

Preventing Falls in the Acute Care Setting

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1. **Problem:** In 2000, falls were identified as a major problem in our institution. The fall rate was 12% (per 1000 patient days). Falls have been documented in the literature as a main cause of patient mortality and morbidity, as well as increasing length of stay.

2. **Evidence:** The problem was identified and assessed through our risk management department as well as concerns raised by individual staff nurses. In addition, the literature highlights hospital falls as a concern for all healthcare facilities.

3. **Strategy:** In late 2000/early 2001 the Nursing Division spearheaded a hospital wide comprehensive Fall Prevention program based on protocols developed by the NICHE project (Nurses Improving Care to the Hospitalized Elderly). The protocol is research based thus providing the critical foundation of knowledge that has been research tested. The protocol provided a sound basis for the delivery and improvement of care.

4. **Practice Changes:** Falls are not random occurrences. Falls can be predicted using a valid and reliable assessment tool. For our program we chose the Hendrich Fall-Risk Assessment Tool. The ongoing use of a standardized functional assessment promotes the communication of patients' health status between caregivers and healthcare settings and assists in measuring outcomes of care rendered. In addition, our nursing documentation tools were changed, our environmental risk factors assessed, and an advanced program was put into place for prevention of hospital falls.

5. **Evaluation:** Each fall is immediately audited and evaluated for causes and solutions. Fall rates are reported rather than number of falls to provide a more accurate measure of improvement. All injuries are classified by severity of injury. The program also tracks other factors including location, time of day, circumstances of the fall, as well as patient risk factors. This information identifies high risk times and units. These trends are used to suggest staffing changes and to use in staff education.

6. Results:

In 2001 there were 395 falls at a rate near 12%

2002 there were 269 falls at a rate of 5.9%

2003 there were 258 falls at a rate of 5.8%

2004 there were 200 falls at a rate of 5.09%

2005 there were 179 falls at a rate of 4.81%

2006 there were 157 falls at a rate of 4.6%

7. **Recommendations:** Fall prevention is an ongoing issue that needs to be addressed each and every day. The hospital instituted a multidisciplinary "Fall Code Team" that is activated after every patient fall by calling a "Code Star". This code would trigger each hospital department to report to the site of the fall for evaluation and immediate

institution of actions to prevent further falls. The most important lesson we have learned is that fall prevention is a multidisciplinary process. Hospital wide buy-in is a must for success.

Bibliography:

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