# Partnering to Prevent Falls: Utilizing a Multi-Modal Approach
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## Background

- The Joint Commission mandates that Fall Reduction programs be implemented in order to address the alarming incidence of patient falls in the healthcare systems (National Patient Safety Goal 9 - 09.02.01).
- The American Nurses Credentialing Center (ANCC) Magnet Recognition Program® requires Magnet hospitals to monitor nurse-sensitive indicators such as fall rates and to be below the mean/median of national benchmarks for those indicators.
- According to the Centers for Disease Control and Prevention(CDC), in 2000, falls among older adults cost the U.S. health care system over $19 billion dollars.
- Patient falls in hospitals are common and affect approximately 2% to 17% of patients during their hospital stay. Fall rates vary from 1.4 up to 17.9 falls per 1,000 patient days depending on hospital type and patient populations (CDC).
- The fall rate at our healthcare system was 3.4 falls /1000 patient days in late 2009 despite many efforts to address this issue

In 2010, the HealthCare System Board of Trustees , Senior Management, and the Nursing Department made the fall rate a priority and set an organizational goal to reduce the fall rate below the national Midas bench mark of 2.85 falls/1000 patient days. The fall rate was a priority not only to nursing but to the entire organization.

## Strategies

The first step included a review of the current Fall Prevention Plan and incorporation of the Institute for Healthcare Improvement (IHI) evidenced based guidelines.

- An Integrative Fall Council (IFC) was formed with senior level involvement
- Members of the IFC included Nursing staff, Physical Therapy, Risk Management, Quality Management, Patient Safety, Nursing Performance Improvement, Pharmacy, Radiology, Environment Services, Nursing Staff Development, Nutrition, Nursing Supervisors, Plant Engineering, and Transportation. These departments were vital in addressing the fall rate.

In addition, the IFC identified needs and issues such as:

- The need for policy unification for all campuses.
- The definition of a fall needed to be consistent throughout the system
- The perception that this is only a nursing issue by allied health and ancillary departments. All departments must participate in maintaining a safe hospital environment.
- More consistent assessment and evaluation by nursing while completing hourly rounds, especially room environment.
- Prevention needed to be key focus. All falls are preventable.
- Fall tracers were completed on all units, and the results were sent to the NMs and Directors.

In an attempt to drill down into the exact cause of each fall, the Sr. V.P./CNO of Nursing decided to start a Friday Fall Review. Every Friday morning at 7am, Nurse Managers who had a fall on their unit, reported at this meeting. They described when, where, how, and why the fall occurred and what could have been done to prevent it. Trends were noted and interventions were developed to address these trends.

Allied and ancillary staff were engaged and thanked for their assistance. One unit started a Hero Award to recognize their assistance.


## Interventions

Themes were identified that contributed to falls. Interventions to address these issues were implemented and Fall Tips were sent out by the CNO for all staff. Issues that were identified and addressed:

- Dosages of zolpidem and temazepam on order sets were changed to the lowest dosage for those over 65 years. In addition, all order sets with orders for zolpidem and temazepam have to be a checked item, and deliberately ordered by the physician.
- Large focus on assessing types of alarms needed and making alarm checks part of hourly rounds
- Post fall huddles were started on every unit and included anyone present during the fall event.
- Physical therapy made sure that they had the chair alarm on after they ambulated a patient.
- Nutrition aides who delivered and picked up meal trays would put on the call light and stay with a patient if they noticed them trying to get out of bed.
- Tips and Pointers were sent out by the CNO after the Fall Review. These went out to all staff.

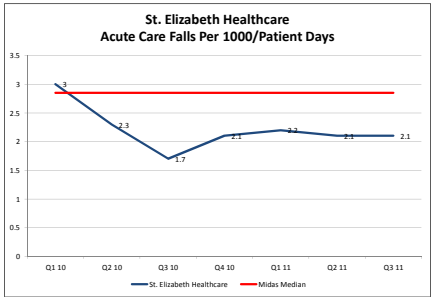
**Fall Tip example**

**TIPS and POINTERS to help reduce and prevent falls:**
**Thanks for all your help!**

- Bed alarms continue to be a common issue associated with falls. For those at high risk for falls, especially our elderly patients, ensure the bed alarm is in place, that it is turned on, that the bed is plugged into the wall, and that the alarms are in working order during each hourly round. If you turn off the alarm when the patient is assisted out of bed, be sure it is turned back on when the patient is returned to bed.
- Don't leave the patient in the bathroom alone. Many of our falls still occur in and around the bathroom. Continue to offer patients frequent toileting when making hourly rounds. Pay particular attention to patients who have a history of blood pressure or blood sugar issues, who have recently been medicated and patients who have not been out of bed on their own regularly. Ensure the patient has non-skid slippers when appropriate.
- Thank you for helping to keep our patients safe!

## Results

The initiative was extremely successful! The Friday Fall Reviews were especially helpful in identifying common causes for falls. The fall rate has remained below the Midas 2.85 benchmark




## Implications

The Friday Fall Reviews were so successful in identifying causes of falls and initiating interventions to prevent future falls that they are continuing on a bi-weekly basis. These meetings are open, non-punitive discussions that have resulted in a sustained decrease in our patient falls throughout 2011.
Although the fall rate was not an organizational goal for 2011, it remains a priority for the organization. Fall rates are still reported at the monthly System Management meetings. The process was so successful, that Quality Management adopted it to review any Core Measure indicators that are missed.
Further discussion centers on having the staff nurses report at the bi-weekly meeting to discuss their patient falls.

## Contact Information

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