

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

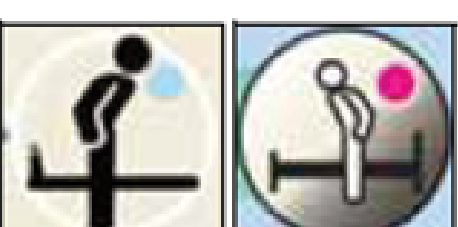
Implications for Nursing Practice

- 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!
	  Bed Exit Alarm System    

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

