HEALTHSOUTH
Rehabilitation Hospital of York

The Continuum of Care: Navigating the Road to Recovery

STEPPING UP TO STOP FALLS BECAUSE WE C-A-R-E

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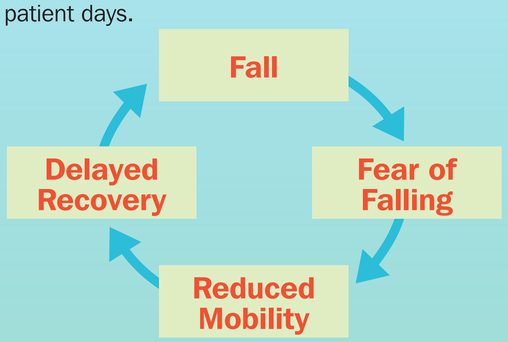
Introduction

Falls are a very common and serious problem among the elderly population in all settings. Among adults 65 and older, falls are the leading cause of injury or death. Falls are also the most common cause of non-fatal injuries and hospital admissions for trauma. Twenty to thirty percent of people who fall sustain moderate to severe injuries such as lacerations, fractures or head traumas. The rate of falls in hospitals is three times higher than the rate for community residents. During their stay at a healthcare facility, patients are exposed to an unfamiliar and potentially hazardous environment, which increases their possibility for falls. If a fall occurs, even if no injury is sustained, a patient is more likely to develop a fear of falling which causes the patient to limit their activity. This leads to a decrease in mobility, which decreases their rehabilitation progress. It is essential to identify patient's risk factors and implement appropriate precautions in order to prevent a fall and promote rehabilitation outcomes.

The Healthsouth Rehabilitation Hospital of York Pennsylvania noticed an increase in the inpatient fall rate over 2011. The average fall rate for the year was 10.7 per 1,000 patient days, which stimulated us to develop a more effective fall program to reach our goal of eight falls or less per 1,000 patient days.



Objective

The purpose of the program is to decrease the number of falls among our patient population, by identifying and implementing effective fall-prevention strategies. By educating all staff members on the actions in place to reduce falls, and maintaining consistency among staff members, we will decrease our inpatient falls rate.

Methods

The fall committee developed and implemented a fall huddle process which included a fall huddle report sheet that leadership used to educate all staff. The Modified Morse scale is used to assess patients' risk for falls. This assessment is completed upon admission and then updated weekly. The assessment is revised if there is a change in a patient's status or if a fall has occurred. Implementation of fall risk identifiers and enforcing the NO PASS ZONE will be used in the prevention of falls. Bedside reporting at the change of shift is also another method to monitor patient safety and compliance with fall interventions. Strict precautions will be applied if the Modified Morse Score is greater than 45.

Fall Interventions Based on Fall-Risk Assessment
Standard Precautions if Modified Morse Score ≤ 45
Strict Precautions if Modified Morse Score > 45

Standard Precautions	Strict Precautions
• Orient patient and family to surroundings and rehabilitation process • Educate patient and family about fall prevention strategies/safety concerns • Update safety concerns on patient's care plan • Educate on proper transfer techniques (locking brakes, appropriate use of assistive devices, proper body mechanics) • Enforce self-release seatbelts for safety while in wheelchair • Keep call light secured and within reach • Answer call light promptly without passing any call bells (NO PASS ZONE) • Place patient items within reach (including assistive devices) • Eliminate clutter in room • Keeps beds in lowest position with brakes locked • Appropriate footwear and/or safety slippers • Hourly rounds to check on patient's status (bedside reporting at change of shift) • Assign patients to beds that allow them to exit on their stronger side	• Implement all Standard Precautions • Fall Risk Identifiers (fall leaf, yellow charm on identification bracelet) • Low beds with mats • Enable bed alarms • Bed alarm reminders on bedside chart and nursing report sheets • Checking bed alarms hourly and at change of shift • Place alarms on self-release seatbelts • Rooms closer to nurses station • Assess patient's needs ahead of time (toileting schedule)

Post Fall "Huddle" Tool — PATIENT LABEL

This is **NOT** a part of the patient's record -
Team Participants: *Mandatory

Licensed Nurse *		Nursing Supervisor	
PCT/CNA*		Plant Ops Rep	
Charge Nurse		Additional parties:	
Risk Manager			

FALL FACTS:
Assessed as a Fall Risk Prior to Fall? ☐ Yes ☐ No
Modified Morse Scale: _____

Patient Room		Therapy Gym	
Bathroom		Dining Room	
Hallway		Other	

1. **Date and Time of "Huddle"** _____
2. **Was this the patient's first fall?** qYes qNo
3. **Date(s) of fall:** qFirst:_____ qSecond: _____ qThird: _____ **Patient's description of fall:**
4. **Contributing factors:**

qYes	qNo	Attempting to ambulate without assist?
qYes	qNo	Attempting to use the urinal, BS commode, or get to BR without assist?
qYes	qNo	Call light in reach?
qYes	qNo	Call light/phone cords in way?
qYes	qNo	Clothing in way?
qYes	qNo	Clutter on floor?
qYes	qNo	Wheelchair foot rests in way?
qYes	qNo	Wheelchair wheels locked?

