Fall Prevention through Focused Communication

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Background

- In less than 2 months, the 48 bed Medical Surgical unit had 3 falls with serious injury and an overall increase in the fall rate.
- Fall interventions had been fully implemented without any improvement in fall rates or falls with injuries.
- Falls during acute care hospitalization can have expansive consequences including injuries, depression, decreased quality of life, reduced mobility and longer hospitalization. Patients who have an injurious fall on average have an increased length of stay by 6-12 days (Zhao et al., 2019).
- Many risk factors contribute to a fall, but no screening tool has been proven to be sensitive enough to be clinically useful in avoiding falls (Morris & O'Riordan, 2017).

Problem Statement

The Medical Surgical Unit of BSWH Medical Center in College Station Texas had a 300% increase in falls with serious injury during January 1 -April 30, 2021, compared to the previous 2 quarters.

AIM Statement

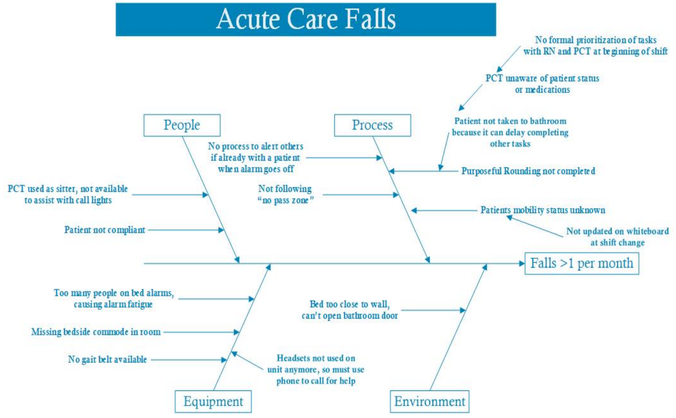
The Medical Surgical Unit at BSW Health in College Station Texas will have ZERO injuries related to falls for the 90-day period (May 1- July 31, 2021)

Defining the Problem

Multidisciplinary task force identified ***PCT and Nurse communication breakdown*** as a significant contributing factor to increase in falls

Abstract / References

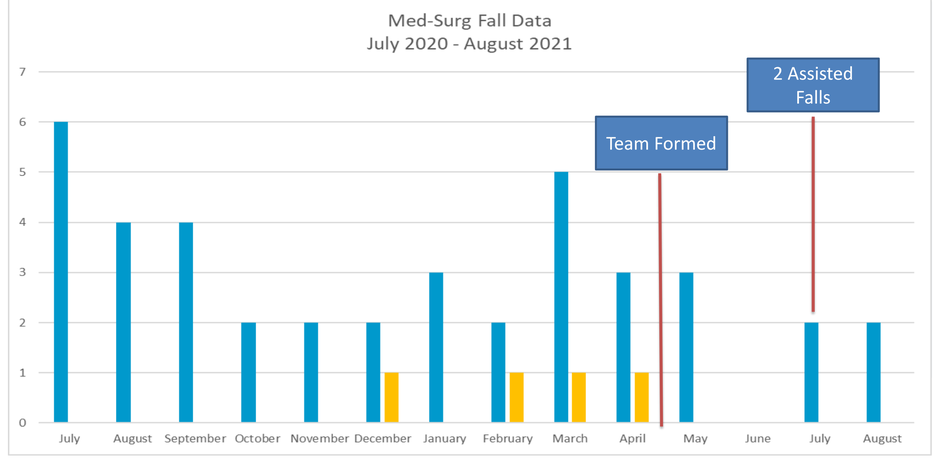
- Zhao, Y. L., Bott, M., He, J., Kim, H., Park, S. H., & Dunton, N. (2019). Evidence on Fall and Injurious Fall Prevention Interventions in Acute Care Hospitals. *The Journal of nursing administration*, *49*(2), 86–92. https://doi.org/10.1097/NNA.0000000000000715
- Morris, R., & O'Riordan, S. (2017). Prevention of falls in hospital. *Clinical medicine (London, England)*, *17*(4), 360–362. https://doi.org/10.7861/clinmedicine.17-4-360



Implementation

- Used Huddle Boards to track barriers to using all fall precautions (April 2021)
- Increased patient friendly signage regarding assistance in bathroom (April 2021)
- Standardized (with frontline design) RN-PCT communication at beginning of shift to help collaboration and prioritization (May 2021)
- Added Fall Risk discussion at Bedside Shift Report (May 2021)
- Standardized with Physical Therapy language around "assistance" (August 2021)
- Increased standardization of white boards in room to identify fall risk, mobility and assistance (August 2021)

Evaluation



From May 1- August 31, 2021, The unit had Zero Falls with injury. The unit also significantly decreased the number of falls, with a reduction of almost 60% in comparison to the previous two quarters. This unit also celebrated a success of 67 days without any falls during their interventions.

Lessons Learned

"As a staff nurse, I appreciated the effort to include multiple disciplines on the task force and the designated time to examine the opportunities for change in improving overall patient safety" - Susan Brown BSN, RN, CMSRN

"Through the fall task force and process implementation we were able to achieve our goal of ZERO injuries related to falls for a 90-day period. My team has built on this success and continues to grow peer and patient accountability as we continue down our journey to ZERO harm" - Ashley Cox BSN, RNC-OB

"Enhancing communication and teamwork leads to more involved patient care fostering a work environment where employees can be proud of their work leading to greater patient outcome" - Sabrina Brown, PCT