Methods

The QI initiative was conducted from August 2011 to March 2012 in an integrated healthcare system located in a southeastern state. The integrated healthcare system consists of four community hospitals, a long-term care facility, physician practice groups, and outpatient services. Eight nursing units were identified based on NDNQI® falls rates from the four community hospitals.

Methods of Evaluation and Analysis

Falls rates were monitored weekly & monthly for each unit. Fall rate calculation methodology was congruent with NDNQI®. Falls were tracked using the hospital’s internal electronic falls database and the NDNQI® quarterly falls report that included falls risk assessment scores, fall characteristics, & nursing process for falls prevention.

An eight-item online evaluation with two free-text questions was developed. The items were rated on a five-point Likert scale from 1 (Disagree Strongly) to 5 (Agree Strongly). The mean score was calculated for the evaluation. The Cronbach’s alpha was 0.83 for the evaluation.

Data were analyzed with descriptive and inferential statistics using SPSS for Windows Release 18.0. Descriptive statistics (means and standard deviations) and inferential statistics paired samples t-tests were used. A p value of < .05 was considered statistically significant.

Findings

Pre-intervention (February-August 2011) units had 146 falls & 110 falls post-intervention (September 2011-March 2012) (Table 1). Fall rates decreased but not significantly post-intervention (M = 3.62, SD = 1.44) compared to pre-intervention (M = 3.82, SD = 1.29) to 3.62 compared to pre-intervention (M = 3.82, SD = 1.29) compared to pre-intervention (M = 3.82, SD = 1.29).

73 staff (30% response rate) completed an online evaluation. A majority responded to the evaluation questions as agree to strongly agree. Average mean ratings ranged from 3.39 to 3.65.

Staff liked having all the falls prevention tool interventions available in one package to use for each patient, the yellow gowns, the glow-in-the-dark portable urinal, the bed alarm reminder sign & large lettering “call don’t fall” signs posted in the patient room. Staff suggested modifying the sign adhesive and changing the patient gown to a soft yellow.

Post-fall huddle forms findings included intrinsic factors: prior fall, unsteady gait, musculoskeletal weakness/illness impacting balance and posture, confusion, & advanced age. Extrinsic factors included: patient not screened as high fall risk, multiple high-risk medications (ranging from anticoagulants to narcotic/anaesthetics), bed alarm not re-activated, bathroom toileting & one patient refused to wear yellow socks.

Environmental assessments were conducted at two hospitals. Findings indicated that hospitals implemented necessary fall prevention strategies.