NIH National Institutes of Health Clinical Center

Patient-Centered and Interprofessional Approaches to Falls Prevention

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Purpose

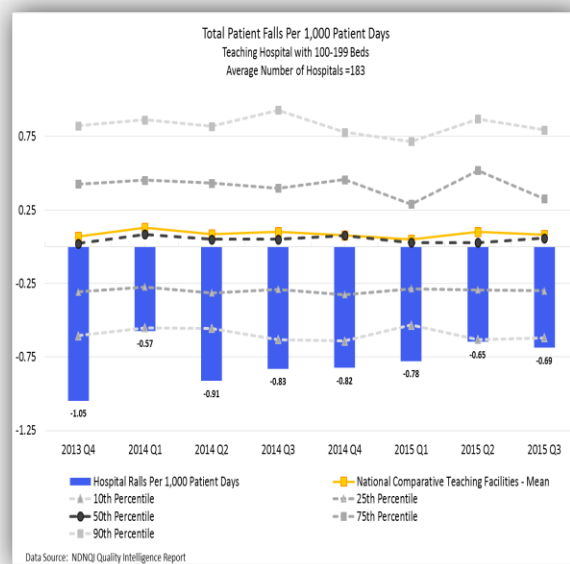
The overall purpose of this initiative was to reduce inpatient falls through development and implementation of a patient-centered evidence-based falls prevention bundle focused on active patient engagement, partnerships with staff, updating educational materials, and interprofessional collaboration.

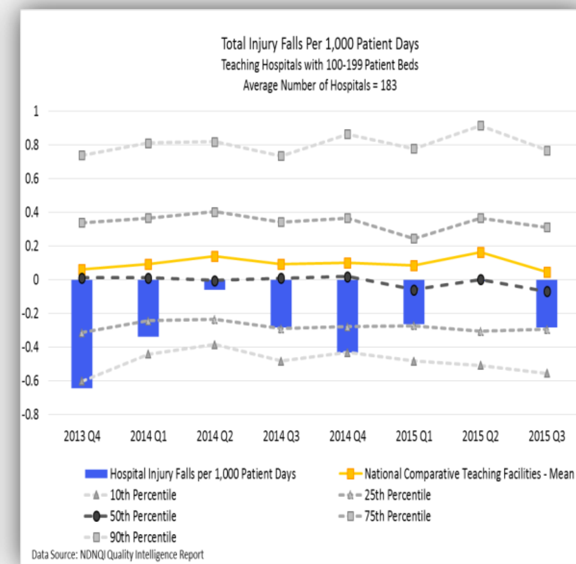
Relevance

There is conflicting evidence on the effectiveness of multicomponent falls programs and little data exist regarding patient-centered approaches to reduce falls.

Despite the availability of the abundance of evidence-based fall risk screening instrument, nurses remain challenged in their efforts to systematically reduce inpatient falls and falls related injuries.

At the National Institutes of Health, hospital level total falls rates as well falls with injury have been well below the mean for teaching facilities with 100-199 beds.





After noting an upward trend in the number of falls on four adult medical surgical units, an interprofessional working group was formed to increase awareness about falls prevention, with an overall goal of reducing inpatient falls.

The authors gratefully acknowledge the contributions of the team to enhance patient safety: *D. Aker, S. Cooper, L. Smith, A. Adams, A. Fitzgerald-Monroe, D. Gutierrez, J. Cunningham, S. Brown, J. Paterson, K. Cox, E. Eckes, C. Drew, I. Jones, K. Jeffries, R. Nudo and S. Menghani*

