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IMPLEMENTATION OF A FALL PREVENTION PROGRAM

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Implementation of a Fall Prevention Program for Hospitalized Patients

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Contents

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Executive Summary

Patients want and need to feel safe in the hospital. Their expectations are to heal and be discharge in a better state than when they arrived. In October 2008, The Centers for Medicare and Medicaid Services (CMS) abruptly stopped reimbursement to hospitals for the cost of patient falls (Fehlberg, et. al., 2017). The Joint Commission only requires fall risk assessments to be performed on each patient (Quigley & White, 2013). It is up to the facility as to what other measures are placed for fall prevention. There is numerous fall prevention measures placed for all patients, but falls still occur. According to the American Nurses Association Code of Ethics for Nurses (2015), nurses have an obligation to participate in the development, implementation, and review of and adherence to policies that promote patient health and safety and establish and maintain a culture of safety. Because patient falls still occur, the nursing profession has an obligation to participate in further research and establishment of measures that will improve this problem. In addition to the usual fall prevention measures, establishment of a fall prevention program is needed to improve and sustain the safety of patients. A fall prevention program includes utilization of bedside shift report, safety huddles, and code fall teams. With the proper training and resources, the patients, hospital staff, and hospital organization will benefit financially, patient outcomes will improve, and the patient satisfaction scores will increase (MacAllen, Stephens, Swanson-Biearman, Kerr, and Whiteman, 2018).

1. Rationale for the Project

Historically, falls are events that have always occurred, even in the hospital setting. The patient population that this mostly affects includes individuals over the age of sixty-five that possess diagnoses such as cognitive impairment, vertigo, gait deviations from previous injuries or surgeries, stroke, Parkinson's disease, multiple sclerosis, etc. (O'loughlin, et. al., 1993). Falls can also occur as a result of medication side effects, improper ambulating devices, or absence of proper footwear (O'loughlin, et. al., 1993). Falls also can bring financial burdens to a hospital. According to the Joint Commission (2015), the average cost for a fall with injury is about $14,000. If the Centers for Medicare and Medicaid Services (CMS) evaluate the fall as preventable, the hospital will not be reimbursed. Hospital administration want successful fall prevention strategies so that the organization can be financially stable. In the past, there are a multitude of interventions that have been placed in order to prevent falls. These include fall risk armbands, non-slip footwear, gait belts, Morse Fall Risk Assessments, bed alarms, and chair alarms. These interventions deem effective, and will continued to be used in all situations at most hospitals. So, why are falls still occurring? These are proven successful interventions, but it seems that patients can still slip through the cracks. In addition to the usual fall prevention tactics placed, a fall prevention program includes utilization of bedside shift report, safety huddles, and

code fall teams. These proposed new changes are significant because they will allow more communication amongst staff about all fall-risk patients. There is hope and promising research that the implementation of a fall prevention program will improve patient fall rate, which will ultimately protect patient safety and improve their outcomes.

1.1 Project Goals

The goal of this benchmark project was to shed light and develop new strategies to address hospital falls. The research performed during this study was captivating and thought provoking. Addressing patient falls seems to be a cumbersome challenge for many because it seems to be an unavoidable event. The challenge was enticing, and the research was promising.

The ultimate goal is to improve patient outcomes and safety, along with providing hospitals with the necessary tools to accomplish this, and as a result, hospitals will end on the upside of finances.

2. Literature Discussion to Support Project

During extensive literature review, there are many research articles that discuss successful fall prevention tactics. As a disclaimer, it is important to remember that all usual fall prevention tactics should and must remain in place. The establishment of bedside shift report, safety huddles, and code fall teams are additions to be added in order to combat patient falls more aggressively.

Bedside shift report allows accurate and timely communications between nurses, while including the patient and their family in their care plan. In return, this delivers high quality care. In a research study conducted by MacAllen, Stephens, Swanson-Biearman, Kerr, and Whiteman,

2018, bedside shift report improved patient and nurse satisfaction, but more importantly, it decreased patient falls by twenty-four percent over the course of four months after implementation. Bedside shift report allows the oncoming nurse to get a full, proper report with patient involvement. There is clear communication between nurses and visual checks can occur to make sure all fall prevention measures are being taken.

