# Together We Stand, Divided We Fall: Nursing Leadership Collaboration with Staff to Reduce Patient Falls and Promote a Culture of Safety

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## Background/Purpose

- Falls in older adults (65 years and older) resulting in injury is a serious patient safety concern in healthcare facilities
- Falls with injury can:
  - Increase Length of Stay
  - Effect Morbidity & Mortality
  - Cost the Organization Thousands of Dollars
- Integrating fall prevention strategies with the focus on auditing interventions and providing immediate feedback on missed opportunities, enables high reliability organizations to establish a culture of safety
- Using nursing leadership to assess adherence with fall prevention interventions and provide education on fall prevention strategies demonstrates to the staff that leadership is highly engaged and values patient safety

## Implications for Nursing Practice

- Fall prevention is a nurse-sensitive indicator
- Nurse-sensitive indicators measure direct outcomes of nursing care
- Magnet Hospitals focus on evidence-based nursing practice that impacts the overall safety and quality of patient care outcomes
- The goal of the "high-risk to fall auditing tool" is to evaluate the use of evidence-based fall prevention strategies and empower nurses to own fall prevention

## Methods

- Patient's with a MORSE Fall Scale score greater than 50 are considered at a higher risk to fall
- Patients at a higher fall risk should have the appropriate interventions in place as identified by the organization's Fall Minimization Policy
- In this fall prevention initiative, nursing leadership utilizes a standardized auditing tool to validate that the appropriate interventions are in place

### Audit Tool for High-Risk to Fall Patients Morse Score ≥50

Date:_____ Unit:_____ Room #:_____

MRN:_____ Morse Score:_____ (≥50)

Primary Nurse:_____

| Fall Prevention Measures | Yes | No/Comment |
|---|---|---|
| Signage placed on patient door frame outside room (Falling man sign) | | |
| Sign placed on patient door frame outside room ("Do not leave patient unattended") | | |
| My Safety Plan | | |
| Yellow fall-risk wrist band on patient | | |
| Yellow socks on patient | | |
| Bed/Chair alarm on | | |
| Bed plugged into wall cable | | |
| Bed in low position | | |
| **Nursing Documentation** | **Yes** | **No/Comment** |
| Falls education documented (Patient education navigator → Essential education → Safety → Fall minimization) | | |
| Plan of care documented daily (Safety → Fall Risk) | | |
| Follow-Up Actions: | | |

### Examples of Fall Prevention Interventions



**My Safety Plan: Fall Prevention**

1. My risk for falling is greater because:
   - _____
   - _____
   - _____
2. I will do these things to be safe:
   - Press the call light for help
   - Wait for help to arrive
   - _____
   - _____
3. My nursing care team will:
   - Respond to my call light for help.
   - Check in on me every hour during the day and every 2 hours at night.
   - May use alarm alerts to remind me to stay in bed or remain seated.
   - _____
   - _____

Mobility Assistance level: 1 2 Gait Belt Lift

Fall Video: Patient Viewed [ ] Family Viewed [ ]

HELP US HELP YOU STAY SAFE!



## Outcomes

- The organization had a total of 168 older adult inpatient falls in 2015 and 136 for 2016
- Since implementing this quality improvement initiative in January 2016, the hospital has been able to reduce older adult inpatient falls by 19%
- This reduction is especially impressive since the hospital added 36 acute-care beds in 2016

### Total Inpatient Falls Age 65 or Greater