Upon evaluating the fall prevention program, the following goals were identified: best practices with specific nursing interventions to minimize the risk of falling. Suggested a need to redesign the existing fall prevention program through adopting innovative practices with specific nursing interventions to minimize the risk of falling. It became evident that the existing program did not ensure a “safe zone” team approach to fall prevention. Furthermore, “Hourly Rounding” evaluation at the unit level revealed gaps in staff knowledge. Those factors suggested a need to redesign the existing fall prevention program through adopting best practices with specific nursing interventions to minimize the risk of falling.

Upon evaluating the fall prevention program, the following goals were identified:

1. Decrease incidence of falls
2. Decrease severity of injuries from falls
3. Decrease incidence of falls related to toileting

The following changes to practice were proposed:

1. Use the Hendrich II Fall Risk Assessment Tool
2. Implement Purposeful Rounding
3. Develop Stay With Me Program
4. Implement a Targeted Toileting Schedule

The purpose of this observational study is to describe the effectiveness of a nursing quality improvement (QI) activity for a fall prevention program, with particular focus on specific evidence-based nursing interventions to minimize the risk of patient falling. In August of 2014, Maimonides Medical Center started a “change champion team” inclusive of a group of individuals with an interest in fall prevention. The team consists of frontline nursing and leadership team representatives. The goal of this team was to explore and implement innovative practices that could result in a decrease in falls. A clear vision of fall prevention awareness including capacity, capability, and sustainability was established. A process change on one pilot medical unit was effectively implemented. At the start of the educational and simulation session for purposeful rounding, a decrease in patient falls, injuries related to falls, and incidence of falls related to toileting became evident. This decline was likely not entirely related to the reviewed rounding practices and testing out “Stay With Me” on the pilot unit. Key program elements such as integrating Hendrich II fall risk model, assessment-related interventions, and early ambulation initiatives had previously been implemented. However, falls related to toileting was saturated at 90% (100/100) patient days for three months after initiation of changes to the program.

Early results of this performance improvement initiative have shown that direct care nursing staff making purposeful rounds at points of care could see significant improvements in preventing patient falls. Results suggest that fall prevention is complex, and careful planning, implementation, and evaluation are required for successful nursing practice change. These findings suggest that all frontline nursing staff should be properly educated and trained on proactive fall prevention initiatives to anticipate hospitalization and early adult falls. Team engagement and staff buy-in are critical to successful implementation and compliance with the policy!