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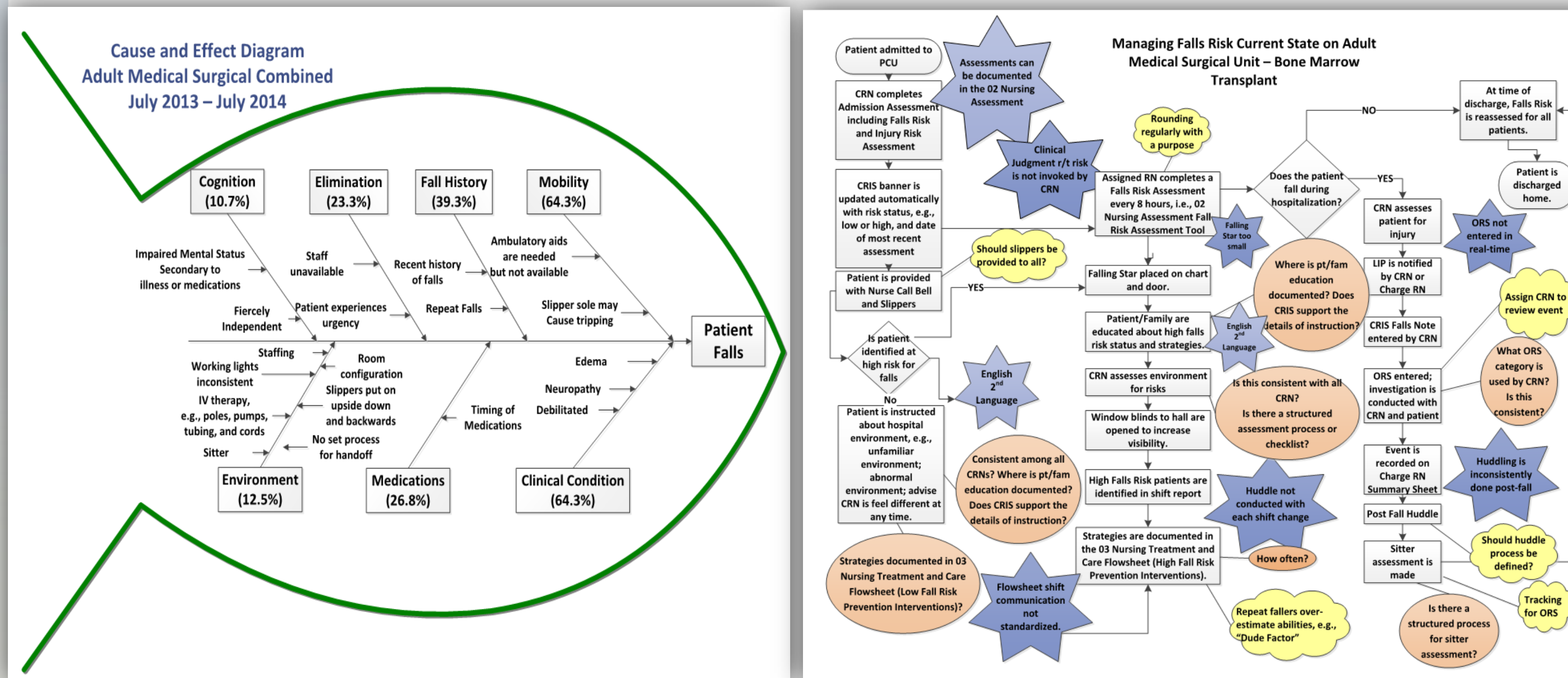
Strategy and Implementation

A falls quality improvement initiative was conducted using the Model for Improvement to guide the work. Interprofessional teams were formed and "SMART" aims were established to reduce falls 25% and falls with injury 50% by December 31, 2015.

Falls data (fish bone diagrams, current state process maps, descriptive data and run charts) were reviewed and ideas were shared in monthly meetings.



