A Novel Process Addressing Inpatient Falls in Acute Care

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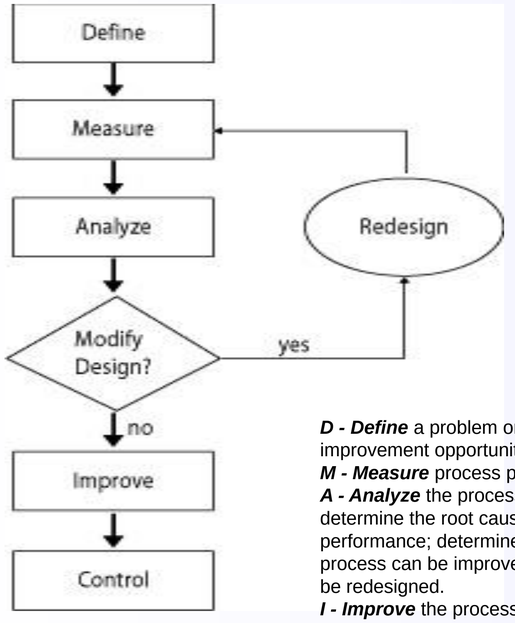
INTRODUCTION

Identifying fall risk and decreasing the incidence of falls in acute care hospitals has been a focus of care for years, although it remains an elusive goal. Falls have been identified as a key nursing –sensitive quality outcome indicator, and the demand for care excellence dictates that institutions reduce the incidence of falls by initiating programs focused on falls prevention.

PROJECT DESCRIPTION

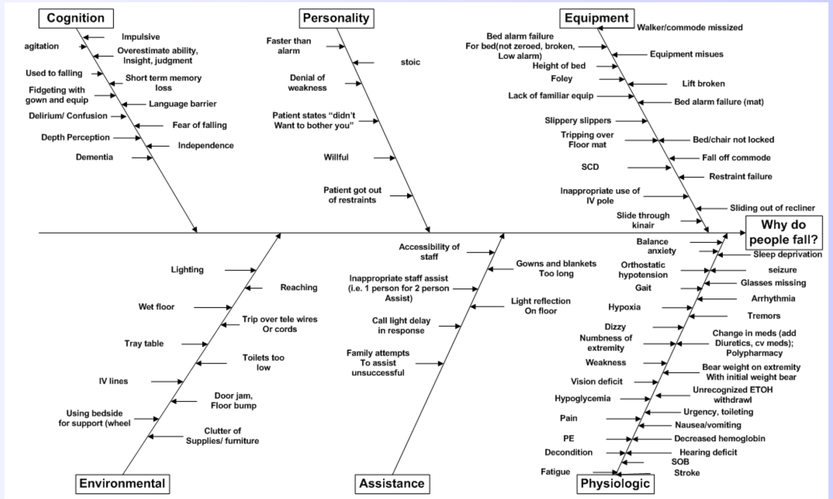
The purpose of this project was to implement a novel approach to address inpatient fall rates on four surgical units that were consistently underperforming against National Database for Nursing Quality (NDNQI) benchmarks.
Falls in the inpatient setting are a critical safety issue. Falls cause injury; they increase length of stay and hospital care costs, and can lead to decreased mobility and quality of life. Falls are complex and multi-factorial, requiring a novel approach to evaluate and understand the issue.



D - Define a problem or improvement opportunity.
M - Measure process performance.
A - Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned.
I - Improve the process by attacking root causes.
C - Control the improved process to hold the gains.

ANALYZE PHASE

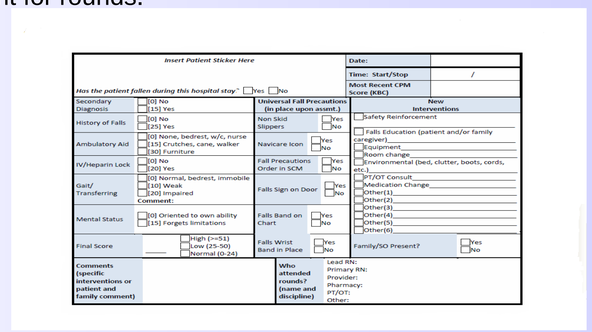
- The interdisciplinary team identified contributing factors and behaviors in high risk patients.
- Fishbone diagram created
- The Interdisciplinary team then identified the presumed top reasons why patients fall in the hospital: Urgency/ Toileting, Polypharmacy/ Medication related, Insight/ Judgment, Impulsivity, Delay in call light response.



