

Falls in Acute Care Settings

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PROBLEM

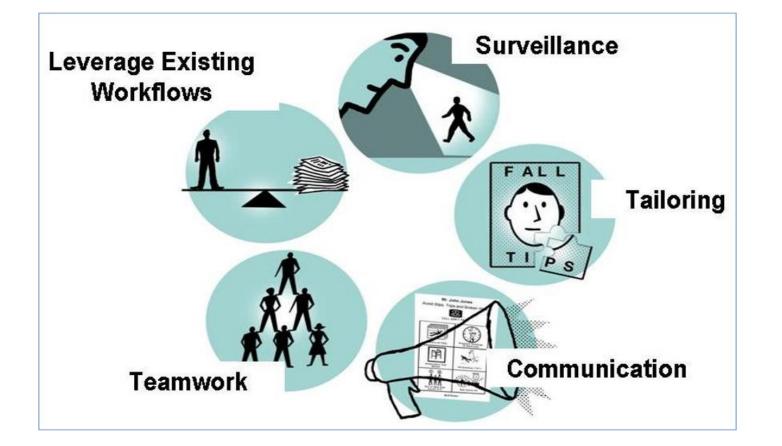
- Falls in the acute care setting continue to be a serious threat to patient safety
- Falls continue to occur despite a fall prevention plan already in place
- 15 falls reported this fiscal year (July 2019-Apr. 2020)
- 2 falls with injury reported this fiscal year
- Falls are a nurse-sensitive indicator

PURPOSE

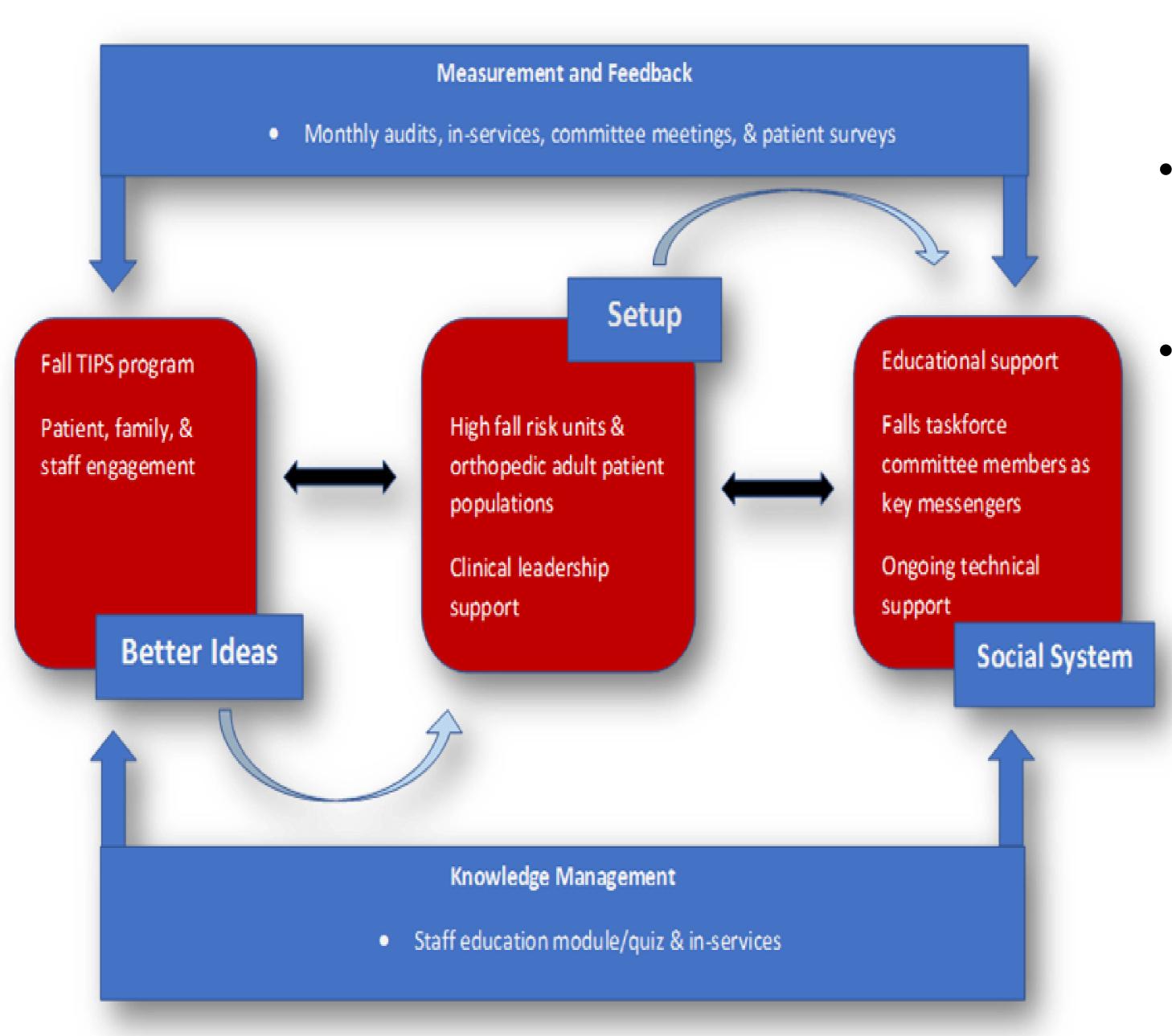
Combine the current fall bundle with the Fall TIPS program to decrease the incidence of falls in the medical-surgical unit of an academic hospital.