There is literature that points to success in fall prevention related to safety huddles. In a research article by Morris and O'Riordan, 2017, daily safety huddles proved to show successful fall prevention. These brief, multidisciplinary meetings occur at the beginning of every shift and quickly address the specific needs of each patient on the unit. The previous shift's charge nurse usually leads the meeting. Fall risk patients can be mentioned and the current precautions taken so that everyone is aware. It allows accountability for everyone, not just the assigned bedside nurse. These safety huddles cultivate teamwork and responsibility to each other and the patients.

In a descriptive study conducted by Godlock, 2016, it was determined that the creation of a fall prevention patient safety team engaged frontline staff and decreased overall patient fall rate. This research article prompted the idea to create a code fall team as one of the components of a fall prevention program. Code fall teams will consist of a patient's primary nurse, charge nurses, unit technicians, physical therapy/occupational therapy personnel if applicable, and primary physician. When a patient falls, a 'code fall' announcement will be announced over the intercom system alerting people that immediate help is needed. With a fast response, the patient will have a better outcome. Most importantly, the fall team will be able to conduct a debriefing session to identify probable causes and areas of improvement that must occur.

3. Project Stakeholders

Identifying the correct stakeholders will ensure proper implementation, sustainment, and evaluation of the project. There are many stakeholders involved in this project. Simply put, every healthcare provider that is involved in patient care is a participant. This includes: bedside nurses, unit technicians/patient care assistants, physicians, clinical directors, house supervisors, chief nursing officers, physical and occupational therapists, lab technicians, food services, etc. Hospital administration may not always have direct contact with the patients. However, they are considered stakeholders because they are involved in policy making and ensuring policy adherence throughout the hospital. Food services and lab technicians may seem like an odd stakeholder, but their role in keeping patient's safe is important. Three times a day, if not more, food service employees bring food trays to patients. It is important that they place the tray so the patient can safely reach it. Lab technicians raise the bed up so they can safely and easily draw blood from the patient. It is a common occurrence for these employees to leave the bed raised, and patients can further injure themselves if they attempt to get out of bed. Bedside nurses and patient care assistants have the most contact with the patients, and they play a major role in fall prevention.

4. Proposed Outcomes

As a result of the implementation of a fall prevention program, which includes mandatory bedside shift report, safety huddles, and code fall teams, the patient population will experience a decrease in falls. This will collectively improve patient outcomes, safety, and satisfaction. In the study conducted by MacAllen, Stephens, Swanson-Biearman, Kerr, and Whiteman, 2018, patient satisfaction was measured by the Press Ganey survey, which had an increase from 87.7% to

91.6%. HCAHPS also showed significant improvement (MacAllen, Stephens, Swanson-Biearman, Kerr, and Whiteman, 2018). The hospital organization that implements this program will also improve financial stability, as they will continue to receive reimbursement from CMS. Any patient fall that is deemed preventable, will not receive reimbursement. This causes the hospital to eat the cost of the incidence. On average, a fall with injury costs a hospital $14,000 (Joint Commission, 2015).

5. Evaluation Design

In order to evaluate the interventions placed for fall prevention, a few steps must happen. First, when a fall occurs, on any unit, the charge nurse or unit director is responsible for completing a MIDAS (Medical Information Data Analysis System) report. The MIDAS incident reporting system allows hospital staff to submit anonymous incident reports of patient safety issues for analysis and improvement (MIDAS System Offers Anonymous Reporting to Improve Patient Safety, (n.d.). When a MIDAS report is submitted, a notification is sent to the associate chief nursing officer. The data sent to the ACNO, allows a tally to be made on the number of falls, which will be placed into an Excel spreadsheet. On the Excel spreadsheet, the individual units will be listed with the number of falls that occurred for each week, up to one month. Day and night shift will also be specified. Placing all the information into a spreadsheet document will allow an easy visual, as all data is one place. To evaluate the effectiveness of interventions, the evaluator will be able to see trends across units, and can determine if patient falls are decreasing as a result of the fall prevention program.