FISHBONE DIAGRAM

IMPROVE PHASE

A **Proactive Falls Rounding Tool** was developed that included Falls Assessment score, checklist of Fall precautions currently in place, new interventions implemented, patient or family comments, and attendance with name and discipline of those present for rounds.



Insert Patient Sticker Here

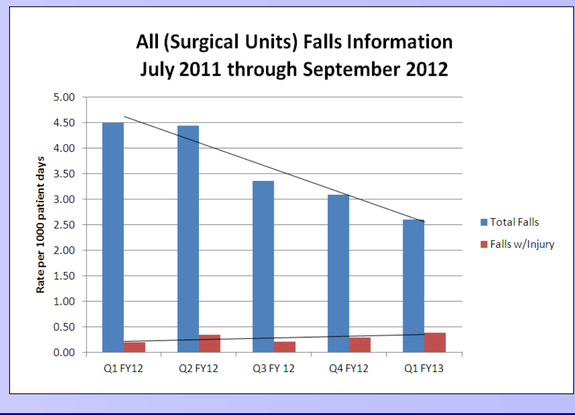
Date:
Time: Start/Stop /
Most Recent CPM Score (KBC)

Has the patient fallen during this hospital stay: ☐Yes ☐No

Secondary Diagnosis	☐[0] No ☐[15] Yes	Universal Fall Precautions (in place upon asmt.)		New Interventions
History of Falls	☐[0] No ☐[25] Yes	Non Skid Slippers	☐Yes ☐No	☐Safety Reinforcement
Ambulatory Aid	☐[0] None, bedrest, w/c, nurse ☐[15] Crutches, cane, walker ☐[30] Furniture	Navicare Icon	☐Yes ☐No	☐Falls Education (patient and/or family caregiver)_____ ☐Equipment_____ ☐Room change_____
IV/Heparin Lock	☐[0] No ☐[20] Yes	Fall Precautions Order in SCM	☐Yes ☐No	☐Environmental (bed, clutter, boots, cords, etc.)_____
Gait/ Transferring	☐[0] Normal, bedrest, immobile ☐[10] Weak ☐[20] Impaired Comment:	Falls Sign on Door	☐Yes ☐No	☐PT/OT Consult_____ ☐Medication Change_____ ☐Other(1)_____ ☐Other(2)_____ ☐Other(3)_____ ☐Other(4)_____ ☐Other(5)_____ ☐Other(6)_____
Mental Status	☐[0] Oriented to own ability ☐[15] Forgets limitations	Falls Band on Chart	☐Yes ☐No	
Final Score ____	☐High (>=51) ☐Low (25-50) ☐Normal (0-24)	Falls Wrist Band in Place	☐Yes ☐No	Family/SO Present? ☐Yes ☐No
Comments (specific interventions or patient and family comment)		Who attended rounds? (name and discipline)	Lead RN: Primary RN: Provider: Pharmacy: PT/OT: Other:	

CONTROL PHASE

Proactive Rounding is an intensive and focused multidisciplinary assessment of individual factors that affect a specific patients risk of falling. During these rounds, unique interventions were recommended and individual teaching to the patient and family were provided. The Pilot units employing Proactive Rounding were able to sustain a decline in falls rate over 5 quarters and decrease the overall fall rate by 23%.



IMPLICATIONS FOR PRACTICE

- Utilizing the DMAIC Process, the Falls Collaborative Interdisciplinary Team successfully defined, measured, analyzed, implemented, and controlled a novel process allowing the team to better evaluate and understand the complex issue of inpatient falls.
- The presence of an interdisciplinary team speaking with one message of promoting a falls prevention strategy delivered a powerful message to patients and families.
- The importance of staff communication, patient education, safety reinforcement, environmental assessment, medication review with medication specific education, and implementation of real time new interventions were additional features of proactive rounding that were associated with beneficial implications for practice.
- Comprehensive proactive falls rounding when done on a consistent and regular basis with a commitment from all team members did have promising and significant results. However, sustainability in a complex, fast paced environment such as an inpatient acute care setting remains a challenge.