ENGAGING NURSING STAFF TO PREVENT FALLS IN THE AREA OF NEUROSCIENCE ACUTE CARE UNIT

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BACKGROUND

Falls are the leading cause of accidental death and non-fatal injuries in older adults. In April 2013, the fall rate for a 39 bed neuroscience medical surgical unit (NSMSU) at a Level 1 Trauma center was 4.4 falls per 1000 patient days. The National Database of Nursing Quality Indicators (NDNQI) benchmark for falls is 3.31 per 1000 patient days. Several factors contributed to the unit's high fall rate. Over time, the staff on the unit became dispassionate and indifferent about falls, believing that falls within the neuroscience population was common and inevitable. A culture of deprioritizing patient falls combined with lack of professional accountability was tolerated by previous nursing leadership. Nurses believed that impulsiveness due to neurological deficits caused patients to be inevitable candidates for falls. In an effort to place the highest priority back on patient safety, the nurse leadership team developed a plan to change the culture around fall prevention.

PURPOSE

- The aim of this quality improvement initiative was to learn effective strategies to reduce falls in a high-fall-risk population.
- Gain insight on initiatives used to change the culture through transformational leadership.
- Implement strategies to increase accountability in the unit's standard of practice through transparency and effective communication.

METHODS

In 2013, nursing engaged in a quality initiative to eradicate falls in the NACU. Close monitoring of high fall risk patients catalyzed the development of the following strategies.

Screening prior to unit arrival by charge nurse

- Room assignment based on fall risk such as rooms with a high visibility and close proximity to the nurse's station
- Low boy bed and floor mats ordered prior to arrival
- Bed alarms

Consistent implementation of fall bundle

- Daily fall rounds with quality, charge, bedside RNs, and PCA
- The John Hopkins Fall Risk Assessment score completed by RN; results discussed with team to ensure proper individualized fall precautions
- Compliance with safety precaution items: bed alarms, floor mats, chair alarms, high visibility room placement
- Fall prevention education facilitated during rounds focusing on patient and family
- Hourly rounding

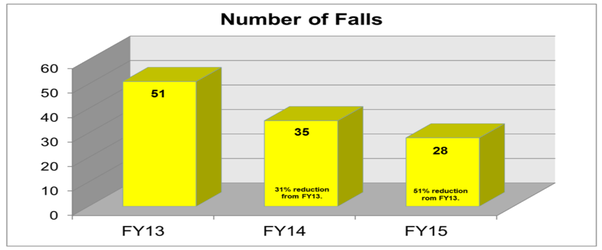
Initiation of the Telestitter Program

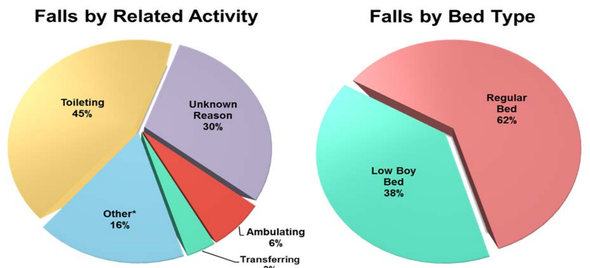
- AvaSys offers a proactive way of increasing patient safety, assisting staff, and reducing hospital costs through Continuous Visual monitoring and verbal redirection by an AvaSys Monitor Technician, or AMT.
- The AvaSys Monitor Tech will act as an extra set of eyes on the patient with the ability to verbally intervene at signs of distress.

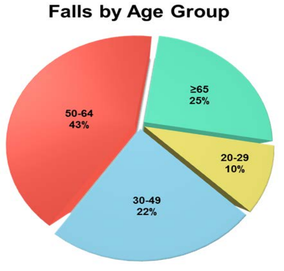
Awareness and accountability

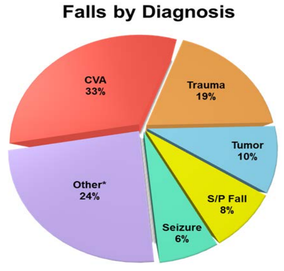
- Monthly meetings started in May 2013 where retrospective fall data was reviewed, including patient activity at time of fall, age, gender, location at time of fall, length of time on unit, and areas of potential improvement
- The Quality RN conducted a root cause analysis (RCA) for each fall that occurred on the unit. Fall data was analyzed and shared monthly with the team. Results were displayed on a quality board, by email, and during staff huddles. A calendar was also displayed as a visual reminder to the number of falls per month

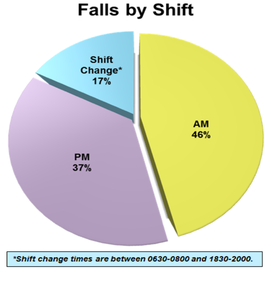
RESULTS

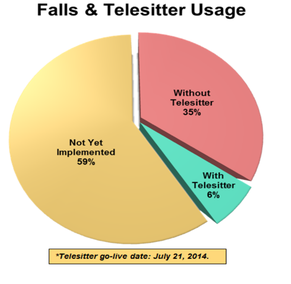












PRACTICE IMPLICATIONS

Staff is more vigilant at identifying high fall risk patients and initiating fall precautions. Hardwiring prevention and a culture of safety ultimately positively impacted patient outcomes in the NSMSU. Culture change required a strategic approach that focused on transparency, accountability, and improved staff communication. Daily focused rounds by the quality RN and nursing team identified patients at highest risk, subsequently significantly reducing the incidence of falls. Improved teamwork and collaboration between the RNs and PCAs was encouraged through development of unit based standards that promoted consistency and a "way of life" for the staff. Nursing leadership during rounds emphasized the importance of a highly engaged staff and empowered the staff to take ownership in the development and utilization of best practice to deliver quality, safe, and compassionate care to every patient, every time.

REFERENCES

Grossman, S. C., & Valiga, T. M. (2013). *The New Leadership Challenge Creating the Future of Nursing* (4th ed.). Philadelphia, PA: F. A. Davis Company.

Marin, L. L. (2011, January 26-28). *Continuous quality improvement efforts on Neurological Step Down Unit result in 66% relative reduction in patient falls*. Paper presented at the Annual NDNQI Conference, . Abstract retrieved from

Ryu, Y. M., Roche, J. P., & Brunton, M. (2009). Patient and Family Education for Fall Prevention Involving Patients and Families in a Fall Prevention Program on a Neuroscience Unit. *Journal of Nursing Care Quality*, *24*(3), 243-249.

Studer, Q., Robinson, B. C., & Cook, K. (2010). *The HCAHPS Handbook Hardwire Your Hospital for Pay-for-Performance Success*. Gulf Breeze, FL: Fire Starter Publishing.

Williams, T., Szekendi, M., & Thomas, S. (2014). An Analysis of Patient Falls and Fall Prevention Programs Across Academic Medical Centers []. *Journal of Nursing Care Quality*, *29*(1), 19-29.