“TRIPPING OVER OUR FALLS”: THE FALLS REDUCTION & PREVENTION PROGRAM AT HAHNEMANN UNIVERSITY HOSPITAL

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FALL PREVENTION RELEVANCE

Governing Factors

- Center for Medicare & Medicaid Services
- The Joint Commission
- National Quality Forum
- NDNQI
- State Authorities
  - Pennsylvania State Reporting System

Fact

Fall are most commonly reported safety event reported among hospitalized patients & most common adverse effect reported in facilities.

Titler, 2011; Rush, 2008

NURSING'S DUTY TO PREVENT HARM

- Code of ethics
- Standards of nursing practice
- Falls are leading cause of injury related death in adults 65 and older
- Adults aged 75 and older are 4 times more likely to experience fall with injury than someone 65 to 74.

PATIENT EXPERIENCE WITH FALLS

- Embarrassment
- Added medical treatments
- Fear of recurrent fall
- Fractures & Injuries
- Loss of mobility
- Increased length of stay (LOS) in acute care facilities
- Admission to Long-Term Care Facility post hospitalization

STAFF NURSE EXPERIENCE

- Guilt, Anxiety, & Self-blame
- Failure to keep patient free from harm
- Increased Workload and Resources
- Increase LOS: 6.27 days
- Financial Implication:
  - $13,316
- Legal Implications

CURRENT KNOWLEDGE

- Current Research
- Multiple Fall Assessment Tools
- Falls Definitions
- Nursing Interventions
  - Ambiguity of reporting falls


Cognitive Impairment
Medications
Mobility Limitations
Elimination Management
Environment
Treatments
Falls

S.W.O.T. ANALYSIS

Strengths:

- Reporting Process
- Care Delivery Model
- Administrative Support
- Corporate Support

Weaknesses:

- Standard Follow-up
- Awareness
- Formalization
- IS Involvement
- Interdisciplinary Support

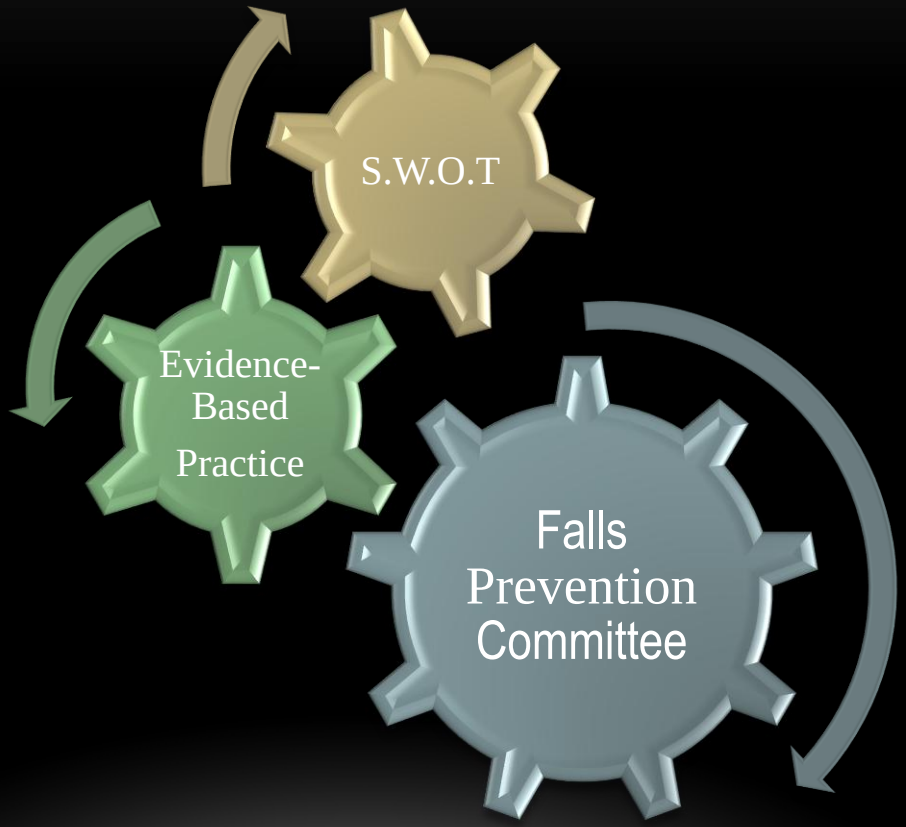
Opportunities:

- Education
- Policy Revision
- Committee Development
- Benchmarking
- State Involvement

Threats:

- Over-Reporting
- Costs
- Patient Safety
- Fear of Reporting
- “Fall Fatigue”

FALLS PREVENTION COMMITTEE DEVELOPMENT



COMMITTEE ELEMENTS

- Consistency
- Analytical
- Accountability
- Creative
- Progressive
- Goal Oriented
- Multi-disciplinary

FALL COMMITTEE ACTIONS

- Weekly meetings
- Fall Alert Team
- Post Fall Investigation
- Unit-based Fall Trending
- Unit-based Fall Champions
- Outpatient Setting Involvement
- PA Hospital Engagement Network (HEN) Project
- National Falls Awareness Day

