Falls in Acute Care Settings

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Structured Abstract

LOCAL PROBLEM
Falls in the acute care setting continues to be a serious threat to patient safety and the healthcare system. Though a fall prevention programs has been instituted in the hospital, falls continue to occur. Not only do falls continue to occur, the consequences of falls impact patient quality of life as well as rising health care costs. Fall are a nurse-sensitive indicator. A review of the existing fall prevention program identified areas that could be revamped to address this issue. In the current fiscal year, 15 falls have occurred on the unit including two falls with injury. Implementation of the Falls Tailoring Interventions for Patient Safety (TIPS) Program in conjunction with the current fall prevention program may prove to be an answer to this important inpatient safety concern.

PROJECT PURPOSE
Combine the current fall bundle with the Fall TIPS program to decrease the incidence of falls in the medical-surgical unit of an academic hospital.

METHODOLOGY
The Framework for Spread Model developed by the Institute for Health Improvement was used to guide the project. The framework is an evidence-based plan comprised of seven components: leadership, setup, better ideas, communication, social system, knowledge management, and measurement and feedback. Each component is predicated upon the other in order to arrive at the best possible outcome of a project. The setting was a 24-bed medical-surgical unit with private rooms specializing in orthopedics. The targeted patient population were adults who recently underwent an elective orthopedic procedure or patients with an orthopedic injury. The Fall TIPS program is a 3-step approach to patient safety that included a plan of care, patient education, and a bed poster. Education from the Fall TIPS program was emailed to staff. Champions for the project were identified and educated on the use of the audit tool provided by the author of the program. Laminated posters were placed in each of the patient rooms. Evaluation of the project entailed completing five audits per month from questions answered in the Fall TIPS survey tool and entering the answers into REDCaps. The plan was for the data collected to be statistically analyzed using a control chart to determine the effectiveness of the intervention over a 3-month period.

RESULTS
There were delays in project implementation due to approval for use of the Fall TIPS Program education related to a continuing education credit through the nursing education council. Twenty-five out of 44 of the staff have completed the education (57%). However, staff had to be reminded frequently to educate the patient on the

project so that audits could be completed. The project is currently in the evaluation stage. Currently no further data have been collected.

IMPLICATIONS FOR PRACTICE

Falls in the acute care setting are a multi-faceted problem that continues to plague healthcare organizations and will require an interdisciplinary approach to combat. These complex factors cost millions in revenue to hospitals as well as debilitating injuries to patients annually. The large healthcare system being evaluated is a Magnet-designated facility. The spike in falls in the last fiscal year is very concerning to organizational leaders and staff. The Fall TIPS program is an evidence-based prevention plan. The program has the potential to incorporate and reinforce a culture of safety in the organization. Discussing the importance of continuing the program with the staff and champions are key to its success. Input from project champions could be a valuable tool to the effectiveness of the program. Reminding staff verbally and electronically to educate patients on the program will need to be consistent. Also, increasing staff diligence to be active participants in the program will likely improve efforts to acquire data to analyze. A decrease in fall rates will have a positive effect on Magnet status and reimbursement for the facility as well. Any means to improve fall rates have been met with optimism, and members of the healthcare team in the identified medical-surgical facility have been encouraged to embrace the project and to take action.

Keywords: falls, prevention, safety, orthopedic unit, stakeholder taskforce

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