Keeping Patients Safe: Preventing Falls

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Background

Prevention of pediatric falls is difficult due to influences contributing to falls in children: horseplay, parental vigilance, developmental fall and baby/child drop. These factors warrant specific age interventions to decrease the number of age-specific falls. Children's Health uses criteria established by National Database of Nursing Quality Indicators® (NDNQI®) to categorize each fall based on injury.

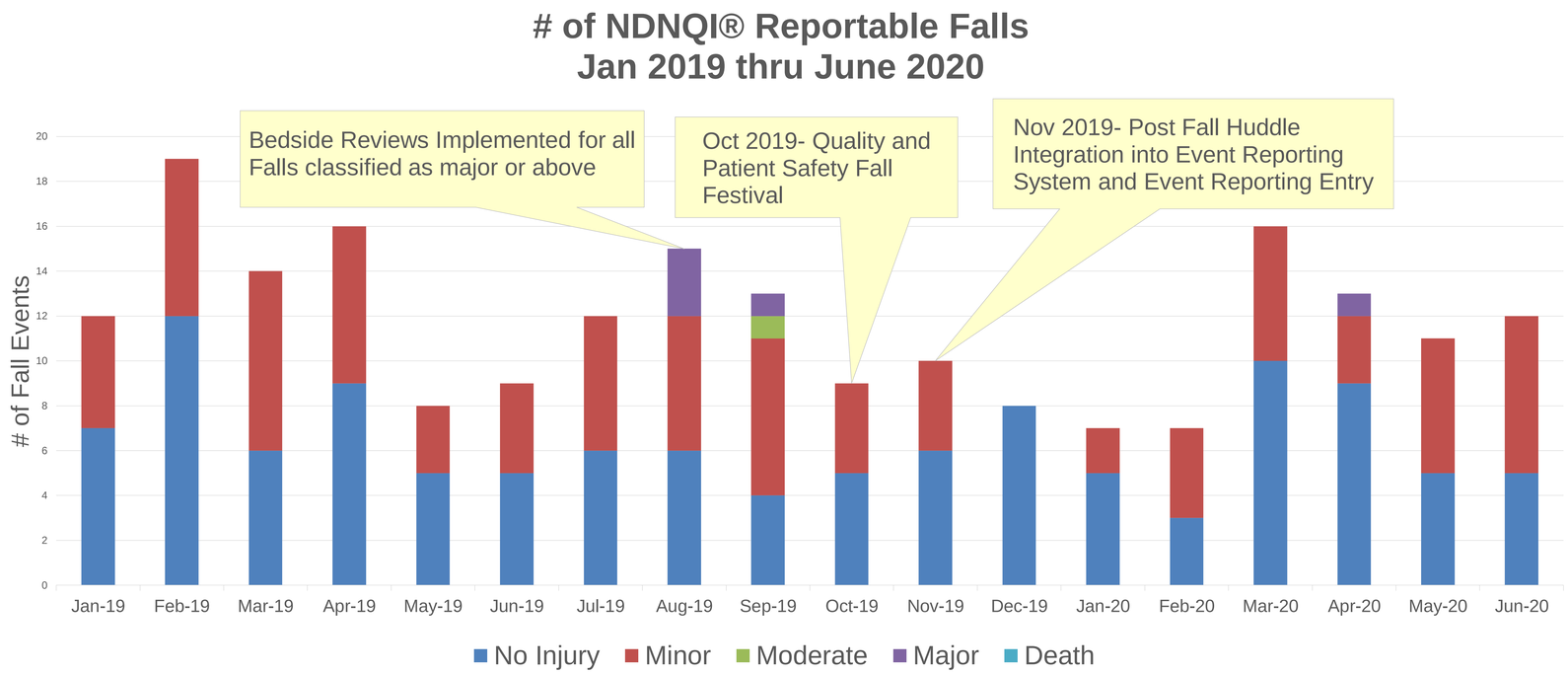
Injury level	Definition
None	Resulted in no signs or symptoms or injury
Minor	Resulted in application of ice or dressing, cleaning wound, pain etc.
Moderate	Resulted in suturing, application of steri-strips, or muscle/joint strain
Severe	Resulted in surgery, casting, traction, consultation from neurological or internal injury, or fracture
Death	Patient died as a result of the injuries sustained from the fall

Aim Statement

While preventing every fall is not a realistic goal, the system-wide Falls Committee strives to continuously implement changes to processes and policies while increasing awareness of fall prevention for the hospitalized pediatric patient to decrease the incidence of falls.

