WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Use of a Fall Prevention Coordinator to Decrease Inpatient Falls

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Purpose

Patient falls are identified as a high safety risk by The Joint Commission and a never event by the Centers for Medicare and Medicaid Services (CMS). The goal of the Fall Prevention Coordinator (FPC) is to provide oversight of the fall prevention program and to prevent hospital inpatient falls.

Significance

An inpatient hospital fall can be a significantly life altering event for an elderly patient. It also puts the hospital at risk for litigation and financial risk for treatment of injuries incurred as a result of the fall. CMS will no longer reimburse any treatment costs caused by an inpatient fall.

Patient falls have been identified as one of the performance measures used to assess nursing care in regards to quality and patient safety by the National Quality Forum.[1] Patient Falls and falls with injury in healthcare organizations are identified as a never-event by the Centers for Medicare and Medicaid as well as identified as a Joint Commission National Patient Safety Goal.[2,3]

Patient falls and falls with injury are estimated to occur in 20% of hospitalizations, adding more than $4000 in charges to the cost of the hospitalization[4] and increasing the patient's length of stay by as much as 34%.[5]

A fall may lead to a decrease in quality of life for the patient. Fear of future falls may itself contribute to an increased fall risk. Fall-related injuries increase resource utilization, not only from increased LOS and increased chance of unplanned readmission, but also through need for discharge to residential or nursing home care.[6]

Contact Information and Acknowledgements

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Strategy and Implementation

Danbury Hospital recognized the need for a FPC to provide oversight of the fall prevention program designed to prevent inpatient falls. This coordinator focuses on making unit rounds, identifying patients at high risk for falls, and evaluating effectiveness of prevention measures implemented for these patients. Through these rounds, the coordinator works directly with the clinical staff to provide real time education, offering bedside support for identifying individualized fall prevention plans of care. The coordinator also has facilitated other prevention improvements including hourly rounding with intention, environmental evaluation, switch to a multi-functional battery operated exit alarm, development of fall prevention champions and daily fall risk huddles, post-fall huddles and investigations, use of divisional activities, and medication review. This focus on fall prevention has also allowed the decrease in sitter hour usage for fall prevention.

Development of the Role

Despite the continued focus on preventing patient falls, Danbury Hospital continued to have up and down results in this area. Our results appeared to be reactionary- when a patient fall occurred in a specific location or for a specific reason, focus would be placed on correcting the immediate cause. We would then see that we would have problems in other areas or as a result of other causes. We were having difficulty sustaining our gains.

The decision was made to have one person dedicated to working with staff on fall prevention, therefore keeping the focus on the overall goal. We were able to justify the creation of this role by looking at the cost savings that would be realized through the avoidance of patient falls and injuries.

Although the tools used by the FPC are not unique, the dedicated focus of one person on this goal has made a difference in our fall numbers.

Unit Rounding with Focus

The FPC rounds on all units during her shift, focusing on the specific needs of the unit patient population. During these rounds, the FPC is able to accomplish maintaining the staff focus on patient safety and fall prevention through many STRATEGIES:

- IDENTIFICATION OF AT-RISK PATIENTS. The PFC reviews charts and rounds on patients to identify patients at-risk for falls, as well as evaluating fall prevention measures in place for these patients. When possible, she actually spends time with these patients in their rooms, helping to toilet and ambulate them. This provides opportunities for further evaluation, identification of more INDIVIDUALIZED FALL PREVENTION PLANS, and opportunities for **real time education** with the staff.
- EVALUATES ENVIRONMENTAL FACTORS that may lead to patient falls and makes suggestions for improvements.
- Participates in HOURLY ROUNDING WITH INTENT to help improve the process as well as again providing real time education to the staff.
- Conducts POST-FALL INVESTIGATIONS. The FPC promptly speaks with all staff involved with a patient post-fall to evaluate factors that may have contributed to the fall. She IDENTIFIES TRENDS on specific units and EDUCATES THE STAFF on the specific factors that are affecting their patients. She helps to develop and implement a plan for fall prevention specific to the unit needs.
- Assists with management of FALL PREVENTION EQUIPMENT. The FPC evaluates available equipment, such as chair alarms, lift equipment, gait belts, and distraction devices to make sure appropriate equipment is available for use on each unit. She also works closely with equipment company representatives to continually evaluate the availability of new products.

Fall Prevention Champions/Daily Huddle

Fall Prevention Champions

A team of Fall Prevention Champions has been developed under the direction of the FPC. This team is made up of Certified Nursing Assistants (CNAs) who are trained to enhance surveillance efforts of fall prevention interventions. The fall prevention champion identifies patients at risk for falling, tailors interventions to prevent falls and communicates information about patients at risk in the fall prevention huddle. The fall prevention champion provides instruction and reinforcement about fall prevention and appropriate interventions to colleagues and, when needed, conducts a post fall analysis and follow-up ensuring the safety plan identified in the huddle was carried out. The champion has advanced level of competency with safety equipment and trials and evaluates new equipment. The fall prevention champion is a role model for the behavior that is expected for all CNAs for fall prevention.

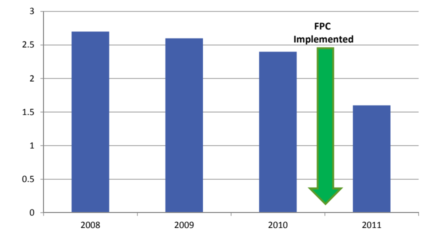
Fall Prevention Huddle

The fall prevention huddle is CNA rounding conducted at the white board. The huddle is facilitated by the Fall Prevention Champion at a specified time on each shift, and all unit CNAs attend. The discussion identifies fall risk status and the fall prevention/safety plan for each patient. The information is captured on the white board and dated, timed and signed by the Fall Prevention Champion. The huddle also includes planning to work together to cover breaks, isolation patients, and answering other CNA's call lights.

Evaluation

Decrease in fall incidence supports the success of the use of the FPC. Fall incidence in 2008 was 2.7, 2009 was 2.6, and 2010 was 2.4 prior to initiating the FPC. Fall incidence decreased to 1.6 since the implementation. Sitter use from 2010 to 2011 decreased almost by half.

Fall Incidence



Implications for Practice

Implications for Practice:

The use of the FPC to support dedicated fall prevention measures is effective in preventing falls and improving patient safety. The PFC helps to keep the staff focused on fall prevention.

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