Innovative Approach to Fall Reduction

Fall Committee

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Background

UT Southwestern Medical Center consists of two tertiary care facilities with a total of 420 beds located in Dallas, Texas.

The fall reduction program at UTSW -University Hospitals underwent a total re-design, including complete revision of the inpatient fall risk assessment tool, inclusion of additional evidence-based interventions and transition into the electronic medical record (EMR).

Aim Statement

The aim of the Fall Committee was to decrease the combined fall rates between the two University Hospitals by an average of one fall per 1000 patient days over CY 2010.

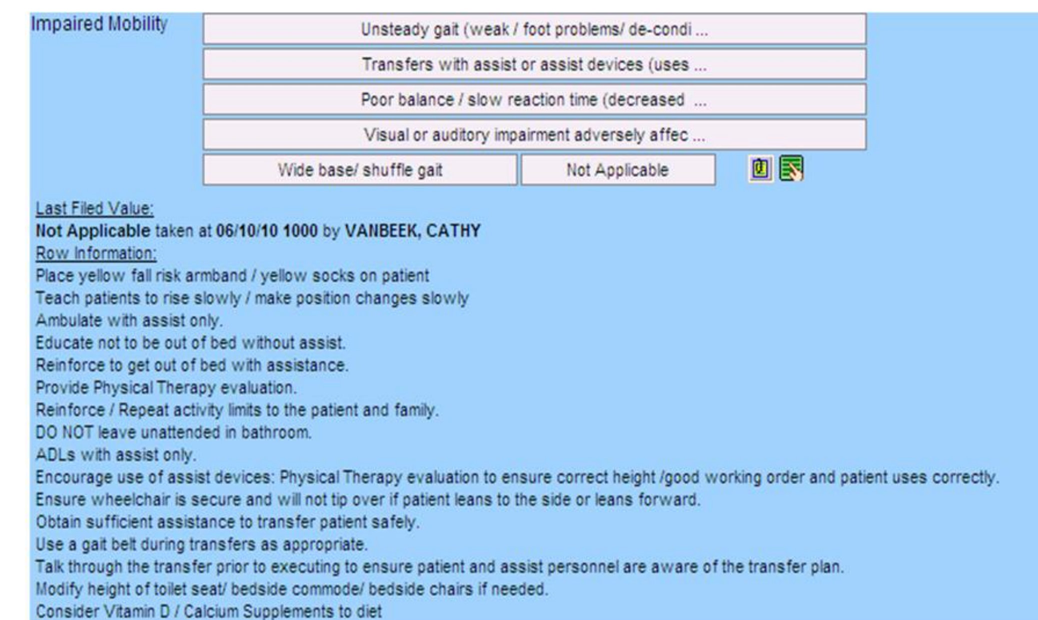
Definition

The Fall Committee conducted a literature review and sought suggestions from a diverse mix of frontline staff . As a result, the committee revised the definition of a fall in our institution to better reflect current evidence-based research.

