Inpatient Rehabilitation Unit Successfully Reduces Inpatient Fall Incidence 75.5%

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INTRODUCTION

Patients in the rehabilitation setting are often at increased risk for falling due to stroke and other comorbid conditions. Effective fall prevention is complex and requires multiple interventions to create a safe environment, identify modifiable risk factors, and implement risk-specific fall prevention interventions. Prior research has been reported on the importance of actions taken by leadership and staff, and ongoing commitment to ensure an interdisciplinary and customized evidence-based team approach.

One of the biggest challenges associated with fall prevention is communication – communication between staff, patients, and family members. The Joint Commission has reported ineffective communications between staff, patients, and family are essential for an effective fall prevention program, and consider cultural differences and the need to communicate fall risk in multiple ways and through ongoing communications.

The Inpatient Rehabilitation Unit of Slidell Memorial Hospital recognized the need to improve fall prevention efforts in the high-risk rehabilitation patient population. Beginning in 2009, the health care team took an evidence-based approach to developing a multifactorial and interdisciplinary fall prevention quality-improvement initiative, which has resulted in a significant decrease in inpatient falls.

METHODS

2009

Interdisciplinary Team Approach: In 2009, an interdisciplinary Fall Risk Focus Group was developed and began meeting monthly, consisting of the following members:
- Unit nursing staff
- Therapy staff (physical, occupational, speech)
- Materials management staff
- Quality and risk-management staff

The Fall Risk Focus Group conducted an event analysis of each fall, in an effort to improve upon patient safety and processes.

All Falls Analyses: The Fall Risk Focus Group conducted an in-depth analysis of all falls, reviewing multiple factors such as demographics, location, time of day, and types of falls, to better understand all circumstances surrounding falls.

Evidence-Based Literature Review: The interdisciplinary team conducted an evidence-based literature review of fall prevention studies and published data, as well as guidelines and evidence-based toolkits, to determine how to update the fall prevention policy and where there were knowledge gaps.

Standardized Approach to Fall Prevention: After a thorough evaluation of the literature and monthly meetings, the following fall prevention interventions were standardized:
- Fall risk armbands were standardized to the color yellow.
- Thicker blankets were obtained to wrap patients in a warm blanket at night – research has shown keeping them warm at night prevents them from getting up.
METHODS continued

• Proper use of the bed side rails.
• Creation of a monitoring tool, called the Patient Safety Rounding Record, to monitor hourly rounding.
• Door thresholds to bathrooms were surveyed by facilities and fixed if hazards existed.
• The charge nurse worksheet was modified to include fall risk patients.

Bed Technology: Implementing bed technology with the addition of bed alarms and patient/bed monitoring technology was helpful to the nursing staff. Staff were trained on the appropriate use of technology and how to maximize and utilize the technology available for fall monitoring.

2010

Electronic Medical Record: The hospital implemented an electronic medical record in January. This required the nursing staff to assess each patient for fall risk by using the Morse Fall Scale once per shift.

Additional Interventions for Fall Prevention:
• Adequate cords and plugs were made available for each bed, and uniform connectivity with the nurse call system was implemented.
• The fall prevention form provided to the patient and family was simplified.
• Trends regarding the types of falls were evaluated, and it was determined that the greatest number of falls were related to noncompliant patients and toileting.
• The rehabilitation unit also reviewed changes necessary for the nurse call system. The nurse call system was upgraded to align with the bed alarms.

Fall Risk Awareness Day: A Fall Risk Awareness Day was held in the first quarter of 2011, during which staff were educated on all fall prevention tools. Education ranged from technological training and nutritional supplementation training to tips for patient and family communications. Training by Stryker on the use of the bed technology educated staff on appropriate use. Several vendors were available on Fall Risk Awareness Day to exhibit specific fall risk equipment, such as lap belts, that Rehabilitation uses today to prevent falls from wheelchairs and sitting chairs.

Call, Don’t Fall: The “Call, Don’t Fall” slogan was introduced on Fall Risk Awareness Day. This is a symbol, which identifies patients at risk for falling and communicates the need for patients and family to call nurses before they get out of bed. The symbol was placed at the foot of every bed to ensure that this message was well communicated.

Seat Belt alarms: As a result of Fall Risk Awareness Day, the inpatient rehabilitation unit purchased seat belt alarms to mitigate falls from wheelchairs and sitting chairs in patients rooms.

Fall Assessment and Reviews:
• The pharmacy director began a review of all falls and assessed medication profiles.
• Administrative supervisors began performing post-fall assessments on nights and weekends.

Increased Patient/Family Communications:
The “Call, Don’t Fall” slogan was added to placemats on meal trays, tent cards, and the admission packet, so the patients were continually reminded to request assistance from the staff.

Fall Prevention Education: Fall prevention classes were also hosted by the liability insurer, Hospital Services of Louisiana, Inc. (HSLI) so staff were aware of claims that have arisen as the result of falls in hospitals.

In July 2011, the focus group agreed to meet quarterly instead of monthly due to the success of the ongoing continuous quality improvement efforts.

2011

Teach Back Method: The Teach Back Method was introduced to staff via a computer based learning module released in July 2012.

Rounding Music Installed: The hospital installed rounding music housewide to prompt staff to conduct hourly rounding. At the top of every hour, a short tune would play as a reminder. These hourly rounds consist of the three Ps: Potty, Pain, and Positioning.

2012

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METHODS  continued

The rounding music was used for several months, but after we received some complaints from patients, it was discontinued. However, due to the benefits received through hourly rounding, the staff continue to conduct hourly rounding even without the music.

**Fall Prevention Education Brochure:** A Fall Prevention education brochure was published and placed on the hospital’s employee SharePoint site. The staff could print out an education brochure for the patient to share fall prevention ideas at home as well as in the hospital.

**Scripting for Improved Communications:** Oftentimes, patients and family members do not call nurses because they believe the nurses are too busy. Therefore, the following key points were added to pocket cards used for customer service training:

- “Is there anything I can do for you before I leave?”
- “Is there anything else I can do for you? I have time.”
- “I am here to take you to the bathroom; let me help you, I have time.”

RESULTS

The Inpatient Rehabilitation falls rate YTD 2009 through July YTD 2012 decreased from 9.0 falls per 1000 patient-days to 2.2, representing a 75.5% reduction in falls.

![Falls Rate Graph]

**Ongoing Communications: Fall rates**

- Fall rates and all specifics related to falls and fall prevention are presented at the Fall Risk Focus Group meetings to ensure ongoing communication. Fall rates are also presented at the Environment of Care and Quality meetings, shared with the director and supervisors, and shared with staff at multiple area meetings.
CLINICAL IMPLICATIONS

• A culture of safety was instilled in our staff in the Rehabilitation Unit after success was realized, and the staff recognized the importance of fall prevention through ongoing education, ensuring accountability, and communication.

• The interdisciplinary team worked hand-in-glove throughout the quality-improvement initiative, and staff were trained to be vigilant with fall prevention efforts.

• Other units have embraced several of the fall prevention initiatives of the Rehabilitation Unit.

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REFERENCES