METHODOLOGY

- The Fall TIPS program developed by Dr.
 Patricia Dykes was implemented on a 24-bed private room orthopedic unit
- Plan is evidence-based & includes:
 - Standard definitions
 - Universal fall precautions
 - 3-Step Fall Prevention Process
- Staff were educated on the program via email and verbally
- Champions for the program were identified and educated on the use of the audit tool
- Laminated signs were placed in every patient room



FRAMEWORK



Framework for Spread Model

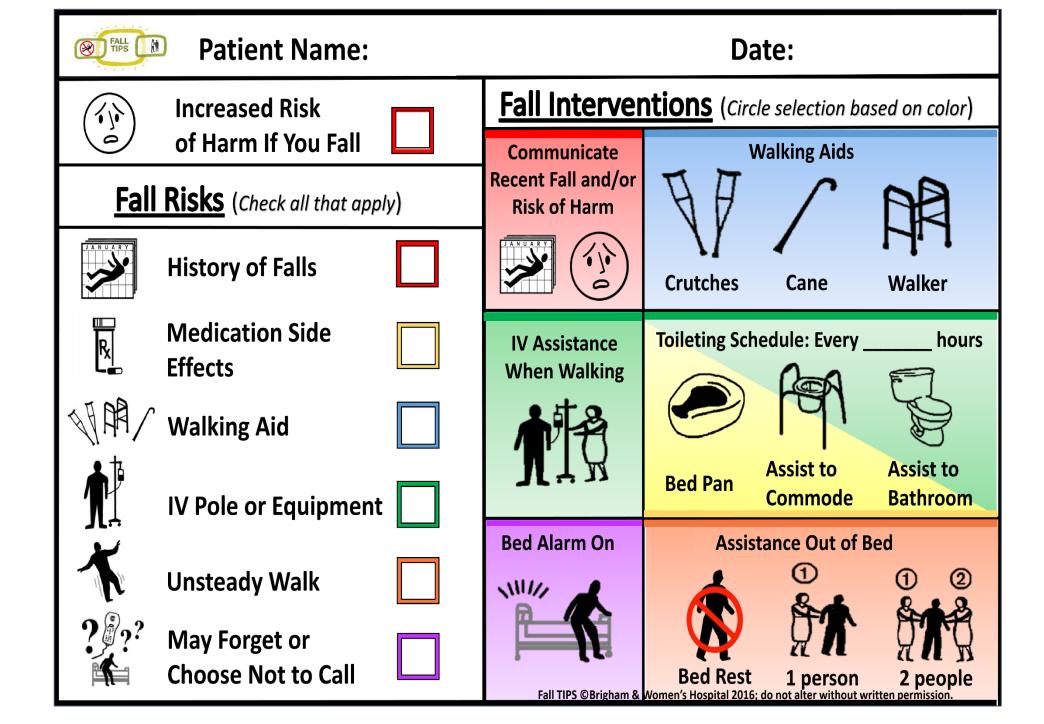
- Developed by the Institute for Health Improvement (IHI) in 1999
- Based on 7 components:
 - Leadership
 - Setup
 - Better Ideas
 - Communication
 - Social System
 - KnowledgeManagement
 - Measurement & Feedback

