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# Rehabilitation Fall Prevention Strategies

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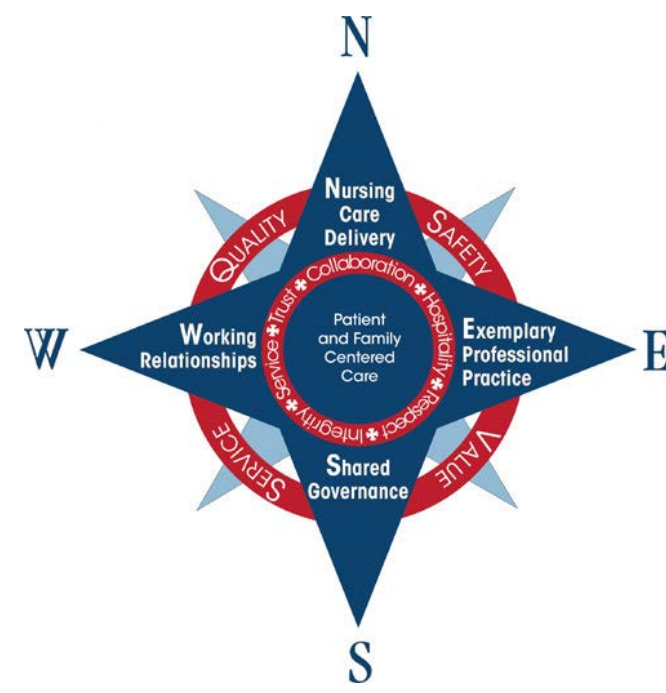
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# Rehabilitation Fall Prevention Strategies

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## Lets STOP Falls

Please help us achieve our goals of **NO Falls** on the Rehab Unit!

Please review these hints:

**High Fall Risk:**  
Implement SAFER PLACE interventions plus the following High Fall Risk Precautions as appropriate:  
S: Sign outside door (magnetic sign or flag) - mandatory  
A: Alert systems (bed alarm, posey sitter, chirper)  
F: Fall risk placed under FYIs if patient falls during this hospitalization or is currently hospitalized as the direct result of a fall  
E: Education about fall prevention measures  
C: Communicate fall risk using SBAR  
A: Activity/ambulation with staff assistance/device and remain within arm's reach at all times  
R: Yellow slippers (yellow arm band in MHU)

**Low Fall Risk Precautions:**  
S: Sit before standing to prevent dizziness/orthostatic hypotension  
A: Assistive devices are utilized as appropriate (canes, walkers, etc)  
F: Footwear is non-skid or hard-soled  
E: Education about low fall risk precaution measures  
R: Rounding for comfort hourly  
P: Personal items within reach  
L: Lighting is appropriate  
A: Access to call light or staff within sight/earshot  
C: Clear pathways to toilet, door, etc.  
E: Ensure bed/recliner/chair in low position with brakes on

**Reassessment occurs:**  
• Once per 12 hour shift  
• After any fall/near fall (document fall in FYI3)  
• Post procedure as needed  
• Transfer to another unit  
• Clinical condition changes  
• More often per nursing judgment

