Quality Improvement Initiative Achieves 82% Reduction in Falls Over 2-Year Period

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BACKGROUND/RATIONALE

Adhering to best practices in fall prevention is essential to prevent accidental falls in the inpatient setting. Patient falls are associated with significant injury (ranging from minor to major), increased anxiety, fear of falling, and a greater likelihood of future falls. Effective fall prevention requires interprofessional collaboration, continuous quality improvement, and multiple interventions ranging from:
- Effective risk assessment
- Risk stratified interventions
- Clinical, patient, and family knowledge of fall prevention

• Appropriate use of technology for patient and bed monitoring
• Structured team collaboration and communication
• Caregiver accountability
• A clinical culture of patient safety

An evidence-based quality improvement initiative (QI) was conducted on a high-risk unit to ensure best practices in fall prevention resulted in improved patient outcomes.
METHODS

Clinical setting: 28-bed high-risk medical unit with patients ranging from high-risk acute care to patients with dementia and chronic conditions.

Root cause analysis: A root cause analysis was conducted, which found the primary challenge for effective fall prevention was addressing the concerns of patients and families, as well as nursing staff, to ensure evidence-based prevention could be carried out at the patient’s bedside with “buy-in” from everyone.

Literature review: A literature review was conducted to help design a QI initiative that ensured staff adhered to best practices in fall prevention.

Gap analysis: A gap analysis was conducted to determine areas that needed strengthening through QI and knowledge gaps that needed to be addressed.

Team collaboration: A team comprised of unit volunteers, administrative and nursing leadership, and bedside nurses and ancillary staff were members of a Shared Governance Team. The team collaborated with the Quality and Safety Committee on a regular basis to help design the QI initiative. Team collaboration identified 5 key topics that needed to be addressed:
1. Standardization of color-coded risk identification systems.
2. Enhanced knowledge of appropriate use of bed technology* for monitoring to ensure risk-stratified interventions were built into the patient’s daily routine.
3. Beds needed to be connected to the nursing call system to ensure rapid response.
4. Accountability needed to be instilled in staff to ensure best practices in fall prevention were adhered to.
5. Quantitative and qualitative metrics were gathered through interdisciplinary collaboration and considered during Share Governance meetings.

Interventions:
- The fall risk identification system was standardized as one color.
- Education, competency training, and in-services were provided on bed technology and risk stratified interventions.
- “Fall Fairs” were conducted to ensure all staff were properly educated on all fall monitoring technology and tools.
- Beds were connected to the nursing call system.
- Audits and rounding were conducted to ensure staff were adhering with best practices and QI intervention.
- A collaborative agreement was developed to ensure ongoing caregiver commitment to fall prevention efforts.

* Stryker S3® Bed configured with Chaperone® Bed Exit with Zone Control® and iBed® Awareness (Stryker Corporation, Kalamazoo, MI)
The success of this interdisciplinary and evidence-based initiative was not attributed to 1 single intervention, but it was the combination of multiple interventions and ensuring the concerns of shareholders and stakeholders were addressed on a regular basis, translating to a clinical culture of patient safety and fall prevention. Through continuous quality improvement and ongoing collaboration, the result of this evidence-based fall prevention initiative was a heightened level of awareness and accountability in caregivers and standardized fall prevention practices, leading to decreased falls and improved patient outcomes.

I would like to thank the Staff of 4 East for all their efforts in our journey to zero falls.
REFERENCES


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