Safe & Sound: Fall Reduction Initiative for the Comprehensive Transplant Unit (CTU), Zayed 9W

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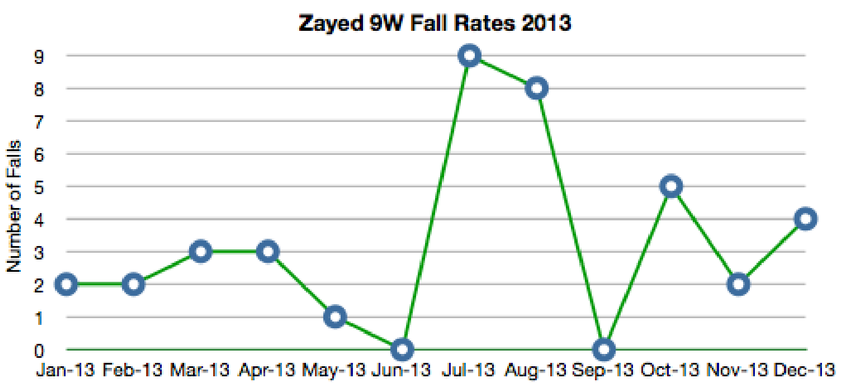
1 Background

The Comprehensive Transplant Unit (CTU) is an inpatient medical-surgical unit specializing in the care of abdominal organ transplant recipients and reconstructive transplant recipients.

The CTU has recently experienced a high incidence of patient falls. Between January 2013 and December 2013, the unit reported 39 incidence of falls, 13 of which were with injury.



An integrative review of fall reductions in hospitals published in the journal *Clinical Nursing Research,* determined that “hospitals need to reduce falls by using multifactoral fall prevention programs using evidence-based interventions to reduce falls and injuries” (Spoelstra, Given, & Given, 2012).

2 Objectives

•Determine the unit-specific predictors of fall risk (beyond commonly identified risk factors)
•Attain a 90% reduction in falls by the end of the first quarter of FY 15.
•Maintain frequent staff communication on fall incidents and interventions.
•Incorporate of evidence-based practices in fall reduction into a comprehensive unit plan.
•Develop a staff education checklist and conduct training.

3 Methods

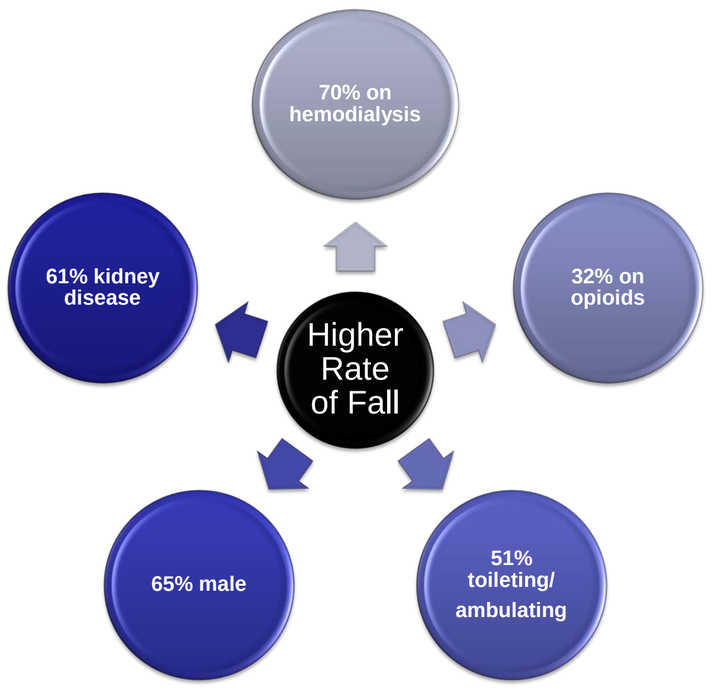
•Analysis of 2013 falls.
•Literature review, attendance at UHC Webinar on fall reduction, and telephone interviews with nurse managers in similar units across the United States.
•Survey of nurses on the unit.
•Observation of nurses on the unit and attendance at Unit CUSP meetings.

4 Results

Literature Review, UHC Webinar, & Telephone Interviews:

•Comfort and patient safety rounds are consistently recognized as a best practice in fall prevention.
•Achieving zero falls is unrealistic; focus on over all reduction and injury management.
•Appoint a fall champion for consistent messaging.
•Assess for consistency among staff.
•Audit for any variations between interventions and documentation.
(UHC, 2013)

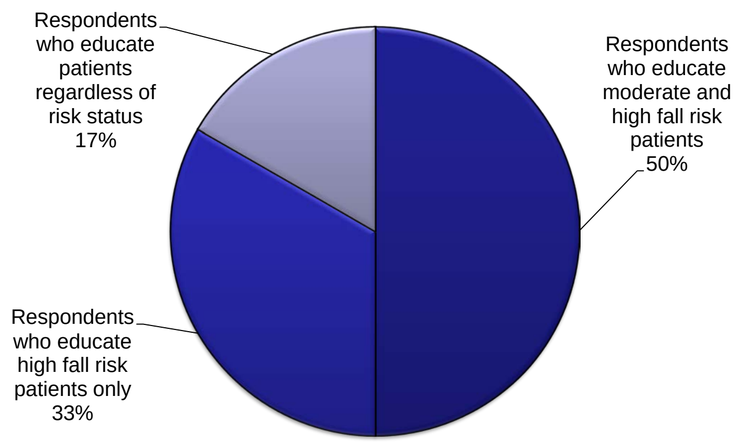
Analysis of Patient Safety Network (PSN) data, in comparison with the patient’s chart:



Survey of CTU nurses (Key Findings):

Most respondents felt they had enough time to implement fall interventions, unless materials could not be found or were broken.

Patient Education on Fall Risk



Observation of CTU Nurses/Attendance at Unit CUSP Meetings:

•Unit population requires heavy medication administration + multiple co-morbidities/ complications -> contribute to time constraints and workflow overburden.
•Nursing staff presence & participation at CUSP meetings -> indicate a strong commitment to patient safety & quality improvement projects.

5 Conclusions

To reach our goal of a 90% reduction in falls by the first quarter of FY 15, nursing and support staff education included:

•Development of a nurse education checklist
•Re-education on fall risk assessment and protocol
•Nurse re-education on documentation
•Education on the incorporation of evidence-based best practices.

The unit will incorporate evidence-based best practices by:

•Co-locating fall risk supplies and education materials
•Designating a Fall Champion to maintain communication among staff
•Conduct purposeful rounds for fall Prevention:
  ➢High Risk: Q1 hour during the day; Q2 hours at night
  ➢Moderate Risk: Q2 hours during the day; Q4 hours at night.

6 Future Directions

•Continuous assessment of Safe & Sound throughout FY15.
•Encourage staff feedback and modify process as needed.
•Explore opportunities to integrate information technology systems (such as Epic) to enhance the program.

7 References

Spoelstra, S., Given, B., & Given, C. (2012). Fall prevention in hospitals: An integrative review. *Clinical Nursing Research*. *21* (92).

UHC (Producer). (2013, August 27). *Preventing Patient Harm: Falls - “Injuries Due to Falls Improvement Collaborative – Falls Workgroup – Knowledge Transfer”* Web conference. Chicago, Illinois.

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