RECOMMENDATIONS

- Remind staff verbally and electronically to educate patients on Fall TIPS program
- Increase staff diligence to be active participants in the fall prevention program
- Champions complete audits at least
 5/month and record in REDCaps

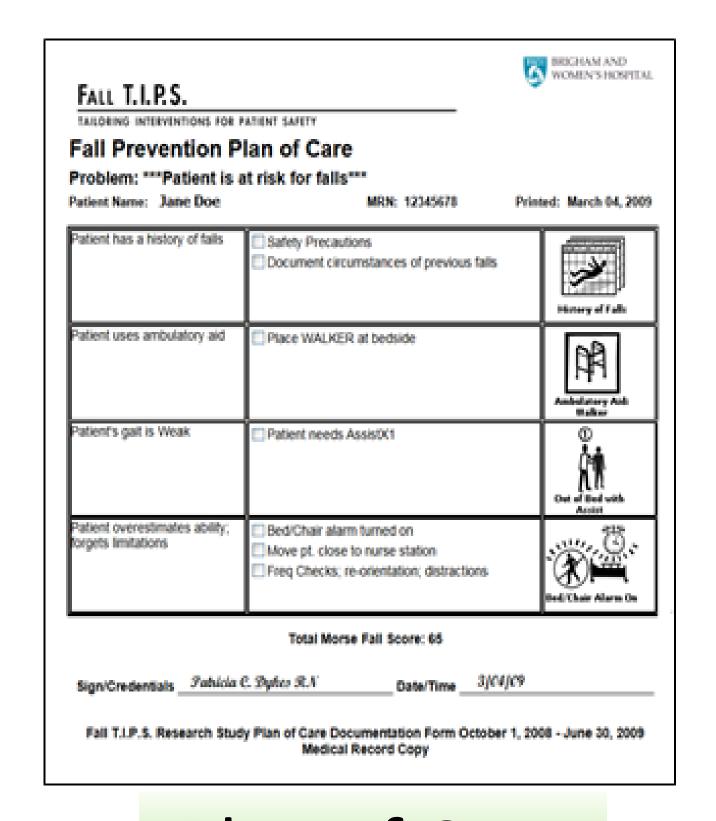
IMPLICATIONS FOR PRACTICE

- Evidence-based fall prevention plan
- Incorporate and reinforce a culture of safety
- Discuss with staff importance of program implementation
- Decreased fall rates will have positive effect on Magnet status and reimbursement for the facility



DISCUSSION

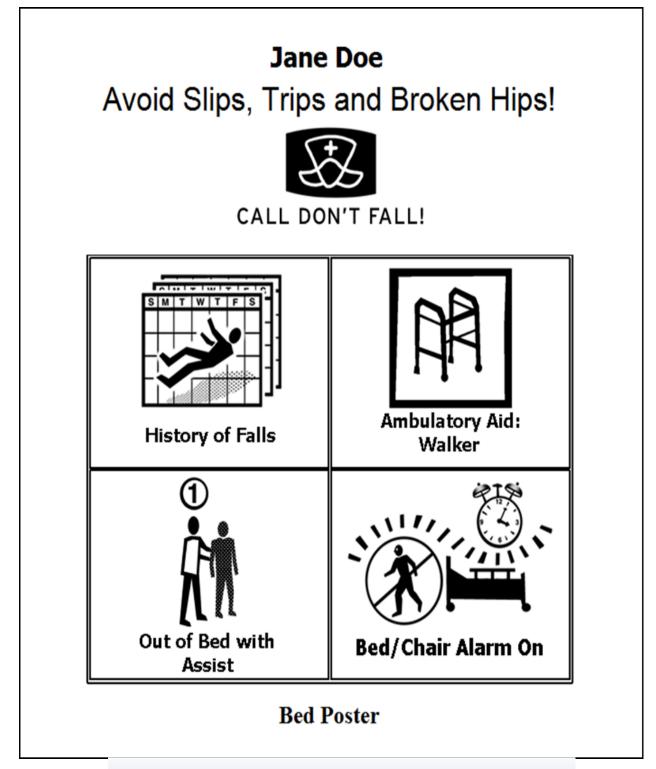
3-Step Fall Prevention Plan



Plan of Care



Patient Education



Bed Poster

- 57% of staff have completed education
- Poor patient education implementation
- Poor adoption of audit tool

CONTACT INFORMATION

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