Fall Accountability Care Program.

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Background

- Despite multiple fall interventions in place, such as bed alarms, chair alarms, fall-risk bracelets, yellow non-skid socks, hi-low bed with fall matts, and patient instructions, falls are increasingly prevalent on medical-surgical units. (Hoke & Guarracino, 2016).
- The LVH post-fall huddles are attended by staff working at that time. The subsequent safety report is then reviewed by unit leadership. Staff not working the day of the fall do not have the learning opportunity afforded by the huddle and review of safety report.
- Goal is to increase awareness by all unit staff of each fall's root causes. .

PICO Question

PICO Question –Will establishing a reflective survey program increase staff awareness of fall causation and reduce falls in medical-surgical patients?

Evidence

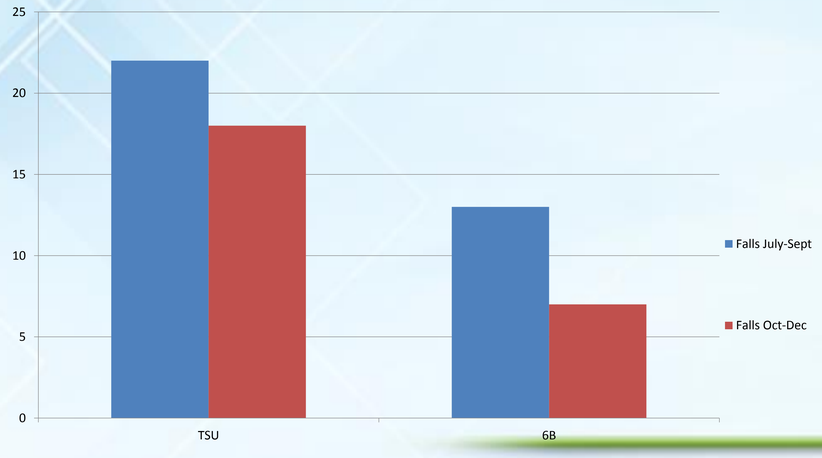
- Interventions designed to increase bed alarm use did increase the usage of alarms, however, had no statistically or clinically significant effect on fall-related events (Shorr et al., 2012).
- Implementing systematic individualized fall-risk management for all residents using a fall-risk assessment tool, high-risk logo, and strategies to address identified risk did not reduce falls or injury from falls (Kerse, Butler, Robinson & Todd, et al., 2004).
- Multiple interventions targeted specifically for each individual patient were effective in reducing the incidences of falls in acute care setting (Ang & Wong, 2011).
- Standard fall precautions can't be shown to be effective in decreasing fall occurrences within literature, and the clinical environment, however, a reflection survey program resulted in decrease in unit's rate of falls and falls with injury (Hoke & Guarracino, 2016).

Methods

- Pre-interventions -- Fall Awareness survey administered to unit staff
- Intervention
  - Post fall reflection survey was requested to be completed by each RN who experienced a patient fall and then sent to all unit staff within 3 days.
- Reflection Survey questions:
  1. Provide a detailed description of what occurred, including actions taken post fall. Did the patient incur injuries?
  2. What fall prevention interventions were in place at the time of fall?
  3. What factors placed the patient at an increased risk of falling? (i.e. medications, clutter in the room, unsteady gait, mews score/vs, fall risk score)
  4. What are some opportunities for learning?
  5. From your Nursing perspective, what did you take away from this fall/what will you change in your Nursing practice for the future?
- Post-interventions – Fall Awareness Survey re-administered to unit staff

Results – Fall Incidence

Implementation process began Oct-Dec. Patient falls decreased on both TSU and 6B after implementation of the survey. Data shows a correlation between survey responses and reduced falls, not causation. Data was not controlled for differences in population over time or between units.



Results – Staff Awareness

- 16 of 25 RNs felt learning details about fall events from their peer was beneficial.
- 4 RNs reported changing practice based on learnings from the Reflection Survey questions. The primary practice change related to not toileting alone and establishing a frequent toileting schedule.

Conclusion

Leadership support is essential for staff accountability to complete the Reflection Survey questions and send to peers.

References

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