# of Days without Falls!



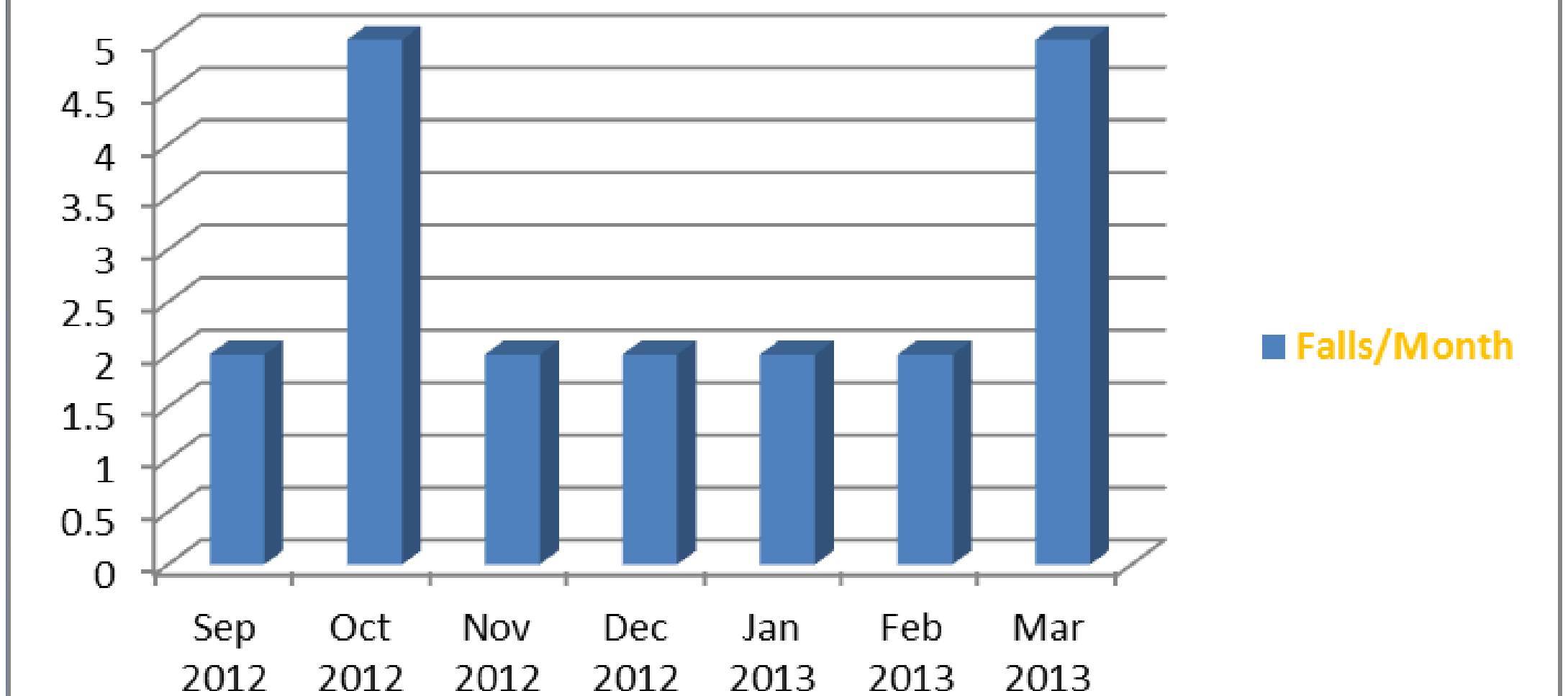
### Goals for Change

- Improve communication among health care workers
- Assisting staff to be aware of how a patient is transfers in a very visible and assessable way
- Alerting staff to the fall prevention measures that have been implemented to reduce the likelihood that patient would fall
- Helping staff to be more aware of ways to prevent falls.
- Reduce the fall rates to equal to or less than NDNQI mean on rehab units
- Prevention of injury/harm to patients
- Patient/family satisfier
- Alert staff to the need to complete a fall assessment on every patient every 12 hours
- Decrease use of 1:1s by using other fall prevention interventions

