MISCOMMUNICATION OF FALL RISK INDICATORS AND FALL PREVENTION INTERVENTIONS

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BACKGROUND

- Both units 6B and 6C at Lehigh Valley Hospital have identified that miscommunication between RNs during shift report effect quality of patient care. The miscommunication has involved the patient's fall risk indicators and specific fall risk interventions in place for each patient. Due to this miscommunications between RNs there have been an increase in patient falls on these two units.

P I C O

During bedside shift report, does communication of a patient's individual fall risk indicators and specific fall prevention interventions increase the RNs awareness of fall risk and fall prevention interventions needed for a specific patient and decrease falls?

P: Registered nurses on 6C.

I: Communication and education.

C: No communication

O: Increase RN's awareness of fall risk indicators and fall prevention interventions.

EVIDENCE

- A critical communication process for nurses to provide seamless, safe, patient care is nursing shift report. At every handoff, there is the possibility of miscommunication of vital information. The Institute of Medicine(2001) concluded that "it is in inadequate handoff that safety often fails first"(p. 45).
- Bedside shift report drives staff ownership and accountability. The reality is that nurses will be with the patient for 3 to 5 minutes while they physically check the patient, update the whiteboard, and do an environmental check. A quick physical check on the patient along with bedside shift report allows the nurse can ensure the patient's room is in good condition and the patient is safe.

BEDSIDE SHIFT REPORT CHECKLIST

- ☐ Non-slip socks
- ☐ Physically check bed alarm
- ☐ Update communication white board in room
- ☐ Make sure bed is in lowest position
- ☐ Educate patient on call bell use and make sure call bell is within reach
- ☐ Communicate need for frequent rounding
- ☐ Communicate unique fall risk indicators based on Hester Davis Fall Scale

Hester Davis Scale

- Last known fall
- Mobility
- Medications
- Mental status/LOC/Awareness
- Toileting Needs
- Volume/ Electrolyte Status
- Communication/Sensory
- Behavior

*Age is automatically scored but also considered

IMPLEMENTATION

- A pre survey on fall scores was handed out to nurses to have a better understanding on if shift report was being done at the bedside and if individual fall risk scores were being communicated during report
- A fall safety checklist was implemented for nurses to utilize during shift report. The checklist is used to help nurses remember to communicate individual fall risk scores and check important safety interventions that help prevent falls.
- The check list was handed out to five nurses on 6C for shift report and the nurses were educated to use this during bedside shift report as a reminder to check off important safety interventions and communicate the patients individual fall score

OUTCOMES/ NEXT STEPS

- The nurses were observed participating in shift report at the bedside and the checklist was observed being utilized
- The nurses were observed for two weekends on 6C
- The nurses on 6C were asked their opinions of the checklist and they stated they liked the check list and felt like it was a helpful tool
- Will continue to monitor throughout the year to see if this is a helpful source at fall prevention

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