What?! Not Another Fall!
Reducing Patient Falls in the Neuroscience Patient Population

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Saint Cloud Hospital

Objectives

- Identify current fall prevention strategies and areas of opportunity for improvement

- Identify strategies to implement at shift exchange to reduce patient falls.
Fall Definition

- A sudden, unintentional descent with or without injury to the patient, that results in the patient coming to rest on the floor, or on against some other surface, on another person, or on an object.

- 700,000-1 million hospitalized patients fall each year
  - between 30 and 51% result in an injury

Cost associated with falls

- Institution -
  - The joint commission reports that the average increase in a hospital's operational costs for a serious fall related injury is more than $13,000
  - Length of stay increases by an average of 6.27 days
  - Decreased patient satisfaction

- Patient -
  - Trust
  - Injury - harm, increased morbidity, decreased mobility
  - Creates fear (or injury) that can impact the quality of life
Fall Prevention

Background

Falls are highly prevalent on Neuroscience units
- patients already weakened upon admission
- gait abnormalities
- history of falls
- unilateral neglect

Patients may not understand their current functional status
Problem!

**FALL RATE**
**NUMBER OF FALLS PER 1000 PATIENT DAYS**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Raw number of falls</th>
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<tbody>
<tr>
<td>Jul-Sep 2015</td>
<td>23</td>
</tr>
<tr>
<td>Oct-Dec 2015</td>
<td>22</td>
</tr>
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<td>Jan-Mar 2016</td>
<td>24</td>
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<tr>
<td>Apr-Jun 2016</td>
<td>17</td>
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<td>Jul-Sep 2016</td>
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<td>Oct-Dec 2016</td>
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- SCH Neuroscience/Spine
- NDNQI Average
Purpose Statement

The purpose of this evidence-based practice project is to reduce the fall rate from 5.52 to less than 4.80 on a Neuroscience/spine unit through increasing staff and patient awareness of fall risk, and application of evidence-based fall prevention practices of communication, patient involvement, and bedside report.

PICO

- **Population**: Neuroscience/spine patients
- **Problem**: High fall rate; lack of individualization on care plan related to falls; staff unaware of fall risk level; patients unaware of fall risk level
- **Intervention**: Increase patient and staff awareness of fall risk/interventions based on evidence
- **Comparison**: Current Saint Cloud Hospital practice
- **Expected outcomes**: reduce falls from 5.52 to less than 4.80
Search Terms:
Fall, accidental fall
Neurological patient
Inpatient, hospitalized patient

Grade of evidence: The strength of the evidence was primarily C level. The current SCH practice was based on this evidence. Evidence for neuro-specific patient population was limited.

The evidence was compared to current emphasis in practice and gaps were found related to actual practice application.
What can we do better?

Literature Review
focus: Gaps in current practice

- Patients are
  - insufficiently educated about fall risk
  - Poorly engaged
- Patients need to be educated on admission AND frequently throughout their stay
- Implementation of education of patients and families during nursing rounds
- Communication among staff is important
- There is a consensus in current literature that staff and patient engagement in fall prevention have been found to be vital to safety of patients.
Action Plan: Low hanging fruit

- Target:
  - Alert and oriented patients
  - Current patient education and hand off procedure

- Delivery method: Bedside report

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Intervention

- Include fall risk, risk factors, and interventions in bedside reporting to communicate during nurse hand off and include patient education into every shift exchange.

- Add fall risk information and important interventions on the sign out report for communication with PCA team members.

- Education at unit based Ed days: January 2017
- Live simulation combining fall prevention and bedside reporting
Bedside report

- EVERY patient, EVERY shift.
- This holds patient’s family and staff accountable, can eliminate “the last nurse said I could do this.”
- Provides continual education for the patient and family during every shift.
- Fall risk during bedside report needs to include:
  - Risk
  - Risk Factors
  - Call light teach back
  - Prevention/Interventions: Specifically, what you are doing to keep them safe.
  - Additional patient teach back

Hand off report

- Sign out report information will increase continuity of care and communication with PCAs
- Also serves as a reminder to complete fall risk in bedside report

In the “To do” portion of the written hand off:

- Main fall risk factor/factors:
- Within arm’s reach with ALL mobility: Y / N
- Leave alone in Bathroom? Y / N
Outcomes: Monitoring/follow up

- Monitored compliance with bedside report and inclusion of fall risk education
  - Quarterly performance improvement
  - Education at time of monitor completion
- Monitored compliance with hand off report
  - Follow up emails and newsletter articles
  - Empowered non-licensed staff
  - Quarterly updates to staff on fall rates

Pre-Measure:

Fall rate
Education evaluation at bedside
Rates of fallers who were alert and oriented
**Problem!**

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Pre-Measure

### FALL RATE
**NUMBER OF FALLS PER 1000 PATIENT DAYS**

Up to 65% of falls per quarter occurred in patients who were alert and oriented.
Bedside Education Survey

- Inclusion criteria:
  - Patient LOS >12 hours
  - Patient has been identified as High Fall risk via documentation
  - Able to answer questions appropriately

- Results: 30% of alert and oriented did not know they were at risk to fall

Post Pilot Measure (outcomes)

Fall rate
Education evaluation at bedside
Rates of fallers who were alert and oriented
### Fall Rate

**Number of Falls per 1000 Patient Days**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of falls</th>
<th>Fall Rate</th>
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<tbody>
<tr>
<td>1QFY16</td>
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<td>3.46</td>
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<tr>
<td>2QFY18</td>
<td>19</td>
<td>5.42</td>
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</table>

*Implementation quarter

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### Percentage of Fallers who were Assessed as Alert and Oriented Prior to Falling

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total number of falls</th>
<th>Alert and oriented fallers</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2QFY17</td>
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<tr>
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<tr>
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<td>11</td>
<td>3</td>
<td>27</td>
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<tr>
<td>2QFY18</td>
<td>19</td>
<td>7</td>
<td>37</td>
</tr>
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</table>

*Implementation quarter
Barriers

**Bedside report compliance**
- Bedside report monitoring
- Frequent reminders and encouragement
  - Evidence, literature based communication in required readings

Recommendations

- Developed EPIC Sign Out Report “dot phrase”, now being shared among the units in the hospital
Recommendations

▸ Hospital-wide Fall Committee Presentation
▸ Continue practice changes on Neuroscience/Spine Unit
▸ IPASSON reporting/handoff May 2018

OK... so what now?
Fall Prevention Team

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Tiffany Omann-Bidinger, BSN RN
Chandra Brower, BSN RN

References