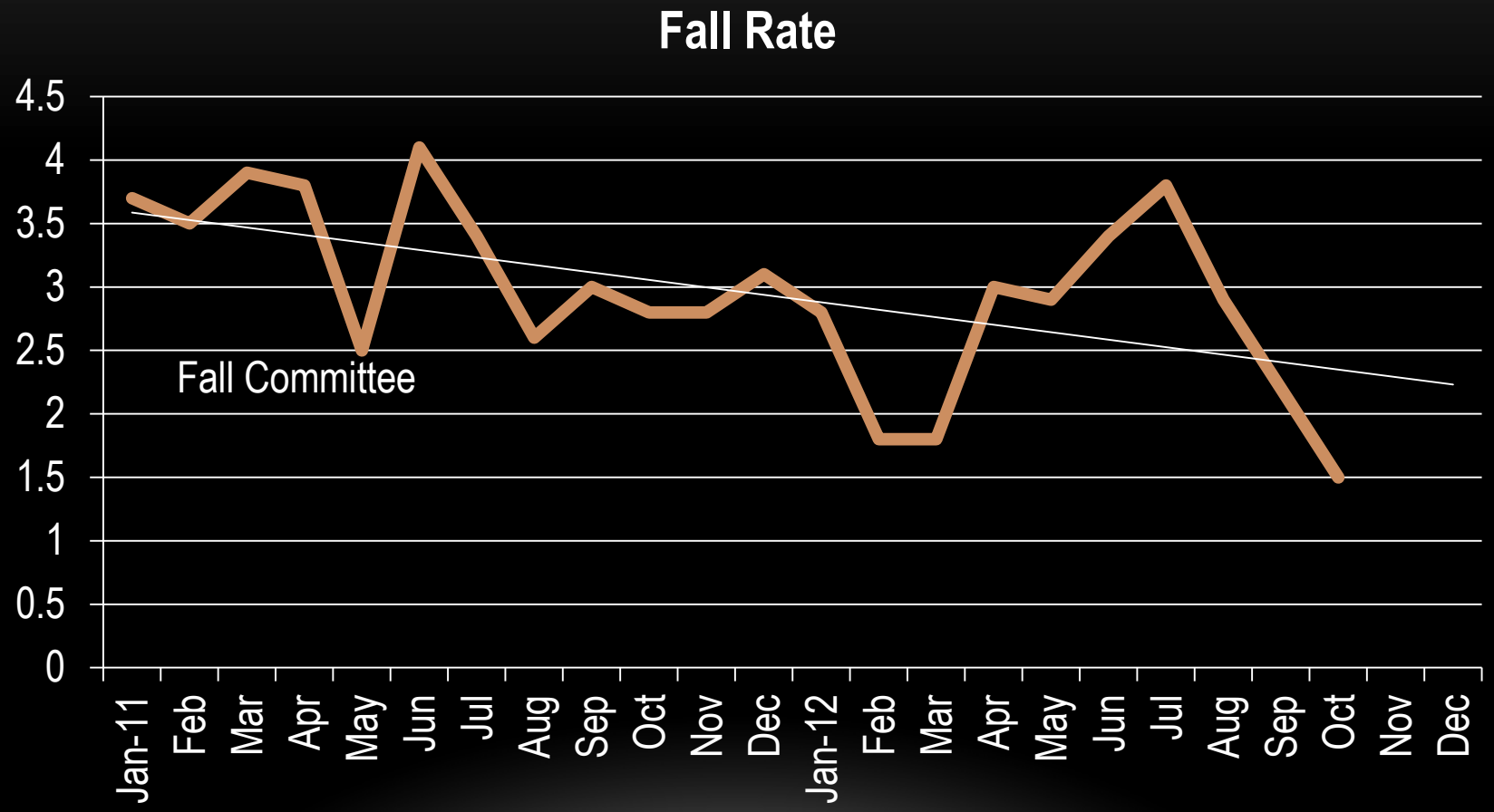
FALLS COMMITTEE ACTIONS

- Equipment
  - BSC with transfer benches
  - Moblility Alarms
  - Beds
    - Low to ground
    - Built-in alarms
- Technology
  - CPOE high risk meds
  - IMPACT Project
- Products
  - Short gown trials
  - Stationary furniture

PREVENTION STRATEGIES

- Safety Huddles every shift
- Recognize Common Risk Factors
- Be proactive, not reactive
- Remain with patients while toileting
- Family Education
- Utilize bed alarms when appropriate
- Bed alarms with every patient falling within 3 mos.
- Tailor prevention strategies to each individual patient.
- Round on patients
  - PEP Rounds (Pain, Elimination, Position)
  - Q2 hours
  - No Pass Zone
- E-Learning competency

HUH FALL RATE TRENDS



CONCLUSION

- Literature
  - Patient centered prevention measures
  - Skill Mix
- Governing Healthcare Agencies
  - ANCC & Magnet
  - CMS
  - AHRQ
- Gap Analysis
- Organizational Awareness

NATIONAL FALLS AWARENESS DAY

REFERENCES

Feil, M. & Gardner, L.A. (2012). Fall risk assessment: a foundational element of falls prevention program. *PA Patient Safety Advisory, 9(3),* 73-81.

Rush, K.L., Robey-Williams, C., Patton L.M., Chamberlain, D., Bendyk, H., & Sparks, T. (2008). Patient falls: acute care nurses' experiences. *Journal of Clinical Nursing, 18,* 257-365.

Titler, M.G., Shever, L.L., Kanak, M.F., Picone, D.M., & Quin, R. (2011). Factors associated with falls during hospitalization in an older adult population. *Research and Theory for Nursing Practice, 25(2),* 127-152.

When the patient falls out of bed, who pays? (2009). *Bulletin World Health Organization, 87,* 169-170.