Title:
Reducing Patient Falls on an Inpatient Oncology Unit by Implementation of the S.A.F.E. Tool

Jessica Anne Barnett, MSN
Nursing, Carolinas Medical Center, Charlotte, NC, USA

Session Title:
Rising Stars of Research and Scholarship Invited Student Posters

Keywords:
Fall Prevention, Quality Improvement and Reducing falls in the acute care setting

References:


Abstract Summary:
Quality Improvement Project to reduce fall rates in the acute care setting that demonstrated a 35% reduction in 2016. Implementation of the S.A.F.E Tool on an inpatient oncology unit. The S.A.F.E Tool is a patient safety contract that educates patients and families on fall risk factors and prevention measures.

Learning Activity:

<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<tr>
<td>The learner will review the strategies used to prevent falls and the introduction of the S.A.F.E Tool.</td>
<td>Discussion of appropriate assessment of fall risks using the Morse Fall Risk Assessment Tool, use of the Visual Cues Bundle, and the S.A.F.E Tool.</td>
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<td>The learner will review results related to use of S.A.F.E Tool in an acute care setting</td>
<td>Usage of the S.A.F.E Tool, including exclusion criteria, that resulted in a 35% reduction and increase in compliance with the Visual Cues Bundle.</td>
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Abstract Text:

Objective:

The purpose of this IRB approved, evidenced based project (EBP) is to reduce the fall rate on an inpatient medical oncology unit by 20% by the end of September 2016.

Significance:

Fall rates vary from unit to unit within a hospital, and oncology is no exception. Patients diagnosed with a malignancy have a significantly increased risk for falling. In 2015, the 36 bed inpatient oncology unit had a fall rate of 2.4 per 1000 patient days, well below the national NDNQI benchmark. In first quarter of 2016, the fall rate increased to 4.23 per 1000 patient days. It was a 75% from the previous year. The unit determined an intervention was needed to stop the increase and reduce the number of falls. The theoretical framework used in this EBP was Jean Watson's Theory of Human Caring and the IOWA model.

Description:

The EBP was accomplished over a nine-week period by ensuring that the Morse fall risk assessments were documented accurately, fall prevention measures that include the visual cues bundle were in use per policy, and that the S.A.F.E tool was implemented on every oncology and breast surgery patient throughout the unit.
Outcome:

Results noted during this study period include a 10% reduction in the falls per 1,000 patient days, a significant increase in compliance with the visual cues bundle and a change in unit culture regarding patient safety. The unit continued to see a sustained decrease of 35% reduction per 1000 patient days through the end of 2016. The S.A.F.E Tool has been adapted for the medical-surgical patient population and translated into Spanish. This tool is now being used as standard admission fall prevention education for all patients admitted to the healthcare facility.

Conclusions:

This EBP supported the hypothesis that when staff are educated and engaged in patient safety, patients fall less. Reducing the number of fall events directly effects patient outcomes. Oncology patients undergoing intensive treatment such as chemotherapy, radiation and surgery are especially fragile and thus requires interventions like the S.A.F.E Tool. Effective fall prevention practices are multifactorial and are most successful when there is a collaboration between staff, patients and families.