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Falls are the leading cause of accidental death and non-fatality 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.

**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.

**RESULTS**

- Number of Falls
- Falls by Related Activity
- Falls by Bed Type
- Falls by Age Group
- Falls by Diagnosis
- Falls by Shift
- Falls & Telesitter Usage

**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**

