall?

New Products

- Toilet Rails
- Adjuncts to bed exit alarms
- Low bed
- Visibility Aids

Falls Web Site

- Aggregates all fall info on one place on the intranet including:
  - Falls Huddles
  - Product Information
  - Educational Content

Falls drills

- Mock Fall
  - Staff stages a fall
  - Staff to respond as they would for a "real" fall
    - Fun
    - Allows lively discussion
    - Dialogue about what may and or may not be working

Falls Agreement

- Completed upon admission
- Facilitates conversation between patient, family and nurses
- Provides cues for key points for nurses to discuss

Measures of Success

- Falls Rates
- Review of qualitative data from post falls huddles
- Patient validation
- Staff feedback

Future Plans

- Educational Offerings
- Qualitative research