Reduction of Falls Utilizing a Safety Huddle at Night

Gabrielle Lopez BSN, RN
Lehigh Valley Health Network, Gabrielle.Lopez@lvhn.org

Bridget Stein BSN, RN
Lehigh Valley Health Network, Bridget.Stein@lvhn.org

Tara M. Kirk ASN, RN
Lehigh Valley Health Network, Tara_M.Kirk@lvhn.org

Tajlynne King ASN, RN
Lehigh Valley Health Network, Tajlynne.King@lvhn.org

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Lehigh Valley Health Network, Allentown, Pennsylvania

BACKGROUND

- Preventing falls is a patient safety initiative at LVHN
- LVHN-M 7T experienced an increase in falls
  - From August 2018 to December 2018, 7T had 11 falls prior to initiating fall huddle

P I C O

- **P Adult inpatient**
- **I Safety huddle at night**
- **C Not doing safety huddles**
- **O Falls**

EVIDENCE

- "The safety huddles were effective as the total fall rates per 1,000 patient days (Table 1) in the second through fourth quarters of 2011 remained lower than presafety huddle levels". (Leone & Adams, 2015)
- There was a decrease in falls after implementing safety huddles. T2 had six consecutive weeks without a fall. (Lee, 2014)
- A hospital in Boston implemented safety huddles and reduced falls by 43% (Joint Commission Center for Transforming Healthcare)

IMPLEMENTATON

- Safety huddle at night with focus on fall risks
  - Examples
    - Presence of bed check
    - Mental status
    - Challenges bed check
- Safety huddle led by CHURN
- Utilization of a standardized huddle sheet
- Perform bi-weekly audits of huddle sheet
  - The safety huddle was being performed but not consistently – did not occur on nights when there was no CHURN

Date: _____ 7T huddle sheet Shift: DAY NIGHT

	Foley	Central Line	Fall Risk	Skin Issues	1:1/ Restraints		Notes
701			Bed ✓ gait belt fall@ home				
702			Bed ✓ gait belt fall@ home				
703			Bed ✓ gait belt fall@ home				
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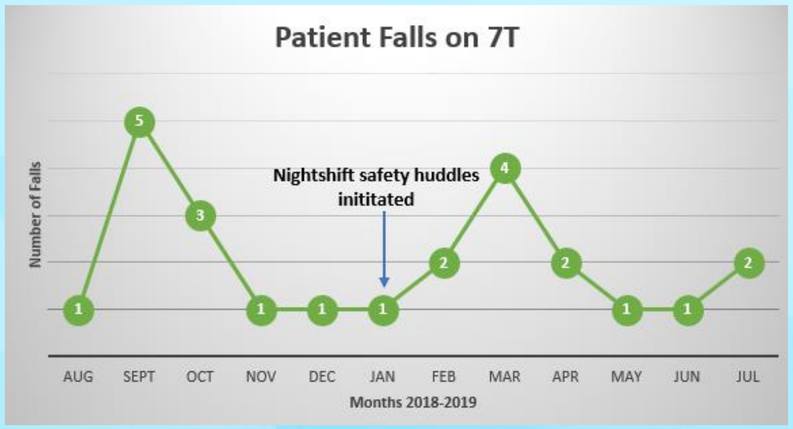
728			Bed ✓ gait belt fall@ home				
729			Bed ✓ gait belt fall@ home				
730			Bed ✓ gait belt fall@ home				

Return form to PCS mail box

OUTCOMES



NEXT STEPS

- Improve consistency of huddle occurrence
- Create alternative huddle initiator if CHURN not available

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