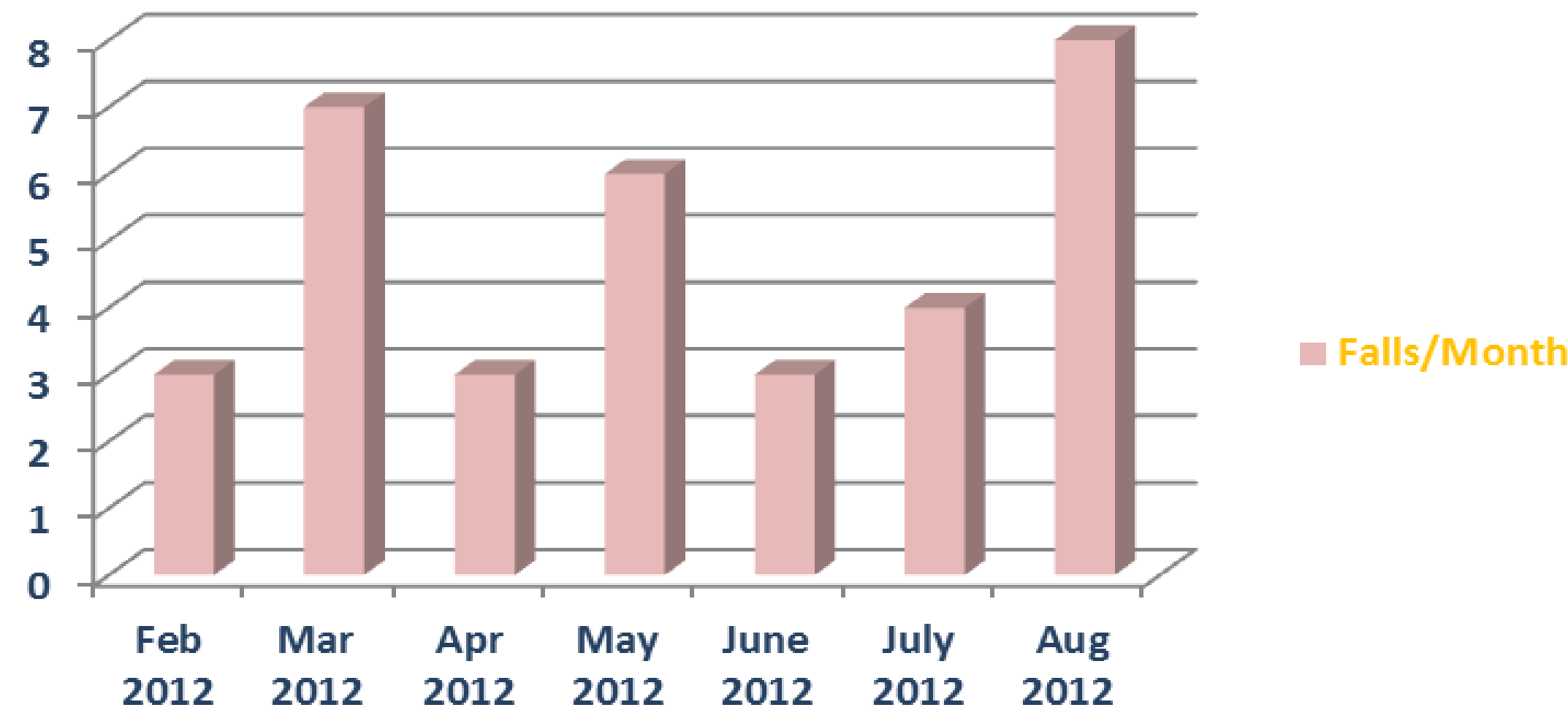
### Findings in the Literature

- A *Rehabilitation Nursing* article (Nelson, Harwood, Tracey, & Dunn, 2008) poses a myth about patient handling it is that nurses, doctors and therapists are on the same wave link when it comes to communication.
- Nelson, Harwood, Tracey, & Dunn, (2008) refuted this myth by indicating that the lack of communication is a known complaint. Ineffective communication amongst health care providers, therapists and nurses was the number one foreseeable mortality rate indicator.
- According to Hempel, Newberry, Wang, Booth, Shanman, Johnsen, Shier, Saliba, Spector, & Ganz, (2013), some of the usual interventions used for all patients include the completion of a fall risk assessment, education of family and patient and evaluating the fall for areas of improvement.
- Hempel, Newberry, Wang, Booth, Shanman, Johnsen, Shier, Saliba, Spector, & Ganz, (2013), wrote that a fall assessment is used to determine what fall prevention measures the patient should be receiving, such as alert signs on doors, beds, and chart. Keeping staff aware of the interventions that are in place for individual patients to prevent a fall.
- According to the Fall Management Policy, (12/2012), the health care provider will be aware of the problems that place a patient at risk for falls, aware of how often patients are assessed and be aware of the interventions that can increase patient and staff safety.

