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.

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

- Red/Red/white wheelie backs & tike raling up
- Red/White all-white and functioning gait belts
- Falling prevention signage in unit & on all gait belts
- Staff remains at bedside or within arm’s reach of patient in bathroom during toileting
- Frequent dry and foul of patient’s needs
- Call light phonecall personal home readiness

Education provided about new signage in all rooms

- Full precaution band on as well as non-skid yellow footwear
- Staff commands at bedside or within arm’s reach
- Staff remains at bedside or within arm’s reach of patient in bathroom during toileting
- Full precaution signage in place & use gait belts
- Nurse (RN) reports patient fall history during hand off communication
- Ensure adequate staffing during breaks and all appropriate fall prevention interventions are implemented after shift change

- Patient education provided
- Do not leave high-risk patients unattended in the bathroom
- Ensure fall risk assessment is completed and all appropriate fall prevention interventions are implemented after shift change
- Patient contract/partnership agreement

Purposeful rounding on patients. Work with staff on scripting- Mr. Smith, let me take you to the bathroom now - be proactive!

Back to old practice

- Gait belts – Staff were not 100% compliant in use of gait belts to assist with mobility and ensure patient safety.
- Yellow 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.

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 team driven Cardiac Step Down Fall Bundle consisting of six strategies to reduce falls.

<table>
<thead>
<tr>
<th>CARDIAC STEP DOWN STAFF FALL BUNDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased bright yellow t-shirts for all fall committee members &amp; leadership; wore on Thursdays to promote fall awareness.</td>
</tr>
<tr>
<td>bed buddies &amp; pillows for high risk patients and patient rails.</td>
</tr>
<tr>
<td>Collaborate with Physical Therapy, Cardiac Rehab, and Patient transporters for increased patient safety and mobility.</td>
</tr>
<tr>
<td>Purchased a camera which is loaded on to whiteboards to alert nurses to patient’s high risk fall history.</td>
</tr>
<tr>
<td>Encourage family to come and stay with the high risk fall patient.</td>
</tr>
<tr>
<td>Red/white bed PI model for fall champion use &amp; team feedback.</td>
</tr>
<tr>
<td>Quarterly fall conference; ongoing education modules for nurses and fall must haves in place.</td>
</tr>
</tbody>
</table>

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 ticket, candy or meal pass.

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.

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.

References


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.

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.

References