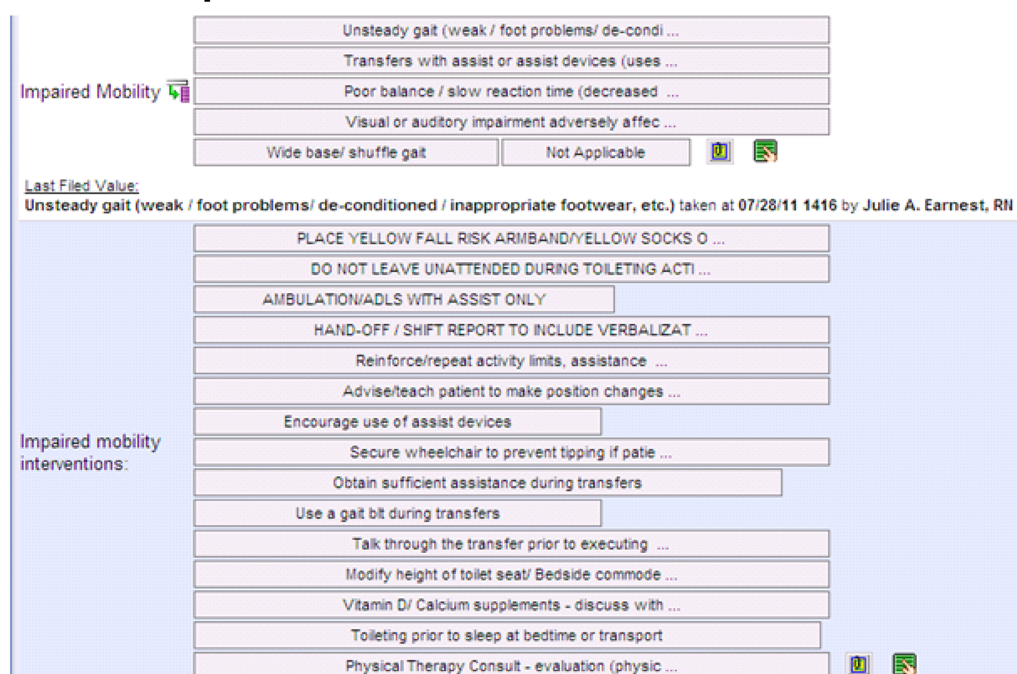
Fall- "A fall is a sudden unintended change in position which results in the person coming to the floor/ground. Assisted falls in the course of physical/occupational therapy are excluded."

EMR Changes

BEFORE… Interventions were listed. No prompt for the staff to select interventions or personalize to the patient.



AFTER… Interventions are to be selected, specific to the patient. Interventions in CAPS are mandatory.



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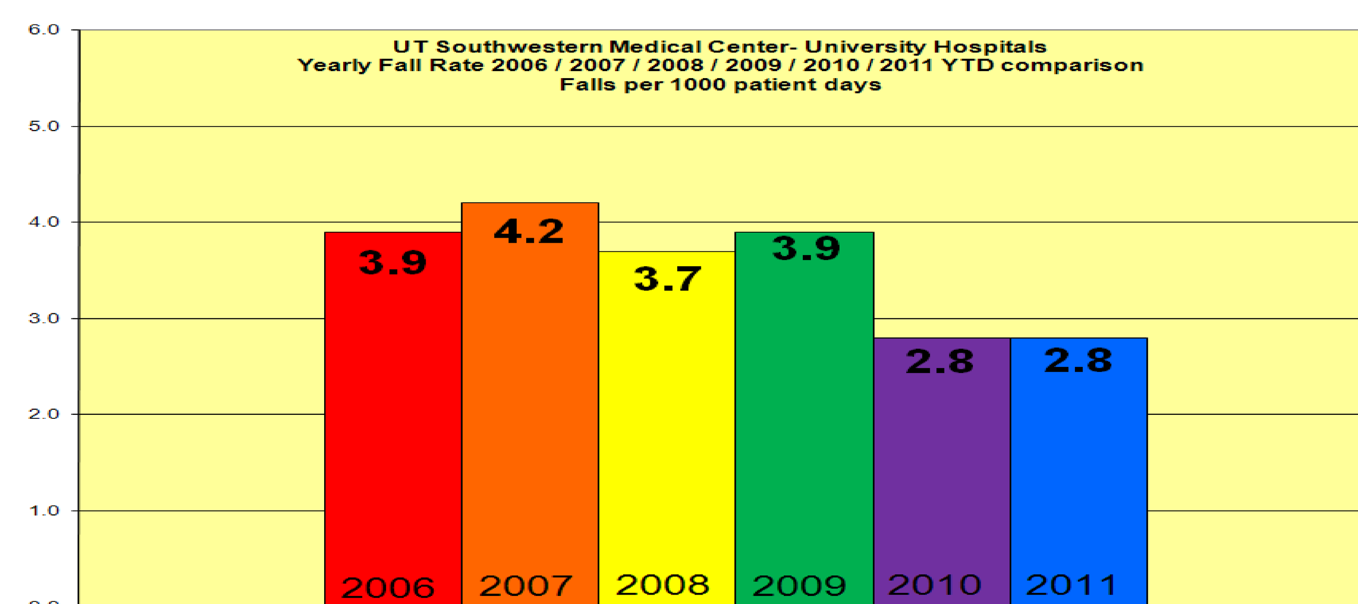