Patient-centered strategies specific to the target population were implemented across all of the units:

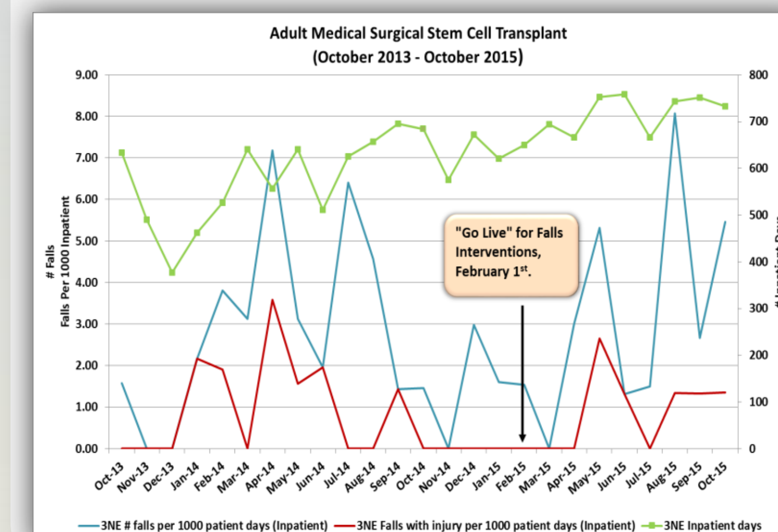
- **Increasing visibility of high risk patients**: *Updated yellow falling star*
- **Enhancing interdisciplinary communication**: *Huddles, sitter checklist, updated "call don't fall" signs, environmental checklists, increasing awareness of medical team, identification of high fall risk patients on the nursing station communication assignments boards*
- **Engaging patient and staff:** *Conversations on admission targeting patient friendly data boards, talking with patients as opposed to "teaching at" patients about falls prevention strategies*
- **Establishing critical partnerships**: *Rehabilitation Medicine and Department of Radiology .*

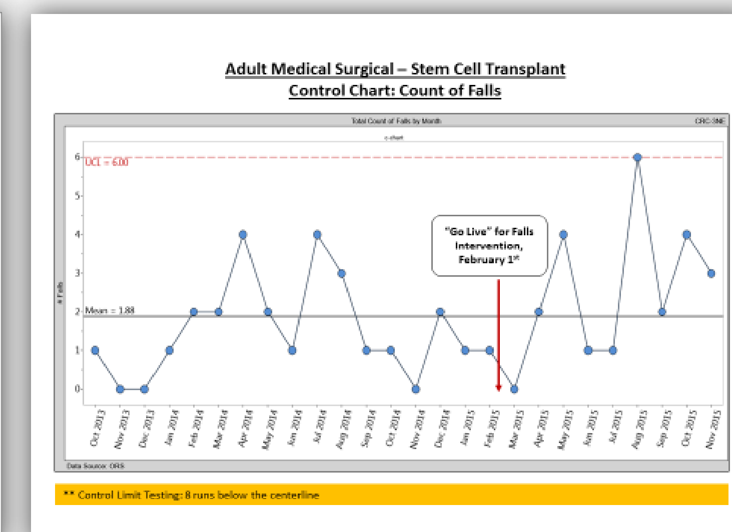
Interventions were initiated on February 1, 2015 and data are currently monitored for post-implementation effectiveness.

Evaluation

Initially, there was a reduction in the number of falls on all units. However, falls continue on all of the units in the initiative. This increase is possibly related to an increased census, and patient population changes with new research protocols. Evaluation tools utilized in the project were:

- ***Monthly data analysis with run charts and control charts***
- ***Exploring and testing post-fall huddles***
- ***Rapid cycle testing of purposeful hourly rounding on high risk patients***
- ***Audit tool of falls prevention strategies biweekly***
- ***Qualitative comments to assess patient, family and healthcare staff awareness of the initiative***





Implications for Practice

Patients and families verbalized to the nurses that the new stars on the doors, communication boards, and frequent conversations about consequences of a fall were helpful reminders. Also, nurses on the units reported a shift in their culture where falls prevention is more central to their work.

A patient-centered approach of engaging patients, families and interprofessional staff in falls prevention may assist in preventing falls. Currently we are continuing to increase awareness of falls prevention by:

- ***Striving to increase patient dialogue***
- ***Guiding interprofessional staff to partner with patients on falls prevention strategies***
- ***Implementing the use of yellow falls wristbands***
- ***Exploring individualized technology mobile bed alarm chair alarm options***
- ***Developing patient engagement speaking points***
- ***Working on strategies with repeat falling patients***