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Facing Falls by Staying in the Zone

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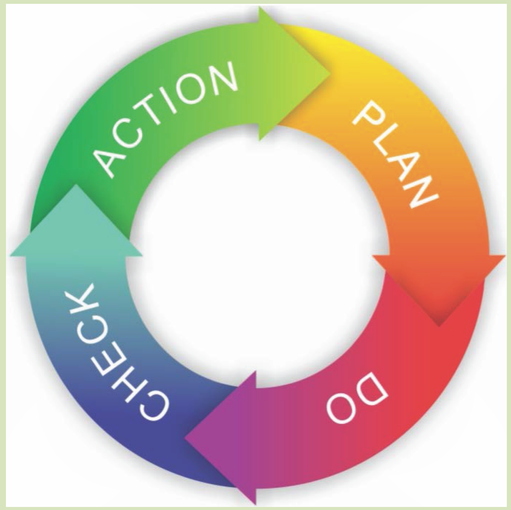
Introduction /Background

- Patient fall-related injuries are a serious problem in acute care hospitals. The Centers for Disease Control and Prevention [CDC] (2010) estimates that by 2020, the annual direct and indirect cost of falls will reach $ 54.9 billion. These falls are reasonably preventable by following the falls prevention guidelines.
- According to fall huddle documentation for the period of April 27th to June, 13th 2013, 3-South at Homestead Hospital had ***10 falls, 3 with injuries.***

Project Goal

- The goals of this performance improvement project were:
  - To determine the root causes of falls on 3-South
  - To eliminate falls with injury to a rate of zero in a one year period.



The Plan Do Check Act (PDCA) model for performance improvement was used to guide the development and implementation of the project.

Plan

- The UPC members examined the falls data to determine root causes.
- Created block assignment process and fall prevention toolkit during June 2013 UPC meeting.
- A pre- and post-implementation data was obtained to determine staff's perception of the effectiveness of the fall prevention tool kit.

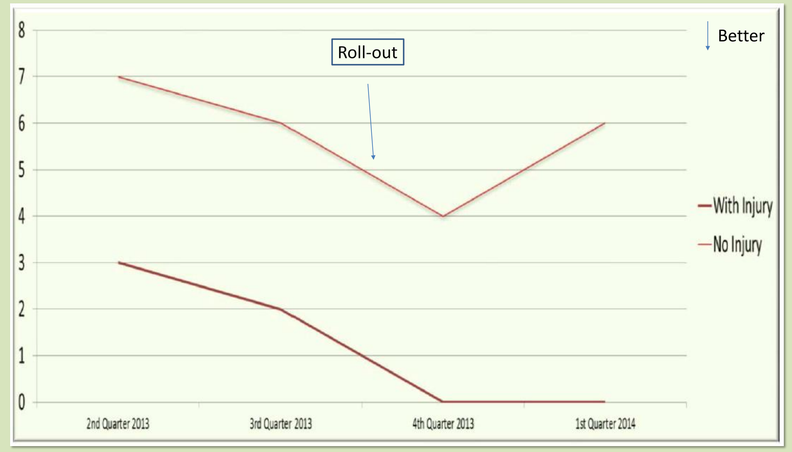
Do

- Education was provided to staff before the implementation and reinforced throughout the project
  - Staff education conducted through in services and reinforced in stand-ups
- The block assignment process & fall prevention toolkit were rolled-out in July 2013
  - Staff positioned to stay in their patient zone
  - Incorporate family in patient care , walking rounds
  - Promote correct use of minimal lift equipment
  - Bed alarms in place for high risk patients
  - Door magnets properly placed for visual alerts
  - MORSE fall score became part of hand-off report (Spiva, & Hart, 2013)

Check

There were no falls <u>with</u> injuries after the implementation of the project.

- Barriers encountered during project:
  - Too many admissions/discharges for some block assignments
  - When blocks had few patients - RN was assigned a high number of admissions
  - Acuity distribution of blocks was uneven
  - Lack of teamwork – need for culture change
  - Bed alarms were off
  - Magnets used, blue (fall risk) and red (already fell)were not being used properly
  - Falls prevention champion was assigned but never exercised role



Number of falls on 3-South with & without injuries January 2013 – December 2014.

Act

- Since the implementation of this project in July 2013, 3-South has had six consecutive quarters with no falls that resulted in injuries. UPC members continue to monitor falls data for changes.
- Periodic in-depth falls assessments to identify problems are also conducted. The current focus is to identify factors that contribute to non-injury falls in order to implement appropriate evidence-based interventions.

References

▪Baptist Health South Florida [BHSF]. (2014). Fall Prevention, Adult Patient: Risk management/Patient safety. Retrieved from http://bhssf.org/en/policy-administration

▪Center for Disease Control and Prevention (2010). Cost of falls among older adults. Retrieved from http://www.cdc.gov/HomeandRecreationalSafety/Falls/fallscost.html

▪Spiva, L., & Hart, P. (2013). Evidence-Based Interventions for Preventing Falls in Acute Care Hospitals. *The American Nurses Association, 7*(27), 2-8.Retrived from https://www.medline.com/media/mkt/pdf/White-Paper-Evidence-Based-Interventions-for-Preventing-Falls-Acute-Care-Hospitals.pdf

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