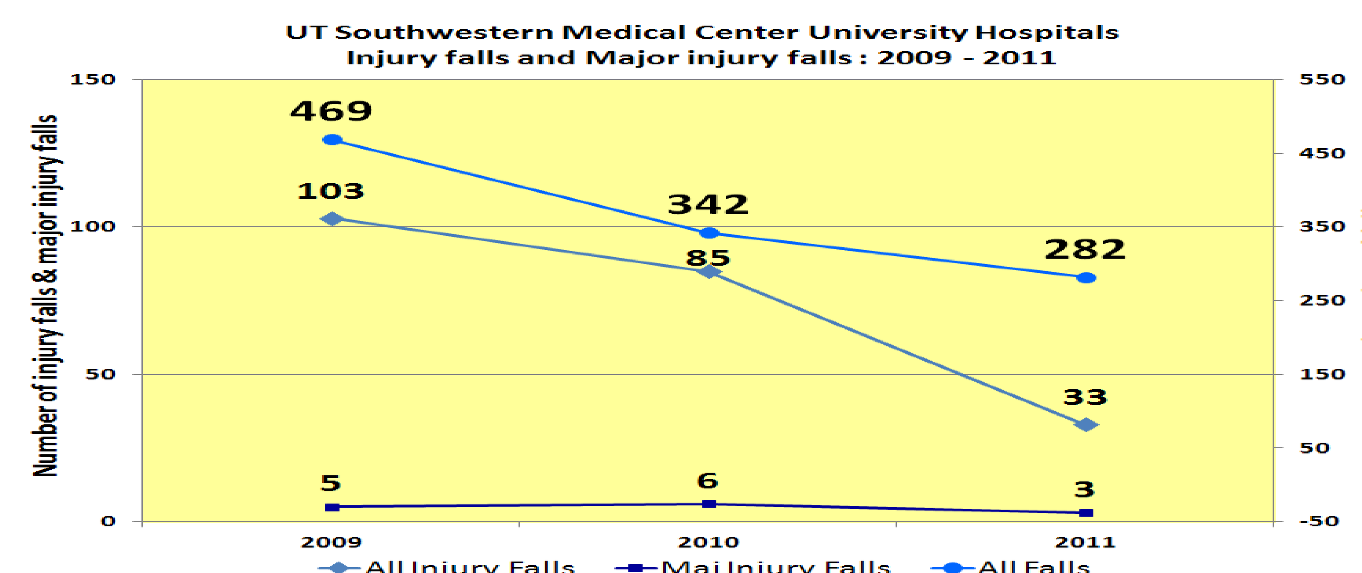

Results and Conclusions

The combined fall rates for both hospitals for the years 2006 through 2009 averaged 4 falls per 1000 patient days. After implementation of the changes, the fall rate for the two hospitals combined, for 2010 was 2.8 falls per 1000 patient days .

The injury fall rate has also appreciated a significant decrease from 0.9 down to 0.4 per 1000 patient days.

Lessons Learned

1. Collaboration between ALL staff is the key.
2. Bathroom related activities are the most common reason for falls.
3. Culture change of the entire organization is the key for success.
4. Visual cues are helpful for patients.
5. Continuous education of staff and patients.

Next Steps

1. Patient assistance agreement.
2. EMR best practice alert for fall risk medications.
3. Yellow gowns in addition to yellow socks for fall risk patients.
4. Awareness video for staff and patients.
5. Mandatory education for all staff.