B.A.C.K to B.A.S.IC.S: A Fall Prevention Bundle

Venessa L. Beck BSN, RN
Lehigh Valley Health Network, venessa_l.beck@lvhn.org

Christopher Castro BSN, RN
Lehigh Valley Health Network, christopher_a.castro@lvhn.org

Sophia C. Fuesler BSN, RN
Lehigh Valley Health Network, sophia_c.fuesler@lvhn.org

Kendall B. Heyer BSN, RN
Lehigh Valley Health Network, kendall_b.heyer@lvhn.org

Yesenia Rivera BSN, RN
Lehigh Valley Health Network, yesenia.rivera@lvhn.org

Published In/Presented At

Beck, V. Castro, C. Fuesler, S. Heyer, K. Rivera, Y. (2016, Oct). *B.A.C.K to B.A.S.IC.S: A Fall Prevention Bundle*. Poster presented at LVHN Vizient/AACN Nurse Residency Program Graduation, Lehigh Valley Health Network, Allentown, PA.

B.A.C.K. to B.A.S.I.C.S: a Fall Prevention Bundle

Vanessa Beck, BSN, RN; Christopher Castro, BSN, RN; Sophia Fuesler, BSN, RN; Kendall Heyer, BSN, RN; Yesenia Rivera, BSN, RN

Lehigh Valley Health Network, Allentown, Pennsylvania

BACKGROUND

Patient falls while in an inpatient setting can have serious consequences, among which include injury to the patient as well as length of stay at the hospital (Ang et al, 2012).

How can hospital staff decrease the likelihood that a patient will fall during their stay at the hospital?

- B.A.C.K. to B.A.S.I.C.S (BTB). BTB is a fall prevention bundle that was initially put together by the Regional Heart Center (RHC) Fall Council in 2013 due to a significant increase in falls.

A recent increase in falls on RHC has pushed the floor over their FY16 goal for patient falls.

The BTB guideline remains in place on RHC, but staff (RNs and TPs) are unaware of it or are only aware of part of the acronym.

B.A.C.K. to B.A.S.I.C.S.

What does B.A.C.K. to B.A.S.I.C.S. stand for?

- B: Bed check criteria and trial periods
- A: Ambulation
- C: Change in status
- K: Keep alert
- B: Bathroom
- A: Assess mobility frequently
- S: Stay with the patient
- I: Inspect the room
- C: Communicate and educate
- S: Supply patient with needs at the bedside

PROJECT PURPOSE

- Assess current BTB criteria for evidence based practice, change criteria if necessary and assess barriers to BTB use/implementation. Assess and compare fall rates on RHC and determine what, if any, fall interventions were in place when the patient fell.

PICO QUESTION

In staff RNs and TPs will education about the “B.A.C.K. to B.A.S.I.C.S.” result in more appropriate use of fall risk interventions to reduce falls?

METHODS

- Pre-education survey for staff RNs and TPs.
- BTB criteria education via a PowerPoint on TLC.
- Discuss BTB criteria during daily safety huddle.
- Review of fall data on RHC during June and September.
- Assessment of fall prevention methods in place during those patient falls.
- Consultation to the bed check representative.

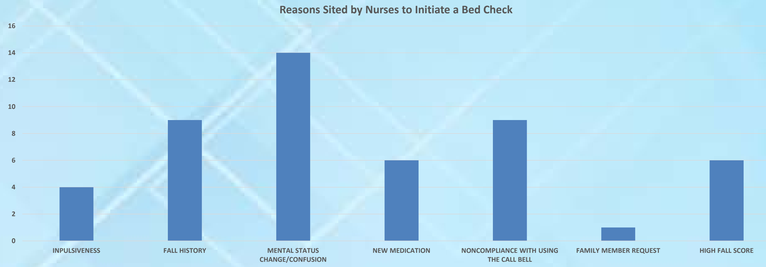
RESULTS and OUTCOMES

After reviewing the evidence available, the current BTB criteria was found to be based in evidence.