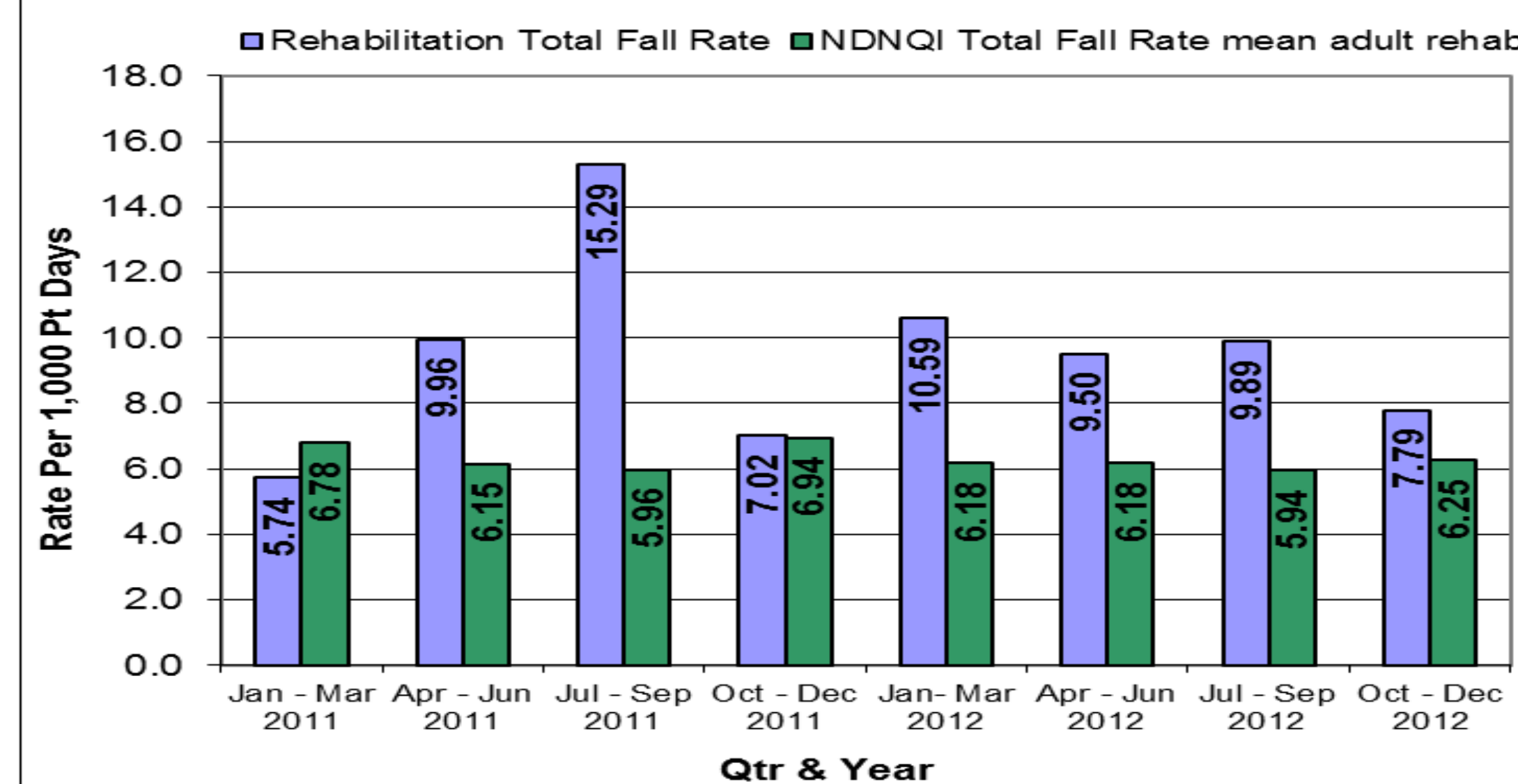
### Falls After Rehab Interventions



### Falls Prior to Rehab Interventions



### Rehabilitation Total Falls Per 1,000 Patient Days: Lower is Better



### Results of Implementation of Posters

- There were 34 falls noted from Feb 2012 to August 2012. Lets Stop Falls poster was implemented September 1, 2012 which showed that the falls were reduced to 20 falls in the next 7 months which was a reduced of 30%.
- In December 2012, the Fall Intervention/Prevention Poster was implemented. Each patient has poster and the interdisciplinary care team (Therapy and Nursing) are responsible every shift to make sure it is updated and current

### Fall Interventions/Preventions

Date Last Reviewed: \_\_\_\_\_ Initial: \_\_\_\_\_ RN \_\_\_\_\_ PCA \_\_\_\_\_

PT Transfer Recommendations				
Ambulate with:	No Device	Gait Belt	Cane	Walker
Assistance of:	A2	A1	CGA	SBA Independent
No Ambulation at this time, wheelchair only				
Other:				

Is it OK to leave this patient alone in the bathroom? Yes No

Can family transfer this patient? Yes No

All patients will have education on fall precautions, sign outside the door, bed in lowest position, and appropriate footwear.

### High Fall Risk - Requires These Additional Interventions

Extra Comfort Rounding:	q 15 / 30 / Other
Bed Alarm:	Medium Sensitivity / High Sensitivity
Chirper:	Bed / Chair / Both
Posey sitter:	Chair / Bed / Both
Floor mats:	Right / Left / Both
Three Side Rails Up	
Mechanical Lift	
Other (please indicate):	

### References

- American Nurses Association, (2013). *Nursing quality indicators: Total falls per 1,000 patient days on adult rehab* (4<sup>th</sup> quarter, 2012). Retrieved from <https://www.nursingquality.org>
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