Fall Prevention Program

The Problem

Falls within our inpatient population had been monitored for many years with the overall average hovering at about 3.0 falls per 1000 patient days. In 2006 we joined NDNQI (National Database for Nursing Quality Improvement) which allowed us to benchmark unit by unit type (medical unit, medical-surgical unit). This exposed that we had some room to improve our prevention of falls.

Aim/Goal

Our goal is to be in the lowest quartile of falls in Academic Medical Centers across the nation.
The targets are:

- Medical Units: 2.62 falls per 1000 patient days
- Medical/Surgical Units: 2.15 falls per 1000 patient days

The Team

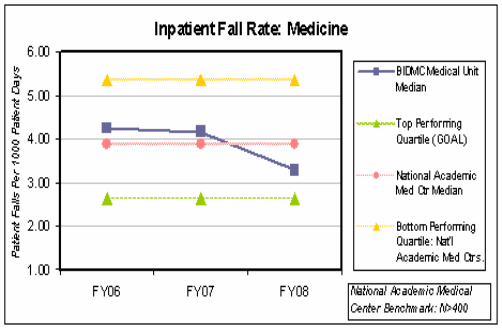
- Nursing Leadership
- Nursing Practice Council
- Healthcare Quality
- Inpatient Falls Prevention Committee
- Geriatric Resource Nurses on every unit
- Information Systems

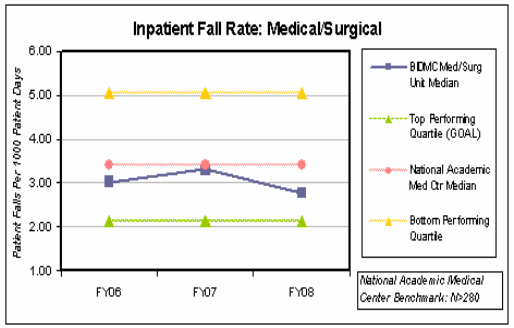
The Interventions

Implemented in 2007-08:

- Daily Morse Fall Risk Assessment implemented
- RN/PCT Hourly Rounding
- New high risk fall signage in patient's room and on the door frame
- Fall risk patients discussed at safety huddles
- Purchase of chair alarms for all units
- Immediate investigation of each fall by the Geriatric Clinical Specialist to reinforce policy and identify patterns
- Failure Modes and Effects Analysis and root cause investigation of falls occurrences by Nursing and Health Care Quality.
- Utilization of low beds
- Patient Education re: Fall Risk Precautions
- Education of all nursing staff to new practices

The Results/Progress to Date





Lessons Learned

Fall prevention requires extreme vigilance. It is not just elders who fall. The average age of a patient who fell during his/her stay in 2008 was 59. Interestingly, more male patients typically fall then our female population. During FY08, 58% of falls occurred by male patients.

Toileting is dangerous! On average, over 50% of our patient falls each month are associated with toileting. We need to carefully communicate to our patients that keeping them safe might mean staying with them in the bathroom – balancing safety with privacy. During toileting, it is important that staff remain with any patient at high risk for fall to help prevent such falls from occurring.

Concerns surrounding audibility and functionality of chair alarms (first implemented mid-2007) have led nursing to investigate other alternatives to the current product. Nursing has identified a wireless chair alarm system which may help address these issues and pilot testing is in process @ BIDMC to evaluate its effectiveness.

Next Steps/What Should Happen Next:

Falls prevention is an ongoing effort which is continually evaluated for further improvement opportunities. New for 2009 are several initiatives currently being piloted to evaluate effectiveness and feasibility:

- Falls Prevention Kits
- Development of falls algorithm to refine interventions based upon fall risk factors
- Investigation of alternative chair alarm options
- Improvement initiatives surrounding care/treatment of patients with delirium *

Beth Israel Deaconess Medical Center | A teaching hospital of Harvard Medical School | The Silverman Institute For Healthcare Quality and Safety

For More Information Contact
Kim Sulmonte, RN, PCS, ksulmonte@bidmc.harvard.edu
Chris Kristeller, RN, PCS, ckriste1@bidmc.harvard.edu
Deb Stepanian, HCQ, dstepani@bidmc.harvard.edu