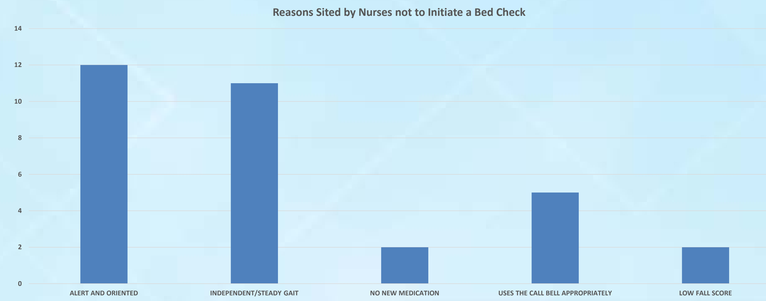
Based on the survey responses, staff RNs and TPs:

- Often felt a bed check was available when needed
- Often ambulated their patents at least daily
- Often rounded according to RHC rounding guidelines
- Always stayed with the patient while toileting
- Always communicated the patient’s activity level during change of shift
- Often communicated the patient’s fall risk to the patient
- Often communicated the patient’s fall risk to the RN at change of shift
- Often communicated the patient’s fall risk to the TP at change of shift
- Often communicated the fall risk interventions already in place to the RN and TP caring for that patient.

Additionally the surveys showed that the most common reasons cited by RNs and TPs to initiate a bed check were: impulsiveness, fall history, mental status change/confusion, new medication, call bell non-compliance and high fall score.



The surveys also showed that the most common reason cited by RNs and TPs not to initiate a bed check were: alert and oriented, independent/steady gait, no new medication, appropriate use of call bell and low fall score.



RESULTS and OUTCOMES CONT.

After review of patent falls on RHC in June (3 falls) it was discovered that multiple fall interventions were already in place when the patient fell.

- Interventions included hi/lo beds, bed checks, falls mats, proper rounding & non-skid shoes/socks.

2 out of the 3 falls in June the patient was on a bed check. The bed check rep was consulted on concerns regarding the wide sensor mat, and it not fastening to the bed, leading to the patient and sensor mat sliding together. This prompted the team to intervene. by having staff RNs and TPs change the location of the bed checks from under the patient’s sacrum to under their shoulders under recommendations from the bed check representative.

- Unfortunately, more research needs to be done to assess the effectiveness of this intervention.

The most common fall interventions charted during data collection in June and September were: assistive device, fall reduction program, and non-skid shoes/shocks

CONCLUSIONS and RECOMMENDATIONS

- A survey, although anonymous, may not be the best method to collect data.
- Based on fall data collection in September (1 fall):
  - Staff RNs and TPs on RHC are either not following the fall prevention policy or are not charting the fall interventions that are in place.
  - Education about the definition of the fall prevention indicators found in EPIC is needed to ensure proper charting
- More research will need to be done to assess the effectiveness of the movement of the bed check from the patient’s sacrum to under their shoulders
- More education is needed to assess the effectiveness of BTB as a fall prevention bundle.

REFERENCES

Ang, E., Mordiffi, S. Z. and Wong, H. B. (2011), Evaluating the use of a targeted multiple intervention strategy in reducing patient falls in an acute care hospital: a randomized controlled trial. Journal of Advanced Nursing, 67: 1984–1992. doi:10.1111/j.1365-2648.2011.05646.x.

Dykes et al. (2010) Fall prevention in acute care hospitals. *Journal of American Medical Association, 304*(10,77-86).

Gates S, Lamb S E, Fisher J D, Cooke M W, Carter Y H. Multifactorial assessment and targeted intervention for preventing falls and injuries among older people in community and emergency care settings: systematic review and meta-analysis *BMJ* 2007; :bmj;bmj.39412.525243.BEv1

Haines, T. P., Bennell, K. L., Osborne, R. H., & Hill, K. D. (2004). Effectiveness of targeted falls prevention program in subacute hospital setting: randomized controlled trial. *BMJ : British Medical Journal*, *328*(7441), 676.

Halm et al. (2009). Hourly rounds: What does the evidence indicate? *American Journal of Critical Care, 18* (6,581-548).

Hill et al. (2009). Evaluation of the effect of patient education on the rates of falls in older hospital patients: description of a randomized control trial. *BMC Geriatrics,* 9:14.

Hill et al. (2011). Evaluation of the sustained effect of inpatient falls prevention education and predictors of falls after hospital discharge. *Journal of Gerontology*.

Huey-Ming Tzeng. (2009). Understanding the prevalence of inpatient falls associated with toileting in adult acute care setting. *Journal of Nursing Care Quality*.

Kalish et al. (2012). Missed nursing care, staffing, and patient falls. *Journal of Nursing Care Quality, 27*:1(6-12)

Miake-Lye et al. (2013). Inpatient fall prevention programs as a patient safety strategy. *Annals of Internal Medicine, 158* (5,390-396).

Tzeng et al. (2013). Most and least helpful aspects of fall prevention educaiton to prevent injurious falls: a qualitative study on nurses’ perspectives. *Journal of Clinical Nursing*.