Problem

An increased trend in patient falls was seen from March 2019 to August 2019. In August of 2019, three patient falls resulted in serious injury. Also, in September 2019, one fall resulted in serious injury and another in moderate injury. Falls while hospitalized impacts the organization in profound ways by prolonging hospitalization, increases costs with diagnostic procedures and treatment, and diminishing the sense of safety while hospitalized. The increase in injuries drove the Falls Committee to analyze data and implement interventions, develop process changes, increase awareness and share lessons learned.



Methods

August 2019- Bedside reviews began

- Interview staff who cared for patient at time of fall to identify process gaps and audit documentation
- Discuss events with quality, frontline staff, unit leadership and falls subject matter experts
- Identify lessons learned and distribute amongst staff

October 2019- Hosted Fall Quality and Safety Festival

- Increased staff awareness of all hospital acquired conditions (HACs)
- Reviewed content specific to falls such as top non-compliant bundle elements (best practices)

November 2019- Incorporated Post Fall Huddle to prevent future falls (debriefing tool used after a patient fall) into SafeLink™ (reporting system for all adverse events)

- Mandated Post Fall Huddle questions were completed
- Increased compliance of Post Fall Huddle from 40% to 100%
- Directed discussion after patient fall with care team and patient/family to mitigate future risk of falling

Results

The interventions described directly correlate with a decrease in patient fall events at the end of quarter 4 of 2019 and into quarter 1 of 2020. This timeframe was also noted to be a high census time.

The number of patient falls continues to fluctuate. An increased trend is observed again beginning March of 2020. This pendulum effect displays the constant need for data review and process improvement measures.

The Falls Committee will continue to work together to prevent pediatric falls in the hospital setting. The developed sustainable processes continue to promote learning and awareness to improve patient safety.

References:

Capture Nursing-Specific Measures. (n.d.). Retrieved August 14, 2020, from https://www.pressganey.com/solutions/clinical-excellence/capture-nursing-specific-measures

Cooper, C., Nolt, J. 2007. Development of an Evidence-Based Pediatric Fall Prevention Program. *Journal Nursing Care Quality*. 22(2):107-112

Graf, E. 2004. *Identifying Predictor Variables Associated with Pediatric Inpatient Fall Risk Assessment.* Children's Memorial Hospital, Chicago, IL.

Hendrich, A. Bender, P.S., Nyhuis, A. 2003. Validation of the Hendrich II Fall Risk Model: A large concurrent case/control study of hospitalized patients. *Applied Nursing Research*.16(1):9-21

Poe, S., Cvach, M., Gartwell, D., Radzik, B., Joy, T. 2005. An Evidenced-based Approach to Fall Risk Assessment, Prevention and Management. *Journal of Nursing Care Quality.* 20(2): 107-116.

Murray, E., Vess, J., Edlund, B.J., Implementing a Pediatric Fall Prevention Policy and Program. *Pediatric Nursing [Pediatr Nurs] 2016 Sep-Oct; Vol. 42 (5), pp. 256-9.*

Jamerson, P.A., Graf, E., Messmer, P.R., Fields, H.W., Barton, S., Berger, A., Daraiseh, N.M., Fix, M., Huth, M., Latta, L., Smith, A.B., Lunbeck, M. Inpatient falls in freestanding children's hospitals. *Pediatric Nursing [Pediatr Nurs] 2014 May- Jun; Vol. 40 (3), pp. 127-35*

Kramlich, D.L., Dende, D. Development of a Pediatric Fall Risk And Injury Reduction Program. *Pediatric Nursing [Pediatr Nurs] 2016 Mar-Apr; Vol. 42 (2), pp. 77-82.*

Post Fall Huddle

Sample Questions

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