“I’VE FALLEN AND CAN’T GET UP”
FALL PREVENTION

Krista Purdie, RN
Concordia College ALABAMA
RN-BSN STUDENT
APRIL 18, 2017
NO COI

• THERE ARE NO COMPANIES, ETC. IN A RELATION OF CONFLICT OF INTEREST REQUIRING DISCLOSURE BY THE PRESENTER(S) IN RELATION TO THE CONTENTS OF THE PRESENTATION.
OBJECTIVES:

• This Presentation will provide an overview of evidence based strategies that have been successful in addressing the reduction of inpatient falls. Additionally, supplemental strategies will be proposed that may further reduce inpatient falls.

• 1. Discuss the prevalence of falls in inpatient settings
• 2. Identify contributing factors leading to cause of falls.
• 3. At the completion of the presentation the audience will be able t
Evidence Based Practice: PICOT Question

For hospitalized adult medical-surgical patients (P), does the use of targeted fall prevention strategies (I) reduce the future risk of falls with and without injury (O) compared with the use of non-targeted fall prevention strategies (C) within 90 days of process improvement implementation (T)?
Evidence Based Practice:

• Building a case for a fall prevention program:
  • Every year in the United States, hundreds of thousands of patients fall in hospitals, with 30-50 percent resulting in injury.
  • 1-6 Injured patients require additional treatment or prolonged hospital stays.
  • The average cost for a fall with injury is about $14,000
  • Falls with serious injury are consistently among the Top 10 sentinel events reported to The Joint Commission’s Sentinel Event database.

The Joint Commission, 2015
Evidence Based Practice:

- Analysis of falls with injury in the Sentinel Event database reveals the most common contributing factors pertain to:

  - Inadequate assessment
  - Communication failures
  - Lack of adherence to protocols and safety practices
  - Inadequate staff orientation, supervision, staffing levels or skill mix
  - Deficiencies in the physical environment
  - Lack of leadership
Evidence Based Practice:

• Process Improvement Interventions:
  • Incorporate safety precautions in all elements of patient care and education
  • Create an interdisciplinary falls prevention team
  • Develop an individualized care plan based on fall and injury risks
  • Use standardized hand-off communication processes, i.e. SBAR
  • Provide One-to-one education of each patient at the bedside
  • Conduct post-fall huddles as soon as possible
Evidence Based Practice:

• Process Improvement Tool:

• Use a standardized tool, i.e. Morse Fall Scale, to identify risk factors for falls

<table>
<thead>
<tr>
<th>Morse Fall Scale</th>
<th>Item Score</th>
<th>Patient Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falling (immediate or previous)</td>
<td>No: 0, Yes: 25</td>
<td></td>
</tr>
<tr>
<td>2. Secondary diagnosis (≥ 2 medical diagnoses in chart)</td>
<td>No: 0, Yes: 15</td>
<td></td>
</tr>
<tr>
<td>3. Ambulatory aid</td>
<td>None/bedrest/nurse assist, Crutches/cane/walker, Furniture</td>
<td>0/15/30</td>
</tr>
<tr>
<td>4. Intravenous therapy/heparin lock</td>
<td>No: 0, Yes: 20</td>
<td></td>
</tr>
<tr>
<td>5. Gait</td>
<td>Normal/bedrest/wheelchair, Weak*, Impaired</td>
<td>0/10*</td>
</tr>
<tr>
<td>6. Mental status</td>
<td>Oriented to own ability, Overestimates/forgets limitations</td>
<td>0/15</td>
</tr>
</tbody>
</table>

Total Score: Tally the patient score and record. <25: Low risk, 25-45: Moderate risk, >45: High risk
Evidence Based Practice:

- Example of Inpatient Falls Clinical Pathway (AHRQ, 2015)
Evidence Based Practice:

• Monitor fall rates and practices
  • Calculated fall rates (e.g., falls per 1,000 occupied bed days)

• Fall rates are monitored at least quarterly, preferably monthly

• Fall rates are reported to staff and stakeholders
“I’VE FALLEN AND CAN’T GET UP”
FALL PREVENTION