5. **Patient's Health Status (prior to fall):**

qYes	qNo	Agitated?
qYes	qNo	Change in behaviors or mental status?
qYes	qNo	Change in blood pressure?
qYes	qNo	Change in diagnosis?
qYes	qNo	Change in mobility/transfer status?
qYes	qNo	Confused?
qYes	qNo	New/increase/decrease in blood pressure, pain or psychotropic medications ?

Risk Reduction Strategies:

	BEFORE FALL (√ if assigned as intervention BEFORE fall)	AT TIME OF FALL (If you indicated an intervention was assigned before the fall were we following each of the assigned interventions) Was the Risk Reduction Strategy Implemented at the Time of the fall? (Y/N)	AFTER FALL What specifically will you change to reduce the risk of patient falling again? (√ if assigned as intervention AFTER fall)
Yellow Charm			
Slipper Socks			
Chair Alarm**			
Bed Alarm**			
Nurse Call Light within Reach			
Bed in Lowest Position			
Restraint*** EXPLAIN:			
Signage			
Patient Equipment within Reach			
Low Bed			
Stryker Bed			
Other			

****Record bed/chair alarm tag # if alarm was pulled from service:** _____

Why does the TEAM think the patient fell? (√) Any areas the team believes may have contributed to the fall.

Staffing Availability		Communication with Patient and Family		Communication among Staff Members	Availability of Information	Equipment Maintenance/ Management	Medication Management
Staff not Present in Bathroom		Safety Interventions Not Implemented		Issues with Physical Environment (furnishing, hardware, lighting, distraction, etc.) EXPLAIN:			
Safety Interventions not followed		Transfer Technique		Type of Bed			

DESCRIBE THE REASONS CHECKED ABOVE:

Acknowledgment of responsible party for implementing new strategies & updating the nursing treatment card:
_____
Signature **Date**

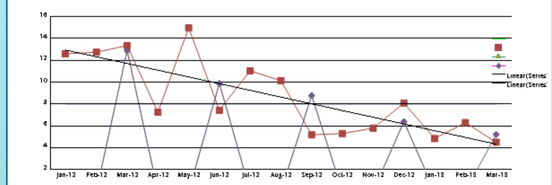
- **C**reate a safe environment
- **A**ssess a patient's risk
- **R**educe the patient's risk
- **E**valuate interventions

Results

The piloting of our new fall prevention program produced a substantial decrease over a year's time in our fall rate. During the first quarter of the year after the program was initiated, the inpatient fall rate was 12.9 per 1,000 patient days. The second-quarter summary decreased to 9.88. The third-quarter average was 8.78, which dropped even further from the second quarter, but did not reach our goal. Our goal was finally reached by the last quarter of the year with a quarter summary of 6.39. The beginning of 2013 is off to a great start of maintaining our goal, with a fall rate summary of 5.21 for the first quarter. The goal of eight or less falls during 1000 patient days was achieved by the staff consistently implementing fall precautions and monitoring compliance.

Inpatient Fall Rate

Indicator	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Goal	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Patient Fall Rate/1000 Patient Days	12.60	12.75	13.35	7.25	14.97	7.42	11.03	10.14	5.17	5.29	5.78	8.08	4.83	6.29	4.50
Number of inpatient falls	23	21	23	12	25	11	17	17	9	8	9	13	8	10	8
Number of patient days	1826	1647	1723	1656	1670	1482	1541	1677	1740	1512	1556	1608	1656	1589	1779
Quarter Summary			12.90			9.88			8.78			6.39			5.21
			Q112			Q212			Q312			Q412			Q113



Conclusions

The fall prevention program was a success. Through hospital-wide participation, our goal of eight or less falls per 1,000 patient days, was reached and surpassed. Our average inpatient fall rate decreased from 12.9 to 6.39 in four quarters. Education of all staff, initiating interventions, and monitoring compliance of patients and staff has lead to great results, but we recognize the need for continued efforts in order to maintain our goal.

References

Centers for Disease Control. (2012, September 20). Falls among older adults: An overview. Retrieved from http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

Tzeng, H., & Yin, C. (2008). The extrinsic risk factors for inpatient falls in hospital patient rooms. Journal of Nursing Care Quality, 23(3), 233-241. Retrieved from http://ovidsp.tx.ovid.com/sp-3.8.1a/ovidweb.cgi?&S=NHAFFPKPLKDDPKBNNCOKDHDCBMKOAA00&Link Set=S.sh.18|1|sl_10

Young Mi, R., Roche, J., & Brunton, M. (2009). Patient and family education: Involving patients and families in a fall prevention program on a neuroscience unit. Journal of Nursing Care Quality, 24(3), 243-249. Retrieved from http://ovidsp.tx.ovid.com/sp-3.8.1a/ovidweb.cgi?&S=GEBLFPLOPJDDELHLNCOKJCDCHKEDAA00&Link Set=S.sh.18|2|sl_10