TOGETHER WE STAND….DIVIDED WE FALL

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MAGNET RECOGNIZED

Abstract

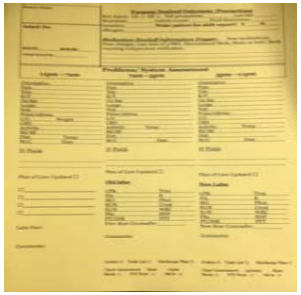
The prevention of falls is paramount to keeping patients safer, decreasing length of stay and reducing hospital costs. Nurses on the Cardiac Step Down Unit were discouraged with the high fall rate, motivating them to take responsibility despite the unique patient population they serve including Ventricular Assist Device and Heart and Lung transplant patients.

Background

- **In 2013 the cardiac step down unit was in "falls crisis" experiencing a total of 51 falls.**
- **In 2014 the Unit Falls Committee was motivated to improve the unit Safety Key Result area (KRA) by decreasing falls.**
- **A performance improvement framework helped the Unit Falls Champions reach beyond existing evidence based practice tools to refocus the staff.**

PICO Question

- **For staff on a Cardiac Step Down Unit, does the implementation of a staff focused falls bundle paired with a patient falls bundle decrease unit falls?**



Yellow colored patient report sheet used by nurses to identify high fall risk patients vs. white report sheet for non fall risk patients.

Unit Falls Committee displaying yellow t-shirts to raise staff awareness.

Synthesis of Evidence

- **A multifactorial approach with staff engagement and accountability are the driving factors to a falls prevention strategy in successfully reducing hospital falls.**

Advocate Fall Must Haves	
• Bed/Chair wheels locked & Side rails up x2	• Bed/Chair alarm on and functioning properly
• Fall precaution signage in place & use gait belts	• Ensure adequate lighting
• Staff remain at bedside or within arm's reach when patient in bathroom during toileting	• Floor dry and free of clutter/cords
• Call light/ phone/table/personal items within reach	• Room close to nurses' station
• Fall precaution band on as well as non-skid yellow footwear	• Notify departments of patient fall history during hand off communication
• Ensure adequate staffing during breaks and lunch periods- staff according to three lunch breaks	• Patient contract/partnership agreement complete and signed
• Patient education provided	• Do not leave high-risk patients unattended in the bathroom!
• Ensure a fall risk assessment is completed and all appropriate fall prevention interventions are implemented after opioid/sedative administration	• Complete fall huddle after any patient fall and share results with team, looking for opportunities for improvement and consistency
• Purposeful rounding on patients. Work with staff on scripting- Mr. Smith, let me take you to the bathroom now- be proactive!	• Communicate patients at high risk during shift/department huddles
• Bed in low position	

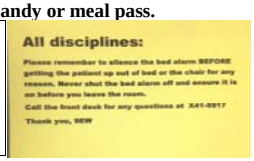
Practice Change

- **Advocate patient "Fall Must Haves" in place since 2009.**
- **Leadership and the Unit Falls Committee identified a lack of staff engagement. Ongoing education was provided to nurses and patient care associates.**
- **4th QTR 2013 the Unit Falls Committee along with the unit leadership implemented a multidisciplinary staff driven Cardiac Step Down Fall Bundle consisting of six strategies to reduce falls.**

CARDIAC STEP DOWN STAFF FALL BUNDLE	
Purchased bright yellow t-shirts for all fall committee members & leadership; wore on Thursdays to promote fall awareness.	4th QTR 2013
Initiated yellow report sheets indicating that the patient was a fall risk patient.	1st QTR 2014
Collaborate with Physical Therapy, Cardiac Rehab, and Patient transporters for increased patient safety and mobility.	2nd QTR 2014
Purchased 5 computers on wheels (COWs) to enable staff to chart near the rooms of high risk fall patients.	3rd QTR 2014
Encourage family to come and stay with the high risk fall patient.	4th QTR 2014
Bed alarm audits weekly by our fall champions with real time feedback.	4th QTR 2014
No new interventions initiated. Ongoing weekly audits to ensure all fall must haves are in place.	1st & 2nd QTR 2015

- **Conducted weekly bed alarm audits with real time feedback:**
  - **Monitored bed alarms for two months and kept a tally to see who the first person was to respond to a bed alarm.**
  - **The person with the most checkmarks at the end of the month received a token of appreciation such as a gift card, lottery tickets, candy or meal pass.**

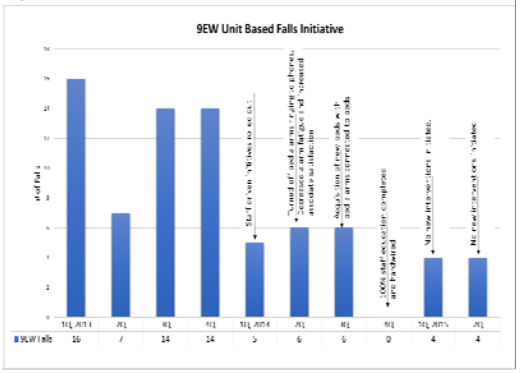
Education provided about new signage in all rooms to silence bed alarms appropriately to the following disciplines for patient safety:
- **Nurses**
- **Patient Care Associates**
- **Physical Therapy**
- **Cardiac Rehab**
- **Patient Transporters**
- **Respiratory Therapist**



Staff proudly displaying 146 days fall free.

Outcomes / Conclusions

- **The total number of falls were reduced from 51 in 2013 to 17 in 2014 reducing falls by 67% overall in one year.**



Outcomes / Conclusions

- **National Database of Nursing Quality Indicators (NDNQI) results showed a significant improvement in the total fall rate moving from 5.34 1st QTR, 2013 to zero 4th QTR, 2014 against the NDNQI median benchmark of 2.39.**
- **1st QTR 2015 fall rate was 1.06 against the NDNQI median benchmark of 2.28.**
- **A six month comparison (1st & 2nd QTRs) over the past three years has demonstrated a decrease in unit falls to 8 in 2015 compared to 11 in 2014 and 23 in 2013.**
- **The Agency for Healthcare and Research Quality (AHRQ) *Learning/Continuous Improvement patient safety subscale* percentile rank increased from the 70th percentile in 2013 to the 78.6th percentile in 2014. This increase represents staff's recognition that their voice in practice changes is heard by unit leadership.**

Implications for Practice

- **Falls are preventable with multifactorial patient interventions paired with staff engagement.**
- **Strategies for staff engagement:**
  - **Share celebrations and stories of wins at morning huddles and monthly staff meetings.**
  - **Consistently seek feedback from Fall Champions at quarterly meetings.**
  - **Monitor outcomes and national benchmarks to guide improvements.**
- **When multidisciplinary team members embrace practice changes, they own the process and outcomes, resulting in consistent behavior , accountability and better care.**
- **Monitor opportunities to improve staff compliance to evidence based care practices:**
  - **Gait belts – Staff were not 100% compliant in use of gait belts to assist with mobility and ensure patient safety.**
  - **Implementation of gait belt and walker fit assessment when completed showed 100% engagement from staff.**

Acknowledgements

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References

Spoelstra, S., Given, B., & Given, C. (2011). Fall Prevention in Hospitals: An Integrative Review. *Clinical Nursing Research*. 21 (1), 92-112. DOI: 10.1177/1054773811418106.