2 Clarke/Neuroscience: Initiative to Reduce Falls and Related Injuries - The Effective Use of Existing Equipment, Tools, and Processes

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2 Clarke/Neuroscience: Initiative to Reduce Falls and Related Injuries
The Effective Use of Existing Equipment/Tools/Processes
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Background/Problem
Patient falls and related injuries present a continuing challenge in healthcare. There is no limit to the negative physical, psychological, and financial impact related to a fall. Risk factors vary based on unit population, staffing, and available fall prevention equipment. Accidental falls can occur with or without risk factors. Over several months, we identified inconsistent use of prevention and injury mitigation measures and inconsistent hand-off communication resulting in a delay to implement appropriate fall measures. Lastly, the ambiguity of roles, communication, and use of fall measures resulted in a lack of accountability.

Our current fall prevention measures consist of a Fall Bundle:
- Fall mats
- Door frame falling stars
- Chair and bed alarms
- Patient/family education
- Non-slip socks
- Morse Fall Scale

We may reduce fall rates by effective identification of those at risk and by consistent implementation of appropriate precautions.

GOAL: Reduce the 2 Clarke fall rate to ≤ 2 per month

Plan
HOW: Implement a unit-based, standardized hand-off tool for better communication and information exchange.
- Room cue cards
- Involvement of Clinical Partners (CPs) during hand-off
- Random room audits by Administrative Partners (APs)
- RNs and CPs held accountable by unit leadership
- All staff was provided education on the initiative

Cue Cards: Updated with the most recent Morse Score during bedside report by the off-going nurse. Both nurses ensure fall precautions are implemented as listed on the form before leaving the room.

Cont: Plan
Clinical Partners: Review the form during hand-off to confirm that each room is equipped with the fall measures.
Room Audits: Completed at random by APs. Outcomes are submitted to supervisors or Patient Outcome Facilitators for review. Concurrent corrections are made when possible.
Accountability: Audit forms are reviewed regularly and accountability for RNs and CPs is addressed by leadership.

Implementation of Change
The initiative was implemented June 6, 2017. With full support and involvement of leadership, expectations were reinforced and re-education was provided. Initially, forgetting to update the cue cards was the most common reason for non-compliance. APs would send out a standardized text to all staff before each shift change as a reminder. Lastly, we identified that the Acute Therapy (AT) team also could use fall measures to promote a safer environment. Partnership with AT was accomplished through communication with their department leadership.

Results
Overall, this new process has reduced the number of falls and we are on our way to meeting our goal of ≤ 2 per month. (Graph 1)

Analysis
Because of the downward trend, we made this new process a permanent part of our shift hand-off. Now we can explore additional measures to reduce fall rates. A Fall Reporting Algorithm is in development to ensure accurate fall details are reported. Our partnership with the AT team is growing. We will have unit walkers for safe transfer/ambulation and the ATs will provide “Train the Trainer” education on walker usage. Re-initiation of a unit-based Fall Committee is under discussion by the Shared Governance Council. Temporary bed sensor alarms are being tested for short term use while non-functioning bed alarms are replaced.

Conclusion
- Organized, efficient, and consistent use of existing equipment, tools, and processes was essential
- Financial impact was minimal
  - Required only printing, lamination, and education
- A nonprofit community hospital in Arlington, VA piloted a similar hand-off communication tool with comparable results

References