6. Timetable/Flowchart

The develop of the PICOT question was develop approximately one year ago, but the planning and implementation phases did not begin until January and February of 2020. Unfortunately, due to the COVID-19 crisis, the decision to switch to a benchmark study had to be made halfway through this semester. I am hopeful, that implementation and evaluation of results can occur beginning in August or September of 2020. This is obviously all dependent on the current pandemic. Once implementation of the fall prevention program begins, the implementation phase must last at least one month before evaluation of results can be conducted.

7. Data Collection Methods

As mentioned earlier, the associate chief nursing officer receives MIDAS reports on each patient fall that occurs throughout the hospital. During this project, successful collaboration has been achieved with this nurse leader, and an agreement has been put in place to meet weekly to collect the data. This will take place each Friday afternoon. The data collection process is quite simple: a simple tally is made on the number of MIDAS reports received. It is then investigated what unit the fall occurred on and on what shift. This data is then placed into an Excel spreadsheet. Each unit will receive a summary at the end of the implementation phase that will show results of the study. Any nurse educators will also have access to the results summary in order to identify specific units that need more education or follow-up.

8. Discussion of Evaluation

Due to the overwhelming changes brought about from the recent COVID-19 pandemic, there is not an official evaluation of this benchmark study. However, there is promising hope from the ACNO, nurse educators, and bedside nurses that in the future, this project can be successful. At the beginning of this semester the support was overwhelming and the teamwork of

all healthcare professionals was refreshing. In the future, hopefully this fall semester, the project will pick up where it was left off, and a proper evaluation can be conducted. Even though this project had to be switched to a benchmark study, the healthcare leaders of the organization were encouraged by the innovative ideas and assured that they would like to proceed with implementation once appropriate.

9. Costs/Benefits

The majority of cost will stem from training staff on the importance of the fall prevention program and the practical applications associated. There will be Healthstream online learning modules the staff will be required to watch. These modules will cost the organization approximately $8 per employee with a total cost average of $8000 (Healthstream, n.d.). Pamphlets, fall prevention binders, and flyers will be available throughout all units of the hospital. These office supplies will average $100. Lunch and Learns will be available for five different days for any staff that can attend. These lunch and learns will highlight all material that was presented in the online learning modules and will bring more practical applications for nurses and unit technicians. The average cost for food will total $1000 for all five days. The presenter will be a registered nurse whose hourly rate is $25. With each lunch and learn lasting one hour, the cost of the presenter will total $100. All of this put together will cost this project approximately $9100.

The benefit clearly outweighs the cost. With the average cost of a fall costing the organization at least $14,000, the financial contribution of $9100 will pay off quickly in the end (Joint Commission, 2015). With all employees receiving high quality education and learning, the patients will greatly benefit, and a reduction of falls will occur.

Conclusions/Recommendations

Patients want and need to feel safe in the hospital. Their expectations are to heal and be discharge in a better state than when they arrived. There is hope and promising research that the implementation of a fall prevention program will improve patient fall rate, which will ultimately protect their safety and outcomes. The fall prevention program includes bedside shift report, safety huddles, and code fall teams. The ultimate goal of this benchmark study was to improve patient safety and outcomes. The current fall prevention practices should continue to be used, and with the addition of the fall prevention program tactics, patients will continue to safely heal in the hospital (Hempel, et. al., n.d.).

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Appendix A

Evaluation Tool

Hospital Units:	Week 1 Number of Patient Falls		Week 2 Number of Patient Falls		Week 3 Number of Patient Falls		Week 4 Number of Patient Falls	
	Days	Nights	Days	Nights	Days	Nights	Days	Nights
6 Ornelas	1	0						
5 Ornelas	2	0						
4 Ornelas	0	0						
4 Dawson	0	1						
3 Dawson	0	0						
OCC	0	0						
LPOHH 4	0	1						
LPOHH 5	1	0						
LPOHH 6/IMC	0	0						
CVICU	0	0						
MICU/SICU	0	0						
PACU	0	0						
Weekly Total	6							