

## PURPOSE

Eliminating falls is the ultimate goal for any hospital. We must continuously strive to challenge ourselves not only to decrease our overall fall rate, but also our falls with significant injury.

## METHODS

The fall rate is calculated as follows: number of patient falls/total patient days. Our hospital benchmark is set <10

Falls with injury are reviewed from hospital incident reporting. Our hospital benchmark is 0

## PROBLEMS IDENTIFIED

- Increased number of falls with injury
- Identified a complicated system for staff to access fall prevention tools
- Care Planning process
- Staff Communication (including hand-off communication and hourly rounding)
- Knowledge deficit

## QUALITY IMPROVEMENT

“Grab and Go” bags have been set up for all team members to allow easy access to fall prevention tools.

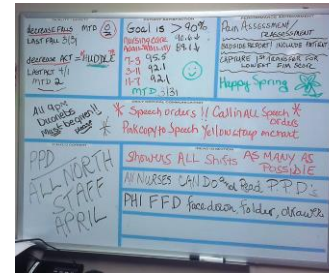
Grab & Go Fall Prevention Bags



Our fall assessment and intervention tool is now located with the TAR (Treatment Administration Record) so that the interventions are ready for the team members to view. In addition, the nursing staff can utilize it during hand-off and hourly rounding to ensure precautions are in place.

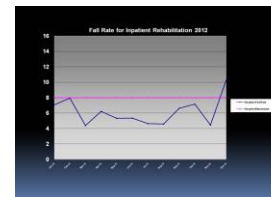
Education on the fall prevention program, strategies and documentation continue to be an ongoing process for all clinical and non-clinical staff

Each nursing unit has started using “huddle boards” which display basic fall data to improve overall safety awareness of fall prevention initiatives.

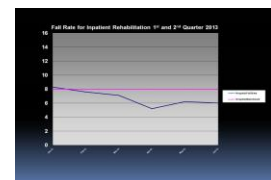


All staff are reminded to activate Stryker bed alarms at all times while patient is in bed. Hourly rounding is completed and this assures all bed alarms are activated.

## TRENDS FOR 2012



## TRENDS FOR 2013



## CONCLUSION

- YTD for 2013 we have seen a decrease in our overall fall rate and also a decrease in the number of falls with injury.
- Staff has an increased awareness of fall prevention strategies.
- Fall prevention tools are more readily available for all team members.
- A new interdisciplinary Fall Prevention Team has been established (FMEA) for review of best practices and to enhance communication among caregivers.

## REFERENCES

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United States Department of Veterans Affairs. (2004) National Center for Patient Safety. Retrieved August 19th, 2013, from <http://www.patientsafety.va.gov/SafetyTopics/fallstoolkit/index.html>

Using SBAR to Communicate Falls Risk and Management in Inter-professional Rehabilitation Teams *Healthcare Quarterly*, 13 (Sp) October 2010: 94-101. doi:10.12927/hcq.2010.21973 [Angie Andreoli, Carol Fancott, Karima Velji, G. Ross Baker, Sherra Solway, Elaine Aimone and Gaetan Tardif](#)